Twelve

Collaboration and Partnership

We must be led by those who have mastery of the skills to mobilize, coordinate, and direct broad collaborative actions within the complex public health system…these skills need constant refinement and honing.

—Institute of Medicine[1]

What Is Collaboration?

Improving public health requires collaborative approach among many actors and sectors. Therefore, public health leaders need to cultivate leadership competencies to foster effective collaboration with appropriate actions to build successful partnerships. In this chapter we will:

- Describe alternative strategies for collaboration and partnership among organizations focused on public health goals
- Discuss ways to use collaborative methods for achieving organizational and community health goals
- Present strategies to motivate others for collaborative problem-solving, decision-making, and evaluation

Collaboration is defined as "exchanging information and sharing or pooling resources for mutual benefit to achieve a common

[1] Institute of Medicine (IOM). (2002). Future of the public's health in the 21st century. Washington, D.C., USA: National Academies Press.

purpose."[2] Thus, collaboration goes beyond communication, cooperation, or coordination.[3] It means to "work together." It is a mutually beneficial relationship between two or more parties to achieve common purpose or goals by sharing responsibility, authority, and accountability for achieving results. It goes beyond sharing information or cooperating or coordinating to achieve each party's own goals. Thus, a common purpose or goals derived from a shared vision is fundamental to any collaboration.

Why Collaboration?

Traditionally, society has looked to the health sector to deal with its concerns about health and disease. Certainly, suboptimal distribution of health care—not delivering care to those who most need it—is one of the social determinants of health, or ill-health, in this case. But the high burden of illness responsible for appalling premature loss of life arises in large part because of the conditions in which people are born, grow, live, work, and age.[4]

Therefore, most public health problems are complex. These types of problems require many sectors to "own" the solution for it to be successfully implemented, utilizing a systems approach with diverse inputs and multiple perspectives. Many of the factors which determine health outcomes rest outside the health system. Primary prevention, a central goal of public health, requires productive relationship outside the health sector. For instance, tobacco use is responsible for one in 10 global deaths. It affects population health, the economy, the environment, and society. Efforts to prevent and control the global tobacco epidemic include

[2] Turning Point Leadership Development Collaborative Leadership. Retrieved from www.collaborativeleadership.org/.

[3] Chrislip, D. D. (2002). *The collaborative leadership field book*. San Francisco: Jossey-Baas.

[4] CSDH. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*. Geneva: WHO.

population level education, legal and policy changes on use of tobacco, the ethical dimensions of tobacco control policies, and the activities of the tobacco industry and its allies.

> Who is responsible for health? Almost all sectors have more or less influence on health.

Action on the social determinants of health must involve the whole of government, civil society and local communities, business, global forums, and international agencies. Policies and programs must embrace all the key sectors of the society, not just the health sector. However, health sector can champion a "social determinants of health" approach at the highest level of society, it can demonstrate effectiveness through good practice, and it can support other ministries in creating policies that promote health equity. All this requires collaboration with other sectors and actors.

Thus, public health has many issues which cannot be resolved by technical expertise or routine behavior. Instead, it requires innovation and fostering change which, in turn, requires new learning about such adaptive behaviors.[5] To bring about such adaptive behavior, many agencies need to come together.

Building Collaborative Relationship with Other Sectors

As mentioned earlier, all sectors affect health albeit to a varying degree. To illustrate:

- A comprehensive approach to early child development would be critical for health later on.

[5] Heifetz, R., & Linsky, M. (2002). *Leadership on the Line. Staying alive through the dangers of leading*. Boston, USA: Harvard Business School Publishing.

- The daily conditions in which people live have a strong influence on health equity. Access to quality housing, shelter, clean water, and sanitation are human rights and basic needs for healthy living.
- Urban planning can promote healthy and safe behaviors equitably, through investment in active transport, retail planning to manage access to unhealthy foods, and through good environmental design and regulatory controls, including control of the number of alcohol outlets.

Strategies for such collaboration between sectors or among multiple sectors could be

- Coordinating activities and services
- Sectors other than health to include appropriate health education and services
- Public health sector to include education and services for other sectors such as water and sanitation
- Sharing information to improve population health
- Collaborating to improve health promotion and protection
- Collaborating to plan for future health system development

The implementation of these strategies can be illustrated through collaboration between medicine and public health synergies, as discussed in the following paragraphs.

The structural foundations that can be used in the collaborations include:

- Forming coalitions
- Entering into contractual agreements
- Designing appropriate administration/management systems
- Constituting advisory bodies
- Establishing intra-organizational platforms

In these collaborations, professionals continue to work within their own organization while, at the same time, transcending the boundaries of that organization to link up with professionals and organizations in other sectors.

Collaboration between Medicine and Public Health

To begin with, public health leaders need to build synergistic collaboration with medicine.[6] Because of health transition from communicable diseases to NCDs and from mortality reduction focus to morbidity reduction and enhancing wellness, the medical and public health sectors are becoming increasingly dependent on one another in achieving their missions. Although a specific collaboration may be designed to address a particular health problem, a set of common and generally applicable strategies have emerged from analysis of several experiences. One aspect of such a framework focuses on ways that professionals and organizations in medicine and public health—and often other partners in the community as well—combine their resources and skills, and the benefits that can be achieved by doing so. These reinforcing combinations provide "synergies" between the two sectors in health. Experience shows that these synergies could involve virtually every type of professional and organization in the two health sectors. They encompass all domains of medicine and public health—practice, policy, education, and research—and they occur at local, state, and national levels.

There are many assets that these two sectors bring to collaborative endeavors:

- Technical, scientific, and pedagogic expertise
- Methodological tools
- Individual-level services and population-based strategies
- Administration and management skills
- Legal and regulatory authority
- Convening power
- Influence with peers, policymakers, and the public
- Data and information systems
- Buildings and space
- Financial support

[6] Lasker, R. D., & The Committee on Medicine and Public Health. (1997). *Medicine and public health: The power of collaboration*. New York: New York Academy of Medicine.

These assets are valuable in and of themselves. But, by combining them in certain ways, the individual partners in the collaboration are able to transcend their own limitations and achieve additional benefits that are important to their patients, their populations, and themselves.

The synergistic relationship between the two can be operationalized in a mix of the following ways:

1. **Improve health care by coordinating services for individuals** through providing medical care and addressing determinants of health that go beyond medical care. These objectives can be achieved by combining clinical services with one or more of the following:

    a. *Wraparound services* that overcome logistical, cultural, and social barriers to care
    b. *Counseling and educational services* directed at personal risk behaviors
    c. The *management of particular health problems* and the use of health services
    d. *Outreach services*, such as home visits, that assure the delivery of needed care and that promote compliance with complex treatment programs
    e. *Case management services* that identify health-related needs of individuals, link individuals with health professionals and programs in the community, and coordinate care
    f. *Social services* that address socioeconomic determinants of health

2. **Improve access to care by establishing frameworks** to provide universal care by overcoming the logistical, financial, and legal barriers that medical practitioners face in delivering such care through collaborative activities that bring them together with one or more of the following:

    a. *Administrative services* to plan and coordinate the effort
    b. *Convenient sites* to provide clinical care

c. *Ancillary staff*, supplies, and services (such as lab, X-ray, pharmacy, etc.)
d. *Screening programs* to identify patients eligible for care
e. *Referral mechanisms* to link patients with appropriate practitioners
f. Offering *immunity from liability* for medical malpractice

3. **Apply a population perspective** to medical practice to improve the quality and cost-effectiveness of clinical care, as well as to ensure the economic viability of medical professionals and institutions. These collaborations may combine medical care for individuals with one or more of the following:

    a. *Population-based information*, such as data about the prevalent health problems and health risks for a particular population; the underlying causes of health problems; the risks, benefits, and costs of various approaches to diagnosis and treatment; and health resources available in a geographic area
    b. *Population-based strategies*, such as community-wide screening, outreach, and case finding
    c. *Population-based analytic tools*, such as practice-based risk assessment, cost-effectiveness analysis, and the measurement and evaluation of performance

4. **Use clinical practice to identify and address community-wide goals** of public health through interactions that combine clinicians' access to and influence with individuals with one or more of the following:

    a. *Community-wide frameworks* for collecting health-related information
    b. *Population-based strategies* to facilitate the delivery of clinical services in mainstream medical practices
    c. *Community programs* to address health risks in the social and physical environment

5. **Strengthen health promotion and health protection** through mobilizing community campaigns by working together on population-based strategies, professionals and institutions in medicine and public health to address underlying causes of some of the most pressing health problems, such as tobacco use, poor diet, inactivity, injuries, and violence, and strengthen essential functions of public health. They do so by bringing together two or more of the following non-clinical resources' influence with peers, policymakers, and the public:

    a. Legal authority
    b. Convening power
    c. Information
    d. Scientific and technical expertise
    e. Advocacy, lobbying, and public relations skills

6. **Shape the future direction of the health system by collaborating around policy, training, and research** by influencing health system policy, by educating the future generation of health professionals, or by expanding the knowledge base that supports health professionals' work. These are based on combinations of two or more of the following skills and resources:

    a. Influence with peers, policymakers, and the public
    b. Practical experience
    c. Scientific expertise
    d. Pedagogical skills

Collaborative Leadership

Collaborative leadership needs to be used to foster collaboration for achieving policies, programs, and systems change to improve public health.

A collaborative leader safeguards and promotes the collaborative process that includes activities and relationships in which a group and its members engage in collaboration. It is the type of leadership shown by a group that is "working together" to achieve common purpose by strategically addressing agreed-upon issues.[7]

Collaborative leadership requires all the attributes and competencies of public health leadership. These include creating shared vision and values, assessing the vision–reality gap by analyzing environment, developing people and self-reflection. However, as collaboration will involve people and organizations with diverse perspectives and cultures, building trust and sharing power and influence become critical. Building trust comes from creating safe places for developing shared vision, purpose, goals and action. It requires higher level of negotiation, conflict management, and communication capability.

Collaborative leadership requires new notions of power. Often it is thought that when power is shared, the person sharing it will have less power. However, once common vision, purpose, and values are firmly established, the more power is shared, the more there is to use. It utilizes supportive and inclusive methods to ensure that all people affected by a decision are part of the change process. Therefore, sharing power and influence develops the synergy of people, organizations, and communities to accomplish a shared vision.

Sometimes, collaborative leadership is considered akin to "servant leader" as one who values the common cause much higher than self through an attitude of service. Such a leader is an "active listener," promotes a sense of community and keeps focus on what is best for the community or group versus individual self-interest.

Thus, collaborative leadership is the skillful and vision-oriented leadership of people and relationships by building structures and processes to support and sustain productive relationships over time.[8]

[7] Turning Point Leadership Development Collaborative Leadership. Retrieved from www.collaborativeleadership.org/.

[8] Hank, R. (2009). *Collaborative leadership: Developing effective partnerships for communities and schools*. California, USA: Corwin Press.

Focuses for Collaboration

Ad hoc collaborations may be organized around a specific issue or event. But for more durable collaborations with some sustainability, two focuses can be used: (1) community or regionally-based multi-stakeholder collaboration or (2) local health or government-based in which inter-organizational or inter-institutional collaboration takes place.

Community-Based Multi-Stakeholder Collaboration

Arising out of concern to create healthy communities, collaborative partnerships involving many sectors and organizations can be an important strategy for improving public health. Therefore, community collaboration is a cornerstone of public health practice. Successful community collaboration not only builds skills and capacity within the community but involves them in making decisions and taking actions, which are fundamental to improving health.

There are various levels of community collaboration moving beyond information dissemination, cooperation, or coordination. It involves joint planning and actions, financial contributions from the community, and ultimately community guiding the collective action, with the local health system as a partner. Such collaboration should stem from the needs, expectations, and desires of the community.[9] However, community can be defined in many ways such as:

- People: Socioeconomic, demography, health status, risk profile, cultural, and ethnic characteristics
- Location: Geography
- Connectors: Shared values, interest, or communication patterns

[9] Minnesota Department of Health. Community engagement. Retrieved from www.health.state.mn.us/communityeng/.

- Power relationships: Formal and informal lines of authority, influence, and resource flows

Typically three stages in engendering community collaboration can be seen:

1. Coming together: Sharing the dialogue, building trust and safe spaces for people to think, debating, reflecting upon and making decisions
2. Moving forward: Converting dialogue into activity, reaching out beyond the original planning group, and creating partnerships to implement programs and providing services
3. Sustaining momentum: Building structures, developing and sustaining leadership, assessing and improving programs, measuring change, and communicating results

Government public health agencies must find ways to improve communication and openness with the public to maintain and increase their trustworthiness. (Institute of Medicine, USA Healthy Communities, 1996)

For active collective action by the community, there is a need for professionals with public health institutions to understand that communities can deal with complex issues, and that people interrelate various community concerns. And that they can be mobilized to address their concerns with appropriate technical support. For a public health leader to build community collaboration, the following steps will be important for the above three stages:

- *Coming together*: Identify the community in which collaboration is to be built and clarifying its purpose; become knowledgeable about its socioeconomic conditions, politics, norms and values, health practices; establish relationships, build trust, and work with formal and informal community leaders
- *Moving forward*: Partnering with the community to create changes and improve health; identifying and mobilizing the community assets; developing capacities and resources for community health decisions and action

- *Sustaining momentum*: Release control to the community; commit to the activities for the long term

A community balanced scorecard has been developed[10] for generating community-focused collaboration (see Table 12.1).

Table 12.1: *Community Balanced Scorecard*

Balanced Scorecard Perspectives		*Community Balanced Scorecard*
Financial performance	→	Improve community health/quality of life outcome
Customer	→	Community implementation including investigations, enforcements, health promotion, and health services
Internal business processes	→	Community capabilities, processes and learning-policies and plans, evaluation, health status monitoring, and research
Learning and growth	→	Community assets including engaged community members, public health partners, and competent health workforce

Source: Paul, 2009. [11]

A "Healthy Living" theme, for instance, may focus on healthy eating, better exercise, reduced smoking and substance abuse, water and sanitation, and chronic disease prevention, early detection, and management. For this purpose partners, including health department, schools, parks, environment, nutrition, and so on, would need to collaborate. The collaborative process involves: creating a shared vision for desired outcome.

- Developing performance measures
- Developing strategies for each outcome
- Forming teams for each outcome
- Creating a "community results compact"
- Implementing strategies

[10] Paul, E. (2009). *Community balanced score cards for strategic performance management*. Presentation at ASPA Annual Conference, Florida, March 2005. Retrieved from www.RTMteam.net/.

[11] Ibid.

A feedback cycle from the gap between desired and current realities as well as the monitoring and evaluation system would help steer this process.

Local Public Health System Partnerships

National public health strategies operate within the broader health system, interacting and interdependent with all aspects of health care and health service delivery systems. Within the health system these involve a complex interplay of the range of activities which span from specialist clinical services to universal public health prevention and protection programs; their focus may range from the individual through to the entire population and their interventions may target the settings in which health services are provided or where people live. They may seek to modify health behavior and/or health care seeking behavior.

Thus, partnerships to improve public health may be initiated by the local public health agency. In this case, the partnerships are generally formed with other government agencies, hospitals, medical practices, or clinics. Sometimes, community-based organizations or direct citizen participation could be elicited.

The motive for forming partnerships could arise from the need to address a specific health problem or availability of finances, or government mandates.[12] The types of health problems that may be successfully addressed include maternal and child health, NCD prevention, and control of epidemics or emergencies. Sometimes such partnerships may be limited to specific collaboration for conducting community health events or disseminating information to the community. However, more complex form of partnerships would include joint-action planning and goal setting which are more difficult to engender.

The partnership success is predicated on many factors depending upon context, purpose, and content of partnerships and is,

[12] Zahner, S. J. (2005). Local public health system partnerships. *Public Health Reports, 120*, 76–83.

therefore, difficult to generalize. A mix of factors has been linked to successful local health system partnerships. These include having a budget, partners making financial contributions, and having a broad array of partners involved for a longer duration and more capacity to implement. Some other studies have identified as having a clear vision, conducting action planning, developing and supporting leadership, having systems for evaluation, and availability of necessary human and financial resources for successful local health partnerships.

Strategies for Successful Partnerships

For sustained collaborations, partnerships need to be established. However, partnerships are not always successful, and those that are, usually have difficult weather and stormy periods.[13] While collaborations fail for a variety of reasons, it is fair to say that most problems revolve around the relationships of the partners involved. Cross-sectoral collaborations bring together a broad range of individuals and organizations, not only in medicine and public health, but often from other sectors in the community as well. Many of these partners are separated by deep cultural differences; some are competitors; few have any history of working together. Viewed in this context, there would seem to be daunting barriers to getting potential partners to acknowledge their mutual interests in collaboration, let alone to establishing working relationships that allow them to put their ideas into action.

Research shows that for partnerships to succeed, partners must perceive a compelling *need* to work with professionals or organizations in other sectors and be *willing* to do so. To some extent, the willingness to participate in a collaborative enterprise depends on whether potential partners give it a high priority. That decision, in turn, relates to whether the expected benefits

[13] Lasker, R. D. (1997). *Medicine and public health: The power of collaboration.*

appear to be worth the investment and commitment, and whether the project is likely to be feasible and well-run. Willingness to participate also hinges on relationship issues. Unless potential partners have confidence and trust in the leaders of the enterprise and the other participants, they are unlikely to get involved in a meaningful way. If confidence and trust dissipate after the project gets started, it is difficult, if not impossible, to sustain a collaborative partnership.

Therefore, generally it is believed that for successful partnerships, partners should have a shared vision and interest in addressing common goals.[14] The relationship needs to be built around individual leaders and what partners know of each other. Finally, partnership benefits should exceed costs.

However, an alternative view has also emerged which holds that such stringent conditions may not be necessary for successful partnerships. Such partnerships involve the right combinations of partners to achieve partnership objectives that are shaped around common or shared objectives but also contribute toward each partner's aims. As partnership progresses, individual relationships need to be supplemented by structured methodologies defining roles and structures of functioning. A partnership's success often depends on its evolution in terms of memberships, wider relationships, or its purpose.

For determinants of successful cross-sectoral partnerships, the following eight strategies gleaned from literature may be helpful to leaders who are considering engaging with or leading medicine and public health collaborations:

- Build on self-interests as well as health interests
- Involve a "boundary spanner," somebody outside the partnership, in the project
- Seek out influential backing and endorsements
- Don't expect other partners to be like you
- Be realistic

[14] Business Partners for Development. (2001). Putting partnering to work. Retrieved from www.oecd.org/dataoecd/14/58/2082379.pdf/.

- Pay attention to the process
- Ensure adequate infrastructure support
- Be "upfront" about competition and control issues

Leading Beyond the Walls: How High-Performance Organizations Build Alliances for Shared Success[15]

We know that effective partnerships can be achieved. In fact, there are many success stories. What is needed is for leaders of all sectors to take leadership responsibility beyond their own sectors or institutions, leading beyond the walls, so to say. They have to lead not only entire institutions and lead them to performance but at the same time, take community responsibility beyond the walls of their institutions (see Box 12.1).

Box 12.1: *Leadership without Walls: Challenges*

- Build strategic alliances with partners to upscale success
- Change the mind-set of leaders
- Get commitment of leaders to address the health problem as a whole
- Leaders should be willing to learn from different values of partners, accept, and respect them

Source: Hesselbein, Goldsmith, & Somerville, 1999.[16]

This is not easy. There is a need not only to address performance and personal dimensions but also a different mind-set. Each institution is like an instrument in an orchestra that plays its own part. But it is the score that dictates how each instrument plays its part to achieve the end result for the pleasure of the listeners. The community is the score. And only if each individual instrument contributes to the score is there music. Otherwise, there is only noise.

[15] Hesselbein, F., Goldsmith, M., & Somerville, I. (1999). *Leading beyond the walls*. New York: The Drucker Foundation.

[16] Ibid.

Leadership Roles

First, leaders must define the inside and outside of the organization by reference to core values and purpose, not by traditional boundaries. *Second*, they must build mechanisms for connection and commitment rooted in freedom of choice rather than relying on systems of coercion and control. *Third*, they must accept the fact that the exercise of true leadership is inversely proportional to the exercise of power. *Finally*, they must accept the fact that the trend toward partnerships will accelerate.

It is often easier to build and sustain partnerships at the frontline who deal with people. As we move away from the grassroots, partnerships become more difficult. Therefore, partnership champions and managers need to be created in each institution/sector.

Partnerships are built on the mind-set of mutual benefits. It is a deep inner commitment toward achieving win-win. To build a strong relationship between organizations, both sides must win. By attacking a problem from several angles, a mutually beneficial solution will, more often than not, become apparent from both sides. However, having the right mind-set is only the first stage. Leaders will also need special skills set especially the skills of communication and synergy.

Communicating effectively requires that you first understand the other party's view before you try to explain your own. Once you understand other people's point of view, you must then get them to understand yours. If you fail to do this, the richness of your ideas will remain untapped. It is only through sharing of ideas that the next piece of puzzle can be put in place: Synergy!

Synergy is finding the third way that is better than the way either of us could come up with independently. The steps in creating synergy are

- Identifying what both parties really want
- Creating alternatives that lead to betterment of all organizations
- Determining acceptable solutions for all parties

- Fostering a spirit of mutual benefit
- Building relationships

Leadership Skills

The following four abilities are vital skills for leaders beyond walls:

- The ability to design powerful relationships: Many contributing factors—religious beliefs, differing views, diverse participants, and cultures—affect a leader's probability of success in developing powerful relationships. Diversity can make it difficult to create or sustain cross-domain relationships. Successful, powerful relationships require the creation of new culture and sustainable structures unique to the needs of the relationship.
- The ability to create a systemic change: Leaders in future must be able to envision and lead systemic change. Leaders will have to establish shared expectations and set clear priorities for performance and results.
- The ability to develop comfort with risk while building trust: There is no better way to reduce risk than to build trust. Leading beyond the walls will require learning new rules of trust and going beyond the old earned trust. Earned trust is built over time and is entirely based on performance. It is important but insufficient to build partnerships. Leaders must learn to generate granted trust, the trust individuals need to create with others and to obtain early action and results while establishing earned trust over time.
- The ability to value diversity and source of contribution: While leaders would need to establish common ground, the commitment to address health problems, they also need to establish uncommon ground, the ground of diversity of different sectors. They would have to learn to employ diversity on behalf of the common commitments.

CASE STUDY 1: **Partnering with Civil Society Organizations, Communities, People Living with HIV (PLWHIVs), and Private Sector in HIV/AIDS Programs**

One of the characteristics of successful national HIV/AIDS prevention programs is active involvement of multiple sectors of the society including civil society, religious leaders, and NGOs in the response to AIDS. Therefore, partnership has emerged as a message that we should embrace, share, adapt, and build upon.

The primary role of the government is to pave the way so that all sectors of society can contribute to the response. No one organization can do things on its own and attain success in AIDS prevention, treatment, and care. For instance, health education alone cannot even breach the surface for public education on HIV/AIDS, and, similarly, the national education system on its own cannot have the desired impact. Providing care and treatment is also multifaceted requiring not only involvement of the public health facilities but also professional associations, social and behavioral scientists, private sector, and communities. Another aspect requiring partnerships is programs to eliminate the stigma and discrimination against PLHIVs. Such programs cannot attain success without collaboration with human rights institutions.

As mentioned earlier, it is well recognized that success will require working in partnership with communities, civil society, PLHIVs and vulnerable groups, and private sector. Each has complementary strengths. Governments have decision-making power, political will, and infrastructure while NGOs have access to people and grassroots-oriented approaches. PLHIVs and vulnerable groups have both the understanding of needs and how best to meet them. They are not only the recipients of services but are a significant resource themselves. The private sector can assist in making the drugs available at low cost, in ensuring that appropriate drug regimens are followed, and

in workplace programs. Experience on these issues is growing. Distilling lessons from these experiences and sharing them may enhance the capacity of the programs for effective partnerships.

In this regard, strategic competencies include building strategic alliances with partners to upscale success. However, this will require a different mind-set. Leaders are not only responsible and accountable for the performance of their organizations, but more importantly, the commitment to address the HIV/AIDS epidemic as a whole. This will involve acceptance of the different partners' values, respect for these values, and willingness to learn what these values are. All of these require commitment, conviction, and dedication to the common cause. The basic issues that leaders need to address are how to

- create a common vision for sustained partnerships?
- delineate synergistic roles for each partner?
- build alliance competence among partners?
- create effective institutional structures for results-oriented partnerships?

***CASE STUDY 2:* Leadership Development to Strengthen Partnerships in Ethiopia**[17]

In early 2002, Ethiopia mobilized more than 250 leaders at all levels of government and civil society to step up efforts to reduce the number of people contracting HIV/AIDS and improve treatment and care for those infected with the disease.

UNDP and the Ethiopian International Institute for Peace and Development conducted a seminar for top government

[17] UNDP Communications Office. (2002). Retrieved from www.undp.org/content/undp/en/home/ourwork/hiv-aids/Projects-initiatives/hiv-epidemic-ethiopia-case-study-transformational-change/.

executives, in early 2002, to launch the Leadership Development Program to slow the epidemic.

Ethiopia was hit hard by the deadly disease, with 2.1 million adults and children living with HIV, according to the Joint U.N. Programme on HIV/AIDS (UNAIDS). Over 6 percent of Ethiopians aged 15 to 49 were infected with HIV, and an estimated 120,000 Ethiopians died of AIDS in 2001. Despite its devastating impact, many Ethiopians remained unaware of the risks HIV/AIDS poses. A survey in 2000, for example, found that more than 60 percent of women aged 15 to 24 did not know that a person who looked healthy could be infected with HIV.

President Girma Woldegiorgis, who chaired the National AIDS Council Secretariat, said while the community should be mobilized to fight the epidemic, there was a pressing need for leadership. "The Government should be in the forefront to coordinate efforts by all stakeholders for the control and prevention of the epidemic and alleviate its impact," he emphasized.

Experience from other countries showed that leadership was critical in combating HIV/AIDS and in achieving progress toward the objectives set by 2001 U.N. General Assembly Special Session on HIV/AIDS, the U.N. Millennium Development Goals, and the government's HIV/AIDS action plan.

The leadership program was a new approach that aimed to build on individual and organizational responsibilities to address the causes that fuel the epidemic. The process would take nine months, involving leaders from all sectors of the society including government officials and civil society organizations, such as youth groups, religious organizations, women's groups, and the private sector.

The seminar for government executives focused on the experiences of countries such as Thailand and Uganda in reversing the epidemic and how they could be applied in Ethiopia. They also discussed practical steps and strategies at the federal, regional, and local levels to combat the epidemic.

Support for the program was part of the overall UNDP strategy on HIV/AIDS, which helped countries to

- Promote advocacy and policy dialogue
- Build capacity to control the epidemic
- Mainstream HIV/AIDS programs across government agencies
- Protect the human rights of those affected by HIV/AIDS
- Carry out information and awareness campaigns

***CASE STUDY 3:* Regional Collaboration: Controlling Chagas Disease in the Southern Cone of South America**[18]

Brazil's early success with the program demonstrated the technical feasibility of vector control efforts. However, the program also exposed two challenges facing the fight against Chagas disease: border-crossing insects and wavering political commitment. Despite the diligent mapping and control efforts within its borders, Brazil's campaign faced disease transmission from neighboring countries. The insect vector could easily cross borders and was thought to have originated in Bolivia and spread across a large swath of the continent, hidden in people's belongings as they moved from one place to another. As such, Brazil's experience demonstrated that unilateral control efforts would be unable to defeat the disease.

In 1991, a new control program known as the Southern Cone Initiative to Control/Eliminate Chagas (INCOSUR) addressed these challenges and marshaled the commitment of the countries of the southern cone region where Chagas was an endemic threat. The initiative was a joint agreement among the governments of Argentina, Bolivia, Brazil, Chile, Paraguay, Uruguay, and later Peru, which set out to control Chagas

[18] Center for Global Development. (2004). Millions saved: Proven successes in global health. Retrieved from www.cgdev.org, accessed in 2010.

disease through the elimination of the main insect vector. Led by the PAHO, the initiative was designed to bolster national resolve and prevent cross-border reinfestations.

Within the INCOSUR, each country financed and managed its own national program. However, regional cooperation has proved essential to the program's success and has been coordinated by PAHO. Each year, representatives from the collaborating nations shared operational aims, methods, and achievements at a PAHO-sponsored annual meeting of the Intergovernmental Commission of the Southern Cone. A series of inter-country technical cooperation agreements has fostered the sharing of information among scientists throughout the region and their respective government organizations.

Incidence in the seven countries covered by the initiative fell by an average of 94 percent by 2000. By 2001, disease transmission was halted in Uruguay, Chile, and large parts of Brazil and Paraguay.

***CASE STUDY 4:* Collaboration with Private and/or NGO Sector: Cataract in India[19]**

Although the Blindness Control Program's quantitative achievements in India were remarkable in its early years, the impact on health was disappointing as outcomes were relatively poor. According to at least one study of 24 villages, less than half of those operated had good visual outcomes. The reasons for this underperformance were many. First, the intracapsular cataract extraction, known as ICCE surgery, itself had a significant failure rate, even under the best circumstances. And the camps where this was done were in no way the best circumstances. Surgeons were serving a rural population that did not always understand instructions for post-surgical care

[19] Center for Global Development. (2004). Millions saved: Proven successes in global health.

at home. It was difficult (and often impossible) to maintain a sterile field during the operation. Local doctors were either not present or not able to provide follow-up monitoring and care.

So, while the program was increasingly successful at stimulating a demand for surgeries, it was unable to keep up with that demand. A backlog of people asking for treatment led to long lines and increased pressure to work quickly and move on.

In part, in response to the shortcomings of the public sector program, the private sector—and particularly NGOs—sought to fill the void.

The Aravind Eye Care System, an NGO with a 30-year history of providing very low-cost vision care, has been a leading partner to the Government of India in its blindness program and a leading example of social entrepreneurship in the health sector. Among the NGOs providing cataract treatment in India, Aravind is by far the largest, conducting more than 1,000 screening camps and performing close to 1 million cataract surgeries each year. Within the context of the Cataract Blindness Control Program (CBCP), Aravind's role was particularly significant in Tamil Nadu, where some 95 percent of the surgeries were performed under the organization's auspices.

Aravind had its start in 1976 when its founder Dr Govindappa Venkataswamy, after mandatory retirement from government service at the age of 58, opened a 12-bed hospital in the South Indian city of Madurai. Starting with little money but a strong sense of mission toward saving the vision of those in need—and inspired, serendipitously, by the large-scale success of the McDonald's fast-food marketing strategy—over time Dr Venkataswamy established a network of specialty eye hospitals throughout India that uses a sustainable business model to provide high-quality patient care. He devoted himself to this effort until his death in 2006, his family continues his work. Three key elements define the Aravind business model:

1. Economies of scale: With excellent management and high patient volume, Aravind keeps productivity high,

with surgeons performing 25–40 procedures daily; unit costs are maintained at the very low level of about $10 per cataract operation.

2. Cross-subsidies: Aravind provides free or very low-priced care to two-thirds of its patients with the revenue derived from the one-third of patients who are able to pay moderate prices. The only difference in the treatment of those who do and don't pay is in the amenities, such as the air-conditioning in the recovery room.
3. Vertical integration: Recognizing that the imported intraocular lenses constituted a major component of the total surgical costs, Aravind obtained a transfer of technology through the US-based Seva Foundation, and additional support from the Combat Blindness Foundation, to permit it to manufacture these lenses at a fraction of the cost. The manufacturing activity scaled up quickly, from 35,000 in 1992–1993 to nearly 600,000 lenses today. Now, at the Aurolab subsidiary established for this purpose, a workforce of about 200 young women from rural backgrounds produces lenses to a global standard of quality that are used at Aravind, as well as at facilities throughout India. The affordably priced intraocular lenses are exported to some 85 countries around the world, providing another source of revenue for Aravind. The system of eye hospitals also is considered one of India's premier ophthalmic training institutions, providing a steady flow of well-prepared professionals and support staff.

Beyond the mechanics of the business model was the leadership of Dr Venkataswamy, a surprising combination of marketing savvy and spirituality. "If Coca-Cola can sell billions of sodas and McDonald's can sell billions of burgers," Dr Venkataswamy asked,

> "why can't Aravind sell millions of sight-restoring operations, and, eventually, the belief in human perfection? With sight, people

> could be freed from hunger, fear, and poverty. You could perfect the body, then perfect the mind and the soul, and raise people's level of thinking and acting."

With this approach, he attracted both financial and technical support from many organizations outside of India, from Lion's Club to the WHO to the Seva Foundation, and inspired a generation of health professionals in South Asia and beyond.