

Chapter I | INTRODUCTION

Why Collaboration Matters and Why It Happens Too Rarely

In the mid-1980s several organizations involved in global health wrestled with how to get a stalled immunization effort back on track. They formed the Task Force for Child Survival, a partnership that quickly reinvigorated the effort and allowed the organizations to reach the goal.¹ The partnership had another impact: it provided a stunning example of what partnerships could achieve through real collaboration. Briefly, this is how the story of the Task Force unfolded.

In 1974 member states of the World Health Organization (WHO) had passed a resolution to bring vaccines to children across the globe. At the Alma Ata Conference in 1978 they had set a concrete goal of immunizing 80 percent of the world's children against common childhood diseases by 1990. But by 1984, after climbing from 5 percent to 20 percent, immunization coverage had leveled off.

To break the impasse, these organizations decided to form a task force composed of senior leaders from WHO, the United Nations Development Program (UNDP), the World Bank, UNICEF, and the Rockefeller Foundation. They formed a secretariat, the Task Force for Child Survival, and charged it with helping the partnership rejuvenate immunization efforts and overcome the competitive and divisive forces that had slowed down the previous effort. The Task Force did more than coordinate efforts of the

respective organizations. The individuals in the partnership were able to look beyond the separate interests of their own organizations and problem-solve together. They became a team. Under their guidance the Task Force secretariat created a unified plan of action, addressed political roadblocks to pave the way for in-country efforts, solved technical problems as they arose, and kept the commitment and momentum alive.

By 1990 this partnership had raised immunization rates from 20 percent to 80 percent. James Grant, director of UNICEF at the time, called the initiative the “largest peacetime mobilization in the history of the earth.”²

This collaboration would become a touchstone in global health.

Because of efforts like this, the closing decade of the twentieth century saw a rapid rise in partnerships responding to emerging health threats. From 1995 to 2000, for example, key partnerships (including “alliances” and “coalitions”) emerged in the following five disease and threat areas:

- *Onchocerciasis (1995)*. The African Program for Onchocerciasis Control (APOC) launched an effort to help local communities in nineteen African countries organize and manage treatment for river blindness with the drug Mectizan. APOC was formed by the World Bank, WHO, UNDP, the Food and Agriculture Organization of the United Nations (FAO), the governments of nineteen developing countries and twenty-seven donor countries, twenty nongovernmental organizations (NGOs), and the global pharmaceutical Merck.
- *HIV/AIDS (1996)*. Seven UN agencies established the joint United Nations program called UNAIDS.
- *Tuberculosis (1998)*. Attendees at the World Conference on Lung Health launched the STOP-TB initiative.
- *Malaria (1998)*. WHO, UNICEF, UNDP, the World Bank, and other partners founded the Roll Back Malaria Partnership (RBM), with the goal of cutting the incidence of malaria in half by 2010.
- *Vaccine preventable diseases (1999)*. A combination of governments, foundations, development agencies, and NGOs formed the Global Alliance for Vaccines and Immunization (GAVI).

Partnerships had become the preferred approach to global health.

As the coordination costs of global partnerships became clearer, however, participants and donors had second thoughts. Participants themselves became more conscious of the huge time requirement for traveling to global meetings and the slow pace of building trust across organizations, time zones, and cultures. Donors began looking at the return they were getting on their investment of time, effort, and money, to see if partnerships really paid off.

KEY DONOR REPORTS: DO PARTNERSHIPS PAY OFF?

The attempt to measure impact was complicated. While businesses typically measure cost-effectiveness, public health had traditionally measured input or output—the level of demand for services or the number of people treated, for example. Russell Linden, a writer and lecturer on management, recalls: “When I directed a nonprofit organization that served handicapped people and their families back in the 1970s, I simply had to show an increasing demand for my nonprofit’s programs in order to justify a budget increase from its funding agencies.”³

By the 1990s, however, that approach to measurement was no longer considered satisfactory, and funders began to look for better ways to measure results (reduction in the number of people affected by a disease, for instance) and, ultimately, cost-effectiveness. Measuring such impacts was challenging, since global health projects typically lacked the accountability, tracking systems, and financial controls common in business. Nevertheless, two donors analyzed the results of projects they had funded, and produced reports: The Bill & Melinda Gates Foundation (the Gates Foundation) and the British government’s Department for International Development (DFID).

The Gates report, developed by a team from the management consulting firm McKinsey & Company and released in April 2002, recognized the dominant role partnerships had come to play in global health: “Simply put, there are few global public health challenges where any single player has the funding, research, and delivery capabilities required to solve the problem on a worldwide scale. . . . As one measure of their importance, alliances represent nearly 80 percent of the value of global health investments made by the Bill & Melinda Gates Foundation.”⁴ The McKinsey team found that “more than 80 percent of public health alliances appear to be working.”⁵ By

“working,” they meant the alliance had accelerated, improved, or reduced the cost of an initiative, compared with what agencies could have done on their own. But using a higher standard for realizing their potential, the Gates report concluded that those alliances had not performed as well: “For example, some alliances spend the first six to eighteen months doing little more than developing operating plans rather than attacking the disease burden. And other alliances, even after being launched, are hamstrung by limited resources or difficulties in arriving at decisions among the various partner organizations.”⁶ Partnerships, in other words, were worthwhile, but many were underperforming.

DFID reached a similar conclusion in its report, released in 2004. It looked at the global health partnerships (GHPs) it had been involved in and concluded that “individual GHPs are seen overall as having a positive impact in terms both of achieving their own objectives and of being welcomed by countries studied. . . . The general theme of findings from most evaluations is one of GHP success, but with clear scope for yet further achievement if challenges are resolved.”⁷ The return-on-investment answer was a qualified yes. Even in the polite language of the reports, it was clear many of these partnerships fell far short of their potential. An improvement opportunity undoubtedly existed.

LINK BETWEEN SUCCESS AND CLOSE COLLABORATION

How could partnerships perform better? As these reports were being released, we had already begun to explore the issue of how to improve ,

“How is it possible that in the year 2006 we can be losing so many young women unnecessarily? We have the drugs to keep them alive. How is this possible? And you know that it’s happening because of the failure, the failure of the world at the level of the country, to join together and respond to the pandemic, to defeat it, to collaborate with each other in the service of keeping these women alive so that the orphans aren’t left behind, so these young women have a life to lead, and it’s not snuffed out in agony.”

STEPHEN LEWIS, United Nations special envoy for HIV/AIDS in Africa, upon returning from a women’s HIV/AIDS ward in Mozambique, October 19, 2006, interview

Degree of partnership integration

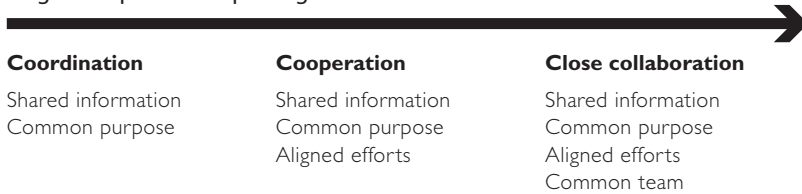


FIGURE 1.1 The spectrum of collaboration. Partnerships exist along a spectrum from coordination, to cooperation, to close collaboration.

collaboration in global health. To begin with, we found that no definition of collaboration was widely accepted. Global health leaders (from all sectors) use the word “collaboration” broadly. As Linden points out, “To some, it suggests polite cooperation. To others, it includes everything from shared data to joint operations.”⁸ We realized that collaborative partnerships existed along a spectrum, from having a common purpose but *operating independently* (perhaps with one organization coordinating activities) to aligning efforts and *acting cooperatively* to actually *forming an integrated team*, where members work together toward a single shared goal. The words “coordination,” “cooperation,” and “close collaboration” are sometimes used to make distinctions along that spectrum and suggest a useful framework.

Using this spectrum (Figure 1.1 and Table 1.1), we looked for examples of each type of collaboration in global health, and we began to understand some distinctions. The left side—coordinating in some way but continuing to operate independently—seems to be the most feasible way to respond to such large disasters as the tsunami that struck Indonesia in 2004 and Hurricane Katrina, which ravaged the Gulf Coast of the United States in 2005. For the tsunami UN officials played a major role in coordinating efforts. These efforts were run in parallel, without much sharing of information about survivors’ needs and capabilities. A report from the Federation of the Red Cross and Red Crescent Societies indicates that fewer than a quarter of the two hundred agencies present in Aceh a month after the tsunami had provided UN coordinators with activity reports.⁹ While more extensive sharing of information would undoubtedly have

TABLE 1.1 Coordination, cooperation, collaboration

<i>Coordination is appropriate when</i>	<i>Cooperation is appropriate when</i>	<i>Close collaboration is appropriate when</i>
<p>A recognized authority is available to coordinate efforts</p> <p>Implementation is limited to a single country or region</p> <p>An immediate and efficient response is required (as with disasters)</p>	<p>The sharing of information will allow participants to accomplish a goal they cannot reach through parallel efforts</p>	<p>The timeframe is measured in years, not months</p> <p>The goal is so ambitious, it cannot be met through coordination or cooperation</p> <p>The nature of disease/threat presents formidable social and political challenges</p> <p>A core team of willing members emerges, willing to invest time and expertise</p>

been helpful, organizations will always be driven to save lives first in times of disaster.

The middle of the spectrum—acting cooperatively—allows a more coordinated and targeted response. Clinton Foundation efforts to support developing nations are a good example. After conducting focus groups in Africa to determine the key development issue, the foundation heard a clear answer: AIDS! With treatment then averaging US\$320 per case each year, the cost of drugs was a major problem, and analysis showed that unpredictable demand kept prices high. The foundation pooled demand from twelve countries, ensuring predictability of demand so that drug companies could manage production and lower costs. Interestingly, no drugs were ordered through the foundation: orders and shipments went directly between countries and drug companies. The Clinton Foundation simply helped these countries cooperate to effectively share information as a way to lower costs.

The right side of the spectrum—forming an integrated team—is appropriate, we realized, in highly challenging, long-term projects like the childhood immunization project of the 1980s. Because the Task Force for Child Survival became an integrated team, they were able to debate challenges and come up with practical solutions. This close form of collaboration, referred to in the title of this book as “real collaboration,” is not and should not be the norm for global health partnerships, because it requires the greatest resources. It is also, however, absolutely necessary to accomplish certain goals and is the most powerful form of collaboration.

Rob Lehman, who heads the Fetzer Institute, describes the nature of close collaboration. “Collaboration, on the surface, is about bringing together resources, both financial and intellectual, to work toward a common purpose. But true collaboration has an ‘inside,’ a deeper more radical meaning.” He continues: “The inner life of collaboration is about states of mind and spirit that are open—open to self-examination, open to growth, open to trust, and open to mutual action. . . . The practices of true collaboration are those practices of awareness, listening, and speaking that bring us into openness and receptivity.”¹⁰ After interviewing dozens of global health leaders throughout the course of our research, we are convinced this willingness of partners to set aside business-as-usual and consider new possibilities together is what sets apart the most successful collaborations.

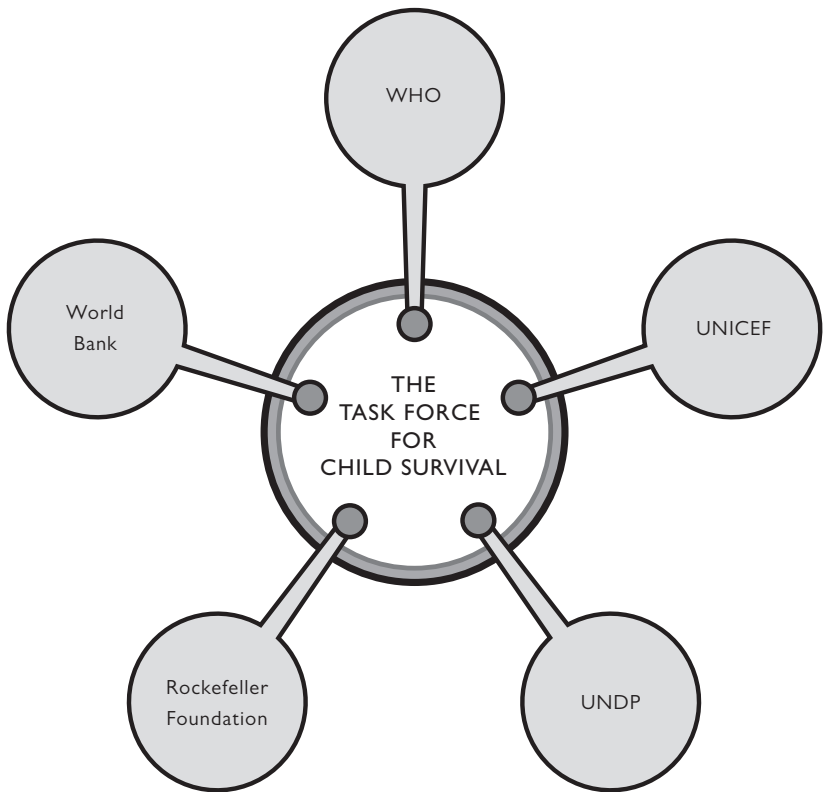


FIGURE 1.2 The Task Force for Child Survival. Close collaboration takes place between individuals, not between the organizations they represent.

As with the Task Force for Child Survival, close collaboration has to take place between the individuals in the partnership, not between the organizations they represent. Open, productive debates and problem solving can only occur among a core team of individuals who bring the passion, willingness to understand other points of view, creativity, and sheer force of will to make the effort work. In Figure 1.2 these individuals are indicated inside the center circle. This realization helped us define what our book would not be about (Table 1.2). After considering the spectrum of collaboration, we realized we had found an area of focus for our research: partnerships pursuing a single, shared goal performed better when they became an integrated

TABLE 1.2 This book is not

A survey of all global health partnerships

An exploration of partnerships that

- lack a core team of individuals working together over time
- involve constantly rotating representatives of member agencies
- rely on presentations as the primary form of communication
- are semipermanent, comprised of individuals whose primary identification is with the partnership itself

An academic review with extensive technical references, facts, and footnotes

team—the end of the spectrum called “close collaboration.” That was where we wanted to concentrate our research efforts.

RESEARCH ON CLOSE COLLABORATION

Unfortunately, that kind of collaboration does not happen often. Leaders in the field of global health often talk about “collaboration” as if it were an ordinary and expected quality of partnerships. And it is, if you consider the spectrum of definitions. However, our experiences at the Task Force for Global Health (the Task Force) have taught us that, despite excellent role models and our predisposition to work collaboratively, our own teams and our colleagues’ teams often lack the insights and skills to achieve real collaboration. At the Task Force, for example, we had ample opportunity to work collaboratively. Tackling global issues like tuberculosis, river blindness, and the rising toll of road-traffic injuries in developing countries meant we had the chance to work with partners across the world, including governments, UN agencies, and NGOs. But these partnerships often failed to deliver the full impact we had anticipated. Why was that? And what could we do about it?

In 2004, with grants from the Gates Foundation, the Rockefeller Foundation, and the Centers for Disease Control, we launched a research effort to explore the question, How can global health leaders achieve close collaboration and have a bigger impact? When our planning was complete, we had decided to conduct more than a hundred interviews, hold dozens of face-to-face meetings with thought leaders in the fields of collaboration and

global health, form an advisory group to provide early guidance, and convene a symposium to communicate and explore our emerging conclusions. We would look for specific examples of partnerships that either achieved close collaboration or learned valuable lessons through their successes and failures. And we would consider each partnership in the broad context of other efforts to address the disease/threat, outlining the history of those efforts.

The most important part of our research turned out to be the interviews. People from global health, organizational development, education, business, and government were candid and engaging, working with us to make sense of the contradictions and challenges inherent in every global health project. They also told us the stories that anchored our research in the realities of day-to-day work in a partnership.

Based on their input, we came up with a list of partnerships that demonstrated the elements needed for close collaboration (Table 1.3). Bill Foege, former director of the CDC and a leader in numerous global health partnerships, provided a great deal of guidance in making these selections, encouraging us to include such partnerships as the bottom three in the table, which are focused on political outcomes and are inherently more difficult to measure. We did not select the partnerships based on their success or because they represented the full range of global health issues. Rather, we chose them because they were rich in lessons to apply to other partnerships and because the partners were willing to look back on their efforts to reflect on their strengths and weaknesses. We have supplemented this list with lessons from efforts to address other diseases, such as HIV/AIDS, malaria, and guinea worm.

These were not broad efforts to attack a disease/threat, and they were not permanent organizations. They were temporary partnerships of people whose primary identifications were with their own organizations.¹¹ While each of these partnerships had their imperfections, the stories are about real collaboration—those *rare* times when people from different organizations come together with passion and purpose and accomplish dramatically more than any agency or person could do alone. After almost two years of research, we convened an advisory group in November 2005 to help us calibrate what we had learned. With their input over the next year we refined the framework for organizing the lessons learned and began drafting this book.

TABLE 1.3 Example cases

<i>Disease/tbreat</i>	<i>Partnership</i>	<i>Type</i>	<i>Impact</i>
Smallpox	Partnership to eliminate smallpox in India (1973–1975)	Intervention	Eradicated smallpox in India
Childhood immunization	Task Force for Child Survival (1984–1990)	Intervention	Achieved goal of immunizing 80 percent of the world's children
Polio	Polio partnership of the Americas (1985–1991)	Intervention	Eradicated polio in the Americas
River blindness (onchocerciasis)	African Programme for Onchocerciasis Control (since 1995)	Intervention	By 2006, 117,000 communities were conducting their own treatment programs for more than 46 million people.
Tobacco	Policy Advisory Committee of the Tobacco Free Initiative (1999–2003)	Advocacy to generate political will	Led to adoption by the WHA of a Framework Convention that focused on advertising, air quality controls, and smuggling
Road-traffic injuries	Global Road Safety Steering Committee (2002–2004)	Advocacy to generate political will	Resulted in a UN General Assembly meeting and resolution calling for international cooperation to deal with road safety in developing countries
TB	PARTNERS TB Control Program (2000–2006)	Pilot program to prove feasibility of integrating TB and MDR-TB treatment	Demonstrated feasibility of treating MDR-TB and led to a declaration by WHO that MDR-TB should be treated wherever it occurs

In October 2006 more than a hundred leaders from the public, private, and social sectors joined us for a symposium at the Carter Center, called “Coalitions and Collaboration in Global Health.” Former president Jimmy Carter challenged us to generate concrete proposals for improving collaboration; Bill Foege called for a passionate commitment to making real collaboration a priority; and leaders from every sector spoke honestly about the shortfalls of projects, suggesting ideas for better collaboration.

Susan Holck, director of general management with WHO, was one of those leaders. We had invited Holck to participate in a panel, drawing on her experience in the development of UNAIDS. She told us this story:

Before coming to the symposium a colleague had asked her, referring to the early days of UNAIDS, “Are you going to tell the truth?” Her response: “Of course, there’s no reason not to tell the story now, ten years later.”

According to Holck, the early problem of UNAIDS “was a failure of the global health community to recognize the extent of the problem and really work together to do something about it. . . . There were conflicting goals among the specific organizations involved, WHO, UNICEF, World Bank, and UNDP in particular. . . . Conflicting goals of the individuals involved . . . and the fear of loss of power. I think that played an enormous role, that the individuals who were in a position of power in the early days of AIDS, before UNAIDS was born, feared loss of power. . . . The donors effectively forced this collaboration on the UN institutions . . . to set an example in UN reform. Almost no one, in setting up UNAIDS, really had AIDS in mind as the goal for what we were doing.”

She added, “Over the years [UNAIDS] did manage to create a central focus. . . . It forced the players to work together.”¹²

In honest appraisals like this one, global health leaders shared with us the missteps as well as the successes in their own efforts. In this book we present the assessments in their own voices.

CONCLUSIONS

Repeatedly, during our interviews, we heard the lesson that success in reaching a shared goal comes through close collaboration. Partnerships have the best chance for achieving that when they lay the foundations for collabora-

tion in the First Mile and carry a spirit of shared responsibility along the Journey. Three conclusions support this theme:

1. *Real collaboration is highly challenging because of the complex forces at play in global health efforts.* One of the greatest challenges outside the partnership is the landscape of global health today, a changing web of relationships and expectations. The nature of the disease or threat also presents its own special problems, including social stigmas or political sensitivities. And the cultural and social dynamics within a partnership are particularly challenging in global health, where the diversity of cultures is very broad.
2. *At each stage of a partnership's pathway—the First Mile, the Journey, and the Last Mile—partners need to focus on key tasks and shared responsibilities.* For example, the seeds of success or failure are sown in the early stage of a partnership—that awkward period when disparate organizations come together to start a common effort. Many partnerships begin with a lengthy legal process of chartering (defining roles and processes). These are important activities, but focusing primarily on these processes can make teams miss some of the essential work that needs to be done. The attention in the First Mile should be on gathering the right members, developing a goal that is really shared, and agreeing on the basics of strategy, structure, and roles. By discussing these subjects in a thoughtful, open, and respectful atmosphere, partners can begin to establish the social capital and trust that will carry them through the Journey.
3. *Donors can play an important role by encouraging collaborative practices.* For instance, while the Gates report cited excessive planning by some coalitions, the opposite is just as worrisome. The lack of funding and other assistance to allow for appropriate discussions, relationship building, and planning in the First Mile actually undermines collaboration because projects march on while participants have varying interpretations of what they should be doing. By changing grant requirements to support good collaborative practices (including but not limited to planning), donors can leverage the contribution they make to global health.

The book is divided into two sections that expand on these conclusions: Part 1, challenges affecting collaboration, and Part 2, insights from successful and unsuccessful partnerships. Each chapter draws from the rich stories of those who have provided leadership in global health initiatives. By tapping these findings from people across all sectors, leaders in global health can generate new energy and impetus in global health efforts. If even half of the partnerships appropriate for close collaboration could actually achieve it, the collective impact would mean a sea change in health across the globe. In the remaining partnerships, where close collaboration is inappropriate or the barriers are too high, partners can still find ideas to improve the impact and satisfaction of their work. This book offers the lessons we have learned in the hope these things might happen.

NOTES

1. Although the authors of this book are proud to be associated by name with that partnership, we should clarify that we were not associated with the Task Force for Child Survival in its formative years. We should also note that its successor, the Task Force for Child Survival and Development, has recently changed its name to the Task Force for Global Health.
2. Jim Yong Kim, "William H. Foegen—Physician: A Lifelong Battle against Disease," *US News and World Report*, posted November 12, 2007, available online at <http://www.usnews.com/articles/news/best-leaders/2007/11/12/william-h-foege.html>.
3. Linden, *Working Across Boundaries*, 16.
4. Bill & Melinda Gates Foundation, *Developing Successful Global Health Alliances*, 1.
5. *Ibid.*, 1.
6. *Ibid.*, 2.
7. Caines, *Assessing the Impact of Global Health Partnerships*, 4.
8. Linden, *Working Across Boundaries*, 6.
9. International Federation of Red Cross and Red Crescent Societies, *World Disasters Report 2005*, Chapter 1.
10. Lehman as quoted in Olson and Harris, "Defining Common Work," 6.
11. In chapter 3 we look at broader efforts to lay a context for individual partnerships.
12. Holck's presentation at Coalitions and Collaboration in Global Health: A Symposium for Global Health Leaders, October 19, 2006.