A Partnership Model for Public Health

Five Variables for Productive Collaboration

Child Survival Collaborations and Resources Group

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Acknowledgements

About The CORE Group

The CORE Group, established in 1997, is composed of 35 US-based NGOs that implement child survival and child health programs throughout the developing world. The CORE Group strengthens local capacity on a global scale to measurably improve the health and well-being of children and women in developing countries through collaborative NGO action and learning. CORE Group members serve a combined total of 250 million women and children in over 140 countries.

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CORE Group Members

Adventist Development & Relief Agency

African Medical and Research Foundation

Africare

Aga Khan Foundation, USA

American Red Cross

CARE International

Catholic Relief Services

Christian Children's Fund

Concern Worldwide USA

Counterpart International, Inc.

Curamericas

Doctors of the World

Food for the Hungry International

Foundation of Compassionate American Samaritans

Freedom from Hunger

Health Alliance International

Hellen Keller International

Hesperian Foundation

International Eye Foundation

International Rescue Committee

La Leche League International

Medical Care Development, Inc.

Mercy Corps International

Minnesota International Health Volunteers

Partners for Development

Program for Appropriate Technology in Health

Pearl S. Buck International

PLAN International USA

Population Services International

Project Concern International

Project HOPE

Salvation Army World Service Office

Save the Children

World Relief Corporation

World Vision

Contents

Acronyms

CBO	community-based organization
CGPP	Core Group Polio Partners
CORE	Child Survival Collaborations and Resources Group
IAF	Inter-American Foundation
IMCI	Integrated Management of Childhood Illness
LQAS	lot quality assurance sampling
MCH	maternal and child health
MDG	Millennium Development Goal
NGO	nongovernmental organization
OECD	Organisation for Economic Cooperation and Development
PAHO	Pan American Health Organization
PD	positive deviance
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

Summary

This paper presents a framework for assessing strategic partnering as a way to reach populations that have been traditionally bypassed by maternal and child health (MCH) interventions. The framework is applied to the Child Survival Collaborations and Resources (CORE) Group, a network of 35 U.S.-based nongovernmental organizations (NGOs) engaged in MCH activities. Concrete examples are given of how this partnership contributes to improved outcomes for mothers and children; enhanced policy dialogue; expanded local and national capacity; and the generation of new resources. The paper concludes with the identification of relevant lessons for MCH donors and NGOs that might wish to enter into similar partnership arrangements.

Introduction

Telecommunications professionals in the North know that their technology's full potential cannot be realized until the "last mile barrier" is crossed. What is this elusive barrier and why is it so hard to traverse?

The answer lies in the bottleneck found on that "last mile" of old copper phone lines that link individuals to ultra-modern fiber-optic networks. Such networks, capable of linking far-flung locales, are relatively cheap and simple to build in relation to the coverage they provide. In contrast, forging that critical connection between an actual end-user and the nearest switch—usually not more than a mile away—is far more complex. Solutions for covering this final bit of terrain typically involve significant trade-offs between cost and service quality (e.g., bandwidth).

MATERNAL AND CHILD HEALTH PRACTITIONERS WORKING IN DEVELOPING COUNTRIES TODAY CONFRONT THEIR OWN VERSION OF THE "LAST MILE BARRIER."

Maternal and child health (MCH) practitioners working in developing countries today confront their own version of this "last mile barrier." Campaigns to immunize children against major vaccine-preventable diseases are, illustratively, analogous to fiber-optic networks. Such campaigns link a network (the Health Ministry's infrastructure) to switching stations (clinics or health posts) in order to extend the network's coverage. Establishing these requisite linkages is often quite demanding. However, a far more daunting challenge lies in forging the necessary connections between the clinic/switching station and those end-user households that lie beyond the invisible boundary that separates "periphery" from "hinterland."

There are two other striking parallels between the "last mile barrier" issues of MCH and telecommunications specialists. In both worlds, the extension of service coverage to "elusive" populations entails a compromise between affordability and "bandwidth" (the potency of an intervention package). As well, professionals in both arenas pursue strategies that combine "hard" and "soft" sciences to achieve the holy grail of universal coverage. The "soft" sciences include systematic and empirical thinking about such issues as social policy and investment priorities, organizational capacity development, grassroots coalition formation, and interpersonal communication.

This paper describes in detail one approach, *strategic partnering*, that can be used to respond to the MCH "last mile" challenge. A framework for effective networking in the public health field is offered and then illustrated in the context of a case study that details the work of the Child Survival Collaboration and Resources (CORE) Group. The paper concludes with recommendations to public health practitioners interested in launching or refining field-based inter-institutional partnering activities. We believe the partnering model offered here has widespread applicability for public and private sector organizations working in developing countries to improve public health.

Methods

This study builds on three separate field-based investigations conducted by the authors on the impact of strategic partnering for the rural poor in developing countries. Effects considered largely relate to service coverage and the expansion of favorable outcomes for vulnerable populations. These studies were undertaken over a period of three years, and each, in turn, will be briefly described.

The first, conducted for the Inter-American Foundation (IAF), examined the experiences of 12 unrelated grassroots development-oriented partnerships among non-governmental organizations (NGOs), local governments and, in some cases, private sector businesses (Levinger and McLeod 2002). Fieldwork was conducted in five Latin American countries. That study yielded robust insights on the stages and types of partnerships as well as the benefits and burdens associated with these relationships. These insights were used to create the framework reported in this paper.

Fieldwork conducted in five Latin American countries yielded robust insights on the stages and types of partnerships as well as the benefits and burdens associated with these relationships.

A second investigation, conducted for the United States Agency for International Development (USAID), detailed the partnering practices and benefits of Katalysis, a Central American microfinance institutions affiliated with a single network (Levinger and McLeod 2001). Fieldwork was carried out in three countries. Both the IAF and USAID studies included interviews with representatives of partner institutions and members of their beneficiary populations. The methods developed for the USAID study (including thematic analysis of partner documentation, participant observation at formal and informal network events, and open-ended interviewing) were used in the current inquiry.

The third piece of research, carried out for the World Bank in 2003, focused on partnerships between businesses and the Ministry of Education in El Salvador (Tsukamoto et al. 2003). The aim of these collaborative efforts was to improve education quality and coverage at the primary and secondary levels. Unlike the earlier two studies, this work was chiefly concerned with the policy-related implications of partnering rather than questions of service delivery and extension of benefits to under- or unserved populations. The World Bank work enabled the research team to develop methods for relating partnering behaviors to policies governing coverage and service quality in relation to a single sector (education).

The present study involved testing conclusions drawn from the earlier research in the context of a new sector (public health) and a broader range of geographic regions (Asia and Africa as well as Latin America). To do this, we applied the approach followed in the USAID study (i.e., examining a single, multi-country network) and selected the CORE Group as the focus of this study.

Research techniques included interviews with CORE partners; the use of participant-observer methods at two of CORE's annual meetings; a comprehensive review of program documents provided by CORE partners (including project proposals, evaluations, and "lessons learned" compilations); as well as interviews with leading edge public health practitioners familiar with the field-based work of CORE members.

Discussion: A Framework to Analyze Networking and Partnering Behaviors

Context

Significant progress has been achieved in meeting MCH goals in many developing countries. Illustratively, childhood immunizations against the major vaccine-preventable diseases increased from less than 10 percent in the 1970s to nearly 75 percent in 2001 (UNICEF 2004).

Reported cases of polio fell by 99 percent during the 1990s, and deaths caused by diarrheal disease fell by half. With regard to under-five child mortality, 63 countries achieved a one-third reduction in this decade, while another 100 countries achieved a one-fifth reduction in this same measure (UNICEF 2002).

SIGNIFICANT PROGRESS HAS BEEN ACHIEVED IN MEETING MATERNAL AND CHILD HEALTH GOALS IN MANY DEVELOPING COUNTRIES. FOR EXAMPLE, CHILDHOOD IMMUNIZATIONS AGAINST THE MAJOR VACCINE-PREVENTABLE DISEASES INCREASED FROM LESS THAN 10 PERCENT IN THE 1970S TO NEARLY 75 PERCENT IN 2001.

The Millennium Development Goals (MDGs), endorsed by the United Nations, call for a reduction in maternal mortality by three-quarters in 2015. To achieve this target, a great deal of attention must be paid to sub-Saharan Africa where half the developing world's maternal deaths occur—most in rural, outlying areas. Current data for that region suggest that one of every 100 live births culminates in the mother's death, and pregnant women are 100 times more likely to die in pregnancy and childbirth there than their counterparts in high-income Organisation for Economic Cooperation and Development (OECD) countries, (United Nations Development Programme 2003).

Another MDG proposes a two-thirds reduction in child mortality. Most attention will be focused on two priority areas, sub-Saharan Africa and South Asia. During the past decade, South Asia made substantial gains, although sub-Saharan Africa appears to have fallen further behind. Its current under-five mortality rate is 170/1000.

Many MCH problems affect disproportionate numbers of the rural poor. Illustratively, less than half of rural children in the developing world receive care for acute respiratory infection, a major cause of infant and child mortality. In general, rural health systems do not have adequate staff or resources to meet the health needs of women and children. (United Nations Development Programme 2003). A recent developing country survey revealed that the poorest 20 percent of the population *always* received less than 20 percent of the benefits associated with investments in public health. In countries with high infant mortality rates, the bottom 20 percent account for less than 10 percent of hospital use (United Nations Development Programme 2003).

To meet the MDGs associated with MCH, three things must occur: (1) new approaches to reaching traditionally bypassed and under-served populations must be developed, tested, validated, and disseminated; (2) new institutional arrangements must be created and tested to expand access to MCH services, particularly in rural areas; and (3) a supportive policy environment must be created. Strategic partnering, if done well, has the potential to make contributions to all three of these areas.

MANY MATERNAL AND CHILD HEALTH PROBLEMS AFFECT DISPROPORTIONATE NUMBERS OF THE RURAL POOR. LESS THAN HALF OF RURAL CHILDREN IN THE DEVELOPING WORLD RECEIVE CARE FOR ACUTE RESPIRATORY INFECTION, A MAJOR CAUSE OF INFANT AND CHILD MORTALITY.

The Framework

In earlier studies, the authors identified five sets of variables that proved useful in analyzing partnership behaviors and predicting partnership efficacy in expanding the quantity and quality of services avail-

able to traditionally bypassed groups. Each variable set will be described briefly and then applied to the CORE case.

The first variable set, *activity domains*, focuses on the actual work of the partnership. The authors' earlier field-based research identified five areas for possible collaborative endeavors among partnering institutions:

- *Program Delivery*: The direct provision to beneficiaries of services linked to such fundamental human needs as primary health care, livelihood support (including credit), and basic education.
- *Human Resource Development*: These activities are designed to help individuals develop a deeper awareness of community assets as well as the skills and self-confidence needed to harness these assets in pursuit of shared development goals. Empowerment is usually an explicit goal of work in this activity domain.
- *Resource Mobilization*: This is the process of securing the financial and technical support required to carry out activities in any of the other domains.
- *Research and Innovation*: These are activities that help local people and development practitioners who work alongside them to test or assess new ways of responding to priority needs and problems. Work in this area is designed to yield development breakthroughs.
- *Public Information, Education, and Advocacy*: These activities generally build upon research and field-based program delivery experience. Often, there is a policy-oriented element to advocacy. Mobilizing public awareness, campaigning on behalf of policy reform, and advocating structural changes in institutions that impact on the lives of the poor are important components of this activity domain.

The second variable set, *process factors*, describe the way partners relate to one another. In earlier research, three process variables were deemed particularly important: commonality of goals (but not necessarily methods), complementarity of experiences and resources, and trust. One of the most surprising findings from the authors' initial field research was that *most successful partnerships do not have formal hierarchical structures*, nor are they generally bound by legal contracts (except in those instances where funds were to be jointly managed). Instead, the high-functioning partnerships studied were built on strong trust that ensured accountability among participants. The openness of such arrangements enabled individual partners to flexibly draw on the complementary skills present in the partnership, allowing each entity to make significant contributions to the common goal—even when circumstances changed and new needs arose. Process factors represent the minimum "relationship criteria" that must be met for entities to form high performance partnerships.

Value-adding mechanisms comprise the third variable set. These mechanisms can be used to explain why partnerships, at their best, can accomplish more than any individual actor in meeting the needs of bypassed populations. Each of these variables is briefly set out below.

ONE OF THE MOST SURPRISING FINDINGS FROM INITIAL FIELD RESEARCH WAS THAT MOST SUCCESSFUL PARTNERSHIPS *DO NOT* HAVE FORMAL HIERARCHICAL STRUCTURES. INSTEAD, RESEARCHERS FOUND THAT HIGH-FUNCTIONING PARTNERSHIPS WERE BUILT ON STRONG TRUST THAT ENSURED ACCOUNTABILITY.

- *Continuity*: Whenever partners create new opportunities for the poor to *maintain or expand upon* skills and competencies acquired through earlier development initiatives, continuity is achieved. Continuity entails planned efforts by partners to consolidate development gains. Thus, for example, a community that has engaged in participatory planning and needs assessment around one set of issues deepens those capacities when it has the opportunity to assess and plan in the context of new challenges.
- *Comprehensiveness:* The more comprehensive an intervention package, the greater the number of causal factors it addresses.
- *Coordination*: Awareness of, and collaboration with, other development actors in the community

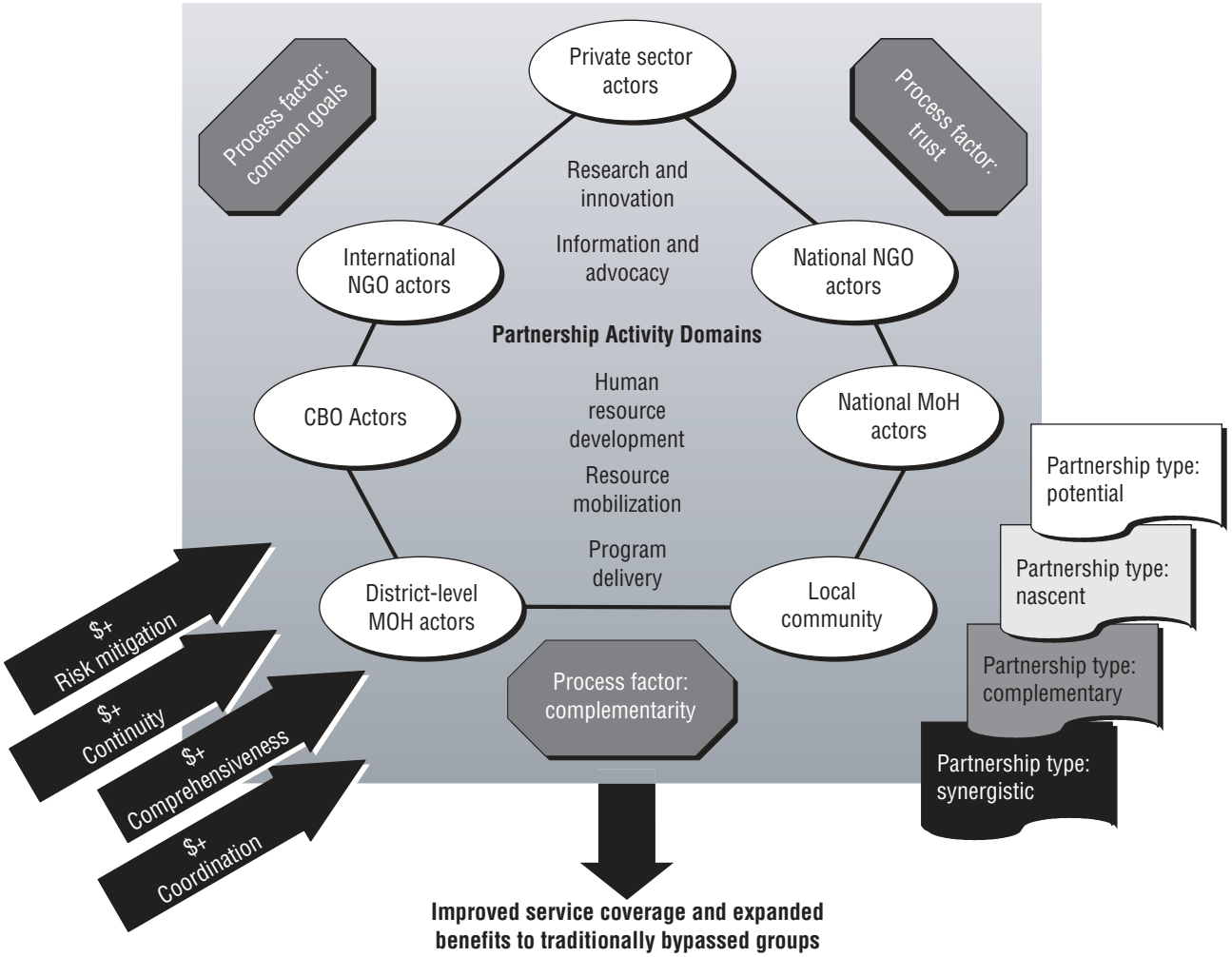
allows partners to achieve better coverage, develop more cost-effective programs, create economies of scale and build social capital that can be applied to future development challenges.

- *Risk mitigation*: All development projects face threats to success. Partnerships mitigate (i.e., *reduce* or *hedge*) these risks, because such arrangements lead to diversification of the actors' skill sets, contacts, spheres of influence, and prior experience. Thus, actors become better able to respond to both internal weaknesses and those related to design or management, as well as external threats. The greater the diversity among partners, the higher the risk mitigation potential of the partnership.

The fourth variable set is *partnership type*. In earlier studies the authors observed several different phases of partnership development. It is important to note that these phases need not occur in the sequence presented below, and that it is not necessary for all partnerships to pass through each of the following phases. Furthermore, a given partnership may fluctuate between two phases (e.g., complementary and synergistic partnership) as needs and resources change or as evaluation activities give rise to program modification.

- *Potential partnership*: Actors are aware of each other but are not yet working closely together.
- *Nascent partnership*: Actors are partnering but the partnership's efficiency is not maximized.

Figure 1: Public Health Partnership Analysis Framework Variables



- *Complementary partnership*: Partners derive benefits and increased impact through greater attention to a *fixed and relatively limited* set of activity domains, generally program delivery and resource mobilization.
- *Synergistic partnership*: Partners derive benefits and increased impact by addressing complex, systemic development problems through the *addition of new activity domains* (e.g., advocacy and research).

AWARENESS OF, AND COLLABORATION WITH, OTHER DEVELOPMENT ACTORS IN THE COMMUNITY ALLOWS PARTNERS TO ACHIEVE BETTER COVERAGE, DEVELOP MORE COST-EFFECTIVE PROGRAMS, CREATE ECONOMIES OF SCALE, AND BUILD SOCIAL CAPITAL.

When a development effort is relatively straightforward (i.e., few causal factors and proven technologies for addressing them), *complementary partnership* may be the optimal arrangement. In contrast, when the development problem is complex (i.e., multiple causal factors and few technologies that are proven or affordable to address them), a s*ynergistic partnership* is likely to represent the preferred response. In analyzing a partnership, it is useful to determine whether the partnership type is well suited to the development challenge the partnership is addressing.

The final variable set to consider in partnership analysis is *actor types*. In order to achieve maximum risk mitigation, actor diversity is desirable. In general, the ideal mix of actor types is determined by such factors as complementarities of skills and resources, ease of coordination, and the principle of "maximum tolerable unalikeness." This principle is a reflection of the idea that the more *unalike* partners are, the greater the risk mitigation. Suitable actor types include (but are not limited to) national and international NGOs; representatives from different levels of the Ministry of Health structure (national and district levels, e.g.); business groups; community-based organizations (CBOs); and other local community groups (both formal and informal).

Figure One (see page 7), summarizes the five sets of variables considered in the partnership analysis framework presented thus far.

Consistent with this model, the following five questions provide a structure for predicting whether a given MCH-focused set of actors is likely to achieve more through *joint* rather than *individual* effort:

1. To what extent does the partnership mobilize additional resources?
2. To what extent does the partnership organize members according to their comparative advantages?
3. To what extent does the partnership bring promising innovations to new beneficiary groups?
4. To what extent does the partnership allow beneficiary groups and partner organizations to build on previous gains?
5. To what extent does the partnership create conditions for sustainable improvements in public health?

The CORE Group Case Study

THE CORE GROUP BEGAN ALMOST 20 YEARS AGO AS AN INFORMAL NETWORK OF CHILD SURVIVAL NGOS WHO WANTED TO SHARE TECHNICAL INFORMATION AND LESSONS FROM THE FIELD. TODAY, CORE DEVELOPS STATE-OF-THE-ART KNOWLEDGE AMONG ITS NGO MEMBERS, SYNTHESIZES NGO EXPERIENCES AND PROMOTES RECOMMENDED PRACTICES, AND FACILITATES LEARNING AND COLLECTIVE ACTION AMONG PUBLIC HEALTH ACTORS.

Introducing CORE

The CORE Group is composed of 35 US-based NGOs that implement programs to improve the health of children and women throughout the developing world. These groups serve a combined total of 250 million women and children in over 140 countries. The founding organizations began their collaboration in 1985 when they participated in a series of annual workshops for grantees sponsored by the USAID Child Survival Program (Shanklin 2002). These workshops exposed participants to the benefits of sharing technical information and lessons learned through field-based projects. In 1990 these NGOs began organizing to advocate for changes within USAID's child survival program. An informal entity known as the Collaborative Group emerged from these discussions.

In 1996, Collaborative Group members approached USAID with a request for financial support to create a formal network. One year later, CORE received its first grant. Its first workshop, held later that year, was organized around thematic clusters (e.g., Nutrition, Social and Behavioral Change). These clusters later developed into the Working Groups that form the nucleus of CORE's technical activities today (Shanklin 2002). This working group structure allows CORE to capitalize on the strengths and comparative advantages of members across technical areas.

Over the last five years, the network has evolved significantly as it has attracted new donor funds and members. Its working groups on technical activities and innovations have expanded. CORE now has a small staff and a governance structure that includes a board of directors selected from and elected by its membership. Its current focus is on developing state-of-the-art knowledge, products, and collaborative services; serving as a communication link to synthesize experiences and promote recommended practices; facilitating dialogue, learning and collective action among public health actors; and advocating on global health policy issues.

An in-depth review of three CORE activities

Three specific examples of CORE's MCH projects are presented here to highlight features of the partnership's operations.

1. The CORE Group Polio Partners (CGPP) Project

This effort targets potential polio victims in remote, resistant, dangerous, and marginalized communities that have not yet been reached by global eradication efforts. A key strategic element of the approach entails working through CORE NGO members with the strongest ties to target group communities and the institutions that serve them.

CORE staff identified appropriate NGO members and invited them to participate in the initiative through the joint creation of project proposals that reflected global and country polio eradication priorities. Participating NGOs were able to build on their collective, diverse experiences in applying the technical package in multiple geographic regions. The proposals that met the program's technical criteria were bundled together to create a single, multi-country program. This bundling model allowed smaller NGOs to contribute to the joint effort while allowing

THE CORE GROUP POLIO PARTNERS PROJECT CONDUCTS ITS WORK THROUGH CORE NGO MEMBERS WITH THE STRONGEST TIES TO TARGET GROUP COMMUNITIES AND THE INSTITUTIONS THAT SERVE THEM. THE PRESENCE OF A CORE SECRETARIAT IS AN IMPORTANT ELEMENT IN BUILDING TRUST AMONG PARTNERS AND FACILITATING COORDINATION.

each participating organization the opportunity to exercise its unique expertise (CORE Group Polio Partners 2002a).

The presence of a CORE Secretariat remains an important element in building trust among the partners and facilitating the requisite coordination of efforts. The combination of bundled proposals and centralized staff support has proven "synergistic ... having one without the other is less effective. The Secretariat provides the shared goals necessary for a bundled proposal and results-oriented collaboration. Implementation by the consortium of activities described in the bundled proposal provides the shared experiences, challenges and needs that provide direction and priorities for the Secretariat" (CORE Group Polio Partners 2002a p. 13).

Another important component of this initiative has been the systematic introduction of technical innovations. One example is Lot Quality Assurance Sampling (LQAS), a rapid, simple statistical sampling method that is used to draw important conclusions from small samples and has proven valuable in assessing and selecting geographic areas for program coverage (Valadez, 1994). CORE members have not only used the technique in projects but have also trained personnel from NGOs and Ministries of Health in its use. The sharing of information—particularly technical innovations such as LQAS—with local organizations and Ministries of Health has, according to members, contributed to greater understanding of childhood epidemiology at the local and national levels. Participating NGOs report improvements in program coverage, quality, and associated outcomes. The health outcomes are well documented. Project beneficiaries number nearly 14 million under-five children (CORE Group Polio Partners 2002a p. 1).

In 2002, most of the seven projects linked to this initiative supported planning; identified pockets of low coverage; created local partnerships; and conducted social mobilization for supplemental immunization campaigns. Four country projects conducted synchronized vaccination campaigns (CORE Group Polio Partners 2002b, p. 8). Although the initiative fell slightly short of its objective — seven new collaborative entities for the year — six of seven project countries did establish local NGO consortia, which, in turn, conducted technical and management training; mobilized demand for routine immunizations; improved vaccine logistics systems; and encouraged community contribution to delivery of routine immunizations (CORE Group Polio Partners 2002b pp. 3–5). The experience also resulted in key lessons about the time needed to establish trust among partners, the importance of a shared purpose, and the useful role that "honest broker" organizations can play (CORE Group Polio Partners 2002a).

SIX OF SEVEN CORE POLIO PROJECT COUNTRIES ESTABLISHED LOCAL NGO CONSORTIA, WHICH CONDUCT TECHNICAL AND MANAGEMENT TRAINING; MOBILIZE DEMAND FOR ROUTINE IMMUNIZATIONS; IMPROVE VACCINE LOGISTICS SYSTEMS; AND ENCOURAGE COMMUNITY CONTRIBUTION TO DELIVERY OF ROUTINE IMMUNIZATIONS.

CGPP's approach to achieving greater polio vaccination coverage in high-risk areas and hard-to-reach populations entails strengthening local capacity on a global scale. A key feature of the initiative is the coordination and mobilization of community involvement in mass oral polio vaccine immunization campaigns. Local interventions incorporate seven critical components: building partnerships; strengthening existing immunization systems; supporting supplemental immunization efforts; helping improve the timeliness of case detection and reporting; providing support to families with paralyzed children; participating in national and regional certification activities; and improving documentation (CORE Group Polio Partners 2002b, pp. 1–2).

In addition, the project takes into account the interrelationships between polio and other development problems. Representatives of this CORE initiative participate in the Inter-Agency Coordinating Committee for Immunization where they help to build bridges among local-, country-, regional- and global-level ac-

tors. The strength and depth of the partnership allows participating institutions to exert policy-level influence that they would not have absent this collaboration.

2. Positive Deviance/Hearth

These are two public health methodologies with broad applicability, which have been used with particular effectiveness in rehabilitating malnourished children. CORE's approach to promoting these methodologies will be examined in this section.

Positive Deviance (PD) is a strengths-based approach based on the theory that in many resource-poor communities there are some families or individuals who "employ uncommon, beneficial practices that allow them and their children to have better health as compared to their similarly impoverished neighbors." PD practitioners seek to help communities understand these families' or individuals' practices and disseminate them throughout their communities. This is done by determining a specific desirable nutrition outcome, identifying a few individuals who have achieved the good outcome despite high risk, and then conducting a PD inquiry into the behaviors that explain the good outcome. Behaviors that can readily be replicated by neighbors become the focal point of new interventions designed to promote their broader adoption (Marsh and Schroeder 2002).

POSITIVE DEVIANCE IS BASED ON THE THEORY THAT, IN MANY RESOURCE-POOR COMMUNITIES, THERE ARE SOME FAMILIES OR INDIVIDUALS WHO "EMPLOY UNCOMMON, BENEFICIAL PRACTICES THAT ALLOW THEM AND THEIR CHILDREN TO HAVE BETTER HEALTH AS COMPARED TO THEIR SIMILARLY IMPOVERISHED NEIGHBORS."

Hearth is an implementation strategy that mobilizes community volunteers and mothers or caregivers of malnourished children to practice new health behaviors by bringing them together in a structured, safe environment to learn new cooking, feeding, hygiene and caring behaviors (CORE Group 2002a). Hearth sessions usually consist of nutritional rehabilitation and education over a 12-day period followed by home visits (Nutrition Working Group, 2003).

PD/Hearth (PD/H) was developed over many years by several applied nutritionists. Although the United Nations Children's Fund (UNICEF) funded research into the methodology in the 1980s, the first formal PD/H programs weren't initiated until the early 1990s in Bangladesh, Haiti, and Vietnam (CORE Group and BASICS II 2000). In Vietnam, CORE member Save the Children applied the approach to 14 communities. Documented outcomes of PD/H include reductions in the incidence of malnutrition and faster growth rates among children. As PD/H proved successful in rehabilitating malnourished children, other NGOs became interested, and SC began using the "Living University" as a dissemination tool. The Living University uses engaging, interactive techniques to teach the PD/H framework to managers and supervisors, who in turn train volunteers to implement the program at the community level.

The CORE Group's involvement in the PD/H methodology is on two parallel tracks: 14 CORE member NGOs individually manage PD/H programs around the world, and the CORE Nutrition Working Group devotes significant resources to analyzing best practices, formulating strategies and disseminating information about PD/H techniques. Working Group members meet regularly to discuss such technical and implementation issues as monitoring and evaluation methods (CORE Group 2002a, pp. 21–22). Dissemination methods include the Living University, manuals, studies, field visits, consultant visits, training for district and community program managers, and training of trainers.

CORE's role in global PD/H efforts exemplifies its unique approach to scaling up the application of promising approaches that have been successfully demonstrated at the local level. The group seeks to extend coverage by conducting outreach to other actors who implement programs. Outreach entails training, advocacy, knowledge management, and technical support.

CORE'S ROLE IN GLOBAL POSITIVE DEVIANCE/HEARTH EFFORTS EXEMPLIFIES ITS UNIQUE APPROACH TO SCALING UP THE APPLICATION OF PROMISING APPROACHES THAT HAVE BEEN SUCCESSFULLY DEMONSTRATED AT THE LOCAL LEVEL.

In 2003, CORE's Nutrition Working Group released *Positive Deviance/Hearth: A Resource Guide for Sustainably Rehabilitating Malnourished Children*. This comprehensive, field-oriented manual enunciates the "essential elements" that are fundamental to any PD/H program.

3. The Community IMCI Framework

Integrated Management of Childhood Illness (IMCI), a World Health Organization (WHO) and UNICEF initiative launched in the early 1990s, aims to significantly reduce mortality and morbidity associated with the five major causes of disease in children under five. Over the years, the program has been subdivided into three components: improving case management skills of health workers; improving health system support for high-quality care for children coming to health facilities or outreach sites; and improving household and community practices related to child health, nutrition, and development.

CORE is primarily involved in activities related to the third component, referred to as Household and Community IMCI. CORE's IMCI Working Group activities address policy and service delivery issues at the global and local levels. Globally, the CORE Working Group participates in the official Interagency Working Group (IAWG) charged by WHO and UNICEF with guiding IMCI policy and overseeing early implementation (Winch et al. 2002). At the regional level, CORE has worked with the Pan American Health Organization (PAHO) to test technical tools and to formulate communication and behavioral change strategies. At the national level, CORE members have participated in advocacy task forces to help district- and community-level actors influence national policy; have worked with Ministries of Health to adapt technical tools for use by community health workers; and have helped identify appropriate tools and practices for countries. At the district and community levels, CORE members have engaged with Ministries of Health and other local actors (Child Survival Technical Support Project 2001).

CORE members have helped district- and community-level actors influence national policy on Household and Community Integrated Management of Childhood Illness. Members have also worked with Ministries of Health to adapt technical tools for use by community health workers.

One of CORE's key contributions in this area has been its work on a descriptive IMCI implementation framework based on members' field experiences (Winch et al. 2001). A key aspect of the framework is Community Mobilization: "maximum community leadership in the process of identifying, planning, organizing, and mobilizing resources for community-level health activities." Organizations using the framework are urged to promote community involvement in such tasks as identifying health needs and priorities; community surveillance; and investigations into causes of child mortality (Child Survival Technical Support Project, 2001). This emphasis on community involvement supports an increased level of sustainability in health efforts, thereby allowing program outcomes to be maintained on the local level. In addition, CORE and its membership have been heavily involved in IMCI policy, planning, and evaluation meetings at the local, regional, national and international levels. These contacts have given CORE the opportunity to disseminate community-based perspectives to national and international policymakers.

The framework includes some standard implementation procedures and a consensus-building process focused on uniting diverse partners around improving child health and nutrition at the district level (Child Survival Technical Support Project 2001). The framework groups IMCI implementation activities around three key linked requisite elements: improving partnerships between health facilities and the communities they serve; increasing appropriate, accessible care and information from community-based providers; and integrated promotion of key family practices critical for child health and nutrition (Winch et al. 2001). The framework also stresses the importance of "optimizing a multi-sectoral platform."

Practical application of the framework has led to improved family and community practices in relation to all three elements. For example, with regard to strengthening the partnership between health facilities and the communities they serve, a CORE

member, Project HOPE, trained staff at a local clinic in the Dominican Republic in IMCI, which then used the IMCI form and codes to record information about children visiting the clinic. The clinic's community outreach staff were also trained to use the form to identify children needing follow up visits. As a result of the methodology, research found significant increases in the proportion of caretakers who brought their children back for follow up visits.

In a 2001–2002 survey, CORE Group members reported that the IMCI Framework had been valuable in providing them with a common language for describing their current activities and explaining Household and Community IMCI to outside actors.

Another key element of the framework is the Multi-Sectoral Platform, an explicit effort by the IMCI community to "think and work beyond the health sector" (Child Survival Technical Support Project 2001). The Platform "focuses on innovative strategies for linking broader development activities with child health and nutrition," based on the principle that "people may find it difficult or impossible to adopt new [health promoting] behaviors if other problems that they face, such as food insecurity or lack of access to clean water, are not also addressed" (Child Survival Technical Support Project 2001). The framework proposes many ways in which NGOs can collaborate with local governments and national Ministries in multiple sectors.

In the CORE 2001–2002 member survey, respondents reported that the Framework had been valuable in providing them with a common language for describing their current activities and explaining HH/C IMCI to outside actors, discussing child health issues with Ministries of Health and other collaborators, designing interventions to address specific situations, and articulating an overall vision for community-based child health work (Winch et al. 2002). In an internal survey of CORE members, 79 percent of respondents reported using CORE-supported materials in implementation of IMCI, and each of them had, in turn, trained approximately four to five other organizations in the methodology (CORE Group 2002b p. 22).

Case Analysis

The CORE case, in many respects, represents "best partnership practice" in terms of the five sets of variables presented earlier. Furthermore, the case illustrates that innovative, synergistic partnerships can make a significant contribution in improving the coverage and quality of MCH services, particularly with respect to the "last mile" populations of rural sub-Saharan Africa and Asia. Table 1 summarizes the case in terms of the key partnering variables.

Table 1: Analysis of CORE's Critical Partnering Practices

	Program delivery	**Human resource development**	**Resource mobilization**	**Research and innovation**	**Information and advocacy**
Activity domains	Substantial involvement in field-based service provision woven into major initiatives	Emphasis placed on community empowerment, local skills-building, and policy-oriented training	Practice of "bundling" proposals and working jointly to secure funds resulted in substantial in-flows of new resources	Emphasis given to bringing promising innovations to scale and to refining internationally accepted methodologies	Significant attention given to documentation of lessons learned and participation in policy-setting bodies
Partnership type	Initial contact among founding members at USAID Child Survival workshop illustrated a *potential* partnership that entered into the *nascent* phase when the Collaborative Group was established. The three initiatives presented here represent *synergistic* partnership as there is significant activity in all five activity domains. This partnership is probably most appropriate for reaching "last mile" populations.				
Actors	CORE strengthens linkages among US-based NGOs. However, it also gives significant attention to the development and strengthening of linkages with the international MCH community; national and district-level ministerial personnel; community actors; and, through the in-country collaborative groups established in support of the initiatives described, national organizations. Thus far, little outreach is observed to the private sector.				
Process factors	**Common goals**	**Trust**		**Complementarity**	
	Members share a strong commitment to local empowerment and community-based approaches to MCH. A mission statement sets forth the group's shared goals and vision.	CORE members began working together 20 years ago. The shift from informal to formal network took five years. This time was a vital investment, since member NGOs often compete for USAID and other funds and therefore might view one other as competitors. CORE's policy of transparency in decision-making allowed members to build personal relationships and trust in one another, and to establish a culture of collaboration on CORE projects regardless of their competitive stance vis a vis other activities.		CORE's members have different but complementary resources, strengths and experiences. Illustratively, some members have strong technical skills in a particular methodology, but, because of factors related to size and history, do not have the capacity to scale-up promising innovations on their own. Other members have significant ties and presence in traditionally bypassed or under-served communities but lack the technical capacity to introduce promising new MCH methodologies to communities they serve.	
Value-adding mechanisms	**Risk mitigation**	**Continuity**	**Comprehensiveness**	**Coordination**	
	Diversity of partners' experiences, resources, networks, and roles reduces risks to project activities associated with inadequate design or changes in the external environment.	In most instances, CORE activities built upon earlier development initiatives serving the same populations.	All 3 initiatives involve a rich intervention package that includes community mobilization, local capacity building, direct service delivery, and the forging of new institutional linkages.	CORE initiatives demonstrate multiple mechanisms to promote coordination at national and international levels. These include Working Group meetings, publications, and in-country task forces. CORE secretariat staff play an important role in stimulating timely and useful partner communication.	
Impact on service coverage and quality	All 3 initiatives have a distinct impact on extending service coverage and quality. This is accomplished in two ways: through direct service provision to typically bypassed populations, and through "indirect scaling," which entails systematic outreach, training, and information dissemination to potential replicators.				

Conclusions: Lessons for Partnering and Policy Implications

There are many replicable elements of the CORE model. For a partnership to have added value, it must demonstrate its ability to mobilize resources; organize members according to their comparative advantages; bring promising innovations to new beneficiary groups; allow members to build on previous gains; and create conditions for sustainable improvements in public health. These tasks can be readily accomplished if sufficient attention is paid to the five sets of partnership variables outlined in this article.

Some of the details of CORE's partnership model deserve particular mention, because they can be readily replicated and confer significant advantages. The division of labor within the partnership between a secretariat and thematically focused working groups facilitates the organization of members according to their comparative advantages.

SYNERGISTIC PARTNERSHIPS CAN MAKE A SIGNIFICANT CONTRIBUTION IN IMPROVING THE COVERAGE AND QUALITY OF MATERNAL AND CHILD HEALTH SERVICES, PARTICULARLY WITH RESPECT TO THE "LAST MILE" POPULATIONS OF RURAL SUB-SAHARAN AFRICA AND ASIA.

CORE's policy of openly sharing technical innovations allows for promising methodologies to be introduced and replicated more rapidly than is generally the case with "pilot" or demonstration projects. The partnership's strong emphasis on disseminating effective MCH tools and methods along with its culture of trust have also allowed members to build on previous gains. Finally, CORE's wide range of relationships at the local, district, national and international levels provide an opportunity for it to influence policy and shape a context conducive to sustainable improvements in MCH outcomes.

Black et al. (1993) argue that the key to saving children's lives is not technological innovation but effective management of the knowledge that is already available. Effective partnerships along the lines of the CORE model could play an important role in this area.

Successful replication by other organizational public health actors will, however, depend on *five critical factors*:

- the development of mechanisms that foster simultaneous outreach to local, traditionally bypassed communities and the health sector "influentials" who set global and national priorities;
- the ability to perform the reconnaissance required to identify promising innovations that are ready for scale-up;
- the ability to access funds to cover the costs of a Secretariat;
- the ability to strike a suitable balance between service provision to beneficiary groups (an external focus) and activities that build member capacity (an internal focus); and
- the ability to allow the partnership to evolve at a pace that is appropriate for building trust and cohesion.

Bilateral and multilateral support for strategic partnering is likely to be a cost-effective investment in securing the well being of bypassed mothers and children *if* these five elements are in place and *if* prospective partners are committed to paying close attention to the five sets of partnership variables discussed earlier. If these conditions prevail, strategic partnering will one day be considered as critical to good outcomes for mothers and children as "growth charting."

References

Bell PD, Stokes C. 2001. Melding Disparate Cultures and Capacities to Create Global Health Partnerships. *American Journal of Public Health* **91**: 15524.

Black RE, Morris SS, Bryce J. 2003. Where and why are 10 million children dying every year? *The Lancet* **361**: 2226–34.

Child Survival Technical Support (CSTS) Project. 2001. Reaching Communities for Child Health and Nutrition: A Framework for Household and Community IMCI. CSTS Project: Calverton, MD.

CORE Group. 2002a. Positive Deviance/Hearth for Nutrition: Technical Advisory Group Meeting. Washington, D.C.: The CORE Group. Unpublished document.

CORE Group. 2002b. Benefits Survey for CORE Members. Washington, D.C.: The CORE Group. Unpublished document.

CORE Group and BASICS II. 2000. Hearth Technical Advisory Group Meeting. April 11–12, 2000. Arlington, VA: BASICS II. Unpublished document.

CORE Group Polio Partners. 2002a. Lessons Learned: CORE Polio Partners Project Midterm Review: 1998–2002. Washington, D.C.: The CORE Group. Unpublished document.

CORE Group Polio Partners. 2002b. CORE Group Polio Partners Project: 3rd and 4th Quarter Narrative Report, FY 2002, April–September 2002. Washington, D.C.: The CORE Group. Unpublished document.

Department of Child and Adolescent Health and Development, World Health Organization. 1999. Integrated Management of Childhood Illness and Health Sector Reform. *IMCI Information.* Geneva: World Health Organization.

Jones G, Steketee RW, Black RE, Bhutta ZA, Morris SS, and the Bellagio Child Survival Study Group. 2003. How many child deaths can we prevent this year? *The Lancet* **362**: 65–71.

Levinger B, McLeod J. 2001. "Partnership Principles, Practices and Methodology: A Southern Perspective." [Online] Available at http://www.dec.org/pdf_docs/PDABZ297.pdf [Accessed 2/13/04]

Levinger B, McLeod J. 2002. *Togetherness: How Governments, Corporations and NGOs Partner to Support Sustainable Development in Latin America.* Washington, D.C.: Inter-American Foundation.

Marsh DR, Schroeder DG. 2002. The positive deviance approach to improve health outcomes: experience and evidence from the field. In: *Food and Nutrition Bulletin* **23**: 3–5.

Nutrition Working Group, Child Survival Collaborations and Resources Group (CORE) 2003. *Positive Deviance/Hearth: A Resource Guide for Sustainably Rehabilitating Malnourished Children.* Washington, D.C.: The CORE Group.

Shanklin D. A Brief History of The CORE Group: A R/evolution in Collaboration Among U.S.-Based International Child Survival Health Service Providers. Washington, D.C.: The CORE Group. Unpublished document.

Tsukamoto M, Twose N, Levinger B, Mulroy J. 2003 Ministry of Education Framework for a CSR National Action Plan, World Bank Technical Assistance Note. Washington, D.C.: World Bank.

United Nations Development Programme. 2003. Millennium Development Goals: A compact among nations to end human poverty. *Human Development Report 2003*. New York: Oxford University Press.

UNICEF. 2002 "United Nations Special Session on Children." 8–10 May 2002. [Online] Available at http://www.unicef.org/specialsession/about/end-decade-results.htm [Accessed 2/18/04]

UNICEF. 2004 "Expanding Immunization Coverage." [Online] Available at http://www.unicef.org/immunization/index_coverage.html [Accessed 2/14/04]

Valadez J, Bamberger M. 1994. *Monitoring and Evaluating Social Programs in Developing Countries.* Washington, D.C.: Economic Development Institute of the World Bank.

Winch P, LeBan K, Kusha B, et al. 2001. Reaching Communities for Child Health: Advancing PVO/NGO Technical Capacity and Leadership for Household and Community Integrated Management of Childhood Illness (HH/C IMCI). Calverton, MD: CSTS Project. April 2001.

Winch P, LeBan K, Casazza L, Walker L, Pearcy K. 2002. An implementation framework for household and community integrated management of childhood illness. *Health Policy and Planning* **17**: 345–53.

World Bank Operations Evaluation Department. 2003. Achieving Development Outcomes: The Millennium Challenge. *OED Reach*. February 4.

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