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Understanding the Early Stages of Development of A Global Health Partnership

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Understanding the Early Stages of Development of a Global Health Partnership

by

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Submitted in Partial Fulfillment of the Requirements

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DEDICATION

A mis papás Howard y Raquel.

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Pablo, all my love and thanks to you. I am ready for our next adventure!

ABSTRACT

Maternal and child undernutrition contributes to more than one-third of child deaths. Global Health Partnerships (GHP) have emerged as a response to undernutrition and other pressing health problems. GHPs promote joint decision-making among donors, multilateral agencies, and country partners. Despite their positive impact on health problems, GHPs have generated unintended negative effects on country partners. This study aimed to understand the factors, strategies, and processes conducive to the establishment of an effective GHP in the context of a cooperative regional effort to reduce undernutrition and improve maternal and child health in eight countries of Latin America, the Regional Health Initiative (RHI). The study used participant observation, document review, and semi-structured interviews to examine the planning and implementation of RHI overall and particularly in two of the eight countries. Deductive analysis was conducted using predetermined themes from the policy science framework. We also conducted inductive analysis that allowed for the identification of emergent themes.

RHI partners had different, and in some instances, diverging perspectives. The lack of alignment of perspectives caused unintended consequences to the implementation of RHI in two countries such as the establishment of unrealistic aims for the country

action plans, tension during the formulation of the action plans, and disagreements among partners that led to unexpected changes to the country action plans. We identified three factors that influenced this lack of alignment: 1) challenges in knowledge management, 2) non-inclusive governance structure, and 3) limited time for planning.

Formulation of country action plans is often a contentious process. The successful formulation of an action plan occurs when the process pursues goals of feasibility, alignment, and ownership. Although RHI promoted feasibility, ownership, and alignment, the country context was a key determinant of the attainment of these goals. Lack of national health plans and aims, weak leadership of the Ministry of Health, and an upcoming political transition were factors that prevented reaching these three goals.

These findings bring attention to the process of development of GHPs. The establishment of mechanisms to build trust and promote frequent communication among partners can lead to the early identification and alignment of perspectives. Furthermore, sociopolitical factors of country partners influence GHPs and should be taken into consideration during their planning and implementation. By recognizing that a complex context can delay or impede the attainment of goals during the formulation of country action plans, GHPs can be responsive to the country-specific challenges, devise appropriate procedures to address them, and adapt expectations to the context

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LIST OF ABBREVIATIONS

ARENA.....	Nationalist Republican Alliance
ECOS.....	Community Team of Family Health
FMLN.....	Farabundo Martí National Liberation Front
FOSALUD.....	Solidary Fund for Health
GAVI.....	Global Alliance for Vaccines and Immunization
GDP.....	Gross Domestic Product
GHP.....	Global Health Partnership
Global Fund.....	Global Fund to Fight AIDS, Tuberculosis and Malaria
IDB.....	Inter-American Development Bank
IGSS.....	Guatemalan Social Security Institute
IPHC.....	Integrated Primary Health Care
ISBM.....	Military Health and Teacher Welfare
ISRI.....	El Salvadoran Rehabilitation Institute for the Disabled
ISSS.....	Social Security Institute
MAP.....	The World Bank Multi-Country AIDS Program
MCH.....	Maternal and Child Health
MDGs.....	Millennium Development Goals
MoH.....	Ministry of Health
MSPAS.....	Ministry of Public Health and Social Assistance

NGO.....	Non-governmental organization
NHSR.....	National Health System Reform
Paris Declaration.....	Paris Declaration on Aid Effectiveness
PEC.....	Extension of Coverage Program
PEPFAR.....	The US President's Emergency Plan for AIDS Relief
RBF.....	Results-Based Financing
RHI.....	Regional Health Initiative
RIISS.....	Integral and Integrated Public Health Care Service Network
UCSF.....	Community Unit of Family Health
WHO.....	World Health Organization

CHAPTER 1

INTRODUCTION

In the past decades, a small number of fatal health problems disproportionately burdened the health systems in low- and middle-income countries and, in combination with other challenges, has slowed progress towards the achievement of the Millennium Development Goals (MDGs) (World Health Organization Maximizing Positive Synergies Collaborative Group et al., 2009). Since 2000, Global Health Partnerships (GHP), capitalizing on the urgency generated by the adoption of these goals, have helped grow political support for addressing these health problems (WHO, 2006). Currently, more than a 100 different GHPs (also known as Global Public-Private Partnerships or Global Health Initiatives) exist. A few of these partnerships, including the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund); the Global Alliance for Vaccines and Immunization (GAVI); the US President's Emergency Plan for AIDS Relief (PEPFAR), and the World Bank Multi-Country AIDS Program (MAP), contribute substantially to the funding for health provided by international donors (WHO, 2006).

GHPs are characterized by a set of common features, including their focus on specific health problems, relevance to several countries, ability to generate substantial funding, inputs linked to performance, and their direct investment in countries, including partnerships with nongovernmental organizations and civil society (World Health

Organization Maximizing Positive Synergies Collaborative Group et al., 2009). GHPs differ across a range of variables including their functional aims, the size of their secretariats and budgets, their governing arrangements, and their performance (Buse & Harmer, 2007). GHPs also vary in geographical scope. Some focus on a specific region such as the International Partnership against AIDs in Africa, the African Program for Onchocerciasis Control and the African Malaria Partnership. Others, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the Global Alliance for Vaccines and Immunizations (GAVI) and the US President's Emergency Plan for AIDS Relief (PEPFAR) are truly global in reach (McKinsey & Company, 2009).

GHPs have been successful in raising the profile of certain health problems on policy agendas, mobilizing resources (Buse & Harmer, 2007) and generating an overall positive impact on health outcomes (Horton et al., 2009). GHPs, however, have generated unintended consequences such as imposing donor priorities over national priorities of recipient countries, depriving specific stakeholders a voice in decision-making, implementing inadequate governance practices, and mismanagement of resources through inadequate use of country systems and poor harmonization, among others (Biesma et al., 2009; Buse & Harmer, 2007). To minimize these effects and promote aid effectiveness, the international community established the Paris Declaration on Aid Effectiveness, which expressed the international community's consensus on the direction for reforming aid delivery and management to achieve improved effectiveness and results. The Paris Declaration is grounded on five mutually reinforcing principles which are that 1) aid would be most effective if developing countries exercise greater leadership over development policies and plans (ownership), 2) donors base support on country

priorities and systems (alignment), 3) donor agencies coordinate their activities and minimize transaction costs (harmonization), 4) together partner countries and donors manage for results (managing for results), and 5) partners are accountable to each other in achieving real results from aid (mutual accountability) (OECD, 2005).

In June 2009, the Lancet published the first results of the Maximizing Positive Collaborative Group, which presents a conceptual framework for the systematic assessment of the effects of GHPs on the recipient countries, particularly, on national health systems. Following this publication, the World Health Organization (WHO) released a statement acknowledging the importance of maximizing positive synergies between GHPs and country partners to deliver better and more equitable health outcomes and enhanced values in return for resource inputs. This statement also reinforced the need for further research to understand *how* GHPs and countries can strengthen their interaction to maximize these positive synergies (Horton et al., 2009).

The proposed study intends to understand the “how” in the context of the Regional Health Initiative (RHI), a cooperative effort to reduce inequalities in the coverage of basic health services among the Mesoamerican population in the lowest income quintile. The goal of RHI is to contribute to the achievement of health-related MDGs in southern Mexico and Central America by investing in the implementation of effective interventions to improve: 1) maternal, reproductive and neonatal health; 2) maternal and child nutrition; and 3) vaccinations. These interventions primarily target women and children under 5.

RHI shares common characteristics with other GHPs. It has generated a strong political support and commitment; but, as with other GHPs, concerns about the

engagement of this partnership with countries exist. GHPs have usually focus their attention in regions with fragile and conflicted-affected countries such as Sub Saharan Africa (Bornemisza, Bridge, Olszak-Olszewski, Sakvarelidze, & Lazarus, 2010). In contrast, Latin America is a region with functional health systems and relatively stable sociopolitical context. Engaging with countries with a more stable context might pose new opportunities and challenges to GHPs.

The launch of RHI in 2010 along with detailed information about the planning and development of its initial steps provided a rich opportunity to document and examine the elements that contribute to the establishment of a synergistic engagement between the RHI and the Mesoamerican countries.

The first paper of the dissertation examines the actors involved in the planning of the RHI and in its initial engagement with the countries of El Salvador and Guatemala. The aims of this paper are threefold: 1) to identify the perspectives of the actors involved, 2) to examine whether these perspectives were aligned and the factors that led to this (lack of) alignment, and 3) to examine the consequences of the alignment (or lack thereof) of perspectives.

The second paper consists of two case studies documenting the formulation of RHI operations in the countries of El Salvador and Guatemala. The paper aims to 1) understand the processes that took place and factors that influenced the formulation of the operations, and 2) assess whether the goals of feasibility, alignment, and ownership that are determinants of the success of the process were pursued during the formulation of the operations.

CHAPTER 2

BACKGROUND AND SIGNIFICANCE

GLOBAL HEALTH PARTNERSHIPS

GHPs are “organizations that bring together groups—including governments, donors, NGOs, and a variety of private-sector representatives—into a formal, collaborative relationship dedicated to the pursuit of a shared health goal”(Conway, Gupta, & Prakash, 2006). These partnerships work directly with the governments of partner countries providing resources and technical assistance generally through grants to develop and implement plans for specific health problems. Such partnerships are becoming a prevailing organizational model for addressing global health problems in low- and middle-income countries (McKinsey & Company & Bill and Melinda Gates Foundation, 2005).

Different actors form GHPs to achieve a common purpose. The ongoing interaction of people in their efforts to achieve what they value is known as the policy process (Buse, 2008). Policy focuses on problem-solving; and, although it usually involves a technical component, it always involves people with varying perspectives, power, and interests in the problem and its solution (Clark, 2002). We draw from the policy-science literature to disaggregate the process of development of a GHP into six functions, or stages, of decision making shown in Figure 2.1. Although not depicted in

the Figure, the functions of decision making are often carried out simultaneously, rather than sequentially, and are often mixed together in complex ways (Clark, 2002). While these functions are relevant, studies usually focus on documenting their outcomes paying little attention to the process of how they were obtained (Majone, 1989). The lack of attention to the decision-making functions delimits our understanding of the process and reasons behind the success or failure of achieving a particular outcome. It also prevents the understanding and identification of failures in the process and the implementation of timely corrective actions for improvement.

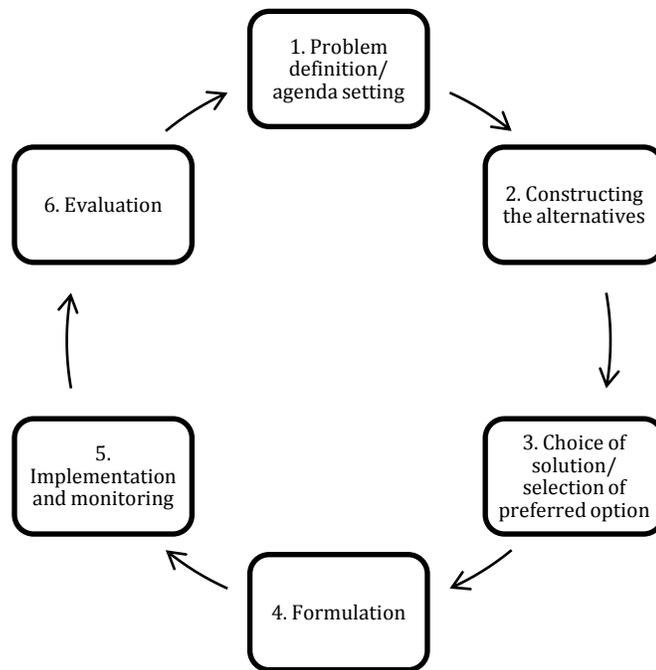


Figure 2.1. Functions of the decision-making process
Source: Adapted from Clark (2002).

During the agenda setting of a GHP, certain health problems rise to the attention of partners while others recede or are ignored completely. Agenda setting involves the process of obtaining and analyzing information about past trends in events related to health problems and the conditions under which those trends took place. Once partners reach consensus about the main health problem to target, they construct and consider options to change conditions and future health outcomes. The following function, formulation, refers to the establishment of the rules and regulations that guide the implementation of the GHP operation. These operations include providing technical assistance and resources for the implementation of interventions aimed at improving the targeted health problems in country partners. As part of evaluation, the GHP assesses the decision process as a whole and the success of a particular operation in achieving its goals. Through evaluation, a GHP can estimate the degree to which their goals have been reached, assess the causal factors involved, determine responsibility and accountability for what happened in a particular decision process, and share with other actors and stakeholders their findings and recommendations (Clark, 2002).

Once the GHP starts engaging with recipient countries to plan their country operations, a similar decision-making process takes place at the country level. As recommended by the Paris Declaration, country partners should take ownership of the GHP, and play a role in defining the specific priorities of the GHP for the country, as well as in designing and implementing the country operation. Recent literature shows that promoting country ownerships of a GHP operation is challenging (Hyden, 2008; OECD, 2005; Roberts, 2010), and evidence regarding effective interventions or strategies that might foster this condition is limited (WHO, 2006). Our limited understanding of the

elements that influence the decision-making process of a GHP, especially during its early development, poses a barrier to understand how countries and GHPs engage and to identify the strategies and actions that a GHP can use to promote country ownership and the other principles promoted by the Paris Declaration.

The first paper of this dissertation focuses on examining the agenda setting and formulation of RHI. This paper provides us with a unique opportunity to understand the elements that influence the early development of a GHP. The second paper examines the implementation of RHI by documenting the engagement between RHI and the countries of Guatemala and El Salvador in the formulation of their respective operations. Both papers prospectively document the stages of development of a GHP, providing a better understanding of *how* a GHP is planned and implemented and *what* can influence its decision-making process.

ELEMENTS THAT INFLUENCE THE DECISION-MAKING PROCESS

Every health problem and decision-making process necessary to solve it occurs within a specific context. The policy-science framework refers to the context in which individuals and organized interests in society interact and make decisions as the social process. Decision-making processes can only be understood if their social process is known. The framework provides a set of concepts and categories for examining the context and interactions of people and institutions in meaningful, functional terms. Table 2.1. describes these concepts and categories, as well as some questions that might be used to map them.

Table 2.1. Overview of the elements of the social process

Category	Definition	Question to ask
Participants	Individual, groups, and institutions who participate, who demand to participate, or who are excluded from participation	Who is participating? Who is demanding to participate?
Perspectives	The demands, expectation and identity of the participants	What are the perspectives of participants?
Situations	Geographic and temporal dimensions Institutions (values, structures) Crisis	In what situations do participants interact?
Base values	Assets or resources possessed by people or groups	What assets or resources do participants use in their effort to achieve their goals?
Strategies	Types of strategies Diplomatic (negotiation) Ideological (ideas) Economic (goods) Military (arms)	What strategies do participants employ in their efforts to achieve their goals?
Outcomes	Short-term, culminating events that indulge or deprive participants in a given situation.	What outcomes are achieved in the continuous flow of interactions among participants? What outcome each participant seeks and which ones each ends up with?
Effects	Long-term outcomes	What changes occurred over time? Are new practices put in place? Are old practices maintained?

Source: Clark (2002)

Original source: Laswell (1971a); Willard and Norchi (1993)

DECISION-MAKING PROCESS OF A GHP AT THE COUNTRY LEVEL

The GHP and country partners work together to achieve a common goal. Building a “good engagement” between a GHP and countries requires following the principles of the Paris Declaration on Aid Effectiveness to prevent unintended consequences in countries and maximize the effectiveness of donor aid. The Paris Declaration is based on the recognition that partner country should take ownership of development strategies. A country partner has ownership when it takes the lead in determining the goals and priorities of its own development and set the agenda for how they are to be achieved. Strengthening the country's ownership represents a shift of power in the way aid relationship worked in the past, while underlining the need for mutual accountability (OECD, 2009). With strong ownership, the prospects for progress against other Paris Declaration principles improve. If partners “own” priorities, plans and programs, they are more likely to exercise effective leadership in getting donors to align to national objectives and strategies, and to use the country's own systems for financial management, procurement, and monitoring and evaluation (OECD, 2009).

Building on the frameworks of Atun et al.(2009) and Shiffman & Smith (2007) on integration of health interventions and determinants of political priority respectively (Atun, De Jongh, Secci, Ohiri, & Adeyi, 2010; Shiffman & Smith, 2007), the establishment of a “good engagement” between GHPs and countries does not depend solely on the country partners but also on the characteristics of the GHP, the characteristics of the health problem, the capacity of the health system, and the political

context. Figure 2.2 shows the factors that influence the engagement of a GHP with country partners.

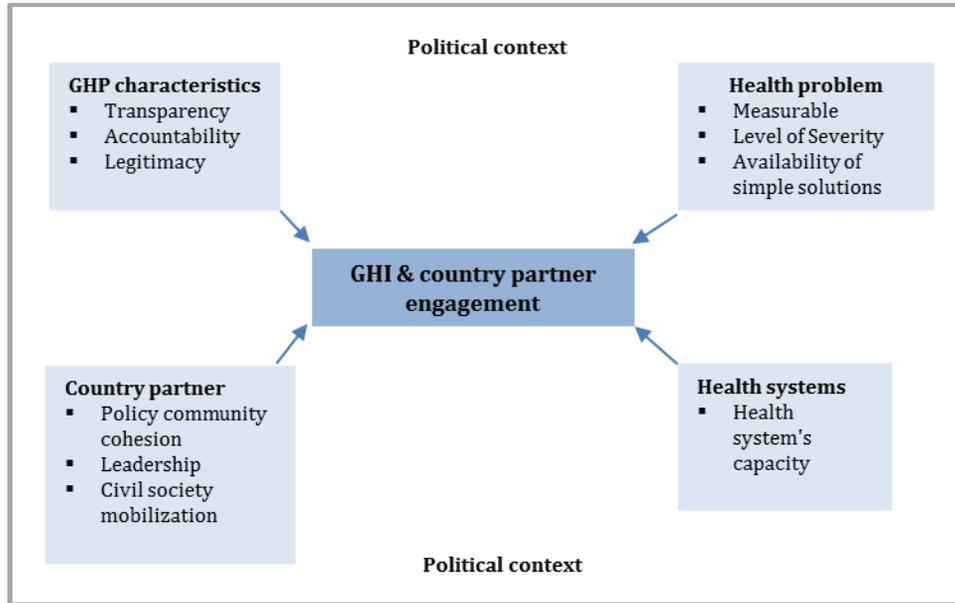


Figure 2.2. Factors that influence the engagement of a GHP with country partners

Country partners

To develop a “good” GHP-country engagement, the GHP must have national political support at the country level. Generating national political support can be challenging, as policymakers deal with a lot of different issues and have limited resources and conflicting political imperatives to address them (Kingdon, 2003). Political priority refers to “the degree to which political leaders consider an issue to be worthy of sustained attention and back up that attention with the provision of financial, human, and technical resources commensurate with the severity of the problem” (Shiffman, 2007a). A health problem receives political priority when: 1) national political leaders publicly and

privately express sustained concern for the problem, 2) the government enacts policies with supported strategies to address the problem, and 3) the government allocates and releases public budgets commensurate with the severity of the problem (Shiffman, 2007b).

The power of the policy communities and other national stakeholders involved in the GHP influence the GHP's acquisition of political support. Factors that shape the degree of power of these actors include: 1) policy community cohesion, 2) leadership of individuals and institutions, and 3) civil society mobilization. Policy communities make up the network of individuals and organizations who are linked by a central concern for the health problem (Shiffman & Smith, 2007). In some instances, a policy community is made up by a dominant core of actors surrounded by a number of other, more peripheral members, all who are capable of engaging in collective action (Walt et al., 2008). These communities include leaders of non-governmental organizations, government officials, bilateral donors, members of UN agencies, other international organizations, and academia. Policy communities that agree on basic issues such as the causes and solutions of a health problem are more likely to acquire political support than those that are divided by such issues, since politicians are more likely to consider those in agreement, authoritative sources of knowledge (Shiffman & Smith, 2007; Shiffman, 2007b). Furthermore, the presence of individuals recognized as strong champions for the cause (Kingdon, 2003) and institutions capable of uniting the policy community help build coalescence and provide direction to the engagement between country partners and GHPs (Shiffman & Smith, 2007). Lastly, GHPs are more likely to generate political support if

they link with grassroots organizations in civil society that have mobilized to press national political authorities to address the health problem (Shiffman & Smith, 2007).

Global Health Partnership

Many of the factors that influence the effectiveness of a partnership relate to the establishment of common goals, roles, processes and structures. Given the difference of power relationship among members of a GHP, it is also important to determine *who* decides these common objectives and structures and *how* they are determined (Buse & Walt, 2000). Therefore, governance, i.e., the process through which power and decision-making are exercised (Santiso, 2001), is central for the GHP-country engagement.

Governance is challenging in the context of GHPs. First, the governing bodies of GHPs are usually made up by members who are, in most cases, representatives of the various constituencies in the partnership. This dual role creates a conflict among governing-body members, who must balance the interests of their institution with those of the partnership (McKinsey & Company, 2009). Secondly, GHPs should guarantee to provide legitimate stakeholders a voice in decision-making on governing bodies (Buse, 2004) as those who are represented in these bodies are more likely to wield more influence over the priorities of the partnership than those who are not (Buse & Harmer, 2004). Limited funding, language barriers, and frequent rotation of personnel from country representatives are barriers that have skewed representation of governing bodies (Buse & Harmer, 2007).

Governing bodies, therefore, should be characterized by having 1) representative legitimacy, 2) accountability, and 3) transparency (World Bank, 1994). Legitimate

representation in GHP raises issues such as whose interests should be represented in the partnership and whose should not, while accountability refers to getting partners to deliver on commitments. There are a number of mechanisms, both informal and formal, that can encourage partner accountability to the GHP, including strategic alignment of partner actions, coordinated and consolidated work planning, establishing good informal personal relationships, and development of formal agreements and establishment of sanctions. Lastly, timely access to relevant information about decision-making processes and substantive evidence and information on the matter under consideration facilitates the accountability of members and enables them to make meaningful contributions to deliberations (Buse, 2004).

Health problem and solution

The characteristics of the health problem help shape the GHP-country engagement. Problems that are easily measured are easier to address than those that are not, since GHPs and countries have information to confirm their severity and monitor progress. Furthermore, problems that are more severe, as indicated by objective indicators, are more likely to attract attention than others by being perceived as more serious than others (Atun et al., 2010; Kingdon, 2003; Shiffman & Smith, 2007). The available solutions to health problems also influence the GHP-country engagement. Problems with fairly simple, inexpensive, evidence-based solutions are easier to promote than will those without these features, since they are easier and cheaper to address (Atun et al., 2010; Shiffman & Smith, 2007).

The way in which the health problem is understood and portrayed, i.e., the framing of the problem is another factor that influences the GHP-country engagement (Atun et al., 2010). Any problem can be framed in several ways. Some frames resonate more than others, and different frames appeal to different audiences. Frames that resonate internally (i.e., internal frames) unify policy communities by providing a common understanding of the definition of, causes of, and solutions to the problems. Frames that resonate externally (i.e., external frames) move essential individuals and organizations to action, especially the political leaders who control the resources that GHPs need (Shiffman & Smith, 2007). The identification of frames about the problem and solutions that appeal to both GHP and country can help build support and shape a better understanding of the common goals of their engagement. For instance, solutions that are congruent with the values of policy communities, have public acceptability, and have politicians' receptivity are more likely to gain support than those without consistent internal or external frames (Kingdon, 2003).

Health system

Health systems play an important role in determining the type of GHP-country engagement. Countries with strong health systems are more likely to provide leadership and promote practices that will facilitate the attainment of the principles of Paris Declaration. Strong health systems have the ability to collect, pool, and spend the necessary resources to become sustainable and equitable; deliver effective, appropriate, and equitable care; generate the necessary resources to make this happen; and provide the

stewardship to ensure its effective governance (Balabanova, Mckee, Mills, Walt, & Haines, 2010).

Political context

The political context influences the engagement between a GHP and country partners (Walt & Gilson, 1994). Two elements of the political context are particularly important in generating support for a GHP: 1) policy windows and 2) global governance structures (Shiffman & Smith, 2007). Policy windows are moments in time when worldwide conditions align favorably for a health problem, presenting advocates with strong opportunities to reach political leaders. For instance, the MDGs have opened policy windows for some health problems such as malnutrition and maternal mortality. The global governance structure for the sector responsible for a given health problem refers to the set of norms (shared beliefs on appropriate behavior) and the institutions that negotiate and enforce these norms. International treaties, laws and declarations for health problems, and organizations in charge of their enforcement can help build a favorable environment to support the GHP-country engagement(Shiffman & Smith, 2007).

In summary, a GHP is shaped by various elements and contextual factors. The policy science framework provides a set of concepts and categories that are useful for examining the process of development of the GHP, in particular its agenda setting, formulation, and implementation. Furthermore, the framework on factors that influence the engagement of GHPs with country partners can guide the documentation and close

examination of the implementation of a GHP. Both frameworks were used for the development of the two studies of the dissertation.

CHAPTER 3

RESEARCH DESIGN AND METHODS

The first section of this chapter presents a description of the RHI and the countries of El Salvador and Guatemala. The second section details the data collection procedures and analysis plan for both studies of the dissertation.

RHI

The RHI is a five-year, public-private partnership between private donor A, private donor B, a bilateral agency, a multilateral agency (MA), and the eight countries of the Mesoamerican region (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama, and Mexico). The goal of RHI is to support the efforts of the country partners in reaching the health MDGs by investing in interventions to improve maternal and child health (MCH). RHI aims to: 1) decrease mortality and morbidity of poor women of reproductive age and children under 5 years of age; 2) increase coverage, use, and quality of interventions in the areas of reproductive, maternal and neonatal health, maternal and child nutrition, and immunizations; and 3) generate globally-relevant learning and knowledge for scaling up MCH interventions with proven efficacy.

As part of the agenda setting of RHI, one donor appointed an academic institution in 2009 to guide a participatory process for discussing the main MCH problems in the partner countries. International experts, Ministry of Health (MoH) representatives, and

international organizations worked together for over six months to develop an assessment of MCH problems and to identify their potential solutions. This work resulted in the development of a Technical Plan approved by the MoH that identified effective interventions to address MCH problems in the country partners.

After its official launch in June 2010, the multilateral agency took charge of managing the RHI, which involved identifying the RHI's strategies, developing its rules and regulations, and discussing them with donors. The RHI defined five main strategies to implement in each of the country operations. These strategies are: 1) supporting comprehensive health packages that deliver the MCH interventions described in the Technical Plan, 2) targeting the poorest areas of the countries, 3) monitoring and evaluation, 4) promoting pro-poor policies and norms, and 5) implementing a results-based financing (RBF) model. The RBF is a financial strategy at the national level for improving health services coverage and health outcomes in the target population. The RHI reimburses half the amount contributed by the country partners if the country operation reaches its previously agreed goals such as increased coverage of health interventions, improvement of quality of health services, and health outcomes.

Implementation of RHI began in July 2010 with the formulation of country operations in El Salvador and Guatemala. These operations were approved by donors in the second semester of 2011 and were expected to begin by 2012. Figure 3.1. presents RHI's timeline.

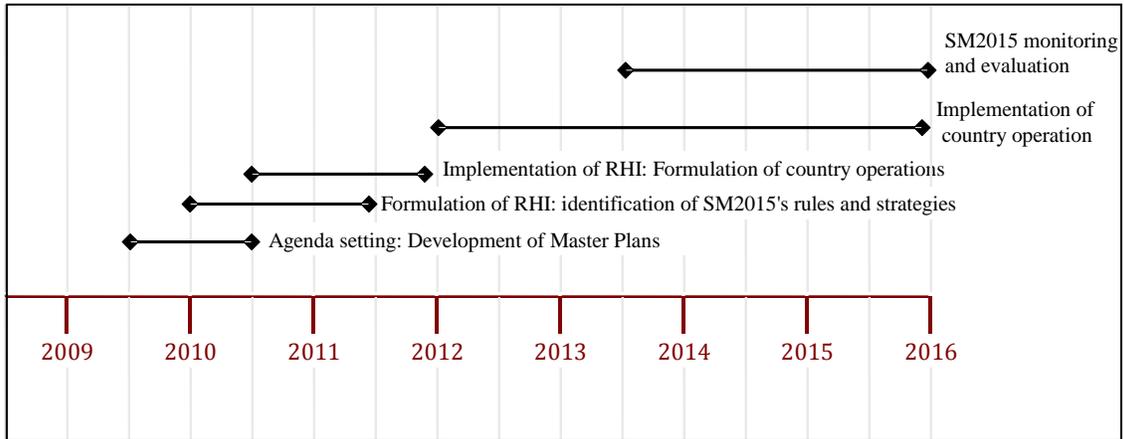


Figure 3.1. RHI timeline

Country operations

The process of development of RHI country operation follows MA policies and procedures as well as RHI specific requirements (RHI Coordinating Unit/SPH/MA, 2011a) (Figure 3.2.). Initially, the country sends a formal letter to the MA stating its interest to participate in RHI. The following stage involves the formulation of the country action plan. Once the action plan is approved by donors and the MA, the country and the RHI sign a Letter of Agreement and the implementation of the action plan begins, followed by its monitoring and evaluation (RHI Coordinating Unit/SPH/MA, 2011a) .

After the country officially becomes involved with RHI, the MA sets up a RHI team that works collaboratively with the country in the design of the RHI operations. RHI entails the implementation of up to three action plans per country, each of a maximum duration of 18 months. The design and approval of a country action plan is a labor-intensive task that can take up to 35 weeks. The RHI team conducts at least three visits to the country to work with its counterpart in the formulation of each action plan. These

visits are referred to as identification, orientation, and analysis mission (RHI Coordinating Unit/SPH/MA, 2011b). During the identification mission, the RHI team presents the scope, structure, functioning, and requirement of the Initiative to its country counterpart. The team also explain in detail the innovative components of RHI, in particular its RBF model.

During the orientation and analysis missions, the RHI team works closely with its country team to prepare the action plan. The action plan provides a detailed description of the overall operation, including its background, justification, theory of change and action, components and activities, budget, implementation plan, executing arrangements, supervision, and monitoring and evaluation plan (RHI Coordinating Unit/SPH/MA, 2011a). Once finalized, the action plan goes through the standard MA review process and reviews by external experts. The MA then sends the action plan to the donors, who have 20 working days to approve or request its revision. Once the action plan is approved by donors, it undergoes a series of MA internal procedures for its final approval. Lastly, RHI and the country partner sign a letter of agreement for the implementation of the first action plan (RHI Coordinating Unit/SPH/MA, 2011a).

EL SALVADOR

Political context

El Salvador endured civil war for over 10 years until its return to democracy in 1992. During the next 17 years, the country was ruled by the right-wing political party Nationalist Republican Alliance (ARENA). In March 2009, the left-wing party Farabundo Martí National Liberation Front (FMLN) won the presidential elections for

the first time. The new government establishes in its development plan (Plan Quinquenal 2010-2014) the ten priority areas for the next five-year period, including poverty reduction and supporting social participation in policy-making processes. This plan also sets long-term goals for 2024, including promoting the development of “*healthy, educated, and productive population*” (Gobierno de El Salvador, 2010).

Besides placing social development as one of its main priorities, the new government made changes to improve aid effectiveness in the country. In June 2010, it presented its National Aid Effectiveness Agenda (Viceministerio de Cooperación para el Desarrollo, 2010) that identifies key actions to meet the Paris Declaration and the Accra Agenda for Action (Viceministerio de Cooperación para el Desarrollo, 2010). Furthermore, the government established the Vice-Ministry for Development Cooperation, a new entity within the Ministry of External Affairs to “*guide the development cooperation towards the strategic priorities of the country*” (Viceministerio de Cooperación para el Desarrollo, 2010).

In January 2011, the government and development cooperation actors signed the Code of Conduct for the conditional cash transfer program in the country, the Rural and Urban Solidarity Communities Program. The Code of Conduct describes the best practices and commitment adopted by the national institutions and development cooperation to coordinate, harmonize, and align the different interventions of the program (Secretaría Técnica de la Presidencia, 2011).

The efforts to improve aid effectiveness also brought changes to the health sector. The government created the Department of External Cooperation within the Ministry of Public Health and Social Assistance (MSPAS) as the body in charge of coordinating the

development cooperation in health. The MSPAS's Annual Report 2009-2010 described the development cooperation in health and some of the coordination challenges faced by the Department of External Cooperation (Ministerio de Salud Pública y Asistencia Social, 2011):

"Low stewardship from the MSPAS to guide the technical and financial cooperation that is mainly expressed through the fact that an important part of the cooperation responds to criteria and agendas built solely from the perspective of the donor; high fragmentation and juxtaposition of initiatives and actions; increase in the number of vertical health programs that have their own source of financing and health framework, including those within the MSPAS; low level of knowledge of MSPAS's central level about the (involvement of) development cooperation in health services (including hospitals and health units), municipalities, and cooperation with national NGOs and social organizations, among others."

Health problems

Among the 6.1 million total population, the poverty rate in El Salvador is 37.8% nationally and 46.5% in rural areas (The World Bank, 2012a). Violence in El Salvador has been intensifying since early this decade, especially from 2008 onward. In 2011, the homicide rate of 62 per 100,000 was the second highest in the world (United Nations Office on Drugs and Crime, 2011). After a truce between the country's leading gangs began in 2012, the average number of daily homicides dropped 64%, from 14 to 5 ("Discurso Sr. Mauricio Funes Presidente de la República, tercer año de Gobierno," 2012).

Since the 1990s, El Salvador has significantly improved its health outcomes, as shown by decreased child and infant mortality and morbidity, and improved coverage of maternal and reproductive health services. Under-five child mortality decreased from 92 deaths per 1,000 live births in 1990 to 19 deaths per 1,000 live births in 2008. Similarly,

infant mortality declined from 48 deaths per 1,000 infants in 1990 to 16 deaths in 2008 (Gobierno de El Salvador, 2008). Furthermore, the country has made progress in expanding coverage of prenatal and post-partum controls and institutionalizing births. Between 2002 and 2008, prenatal-care coverage increased from 61.9% to 69.9% and institutionalized births from 69.4% to 84.6%. El Salvador has also made efforts to improve contraceptive use among its population. In 2008, 72.5% of women between the ages of 15 and 49 years used contraceptives as compared to 67.3% in 2002 (Gobierno de El Salvador, 2008).

Despite good progress, challenges in equity and access to health care remain for the poor. Table 3.1 shows some equity challenges in health outcomes and utilization of health services. While 78.6% of women from the top income quintile use contraceptives, only 65.1% of the women from the lowest quintile use them. With respect to prenatal care, only 68% of women from the lowest income quintile benefitted from the minimum five prenatal visits compared with 88% of women from the highest income quintile. Furthermore, mortality and morbidity of children are higher in the lowest quintile as compared to the top income quintile.

Table 3.1. Health indicators in lowest and highest income-quintile groups of El Salvador

Indicator	National level	Lowest quintile	Highest quintile
Use of health services (%)			
Contraceptive use	72.5	65.1	78.6
Antenatal care ¹	78.3	67.6	86.2
Institutional birth	84.6	68.2	97.0
Postpartum care	58.4	45.2	75.2
Mortality (per 1,000 births)			
Neonatal	9	13	4
Infant (under the age of one)	16	26	6
Under-five	19	29	6
Health problems (%)			
Stunting < 5 years	19.2	31.4	4.6
Anemia (6-59 months)	26.0	30.8	17.4
Anemia in women (15-49 y)	10.0	10.8	8.4

¹Five or more antenatal care visits

Source: Gobierno de El Salvador (Gobierno de El Salvador, 2008)

Health system

Public and private institutions provide health care services in El Salvador. The public-health sector comprises six different entities: the MSPAS, the Social Security Institute (ISSS), the Solidarity Fund for Health (FOSALUD), the Salvadoran Rehabilitation Institute for the Disabled (ISRI), and the Military Health, and Teachers' Welfare (ISBM). The private sector consists of privately-funded clinics and hospitals (Ministerio de Salud Pública y Asistencia Social, 2009).

The health system is highly fragmented and segmented (Banco Interamericano de Desarrollo, 2011; World Health Organization, 2010). Fragmentation, i.e., the coexistence of health services that are not integrated into the health system, causes lack of standardization of the quality of care and inefficiencies in the system. On the other hand, segmentation, i.e., the coexistence of subsystems that provide services to specific

populations, deepens inequity in access to health care among different population groups. (Pan American Health Organization, 2007a). Around 40% of El Salvadorians have limited access to health care services (MINEC & DIGESTYC, 2010).

Other limitations of the health system include low quality of services, lack of trained health personnel, inadequate infrastructure and equipment, low access to medicines, and low public health expenditure (Banco Interamericano de Desarrollo, 2011; Becerril, Muiser, Sáenz, & Vindas, 2008; Ministerio de Salud Pública y Asistencia Social, 2011). The national health expenditure, both private and public, decreased from 7.7% (2002) to 6.1% (2008) of the country's Gross Domestic Product (GDP). The MSPAS's expenditure is low in absolute terms and as percentage of the GDP (Banco Interamericano de Desarrollo, 2011; European Commission, n.d.; World Health Organization, 2010).

The new Minister of Health had strong leadership that brought changes to the MSPAS. During her first months in office, she outlined the priority actions to be taken by the government during its first 100 days to overcome the pressing challenges of the health system (Rodríguez, 2009). The proposed actions include the implementation of the National Health System Reform (NHSR) to restructure the public health services and deliver universal health care based on Integrated Primary Health Care (IPHC) (Rodríguez, 2009).

The NHSR has eight components: 1) establishing the National Health Emergency System to guarantee proper health care in case of emergencies, epidemics, and natural or man-made disasters, 2) improving the supply and access to vaccines and drugs, 3) promoting and strengthening of the inter- and intra-sector work in health, 4) establishing

the National Health Forum to promote social and community participation in health, 5) establishing the National Institute of Health, 6) strengthening the strategic planning in health through the establishment of a National Health Information System, 7) strengthening the capacity of the health workforce, and 8) building the Integral and Integrated Public Health Care Service Network (RIISS) (Rodríguez, 2009).

The RIISS is the network of public institutions that provide health services and work in coordination with the population to improve the social determinants of health (Gobierno de El Salvador, 2011). The RIISS comprises primary health care centers called Community Unit of Family Health (UCSF), and hospitals and clinics of the secondary and tertiary health care.

The Community Team of Family Health (ECOS) is in charge of providing basic health services in the UCSFs. The ECOS team is composed by a physician, a nurse, an auxiliary nurse, an assistant, and health promoters. In rural areas, each ECOS is in charge of providing services to 600 families, while in urban areas, each ECOS serves 1800 families. For approximately every 10 ECOS in rural areas or 5 ECOS in urban areas, there is one ECOS with health specialist (called ECOS Especializados) that provides specialized health services such as physical therapy, pediatric, and dental services to the population.

One year after its launch, the NHSR had accomplished important goals such as the abolition of user fees, the recruitment of new health personnel to cover staff shortages, and an increased budget for the procurement of essential medicines (Ministerio de Salud Pública y Asistencia Social, 2011). The Government has shown its commitment to prioritizing health and supporting the NHSR by considerably increasing the MSPAS's

funds. The estimated annual budget of MSPAS was around US\$517 million for 2011, an increase of over 30% from 2008 (The World Bank, 2011). Nevertheless, the financial gap needed to successfully implement the NHSR is estimated to be over US\$100 million (German Foundation for World Population, 2011).

Currently, the implementation of the NHSR mostly depends on a US\$80 million loan from the World Bank and a US\$60 million loan from the Inter-American Development Bank (IDB) (German Foundation for World Population, 2011). Both loans support the expansion of the RISS by investing in procurement of medical equipment and supplies for the UCSF, and in the training of health personnel. Furthermore, the IDB loan finances the infrastructure work to expand and improve the network of UCSF and public health laboratories. Other components of the NHSR supported by both loans include the development of the National Medical Emergency System, the National Health Information System, and the national network of public health laboratories of the National Health Institute (Inter-American Development Bank, 2009; The World Bank, 2011).

GUATEMALA

Political context

Guatemala has a population of 14.3 million, of which 40% are of indigenous descent. It is one of the countries with the highest economic disparity in the world, with 60% of its income being concentrated among only 20% of its population. Guatemala has

one of the highest poverty rates in Latin America, with 22% living in extreme poverty and 56% in poverty (The World Bank, 2012b).

The Peace Accords signed in 1996 ended more than three decades of civil conflict which left a highly fragmented and inequitable society (The USG Guatemala GHI Team, 2010). Indigenous populations have limited access to resources, opportunities, and health, education, and other public services (The United States Agency for International Development, 2012). These factors result in health and social disparities between indigenous and non-indigenous groups. Almost 56% of indigenous people live in poverty compared to 44% of non-indigenous (Instituto Nacional de Estadística, 2006). In 2009 nearly 60% of indigenous children suffered from stunting compared to 31% of non-indigenous children (Ministerio de Salud Pública y Asistencia Social, 2010). The average years of schooling is 3.8 for indigenous people while for non-indigenous is 6.5 (The World Bank, 2012b).

Guatemala faces fiscal challenges. Tax collection was only 10% of GDP in 2004, falling short from the 12% goal set in the Peace Accords. As a consequence of low taxation, the national social investment is one of the lowest in Latin America, reaching only 4.5% of GDP in 2006 (Bowser & Mahal, 2009). The expansion of the conditional cash transfer and rural development programs increased social investment from 4.4% of the GDP in 2008 to 5.3% in 2009 (The World Bank, 2010).

Underfunding along with inefficiency and corruption had led to very weak capacity and fragility of the governmental institutions (The USG Guatemala GHI Team, 2010). The country faces other challenges such as frequent natural disasters that strike with increasing intensity due to deforestation and rapid population growth. Criminal

activity and insecurity have reached historical high levels, placing the country as one of the most violent in the world (United Nations Office on Drugs and Crime, 2011).

Political parties in Guatemala are numerous and weak. No party has been re-elected to the Presidency since the approval of the new Constitution of 1985. In November 2011, Guatemalans elected a new government that took office in January 2012. The President Otto Perez Molina, a retired military officer, established three main priorities for his government: 1) to improve tax collection, 2) to reduce the high levels of stunting, and 3) to reduce the high levels of crime and violence in the country.

Guatemala has not articulated a single national development plan, but rather a series of development plans. The Secretariat of the Presidency for Planning and Programming released strategic investment plans for specific geographic areas. These plans describe the type of program investments required from 2011-2015 for specific geographic areas. For instance, the Strategic Plan on Food and Nutrition Security is a sub-plan to mitigate the risks of food insecurity and stunting in the most vulnerable populations of priority municipalities in the Western Highlands (Secretaría de Seguridad Alimentaria y Nutricional, 2011).

There are over 40 different development cooperation actors working in the country. To promote coordination, Guatemala has organized the development cooperation in three levels: the Dialogue Group, which is at the Ambassadorial level; the Coordination Group, made up of heads of international donor agencies; and the Technical Working Groups focused on sectors such as security and justice, transparency, education, health, and food security (The United States Agency for International Development, 2012).

Health problems

Guatemala's health outcomes compare unfavorably with those of other countries (The USG Guatemala GHI Team, 2010). Guatemala's infant mortality rate at 34 per 1,000 live births is the highest in Central America and the third highest in the region after Haiti and Bolivia. In addition, its maternal mortality ratio of 134 per 100,000 live births is one of the highest in Latin America (The United States Agency for International Development, 2012; The USG Guatemala GHI Team, 2010).

With 45% of children under-five years of age suffering from stunting, Guatemala has the highest rate of stunting in Latin America and the fourth highest in the world. This problem is especially severe in the lowest income quintile, where 68% of children under-five years of age are stunted. The health, education, and economic consequences of this health problem are long-lasting and severe.

Large differences in other health outcomes exist between the lowest and highest income quintiles (see Table 3.2). For instance, infant and child mortality rates are about four times higher in the lowest quintile as compared to the top quintile. Anemia is eleven percentage points higher among the children of the lowest quintile. Primarily the result of the multifaceted interaction of historical, political, and socio-economic factors, these differences demand careful attention and culturally-appropriate interventions (The USG Guatemala GHI Team, 2010).

Table 3.2. Health indicators in lowest and highest income-quintile groups of Guatemala

Indicator	National level	Lowest quintile	Highest quintile
Use of health services (%)			
Contraceptive use	74.5	52.3	93.9
Antenatal care ¹	93.2	89.6	99.0
Institutional birth	51.4	20.1	94.5
Postpartum care	25.7	18.2	57.3
Mortality (per 1,000 births)			
Neonatal	18	25	8
Infant	34	50	13
< 5 years	45	68	15
Health problems (%)			
Stunting < 5 years	49.8	70.2	14.1
Anemia (6-59 months)	47.7	50.7	39.8
Anemia in women (15-49 y)	21.4	27.9	14.7

¹At least one antenatal care visit

Source: Ministerio de Salud Pública y Asistencia Social (Ministerio de Salud Pública y Asistencia Social, 2010)

Health system

Guatemala's health system comprises public and private providers. The public providers are the MSPAS, the Guatemalan Social Security Institute (IGSS), and the Ministries of Defense and Government (Becerril-Montekio & López-Dávila, 2011). The private sector encompasses for-profit providers authorized by MSPAs, and nonprofits including over 1,000 non-governmental organizations (NGOs) and traditional medicine practitioners (The USG Guatemala GHI Team, 2010).

The Guatemalan public-health financing is one of the lowest in the Latin American region. In 2009, the budget for the public health sector was 1.45% of the GDP, down from 1.69% in 2008. In 2010, the MSPAS budget was further affected by the national budget crisis, a result of the global economic crisis and natural disasters. The

projected MSPAS budget for 2011 was \$425 million instead of the requested \$ 687.5 million(The USG Guatemala GHI Team, 2010).

Access to public health services is limited, especially in rural areas. To improve the limited access to basic public health services, the MSPAS launched in 1997 its Extension of Coverage Program (PEC). The PEC is the only public-health program that serves 4.6 million indigenous Guatemalans living in rural, isolated communities where permanent health centers do not exist. It combines institutional services in MSPAS facilities with itinerant health teams contracted out to around 88 NGOs. This health teams comprise physicians, nurses, and community workers (Pan American Health Organization, 2007b). The NGOs are paid an average of \$8 per capita per year and are responsible for providing basic health services to over 400 communities in the most isolated areas of Guatemala (The USG Guatemala GHI Team, 2010).

While the PEC is the only program that delivers essential maternal, child, and nutrition interventions to most rural areas, it routinely faces challenges for its continuation. Payment to the NGOs is usually delayed or suspended (RHI Coordinating Unit/SPH/MA, 2011b). The MSPAS frequently questions the quality of the services and periodically announces plans to replace the NGOs with MSPAS services that have no clear delivery model or funding. The development cooperation, however, has reiterated the need to maintain the PEC while other more efficient programs are designed and implemented (The United States Agency for International Development, 2012; The USG Guatemala GHI Team, 2010).

Beside expanding basic coverage and primary health services, the MSPAS faces the challenge of integrating traditional indigenous medicine and hiring bilingual staff to

its services (Pan American Health Organization, 2007b). Other challenges are shortage of qualified staff in rural areas, high turnover of high-level personnel (e.g. the past administration had three different Ministers of Health), staff fluctuations following national elections, and short-term contracts with low wages that lead to high rotation and instability of the health workforce (Andersen & Newman, 2005; The United States Agency for International Development, 2012).

DATA COLLECTION

Data collection for the two studies of the dissertation involved: 1) participant observation of key events and meetings interviews with key participants, 2) in-depth, semi-structured interviews with key participants, and 3) document review of RHI reports, documents, and meeting records. The participant observation complements the interviews as it allows for documenting behaviors in the context in which they occur. Interviews allow for understanding the lived experiences of the participants and the meaning they make of that experience (Seidman, 2006). Finally, document review can provide a “behind-the-scene” look at the RHI processes and how they came into being (Patton, 2002).

I participated in key events and meetings of RHI between May 2009 and July 2011. I was part of technical groups that developed the RHI Technical Plans, attended the official launch of RHI, and participated in planning meetings at the MA. During the implementation of RHI, I visited the countries of El Salvador and Guatemala, and attended four in-person meetings organized to formulate their respective action plans. I selected these countries based on the timing of their engagement with RHI. As these were

the first countries formulating the action plans, the RHI was interested in using the results of these studies to draw lessons that could be used for the formulation of action plans in other countries.

I conducted 28 in-depth interviews with participants involved with the RHI, including representatives from the MSPAS in El Salvador and Guatemala, donors, and MA. The participants had different institutional affiliations, and roles or functions in the RHI. I interviewed all the representatives of the donor agencies directly involved with the RHI, all the members of the RHI teams involved with the two countries, the two country team leaders, and other country team members that participated in the formulation of the action plans. The interviews were conducted between June 2011 and February 2012. A first set of interviews was conducted after the formulation of the action plan in El Salvador was completed in May 2011. The second set of interviews was conducted once Guatemala finalized its action plan in August 2011.

The interview guide covered the participants' involvement with RHI in the planning of its strategies and formulation of its action plans in El Salvador and Guatemala, and their views on the process, including the factors that hampered or facilitated the formulation of the action plans in the countries (Appendix). The interviews provided insight into the development of the RHI's strategies and the formulation of the action plans of both countries. The interviews lasted on average one hour and were conducted in Spanish, either face-to-face or by telephone. The participants provided oral consent to be interviewed and recorded. I concealed identifying information to maintain anonymity.

I reviewed two different sets of documents. The first set of documents was related to the RHI and included meeting records, reports developed by donors and multilateral agencies, studies conducted by the RHI in El Salvador and Guatemala, and newspaper articles on RHI. The second set of documents described the characteristics of El Salvador and Guatemala. These documents included government reports, manuscripts, and reports on MCH in the countries, health surveys and country statistics.

ANALYSIS PLAN

Manuscript 1

This paper examines the actors involved in the planning of the RHI and in its initial engagement with the countries of El Salvador and Guatemala. The aims of this study are threefold: 1) to identify the perspectives of the actors involved, 2) to examine whether these perspectives were aligned and the factors that led to this (lack of) alignment, and 3) to examine the consequences of the alignment (or lack thereof) of perspectives.

I initially examined the data to identify recurrent categories and themes. I used Nvivo 9 qualitative analysis software program (QRS International). I established a common set of codes for each interview or field note based on Lasswell's elements of the social process (Clark, 2002). I identified the three elements of perspectives: 1) identities, 2) expectations, and 3) demands. While identities answers the question "on whose behalf are demands made?", expectations refer to the matter-of-fact assumptions of actors about past, present, and future events. Demands are what actors want in terms of values or

organization. The eight base values that actors usually seek as goals or have to influence the social process are: power, enlightenment, wealth, well-being, skill, affection, respect, and rectitude (Clark, 2002; Lasswell, 1971).

Once coding was completed, I constructed matrices to synthesize the data on perspectives and identify patterns. Matrix construction is a systematic task furthered the understanding of the substance and meaning of the data (Miles & Huberman, 1999), and provided a new way of arranging and thinking about the more textually-embedded data.

I used process tracing to examine pattern of causality and identify social processes. Process tracing is an analytic tool for drawing descriptive and causal inferences from diagnostic pieces of evidence that are often part of a temporal sequence of events or phenomena (Collier, 2011). I examined data in detailed to establish whether the processes within the case fit those predicted by alternative explanations (A. L. George & Bennett, 2005; Gerring, 2007).

Manuscript 2

This paper consists of two case studies documenting the formulation of RHI operations in the countries of El Salvador and Guatemala. The study aims to 1) understand the processes that took place and factors that influenced the formulation of the operations, and 2) assess whether the goals of feasibility, alignment, and ownership that are determinants of the success of the process were pursued during the formulation of the operations.

Comparative analysis of cases is useful to generate new understanding of complex phenomena and dynamics (Miles & Huberman, 1999; Yin, 2009). Case descriptions provide rich sources of information that enable recognition of unexpected patterns that might not be captured with other methodologies (Alvord, 2004).

Data analysis was conducted using NVIVO 9 qualitative analysis software program (QRS International). Data analysis was conducted concurrently with the data collection process. After each interview, I wrote down my field notes, generated additional questions, and identified emerging themes for analysis. Following the completed data collection process, data were systematically coded using an initial set of codes based on Lasswell's elements of the social process. Inductive analysis allowed for the identification of emerging themes.

A report was prepared for the RHI that presented each case as a "whole" study in which convergent evidence was sought regarding the facts and conclusions for the case. The report also compared and contrasted the findings from both case studies indicating the extent of the replication logic and providing a better understanding of the factors that predicted similar or contrasting results. Multiple cases strengthen the results by replicating the pattern-matching, thus increasing confidence in the robustness of the proposed theory (Yin, 2009). Three participants reviewed the report and provided additional comments and suggestions. As the data were reviewed, further comparisons were made, codes refined, and consistency checks made to further elaborate and corroborate the analysis.

Trustworthiness of studies

I used various strategies to meet the trustworthiness criteria of qualitative research (Bailey, 2006; Krefting, 1991; Patton, 2002). To strengthen the credibility of the studies, I engaged in a prolonged and varied field experience, and documented the planning process of RHI for approximately 24 months. Repeated observations and interviews, as well as my sustained presence in the study setting helped me rule out spurious associations and collect detailed and varied data to provide a full and revealing picture of the RHI. Furthermore, prolonged field experience allowed the informants to become accustomed to my presence as a researcher. As rapport increases, informants may volunteer different and often more sensitive information than they do at the beginning of a research project (Krefting, 1991).

A threat to the trustworthiness of the study lies in the rapport and close researcher-informant relationships that can develop during the prolonged field data collection. As Krefting notes, "the researcher can become so enmeshed with the informants that he or she may have difficulty separating his or her own experience from that of the informants." (Krefting, 1991). I used reflexive analysis to minimize this threat and ensure the confirmability of the research finding. Reflexive analysis involves critically thinking about how one's characteristics, values, and history, and decisions about research, influence the results of the study (Bailey, 2007). I included some of my reflections in this dissertation for the reader (and me) to be cognizant of my own biases rather than assuming to be "objective". During data collection and analysis, I tried to be attentive to and conscious of the cultural, political, social, and ideological origins of my own perspective.

Triangulation is a strategy used to strengthen the credibility, dependability, and confirmability of the research findings (Guba, 1981). I conducted data and methods triangulation by collecting information from a diverse range of individuals and settings, using a variety of methods. It reduces the risk of chance associations and ensures that the weaknesses of one method of data collections are compensated by the use of alternative data-gathering methods. I used peer reviewing and respondent validation to ensure the dependability and credibility of the findings. Peer examination involved the discussion of the research proposal and findings with researchers who have experience with qualitative methods. Respondent validation involved soliciting feedback about the data and conclusions from the studies to three participants (Mays & Pope, 2000). In this way, I decreased the possibility of misinterpreting the meaning of the interview participants' comments and perspectives.

Finally, I used two different strategies to enhance the transferability of research findings. The first strategy, providing thick, descriptive data, relates to one type of transferability known as "naturalistic generalization" in which each individual reader determines whether the research findings are transferable⁶. The provision of dense background information about the research context and setting allows for comparison of the context to other possible contexts to which transfer might be contemplated. The second strategy refers to identifying concepts and social processes that have theoretical implications or significance beyond a specific setting. Both studies use explicit conceptual and theoretical frames that might allow for analytic generalizations. Multiple case studies allows for exploring the replication logic of the framework and the extent to which these cases had similar or contrasting results (Yin, 2009).

Reflexivity

My home is Costa Rica, a middle-income country that has a functional health system. I grew up believing that access to health services was a human right and that the government should be in charge of providing universal health care. Before joining my doctoral program, I worked in public-health services and met health professionals that had a clear understanding on the public-health challenges that the country faced.

I was partially drawn to my dissertation topic by curiosity. I was interested in understanding how external agencies could support my country and the Mesoamerican region in the improvement of the health of their population. I was a little skeptical but excited about what seemed to be an ambitious endeavor.

I conducted field research following a constructivism paradigm, considering social reality to be dependent on the social meaning given to it by those in the setting (Bailey, 2006). This allowed me to capture and value the multiple perspectives of participants involved with RHI (Patton, 2002). Encouraged by one of my committee members, I was also interested in understanding the organization in which I was conducting my fieldwork. I engaged in multiple interactions and events in an attempt to learn about the visible manifestation of the culture of the organization, its values, and the underlying assumptions behind them (Schein, 1990).

As a participant observer, I paid careful attention to the power dynamics among individuals and institutions involved with RHI. Power differentials were drivers of some of the decisions made by RHI. This research finding caused me unease. It showed, contrary to my beliefs, that governments do not always lead decisions about their health

systems. It also became a motivation to understand the causes of power imbalance, and shaped the aims of the first manuscript of the dissertation.

The two years of fieldwork were a unique professional opportunity which provided me first-hand experience on the challenges of improving public health. It is not easy. I respect the health professionals who are involved with GHPs and are willing to learn about them. There is a long road ahead of us before we gain a clear understanding of the processes and strategies needed to attain sustainable changes to improve and maintain the health of populations. I now recognize that external institutions and individuals can play a role in this process. As commented in one interview:

"The development cooperation has something to give. If not, it would not be entering another country. And those things are not only financial resources but technical expertise that sometimes the recipient country does not have. Once the evidence is there, and once that one is convinced, it is about strengthening the national partners. It is not about giving a recipe and conditioning the donations to changes in policies. It is about finding the right national partners capable of generating those changes. I think it is good. I think that is good to have different ideas from the ones of a country and to try to build different policies as a partner with the country. That is [having] incidence." (Interview no. 10 (I-10))

Participant observation in the organizational setting

Participant observation entails engaging in daily activities with members of a group in a particular setting (Atkinson & Hammersley, 1994). Gaining entry to the study settings can be hard, particularly in organizational settings which have clear boundaries and barriers to "outsiders" (Laverick, 2010). My academic advisor and I discussed my research interests and the objectives with gatekeepers who provided me access to the academic institution and MA.

Negotiating with gatekeepers is not only important for gaining access to a research setting but for defining the conditions under which research takes place. A written agreement between the researcher and organization can be pivotal for defining their roles and responsibilities and aligning their expectations about research. It is a practical way of avoiding misunderstandings and protecting both researcher and institution in case of unexpected events. For instance, the continuity of my research despite the sudden departure of a key gatekeeper in one organization was possible due to the contract that I had established with the organization. Participant observation often entails continual, informal negotiation of access and consent (Laverick, 2010).

Ethical research requires safeguarding the rights and protecting the well-being of those who are being researched. It involves avoiding deception during the research process (Christians, 2000). In both organizations, I was introduced to individuals involved with RHI and their coworkers by executive managers who explained my role in the organization and my status as a researcher. As time progressed and I engaged in different activities within the organization, I constantly reminded the group about my role as a researcher to avoid deception and misunderstanding. I developed an "elevator talk", which quickly summarized the objectives of my research, its rationale, and its possible benefits for RHI. This strategy was also useful for introducing myself to new members of RHI.

Research in an organizational setting can be challenging. Participant observers should learn to be proactive and find solutions to barriers that might limit their engagement with the organization. When I joined one of the organizations, I was placed in an office far away from RHI members. Although I was invited to the RHI meetings, I

quickly realized that I was missing opportunities for collecting data and establishing communication with RHI members. My involuntary seclusion precluded me from having frequent hallway chats with RHI members. I was also risking the chance of being forgotten and missing important email correspondence or discussions.

A few weeks later, I was able to transfer to an office closer to my RHI colleagues. As an avid coffee drinker, I visited the coffee room at least twice a day and was able to engage in short, but meaningful conversations with RHI members on their perspectives about the Initiative, or recent related events or meetings. Hallway chats also became frequent daily activities. I found these interactions particularly useful for two reasons. First, they gave me the opportunity to discuss the Initiative in an informal way outside of the RHI members' offices. Offices have distractions such as urgent emails and phone calls. A person who visits the coffee room has a few spare minutes for a break and therefore, is usually willing to engage in short conversations. Second, informal interactions helped build connections and trust which minimized the Hawthorne effect, i.e., the risk of members reacting or modifying their behaviors in response to the presence of a researcher (Jones, 2010).

Participant observers usually engage in lengthy fieldwork that last over six months (Fetterman, 1998). During that time, researchers develop relationship with members of the organizational setting. In both the academic institution and MA, I was not a detached researcher but a colleague for RHI members. Some researchers argue that participant observers experience pressure at an emotional level to present research findings that are favorable for the organization (Watt & Jones, 2010). Research findings can also have a direct bearing upon future access to such settings for other researchers

and, therefore have the risk of becoming a political issue (Watt & Jones, 2010). Above anything, I consider that research should be guided by ethics, which oblige participant observers to present valid or trustworthy data. Fabrication, omissions, and contrivances are nonscientific and unethical (Christians, 2000). From a pragmatic standpoint, I also believe that research findings can provide important lessons that can be useful to improve the performance of the organization.

Ethical approval

This research was submitted to the University of South Carolina Institutional Review Board for approval and exempted on the grounds that interview participants were in their official capacities and not being asked to share personal information. The participants were informed about the objectives of the study and its procedures to protect confidentiality. Verbal consent to record and transcribe the interviews and to participate in respondent validation was obtained previous to the interview.

CHAPTER 4

RESULTS

DIVERGING PERSPECTIVES OF ACTORS CAUSED UNINTENDED CONSEQUENCES
TO THE PLANNING AND IMPLEMENTATION OF A REGIONAL HEALTH INITIATIVE¹

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Abstract

Global Health Partnerships (GHPs) have recently emerged as a response to global health problems. To maximize the effectiveness of GHPs, global health actors are committed to coordinate and align their priorities, but coordination is a complex and difficult task. While there is broad recognition of the need to understand and overcome the challenges of coordinating GHP actors, few studies have documented the process of GHP development.

This study examined the planning and implementation of the Regional Health Initiative (RHI), a health partnership aimed to improve maternal and child health in Latin America. The aims of this study were to identify whether the perspectives of actors involved with RHI were aligned, and to examine the determinants and consequences of this (lack of) alignment. Data collection involved participant observation of key events and meetings; semi-structured, in-depth interviews with actors involved with RHI; and document review.

We found that actors involved with RHI had different, and in some instances, conflicting perspectives. Although the actors had the common goal of improving maternal and child health, they did not share other expectations and demands about RHI. The lack of alignment of the actors' perspectives caused unintended consequences for RHI's operations in the two countries studied. These consequences were the establishment of unrealistic goals for the country operations, tension during the negotiation of the operations, and unexpected changes to the country operations. Factors that influenced the lack of alignment of perspectives were: 1) challenges in knowledge management, 2) non-inclusive governance structure, and 3) limited time for planning.

GHPs should establish mechanisms that allow for the early identification and alignment of actors' perspectives. By aligning perspectives during the planning of a GHP, actors can define their common expectations and demands, establish common goals, and avoid unintended consequences for country operations.

Introduction

Global health has experienced rapid and remarkable changes over the past 15 years (Emanuel, 2012; Marchal, Cavalli, & Kegels, 2009; McCoy, Kembhavi, Patel, & Luintel, 2009; Moon et al., 2010; Sachs, 2012). The substantial increase in global health funding has been accompanied by the proliferation in the number and heterogeneity of actors involved with global health (Buse & Tanaka, 2011; McColl, 2008). These new actors, including civil society, nongovernmental organizations, and private philanthropists have revamped efforts to address certain global health problems through the establishment of new joint ventures such as global health partnerships (GHP) (Brugha, 2008; World Health Organization Maximizing Positive Synergies Collaborative Group et al., 2009).

Although different authors use different terms and definitions to characterize GHPs (Brugha, 2008; World Health Organization Maximizing Positive Synergies Collaborative Group et al., 2009), we define GHPs as “relatively institutionalized initiatives, established to address global health problems, in which public and private-for-profit sector organizations have a voice in collective decision-making.” (Buse & Harmer, 2007). GHPs share common features such as their focus on specific health problems, relevance to several countries, ability to generate substantial funding, inputs linked to

performance, and their direct investment in countries, including partnerships with nongovernmental organizations and civil society.

GHPs have been successful in raising the profile of certain health problems on policy agendas, mobilizing resources (Buse & Harmer, 2007; Caines et al., 2004), and generating an overall positive impact on health outcomes (Horton et al., 2009; World Health Organization Maximizing Positive Synergies Collaborative Group et al., 2009). GHPs, however, have generated unintended consequences such as imposing donor priorities over national priorities of recipient countries, depriving specific actors a voice in decision-making, implementing inadequate governance practices (Buse, 2004; Caines et al., 2004; Périn & Attaran, 2003; Severino & Ray, 2010; Walt, 1999), and mismanaging resources through inadequate use of country systems and poor harmonization with donors and other health initiatives, among others (Buse & Harmer, 2007; Hill, Brown, & Haffeld, 2011; World Health Organization Maximizing Positive Synergies Collaborative Group et al., 2009).

To minimize the negative effects and promote effectiveness of GHPs, global health actors are committed to achieve better coordination and alignment of priorities (“International Health Partnership - A global ‘compact’ for achieving the Health Millenium Development Goals,” 2007; OECD, 2005). Coordination is a complex task as it entails costs and loss of autonomy for some actors (Moon et al., 2010). Furthermore, although actors form a GHP to address a particular global health problem, each usually has a different definition of the problem and ultimate goal (Kania & Kramer, 2011). These differences in perspectives hinder the establishment of a common set of priorities and goals (Ramiah & Reich, 2006; Sagawa & Segal, 2000).

While there is a great need to understand the challenges of building GHPs (Buse & Tanaka, 2011), particularly in dealing with different perspectives of the actors involved, only few studies have documented the process of GHP development (Ramiah & Reich, 2006). This paper examines the early stages of development of a regional health partnership. The aims of this study were threefold: 1) to identify the perspectives of the actors involved, 2) to examine whether these perspectives were aligned and the factors that led to this (lack of) alignment, and 3) to examine the consequences of the alignment (or lack thereof) of perspectives.

Regional Health Initiative

The Regional Health Initiative (RHI) was a regional, five-year, public-private partnership among private donor A, private donor B, a bilateral donor, a multilateral agency, and eight countries of Latin America. The goal of the RHI was to support the efforts of the governments in reaching the health Millennium Development Goals (MDGs) by investing in interventions to improve maternal and child health (MCH) in extremely poor communities. RHI aimed to: 1) decrease mortality and morbidity of poor women of reproductive age and children under 5; 2) increase coverage, use, and quality of interventions in the areas of reproductive, maternal and neonatal health, maternal and child nutrition, immunizations, and malaria and dengue; and 3) generate globally-relevant knowledge for scaling up interventions with proven efficacy in poor communities and countries.

As a preliminary stage of RHI, private donor A appointed an academic institution in 2009 to guide a participatory process for discussing the main MCH problems of

Mesoamerica. International experts, representatives from Ministries of Health, and international organizations worked together for over six months to develop an assessment of MCH problems and to define the cost-effective interventions to address them. The specific interventions supported by RHI were later defined based on the results of this preliminary work.

After its official launch in June 2010, the multilateral agency took charge of the planning of RHI. This stage involved drafting the operating regulations of RHI and discussing them with donors. In July 2010, the implementation of RHI began. During this stage, the multilateral agency worked in conjunction with the Ministries of Health of country C and country D in the planning of their respective RHI operations, which were later approved by donors in the second semester of 2011. The country operations were expected to begin by 2012.

Methods

A case-study method was used to allow for the prospective examination of the planning and implementation of the RHI (Yin, 2009). This approach is often used to examine the sociocultural, economic, and historical factors that influence how political and social phenomena unfold (A. L. George & Bennett, 2005). Data collection involved first-hand documentation of key events and meetings; semi-structured, in-depth interviews with participants involved with RHI; and review of documents and reports of RHI and its partners. The Institutional Review Board of the University of South Carolina reviewed and granted exemption for this research.

From May 2009 to July 2011, the lead author was involved as a participant observer throughout the early stages of development of the RHI. She was part of the group that discussed the MCH problems in Mesoamerica in the preliminary stage of RHI, attended the official launch of RHI, and participated in planning meetings at the multilateral agency. During the implementation stage of RHI, she participated in four RHI missions to countries C and D and in related meetings at the multilateral agency.

The lead author conducted 28 semi-structured interviews with representatives from the Ministries of Health, donors, and the multilateral agency involved in the planning and implementation of RHI. She used purposive and snowball sampling to identify potential interviewees. The purpose of the interviews was to gain a detailed and rich understanding of the planning and implementation of RHI according to the different actors involved. The interviews lasted on average one hour and were conducted in Spanish, either face-to-face or by telephone. After granted permission by the interview participants, all the interviews were digitally recorded and transcribed verbatim.

We used Nvivo 9 for data analysis. We established a common set of codes for each interview or field note based on Lasswell's elements of the social process (Clark, 2002). We identified the three elements of perspectives: 1) identities, 2) expectations, and 3) demands. Identities refer to who or what actors identify with, expectations are the matter-of-fact assumptions of actors about past, present, and future events. Demands are what actors want in terms of base values or organization. The eight base values that actors usually seek as goals or have to influence the social process are: power, enlightenment, wealth, well-being, skill, affection, respect, and rectitude (Clark, 2002; Lasswell, 1971).

Though we employed these analytic categories, our analytic approach allowed for the emergence of unanticipated themes. Inductive coding allowed for the identification of consequences related to the alignment of perspectives. We used process tracing to examine the pattern of causality and identify social processes. Process tracing is an analytic tool for drawing descriptive and causal inferences from diagnostic pieces of evidence that are often part of a temporal sequence of events or phenomena (Collier, 2011; A. L. George & Bennett, 2005; Gerring, 2007). To minimize threats to validity, we were reflexive on our positionality as researchers (J. A. Maxwell, 2005), and conducted triangulation through cross verification of data from different sources and respondent validation (Patton, 2002).

Results

Perspectives

The actors involved in RHI had different identities that were expressed through the behavior and expressions used by their members (Table 4.1.). The multilateral agency was a recognized institution with a long trajectory of negotiation and collaboration with governments in the region. It was accountable to donors and borrowing countries, and it followed standard procedures for negotiating operations with countries. These procedures involved working collaboratively with governments in developing operations based on the countries' priorities. Similarly, the bilateral donor had over 20 years of experience working with governments of recipient countries in health and development projects. Both institutions had a local office in these countries, were familiar with the countries' sociopolitical landscapes, and supported ongoing maternal and child health projects and

programs. Furthermore, both had endorsed the principles of the Paris Declaration on Aid Effectiveness (PDAE) to harmonize and align their projects and strategies with those of recipient countries, and had enacted institutional policies and strategies to promote PDAE.

Over the past decade, private donor A gained high visibility due to its substantial funding and commitment to global health, and its focus on innovative solutions for health problems. This donor usually did not interact directly with governments but mostly with non-governmental organizations (NGOs), and did not have any health project in the region. Private donor B, a small and new, business-oriented organization, did not have previous experience working in global health. Both institutions were led by highly influential individuals, and showed interest in learning from the initiative and supporting innovations.

Both Ministries of Health in recipient countries had experience working with multilateral agencies and donors. Both recipient countries were lower-middle-income countries with a high prevalence of MCH problems. During the negotiation of the country operations, recipient country C was undergoing health reform aimed at increasing the coverage of primary health care services, while recipient country D was getting ready for national elections. The latter experienced uncertainty about the sustainability of health programs and projects, as a change in government has been accompanied by the discontinuation of at least some health programs.

Although the actors had different identities, they shared the base value of *well-being*, which brought them together to establish RHI (Table 4.2). Their common goal was to improve MCH in the poorest population. Some of the base values, however, were not

common to all the actors. The multilateral agency was interested in gaining *affection* by establishing new partnerships with the two private donors. As the initiative gained support and visibility, the agency experienced increasing pressure from senior management to meet the donors' conditions for establishing RHI. These conditions related to the donors' base values. For instance, private donor A sought to maximize *enlightenment* by using existing knowledge and generating new evidence in the design of RHI and in the planning and implementation of the country operations. As a result, this private donor supported innovations in: 1) the implementation of evidence-based interventions to improve MCH, 2) the use of new mechanisms for the delivery of the interventions, and 3) the establishment of a new partnership model to promote the country's adoption of the innovations. One participant from private donor A referred to the characteristics of recipient countries supporting the innovations promoted by RHI:

"We are talking about countries adopting innovations of interventions and putting into practice innovations in the process of delivering those interventions. Also, (we are talking about) countries having the will to undergo a robust, external evaluation of the effectiveness of the biomedical interventions and of the effectiveness of their implementation." (Interview no. 14 (I-14))

Private donor B was interested in gaining *skills* by demonstrating proficiency in the use of the initiative's resources. Its demands in the design of the initiative included setting up a small, relatively self-contained coordinating unit with a non-discretionary budget to manage its operations. For the country operations, the donor expected the initiative to attain measurable results in a short-term period. On the other hand, the bilateral donor sought to gain *power* for the recipient countries. As it was interested in

building an initiative based on the countries' needs; it demanded that operations follow the priorities and rules set by the countries. One participant summarized the different values and expectations held by the three donors:

"They all think in a different way. For example, the bilateral donor, they are used to making donations and that the governments decide (what to do with it). It is very important for them that the objectives of the project are aligned with the objectives of the countries and are appropriate. They want the recipient population to participate, especially if they are indigenous population... One private donor, its general goal is to test different interventions that can be used in other contexts, in the contexts they usually work on... They are interested in this project because it is a regional project and has the opportunity of being innovative. And then, the other donor, they are new in international cooperation, this is their biggest project and their main interest is to learn how to conduct regional health development (projects)." (I-6)

All actors were interested in gaining *power* to make decisions about the initiative. As a result, each of them had different, and in some instances conflicting, demands. Both recipient countries expected negotiating operations that follow their own rules and priorities. While the multilateral agency expected to negotiate operations solely with recipient countries using its traditional procedures, the donors' expectations were to play an active role in these negotiations. A participant explained the difference in actors' expectations about the level of involvement of donors with RHI's country operations:

"It is my opinion that the donors expect a higher level of involvement than expected by the multilateral agency. And they do not only expect it but have it. They have an involvement of those who want to know the details about the budgets, processes, management, plans, reports, and even in subjects such as communication events. So, I think that the level of involvement that the donors have wanted was not the one originally expected by the multilateral agency...not even expected by themselves, the donors, I think." (I-17)

The various expectations and demands of actors involved with RHI reflected their different perspectives about the initiative and its intended outcomes.

Lack of alignment and consequences for the initiative

The contrasting identities of the actors involved in the initiative hampered the alignment of their expectations and demands. This lack of alignment originated a series of unintended consequences for the RHI during the planning of the country operations, which were: 1) the establishment of unrealistic goals for the country operations, 2) tension during the negotiation of the operations, and 3) unexpected changes to the country operations.

Establishment of unrealistic goals for the country operations

Private donor B was interested in developing country operations that could achieve measurable results in an 18-month period. Although some of the actors considered this to be an unrealistic goal for some of the countries, they were not able to change or negotiate exceptions for this condition. A participant considered that the lack of experience of private donor B was the reason behind the establishment of this condition:

"That is the mentality of an investor from the private sector who does not know that the changes in the social sector need more time. It is a condition that is clearly detrimental to the bigger projects." (I-19)

Consequently, some of the actors were wary about the timeline set for the implementation of the country operations. The unrealistic timeline raised concerns especially in country D, where the upcoming national elections were likely to generate

changes that would affect the operation. Furthermore, the reluctance to extend the length of the operation was interpreted as a sign of mistrust and inflexibility by the counterpart in country D. A participant described some of the challenges that could delay the implementation of the operation:

"It is complicated, with the change in government...norms can change, budget can change...it is whole process of immersion for the new authorities, and the changes are not only at the central level, there are also areas (local levels) that change... I think that they (the donors) should participate (in the operation) all the time but not trying to impose, but trying to collaborate in finding the ways to make things easier." (I-5)

Overall, the actors supported most of RHI's conditions and innovations; however, the establishment of the 18-month period caused uneasiness and raised concerns among the actors involved with the implementation of the country operations.

Tension during the negotiation of the operations

The lack of agreement over the expectations of donors generated an extensive process of negotiation and revision of RHI's operating regulations. This process lasted more than a year and resulted in over a hundred drafts before the donors approved the final version of the operating regulations. Parallel to this process, the multilateral agency had to negotiate the first two RHI operations with the country counterparts. These negotiations were characterized by tension, most of which was generated by the lack of establishment of defined rules and regulations of RHI and clear roles and responsibilities. Some participants commented on the tension that characterized the negotiation:

"...there were so many battles...You did not fight some of them just to avoid starting a

new battle." (I-22)

"The country counterpart was really upset with me because they thought that I was the one who kept changing the rules of the game." (I-1)

"It is about the feeling of anguish, of organizational distress, of pressure for the teams...and for the governments." (I-17)

While the tension between the multilateral agency and donors rose as a result of disagreements about the level of involvement of donors in country operations, tension among donors was a product of conflicting views about the type of interventions to fund. In addition, the relationships with recipient countries were strained during the negotiation process due to continuous changes to RHI's conditions. For instance, one country counterpart had to review more than three different drafts of the indicators for the RHI baseline survey. A participant characterized the negotiation process as unclear and in constant change:

"Well, I think that...the truth is that at the beginning it was like...how should I say this? There was not a lot of clarity. During the continuous process, one of the biggest weaknesses has been the lack of clarity and that all the indications have been changing permanently. That affects everything that we decide to do with the interventions. And that...they practically changed the rules of the game permanently. Then, some actions were proposed and then they would change their mind and say 'no'. " (I-5)

Unexpected changes to the country operations

The multilateral agency and the Ministry of Health of country C worked for over six months in the development of the country operation, which involved funding the construction of primary health care centers. This operation was not approved by donors. The private donors considered that funding infrastructure was not an innovation or an

evidence-based intervention for improving MCH. On the other hand, the bilateral donor had no objection with the country operation, as it was built collaboratively with the country and responded to its needs and priorities. A participant referred to the consequences of this disagreement and described it as an attempt to align the donors' expectations:

"The donors rejected financing infrastructure... That was the first big discussion they had among themselves to align their interests. The bilateral donor was in absolute agreement with the design of the project but the other two were not. So, it was negotiated...it was decided that the initiative was not going to fund infrastructure because not financing infrastructure is part of the policies of the organizations and because they consider that infrastructure, based on the evidences, that infrastructure is not going to have a direct effect on the health status, which is what the initiative is looking for. So, we had to go back to the country to realign this..." (I-6).

The unexpected disapproval of the country operations by the two private donors damaged the trust built with the country during the negotiation of the operation. Furthermore, it brought additional work for both the country and the multilateral agency. This was especially unfavorable for the country, which also had to deal with the expectations and demands of other donors working in the country. A participant referred to the consequences of the unexpected changes to the country operation:

"We had a tough moment with the country because we had to go back several times, changing the rules in a way...So, part of the dialogue was broken; we lost a lot of credibility with our counterpart and was obviously, hard to go back to the negotiation table." (I-8)

Discussion

One of the main problems of partnerships is the inherent tension that exists between cooperation and competition among partners. On the one hand, a partnership is formed to achieve certain objectives, when doing so is more effective than if any one partner operated independently. On the other hand, the benefits of the partnership are shared among partners, and each partner has a strong incentive to compete for a larger portion of the benefits. As a result, partners often face a social dilemma, i.e., a conflict between maximizing their own interests and goals and maximizing the goals of the partnership as a whole through cooperation (Zeng & Chen, 2003)(Zeng & Chen, 2003). This problem is exacerbated when partners have diverging perspectives.

Actors involved in the planning and implementation of RHI had different, and in some instances, conflicting perspectives. Although the actors had the common goal of improving MCH of vulnerable populations in Mesoamerica, they did not share other values and had different expectations and demands about RHI.

The lack of alignment of the actors' perspectives caused unintended consequences during the development of RHI's operations in two countries. We identified three factors that influenced this lack of alignment: 1) challenges in knowledge management, 2) non-inclusive governance structure, and 3) limited time for planning.

Challenges in knowledge management

Understanding actors' perspectives is challenging (Clark, 2002; Ramiah & Reich, 2006) as it involves identifying their values and motivations. Some of these values and motivations are part of the tacit or unarticulated knowledge of individuals or groups that only become explicit through direct interaction with them (Nonaka, 1994). Proposed

mechanisms to generate knowledge about actors include stakeholder analysis (Brugha & Varvasovszky, 2000; Sagawa & Segal, 2000) and the establishment of regular face-to-face meetings and other shared contexts to facilitate the interaction of individuals and groups (Nonaka & Konno, 1998; Sagawa & Segal, 2000). The process of knowledge generation is continuous, and with time, the actors' values and motivations might change. Hence, actors must understand partnerships as a learning process rather than a simple organizational structure created to reach a specific goal (Buse & Hammer, 2007; Widdus, 2001).

Getting to know the values and motivations of actors is most important during the early stages of the partnership's development (Mitchell & Shortell, 2000). While the multilateral agency had frequent one-on-one interactions with donors during the planning of RHI, donors seldom communicated among themselves. Furthermore, the multilateral agency had few interactions with country representatives at political venues that posed limited opportunities to discuss their values and motivations. Although the individuals at the multilateral agency accumulated knowledge about the different RHI actors, they did not have a mechanism to articulate and share this new knowledge within the agency and with other actors.

Non-inclusive governance structure

The two private donors and the bilateral donor were the sole constituents of RHI's governance structure. Similarly, GHPs usually have governance structures with limited representation of country actors (Buse & Hammer, 2007; Caines et al., 2004; Périn & Attaran, 2003). Governance is key to partnership functioning (Butterfoss, Goodman, & Wandersman, 1996; Mitchell & Shortell, 2000), and it is likely to have a profound effect

on its overall performance (Lasker, Weiss, & Miller, 2001). By determining the characteristics of the decision-making process, governance influences the extent to which actors' perspectives, resources, and skills can be combined (Lasker et al., 2001).

Various studies, including evaluations of GHPs, recommend the establishment of inclusive governance bodies as a way to promote buy-in and commitment, build trust among actors, and establish the transparency and legitimacy of decisions (Batniji, 2008; Druce & Hammer, 2004; Fajans, Simmons, & Ghiron, 2006; Kania & Kramer, 2011; Kickbusch & Gleicher, 2012; Ooms, Hammonds, Decoster, & Van Damme, 2011; World Economic Forum, 2005; Yamey, 2011). Inclusive governance structures are better suited for learning critical know-how or capabilities from actors that can be used for the partnership's advantage (Kale, Singh, & Perlmutter, 2000).

The persistence of non-inclusive governance bodies, however, reflects the donors' interest in maintaining power. Power is the capacity to influence the behaviors and interests of other actors, whether negatively or positively (Dahl, 2007; Lukes, 2007). Actors use power to achieve desired outcomes, shape political agendas, and influence other actors' values (Lukes, 2007). Sharing power makes the decision-making process more complex and can work against the short timelines that GHPs often value.

Actors bring different resources to initiatives. Although actors have different perceptions about the importance of these resources, they usually regard financial resources as key for the development of initiatives (Bouquet & Birkinshaw, 2008; Lister, 2000). Therefore, the control of financial resources usually entitles donors' legitimacy for decision-making (Abrahamsen, 2004; S. Maxwell & Riddell, 1998; Ooms et al., 2011). Legitimacy is a form of social approval that facilitates the acquisition of power as it

determines how actors are understood and evaluated by others (Weber, 1947). The power imbalance that characterizes the early development of initiatives obstructs the establishment of governance structures in which power is equally shared among actors. Donors and countries, however, should strive for the establishment of inclusive, power-sharing governance structures as it is a recognized factor of successful partnerships (Brinkerhoff, 2002; S. Maxwell & Conway, 2000). This will likely require greater patience by GHPs and governments alike.

Limited time for planning

The planning of initiatives is a time-consuming process (Butterfoss & Lachance, 2006; Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001; Mitchell & Shortell, 2000; Sagawa & Segal, 2000). It involves identifying the perspectives of actors and establishing shared goals and unified vision. Insufficient time devoted for this step is a common cause of partnership failures (Kanter, 1999).

Before its official launch, RHI spent over six months conducting a participatory process to identify cost-effective MCH interventions for the region. During its official launch event in 2010, high-level politicians and public figures portrayed RHI as an effort to support countries in achieving the 2015 Millennium Development Goals. As a result, RHI experienced mounting pressure to plan country operations that would yield a measurable impact on health outcomes by 2015. It invested most of its time and resources advancing country operations and left little room for building relationships and trust among actors, sharing perspectives and values, or jointly defining RHI's goals. The pressure to achieve short-term results is common to other health initiatives (Marchal et

al., 2009; McKinsey & Company & Bill and Melinda Gates Foundation, 2005; Richard et al., 2011; Severino & Ray, 2010).

Conclusion

RHI represented an opportunity to revamp the efforts to address MCH problems in the region. A complete understanding of the development of RHI would not be possible without considering the different perspectives of the actors involved. By using Lasswell's conceptualization of perspectives, we were able to identify the underlying values and motivations that shaped the demands and expectations of actors and ultimately, defined RHI.

Similarly to RHI, other initiatives have faced challenges due to the lack of alignment of perspectives (Ramiah & Reich, 2006; Sandberg, Andresen, & Bjune, 2010). Identifying perspectives is not a straightforward task. In some instances, mechanisms that build trust and promote frequent communication among all actors might be sufficient to identify their values and motivations (Kania & Kramer, 2011; Ramiah & Reich, 2006). In other instances, GHPs might need to establish mechanisms specifically targeted to expose each actor's perspective explicitly. Zeng & Chen (2003) suggest having face-to-face meetings before formalizing the partnership to discuss the prospective partners' perceptions, including their expectations of other partners' behavior, their feelings of group identity and trust, and their motivation to engage in cooperative agreement. The Partnership Assessment Tool (Hardy, Hudson, & Waddington, 2000) and the Partnership Readiness Framework (Greig & Poxton, 2000) are example of resources that can be used

to determine if actors are ready to engage in a partnership and identify the actions and strategies needed to develop an effective partnership.

A more challenging task, however, lies in taking into account partners' values and motivations for decision-making processes, particularly, for defining shared goals. The latter implies that actors have reached a certain level of commitment for power-sharing and openness to consensus building. Research on social dilemma of partnerships suggests enhancing communication as an effective mechanism to foster collaboration among partners (Balliet, 2009; McCarter & Kamal, 2012; Zeng & Chen, 2003). Communication allows actors to interact with one another and such interaction promotes a better understanding of the positive outcomes of cooperation and negative consequences associated with the pursue of self-interest (McCarter 2012). Thus, communication increases actors' expectations of cooperation and establishes it as a common norm (Balliet, 2009). Thus, actors involved in GHPs should not overlook the relevance of communication and cooperation when pursuing their common goals.

Table 4.1. Characterization of the identity of actors involved in RHI

Actor	Identity
Multilateral agency	<ul style="list-style-type: none"> ▪ Well-established and recognized institution in the region ▪ Accountable to its shareholders (donor and borrowing countries) ▪ Experience working with governments and managing funds from bilateral donors ▪ Adherent to the Paris Declaration of Aid Effectiveness
Private donor A	<ul style="list-style-type: none"> ▪ Prominent actor in global health ▪ Funds innovations ▪ Few health projects in the region ▪ Usually works with nongovernmental organizations (NGO), UN agencies, universities, and other institutions ▪ Experience working in health projects in other regions of the world
Private donor B	<ul style="list-style-type: none"> ▪ Business-oriented ▪ New organization ▪ No previous experience working in health projects
Bilateral donor	<ul style="list-style-type: none"> ▪ Experience working with governments and multilateral agencies ▪ Adherent to the Paris Declaration of Aid Effectiveness
Countries	<ul style="list-style-type: none"> ▪ High prevalence of maternal and child health problems ▪ Follow national laws ▪ Lower-middle- income countries ▪ Experience working with multilateral and bilateral agencies ▪ On-going changes within the ministries of health

Table 4.2. Scope values of actors involved in RHI

Actor	Scope value	Expectation	Demand	Example of quote
Multilateral agency, private donors, bilateral agency, and countries	Well-being	To improve maternal and child health in poorest 20% of the population.	To negotiate operations that will improve maternal and child health in the poorest 20% of the population.	<i>"A vision to support development, to support countries in achieving the Health Millennium Development Goals 4 and 5." (I-15)</i>
Multilateral agency	Affection	To establish new partnerships with private donors.	To meet the new partners' demands and requests (client satisfaction).	<i>"...caring about client satisfaction. In this case, it is not about the countries but about the three donors." (I-16)</i>
Private donor A	Enlightenment	To use evidence in the decision making processes of the initiative and generate new evidence about the planning and implementation of health projects.	To negotiate operations that will support evidence-based interventions and implement innovations.	<i>" In the future we could learn and maybe emulate (our experience with) RHI in other parts of the world." (I-14)</i>
Private donor B	Skills	To demonstrate proficiency in the use of the initiative's resources	To negotiate conditions under which the funds will be used efficiently and will yield measurable results.	<i>"They are very interested in showing specific results in a short time." (I-26)</i>
Bilateral donor	Power for countries	To support decisions made by the countries about MHI operations	To participate in the country missions and review the operations in detail to make sure that the operation follows the decisions made by the countries.	<i>"They are used to making donations and letting governments decide. It is very important for them to have the objectives of the projects aligned with the objectives of the countries." (I-6)</i>

Table 4.3. Scope values of actors involved in RHI (continued)

Actor	Scope value	Expectation	Demand	Example of quote
Multilateral agency	Power	To make decisions about MHI operations	To negotiate operation using the procedures of the agency	<i>"They are the ones who are used to managing the funds and making decisions. In this case, somebody else is in charge of making decisions, and it takes for them to get used to that." (I-18)</i>
Private donors and bilateral agency	Power	To make decisions about MHI operations.	To participate in the country missions and review the operations in detail.	<i>"We want to participate in the process...we want to go to the missions." (I-25)</i>
Countries	Power	To make decisions about MHI operations that will follow the country's rules and priorities.	To negotiate operation that will follow the country's rules and priorities.	<i>"It is a coordinating with others who stand in an equal position as yourself, knowing and being convinced that you can learn from one another. It is a relationship between equals." (I-10)</i>

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PROSPECTIVE ANALYSIS OF THE FORMULATION OF COUNTRY-LEVEL PLANS OF A
REGIONAL HEALTH PARTNERSHIP²

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Abstract

Reducing malnutrition, which contributes to more than one third of all deaths in children under age 5, is currently an urgent global priority. Global Health Partnerships (GHPs) work together with country partners in the formulation of action plans that address pressing health challenges such as malnutrition. Formulation of country action plans is often a contentious process. The successful formulation of an action plan occurs when the process pursues goals of feasibility, alignment, and ownership. We prospectively examined the formulation of two country-level action plans of a regional health partnership in Latin America, and assessed whether these three goals were pursued. Data were collected using participant observation of key events; semi-structured, in-depth interviews with involved actors; and document review. We found that, although a GHP can promote feasibility, ownership, and alignment, the country context is a key determinant of whether these goals can be reached. Lack of nutrition plans and aims, weak leadership of the Ministry of Health, and an upcoming political transition were factors that prevented attainment of these three goals. By recognizing that a complex context can delay or impede the attainment of these goals, GHPs can be responsive to the country-specific challenges, devise appropriate procedures to address them, and adapt expectations to the context.

Introduction

During the last decade, partnerships involving public and private organizations have emerged as organized efforts to address global health problems (Brugha, 2008).

These partnerships, known as global health partnerships (GHP), are characterized by a set

of common features, including their focus on specific health problems in more than one country, ability to generate substantial funding, and direct investment in countries, including partnerships with nongovernmental organizations and civil society (Buse & Walt, 2000). GHPs differ in various ways including their functional aims, the size of their secretariats and budgets, their governing arrangements, and their performance (World Health Organization Maximizing Positive Synergies Collaborative Group et al., 2009).

GHPs have contributed to raising the profile of certain health problems on policy agendas, mobilizing resources, and generating overall positive impact on health outcomes (Horton et al., 2009; World Health Organization Maximizing Positive Synergies Collaborative Group et al., 2009). Some of these partnerships work directly with the governments of country partners providing resources and technical assistance generally through grants to develop and implement action plans to address specific health problems (Bennett & Fairbank, 2003).

GHPs bring together different actors—including governments, donors, NGOs, and a variety of private-sector representatives—into a formal, collaborative relationship with a common purpose. GHP actors make strategic decisions about the goals, missions, and objectives of the GHPs, and formulate specific strategies to reach their agreed goals and objectives. A strategy is "a pattern of purposes, policies, programs, actions, decisions, or resource allocations that define what an organization is, what it does, and why it does it" (Bryson, 1995). In the context of GHPs, these strategies encompass the rules and regulations of the partnership, including its grant requirement, the roles and responsibilities of partners, and its funding mechanism.

GHP strategies are put into operation at the country level through the formulation and implementation of action plans. The formulation of action plan involves identifying and defining the goals and priority interventions supported by the GHP in a country. The action plan details the GHP's country operation, including the priority interventions, target groups, implementation, monitoring, and evaluation mechanisms, along with the delineation of roles and responsibilities of country actors.

The formulation of strategies and country-level action plans are essential for the success of GHPs. Both involve seeking agreements among a wide variety of actors, and can be challenging and contentious processes (Hoey & Pelletier, 2011; Pelletier, Menon, Ngo, Frongillo, & Frongillo, 2011; Shiffman & Smith, 2007). For instance, bilateral donors and private and multilateral agencies have different perspectives (i.e., demands, expectations, and institutional identities) that can lead to disagreements over GHP's strategies and action plans (Buse & Tanaka, 2011). These disagreements can be exacerbated by power differentials, diverging agendas, lack of trust, and weak leadership that are common in collaborative arrangements (Davis, Kee, & Newcomer, 2010; Huxham & Vangen, 2005; Innes & Booher, 1999).

The literature on GHPs proposes some common recommendations to strengthen the GHPs and, in particular, to improve the formulation of GHP's strategies into country-level action plans. The process of formulation of action plans should pursue goals such as promoting national leadership and participation of national stakeholders, making evidence-based decisions, and promoting mutual accountability of the GHP and country partners (Biesma et al., 2009; Buse & Harmer, 2007; Buse & Tanaka, 2011; Druce & Hammer, 2004). These goals are relevant but not sufficient for conducting a successful

process. The successful formulation of an action plan occurs when the process pursues the goals of feasibility, alignment, and ownership (Moore, 2000).

Feasibility exists when the technical complexity of the interventions of the action plan does not exceed the capacity of the health system to manage them (Gericke, Kurowski, Ranson, & Mills, 2005; Gordon, Jones, & Wecker, 2012). The technical complexity of an intervention refers to the resources required for the implementation of an intervention, and it is dependent on the characteristics of the intervention itself and its delivery mechanism (Gericke et al., 2005). The feasibility of an intervention can be affected by multiple constraints, including a lack of infrastructure and equipment, inadequate drugs and medical supplies, shortage and distribution of qualified staff, weak management, technical knowledge or inadequate supervision (Mangham & Hanson, 2010; Victora, Hanson, Bryce, & Vaughan, 2004).

Ownership refers to country partner's ability to take the lead in determining the goals and priorities of the action plan and in setting the agenda for how they are to be achieved (OECD, 2009). Ownership of the action plan can be facilitated if the country partner exerts leadership during the process of its formulation. In this context, leadership refers to the ability of the country team to exercise influence on decisions of the GHP towards the accomplishment of common goals (Anheier, 2005; Tannenbaum, Weschler, & Massarik, 1961).

Alignment refers to the formulation of the action plan that supports the country partner's national development plan, institutions, and procedures. Promoting alignment involves establishing meanings and framings of the action plan that are relevant for the national actors rather than instructing them what to do (Fischer, 2003). It is engaging in a

process that allows for the country partner to translate and reformulate the action plan in ways that support their own plans and address their own priorities (Gordon et al., 2012; Hercot, Meessen, Ridde, & Gilson, 2011; Lehmann & Gilson, 2012).

This study examines a GHP, the Regional Health Initiative (RHI), during the formulation of action plans in two countries. The study aimed to 1) understand the processes that took place and factors that influenced the formulation of action plans, and 2) assess whether the goals of feasibility, alignment, and ownership were pursued during the process of the formulation of action plans.

Background

Regional Health Initiative

The RHI was a five-year, public-private partnership among three donors, a multilateral agency, and eight country partners in Latin America. The goal of RHI was to support the efforts of the country partners in reaching the health Millennium Development Goals by investing in interventions to improve maternal and child health (MCH). RHI aimed to: 1) decrease mortality and morbidity of poor women of reproductive age and children under 5 years of age; 2) increase coverage, use, and quality of interventions in the areas of reproductive, maternal and neonatal health, maternal and child nutrition, and immunizations; and 3) generate globally-relevant learning and knowledge for scaling up MCH interventions with proven efficacy.

As a preliminary stage of RHI, one donor appointed an academic institution in 2009 to guide a participatory process for discussing the main MCH problems for country partners. International experts, Ministry of Health (MoH) representatives, and

international organizations worked together for over six months to develop an assessment of MCH problems and to identify their potential solutions. This work resulted in the development of a Technical Plan approved by the MoH that identified effective interventions to address MCH problems in the country partners.

After its official launch in June 2010, the multilateral agency took charge of the planning of RHI. This stage involved identifying the strategies of RHI and discussing them with donors. The RHI defined five main strategies to put into operation in the country action plans. These strategies were: 1) supporting comprehensive health packages that deliver the MCH interventions described in the Technical Plan, 2) targeting the poorest areas of the countries, 3) monitoring and evaluation, 4) promoting pro-poor policies and norms, and 5) implementing results-based financing (RBF). RBF is a financial strategy at the national level for improving health services coverage and health outcomes in the target population. RHI reimburses half the amount contributed by the country partners if the country operation reaches its previously agreed goals, such as increased coverage of health interventions, improvement of quality of health services, and health outcomes.

Implementation of the RHI began in July 2010. The MoH of countries C and D both set up country teams in charge of RHI. To formulate their respective RHI action plans, each country team engaged in frequent communication and had at least three in-person meetings with the RHI teams. These initial action plans were later revised and approved by donors in the second semester of 2011. The implementation of the action plans was expected to begin by 2012.

Country context: Country C

Country C had recently elected a new government with a strong social agenda and interest in promoting aid effectiveness. During its first months in office, it developed a plan with actions to meet the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. Furthermore, the government established a new vice-ministry to "guide the development cooperation towards the strategic priorities of the country" and a MoH department to coordinate and align the development cooperation in health.

Over the past 20 years, country C had significantly improved its health outcomes, decreasing child and infant mortality and morbidity, and improving coverage of MCH health services. Despite this progress, challenges in health equity still remained for the poor. The segmentation of the health system, low quality of services and drug access, lack of trained health personnel, and inadequate infrastructure and equipment deepened the inequity in access to health services and the MCH disparities between the poor and non-poor.

The new MoH provided new leadership and a concerted plan to address the limitations of the health system. The MoH launched a National Health System Reform (NHSR) to restructure the public health services and deliver universal health care based on integrated primary health care. The NHSR encompassed expanding the network of primary health centers and replacing its current disease- and problem-specific focus with comprehensive health services for the population across the entire lifespan.

The government demonstrated its commitment to health and supporting the NHSR by increasing the MoH's budget. Even so, the MoH still had a limited budget, and the NHSR was largely funded by two loans from multilateral agencies. Although it aimed

for universal health care coverage, the MoH began the implementation of the NHR in priority poor areas of the country.

Country context: Country D

Country D did not have a single national development plan but rather a series of area-specific plans. The current government had organized three groups, with varying coordination capacity, to articulate the efforts of over 40 development actors in the country. Changes in national strategies, policies, and programs were expected to occur as a result of the upcoming national elections. The elections, characterized by numerous and weak political parties, brought uncertainty to the country as the lack of continuity of national strategies was a common consequence of political transitions.

Ingrained societal inequality, weak government institutions, high rates of poverty, and low health and education indicators were some of the country's pressing challenges. The country's health outcomes compare unfavorably with those of other countries, having one of the highest infant and mortality rate and prevalence of stunting in the region. These problems, along with limited access to health services, were severe for indigenous and poor populations living in rural and isolated areas.

The MoH had more than eight programs that delivered MCH services. Each program worked in isolation, with little or no involvement of programs with similar goals. Given the limited budget of MoH, most programs partially depended on uncoordinated donations from development cooperation for the delivery of services.

Methods

We used a comparative two-country, case-study design to examine the formulation of the RHI action plans in two countries. Comparative analysis of cases is

useful to generate new understanding of complex phenomena and dynamics (Miles & Huberman, 1999; Yin, 2009). Case descriptions provide rich sources of information that enable recognition of unexpected patterns that might not be captured with other methodologies (Alvord, 2004).

We selected countries C and D based on the timing of their engagement with RHI. As these were the first countries formulating the action plans, we were interested in drawing lessons that could be used for the formulation of action plans in other countries. This study was exempted by the Institutional Review Board of the University of South Carolina, as respondents participated in their official capacities and were not asked to share personal information.

Data collection involved first-hand documentation of key events and meetings; semi-structured, in-depth interviews with participants involved with RHI; and document reviews. The lead author participated in key events and meetings of the RHI between May 2009 and July 2011. She was part of technical groups that developed the MCH Technical Plans during the preliminary stage of RHI, attended the official launch of RHI, and participated in planning meetings at the multilateral agency. During the implementation of RHI, she visited the countries C and D and attended four in-person meetings organized to formulate their respective action plans.

The lead author conducted 28 in-depth interviews with participants involved with the RHI, including representatives from the MoH, donors, and multilateral agency. The participants had different institutional affiliations, and roles or functions in the RHI, and included members of the RHI and country teams responsible for the formulation of the action plans in the two countries. The interviews were conducted between June 2011 and

February 2012. A first set of interviews was conducted after the formulation of the action plan in country C was completed in May 2011. The second set of interviews was conducted once the country D finalized its action plan in August 2011.

The interview guide covered the participants' involvement with RHI in the planning of its strategies and formulation of its action plans in country C and D; their views on the process, including the factors that hampered or facilitated the formulation of the action plans in the countries. The interviews provided insight into the development of the RHI's strategies and the formulation of the action plans of countries C and D. The interviews lasted on average one hour and were conducted in Spanish, either face-to-face or by telephone. The participants provided oral consent to be interviewed and recorded. We concealed identifying information to maintain anonymity.

We reviewed two sets of documents. The first set was related to the RHI and included meeting records, reports developed by donors and multilateral agencies, studies conducted by the RHI in countries C and D, and newspaper articles on RHI. The second set described the characteristics of countries C and D. These documents included government reports, manuscripts and reports on MCH in the countries, health surveys and country statistics.

We analyzed the data using NVIVO 9 qualitative analysis software program (QRS International). Data analysis was conducted concurrently with the data collection process. After each interview, the researcher wrote down her field notes, generated additional questions, and identified emerging themes for analysis. Following the completed data collection process, data were systematically coded and themes extracted. A synthesis of the results was shared with three participants who provided additional

comments and suggestions. As the data were reviewed, further comparisons were made, codes refined, and consistency checks made to further elaborate and corroborate the analysis.

Results

The first section of results describes the processes that took place and factors that influenced the formulation of the RHP action plans. The second section is the assessment of the formulation of the action plans.

Formulation of country action plans

Country C

The formulation of the action plans involved meetings between the country and RHI teams. The country team included high-level members of the MoH who demonstrated an in-depth understanding and commitment with the NHSR. The RHI team leader had previously worked on the design of the loan of the multilateral agency to support the NHSR. The understanding of the NHSR and rapport built during this experience helped establish a good work environment and trust among members of both teams. As commented by a member of the country team:

"We are very comfortable in [country C] because this person [the RHI team leader] has a comprehensive vision..., knows about the changes to the system that we want to accomplish... Any other person without this background, I do not think would look at it [RHI] in this integrated and comprehensive way." (Interview no. 10 (I-10))

The similarity of the strategies of NHSR and RHI further facilitated the design of the action plan. Both supported the implementation of a comprehensive health package

and targeted the poorest areas of the country. Furthermore, in alignment with the NHSR, the RHI supported the delivery of health package through the MoH's primary health care services. A member of the RHI team commented on the Ministry of Health's interest on the RHI's comprehensive health package:

"For the Ministry, one interesting aspect of RHI was to implement comprehensive interventions...we were able to finance comprehensive interventions, as opposed to vertical interventions, which are usually supported by this type of donors." (I-8)

In parallel to the formulation of the action plans, the MoH was designing a pilot project to test an RBF model in the delivery of primary health care services. Thus, the familiarity of the country counterpart with the rationale of the RBF facilitated discussions about the RHI's model. In addition, the RBF worked as an incentive for the implementation of the RHI. As the reimbursement for reaching the RHI targets came from discretionary funds, the MoH planned to use these resources to scale up the NHSR.

In contrast to the other RHI's strategies, the discussion about monitoring and evaluation was challenging. This strategy involved hiring an external institution to monitor performance and measure RHI's impact. The NHSR, on the other hand, promoted the establishment of a unique health information system as a response to the fragmentation of the MoH's current system. The apparent incompatibility of this strategy with the NHSR brought unease to the process. To facilitate the discussion, the RHI and country teams worked together to identify the potential advantages and uses of RHI's monitoring and evaluation for the country. After deciding to use the RHI's surveys to evaluate the implementation of the NHSR, the country team accepted the monitoring and evaluation strategy as one of the RHI's requirements. Later in the process, the country

teams used the information generated by the RHI's monitoring system to strengthen the national health information system.

Overall, the formulation of the action plan was a process in which the country and RHI teams engaged in discussions that led to consensus and mutual agreements. The country and RHI teams demonstrated commitment and motivation in the formulation of the action plan, and both teams identified the potential synergies that could be created with the implementation of the NSHR and RHI.

Country D

The country team leader was a policy entrepreneur who, from outside the formal position of government, had the ability to influence the decisions made by the MoH. This individual had extensive experience implementing MCH projects and had established a good relationship with high-level MoH officials and MCH program representatives. The country and RHI team leaders had previously worked together in the design of a MCH loan of the multilateral agency. Both had built rapport during this experience and were familiar with the country's main MCH problems and implementation challenges.

The RHI team visited the country multiple times to work on the formulation of the action plan with the country team. In addition, the RHI team met with several other national and local actors who were potential allies and collaborators to RHI. These actors had worked as implementers of MCH project, and had advocated for MCH throughout government transitions.

The MoH's coordination of the MCH programs was weak. The programs did not share a common goal or strategic plan to ensure the delivery of the complete set of MCH interventions to poor areas of the country. The RHI and country teams organized a

workshop with the MCH program representatives to identify their common problems and barriers for delivering MCH services. To design an effective response to the large number of problems and barriers identified, both teams prioritized a selected subset of interventions from RHI's comprehensive health package.

The main MCH program that targeted the poorest areas in the country was under risk of being cancelled. This program lacked the support of some MoH officials and suffered from frequent budget cuts. The RHI and country teams initially decided to use this program to deliver the RHI interventions, but ultimately chose a different, smaller-scale program that was not at risk of being cancelled.

The RHI and country teams used the national poverty maps to identify the RHI's target population. The teams selected poor areas that were also prioritized by a national poverty reduction program. The government later declared a state of emergency in some of these areas due to their high level of violence. Hence, the RHI and country teams had to reassess the feasibility of intervening in these areas considering their high level of violence and civil unrest.

The RHI and country teams dealt with factors that could jeopardize the implementation of the action plan. With the upcoming national election, it was uncertain whether the new government would approve or maintain its commitments with RHI. Furthermore, the MoH did not have available resources to contribute to RHI, a requirement of its RBF model. The possible funding sources were two health loans that were pending approval by the national congress. The approval of these funds was uncertain.

Overall, the formulation of the action plan was a complex process that involved a series of discussions on potential solutions to the challenges encountered in the country to put into operation the RHI's strategies. Members of both teams were highly committed to the formulation of the action plan and invested a high amount of effort and time in the process. Feasibility, ownership, and alignment as goals of the process of formulation of action plans in countries C and D

Feasibility

In both cases, the RHI and country teams pursued the formulation of feasible action plans. They conducted a series of activities to gain an understanding of the technical complexity of the MCH interventions of RHI and assessed the capacity of the MoH to implement them. These activities included reviewing national health surveys and trends, identifying resources and constraints of the MoH, and conducting formative studies to identify the supply- and demand-side barriers to using the MCH interventions. Furthermore, the teams developed implementation plans that described the necessary steps for the delivery of interventions to the RHI target areas.

Several factors in country C facilitated the formulation of a feasible action plan. These factors included a functional MoH delivery mechanism and the strong technical capacity of the MoH. During the recent formulation of the NHSR, the MoH had already identified and planned to address the gap in resources needed to deliver primary health care services to the poorest areas of the country. In contrast, country D faced various contextual challenges such as uncertainties around the sustainability of the MoH delivery

mechanism, and the low operational capacity of the MoH to deliver MCH interventions to the poorest areas of the country. A member of the RHI commented:

"There are great challenges of infrastructure, of disperse communities, even of security... I think that the challenge will be to implement the project given the complex scenario in country D... In that context, the project of country D looks very risky... It might be a project that loses ambition in order to have something more achievable and that can be implemented, feasible in the type of risky situation that we are facing." (I-15)

To address these challenges, the teams in country D adjusted the technical complexity of the action plan by reducing the number of interventions for implementation. In addition, they planned technical assistance projects to address the barriers of access to the MCH interventions identified by the country team and formative studies. By engaging in a flexible and iterative process, the teams were able to reassess some of the early decisions made about the action plan. This led to various adjustments to the action plan such as using a different mechanism for delivering the RHI interventions and targeting a different, safer area of the country.

Ownership

The teams in country C and D pursued the goal of country ownership by conducting a collaborative process with the MoHs that involved joint decision making on RHI. The MoHs were encouraged to set the goals and priorities of RHI and formulate context-specific solutions for MCH problems.

The leadership of the MoH in country C and its established focus on MCH among the poor facilitated the country ownership of the action plans. The coordination of GHPs was a priority for the MoH. The Minister appointed high-level officials to the RHI that

had authority and technical capacity to make decisions and guide the formulation of the action plans. The country team identified the priority health needs, target population, shortage of supplies and resources, and other barriers for the delivery of MCH interventions. Thus, the leadership of the MoH helped devise an action plan that mostly responded to the country's needs and priorities.

The political context in country D posed challenges to promote ownership of the action plan. The MoH did not show strong leadership in establishing the goals of RHI, and high-level MoH officials did not participate actively in the formulation of the action plans. The upcoming national elections were expected to bring changes to the MoH, its health priorities and potentially to the support to the RHI action plan. Members of the RHI commented on the uncertainty that resulted from the elections:

" On the other side, the imminent change of government. The question is whether the new government will be willing to follow the commitments acquired by the previous government, especially, in the scenario of a change of political party, change of governmental people. In that context, the project of country D looks very risky." (I-15)

"The risk that they change the objectives and interests of the country, and that the RHI or the objectives of the RHI does not remain a priorities...that is a very serious theme." (I-6)

The RHI team promoted ownership in country D by building collaboration and responding to priorities identified by the MCH programs at the MoH and other relevant MCH actors in the country. Furthermore, by appointing a policy entrepreneur as country team leader, the RHI had better chances of promoting ownership of the action plan in the next government. This individual had enough credibility, political resources, and willingness to support the RHI action plan. The policy entrepreneur might be able

position the action plan as a valid, desirable, and preferred option for advancing MCH in the country.

Alignment

The teams in both countries pursued the alignment of the action plans with the countries' policies and systems. The multilateral agency promoted alignment as part of its organizational strategy. The RHI team members had experience formulating plans that support national policies and systems. A member of the RHI explained:

"I have a mandate with the governments to align my operations with the ones of the country's system and work on the strengthening of the governmental institutions... You cannot have a discourse of an institutional strategy that ... says 'alignment with the country's system' and then (say) 'by the way, now we are going to have an initiative that is going to work with NGOs'." (I-16)

In country C, the RHI adopted a consistent frame with the NHSR. This facilitated developing an action plan that resonated with the goals and objectives of the country team and supported the national policies and systems, with the exception of the national health information system. The teams, however, discussed ways in which monitoring and evaluation of RHI could better fit with the NHSR and support its goals.

Members of the RHI in country C referred to the alignment of the action plan with the NHSR:

"The RHI can easily insert itself into the conceptual framework of the health reform. The RHI and the country counterpart can have very fluent discussions during the process of the operation design. [This action plan] matches the actions of the health reform." (I-13)

"They say they want integrated actions. So, if the RHI aligns itself with the reform, I do not think there would be a problem. We all have the same objective, of having integrated interventions." (I-11)

In contrast, country D lacked a comprehensive MCH plan with concrete national program goals, objectives, targets, and actions to deliver MCH interventions. The workshop with the MCH program managers and meetings with high-level MoH officials helped identified some of their priorities. It was uncertain whether these priorities would remain the same during the next government. Hence, the RHI and country teams relied on evidence about the main MCH problems and effective interventions to guide the formulation of the action plan. A member of the RHI team commented:

"It has been difficult to establish where we really want to go... because country D has very big needs. The [health] gaps that Guatemala has to close go beyond the funds of the initiative, so it is hard to define what were the strategies that were going to give us the highest return in health... In country D, we had to conduct a much more in-depth analysis of where to go, as the country did not define the path for us ..., we were able to try some strategies given their [the government's] openness." (I-6)

Discussion

We examined the formulation of GHP action plans in two countries. Consistent with other studies, we found that factors related to the characteristics of the health problem, the health systems, and the sociopolitical context influenced the decisions and process of formulating the action plans (Burchett, Mounier-Jack, Griffiths, & Mills, 2012; Simmons, Fajans, & Ghiron, 2007). Leadership of the MoH and existence of national health reform posed opportunities for the formulation of the action plan. Some challenges that needed to be navigated strategically were the high prevalence of MCH

problems, low capacity of MoH, political transition, and resource constraints for service delivery.

Critical strategic actions for the process included framing issues, building support among national stakeholders, joint problem-solving, negotiation of compromises, conflict resolution, contingency planning, and adaptation (Bryson, Crosby, & Stone, 2006; A. George, Menotti, Rivera, & Marsh, 2010). Furthermore, the strong managerial and conflict resolution skills of team leaders as well as trust and commitment among members promoted collaboration and facilitated the process (Alvord, 2004; Bryson, 1995). These factors are essential for building effective partnerships and achieving results (Bryson et al., 2006). At the same time, the process followed had a significant transaction cost that resulted in a high investment of time and financial resources.

GHPs should pursue the goals of feasibility, ownership, and alignment. Without feasibility, the implementation of action plans is unlikely to reach its intended outcomes. GHPs such as GAVI and Global Fund promote the feasibility of their action plans by investing in the strengthening of health systems in countries with low capacity (Brugha, Starling, & Walt, 2002). On the other hand, ownership and alignment help build the sustainability of action plans. In concordance with the Paris Declaration and Accra Agenda, GHPs have adapted their procedures and strategies to support country ownership and the aligning with country's policies and systems (Biesma et al., 2009; Buse & Harmer, 2007; McKinsey & Company & Bill and Melinda Gates Foundation, 2005; Wilkinson et al., 2006). Despite these efforts, challenges remain.

The results of this study suggest that although a GHP can promote feasibility, ownership, and alignment, the country context is a key determinant of whether these

goals can be reached (Brugha et al., 2002). Lack of MCH plans and goals, weak leadership of the MoH, and an upcoming political transition were factors that prevented attainment of these goals. By recognizing that a complex context can delay or impede the attainment of these goals, GHPs can be responsive to the country-specific challenges, devise appropriate strategies to address them, and adapt expectations to the context (Anheier, 2005).

GHPs should closely attend to and examine the results of the formulation of action plans (Buse & Tanaka, 2011). The results of this study suggest that GHPs should avoid using prescriptive blueprints and tailor the process of formulation to each country. Prospective analysis of the process can help identify the factors and strategies that are conducive to successful formulation, and ultimately implementation, of action plans.

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CHAPTER 5

SUMMARY, IMPLICATIONS, AND RECOMMENDATIONS

Over the past 15 years, health aid has changed significantly. These changes include a shift of paradigm from international to global health. International health encompasses the application of the principles of public health to problems and challenges that affect low- and middle-income countries. It often focuses on addressing infectious and tropical diseases, water and sanitation, malnutrition, and maternal and child health (Ooms et al., 2011). Global health places a priority on improving health and achieving equity in health for all people worldwide. It is based on the assumption that countries can no longer “see health as a concern limited by national borders, as they often did in the past.” (Elmendorf, 2010). The "global" in global health refers to the scope of the health problems regardless of where they occur (Koplan et al., 2009).

Global health, as opposed to international health, involves many disciplines within and beyond the health sciences, promoting interdisciplinary collaboration. It encompasses the development and implementation of solutions that often require global cooperation. As such, the shift to global health has brought new actors and changes in the attitudes, expectations, and demands of actors involved with health. The new global-health paradigm promoted the emergence of GHPs. These partnerships were a new mechanism for dealing with global health problems with the sense of urgency needed to

achieve the MDGs. They also represented an alternative to the United Nations and its agencies, which were perceived by some as inefficient (Caines et al., 2004).

High expectations for GHPs translated into pressure to demonstrate an efficient use of resources and achieve short-term results (Brugha et al., 2002). GHPs, however, face difficulties in reconciling their approach and goals. While their goals are usually short-term results, their approach is based on joint decision-making among multiple partners from public and private sectors (Buse & Harmer, 2007). Partnerships are complex, resource-intensive endeavors that take time to build and maintain.

A review by the World Bank suggests that partnerships are processes that require various elements to be successful (S. Maxwell & Conway, 2000). These elements include trust, commitment, alignment with country, shared visions and goals, and the empowerment of weak partners (S. Maxwell & Conway, 2000). The latter involves implementing strategies to overcome the power differentials intrinsic of aid relationship (Abrahamsen, 2004). The fast pace of development of GHPs might prevent fostering these elements of success.

Consistent with our findings, other studies have documented different perspectives on the roles of GHPs in country partners. Some partners are vocal about implementing the most cost-effective interventions to address specific health problems and investing resources to obtain the highest health return possible (Glassman & Chalkidou, 2012). Others place attention to the fragility and fragmentation of health systems, recognizing them as a primary bottleneck for the delivery of quality health services to the target population (Travis et al., 2004). The latter is less concerned about issues of cost-effectiveness, especially since there is little evidence about the cost-

effectiveness of interventions to strengthen health systems. Although these perspectives can be conflicting (Severino & Ray, 2010), they can also lead to the development of complementary approaches to address health problems. The adequacy of these approaches is mainly determinant by each country context (Mills, Rasheed, & Tollman, 2004).

This dissertation examined the process of development of a GHP. The establishment of mechanisms to build trust and promote frequent communication among partners can lead to the establishment of effective partnerships and avoid unintended consequences in country partners. Sociopolitical factors of country partners influence GHPs and should be taken into consideration during their planning and implementation. By recognizing that a complex context can delay or impede the attainment of goals during the formulation of country action plans, GHPs can be responsive to the country-specific challenges, devise appropriate procedures to address them, and adapt expectations to the context.

GHPs have the potential to revamp the efforts of global actors in addressing specific health problems. The Lancet Series on Undernutrition published in 2008 identified fragmentation among global nutrition actors and failure to collaborate with other sectors as key factors that prevented effective global action against undernutrition. Both factors made it difficult for single organizations to act at scale, prevented developing a shared understanding of effective implementation of interventions, and hampered influencing policy-making decisions at the country level (Morris, Cogill, & Uauy, 2008). GHPs can help address some of these problems, as they foster alliances that minimize fragmentation and have the potential to become platforms for collaboration

with other sectors. In concordance with the Series' proposed recommendations, GHPs can help simplify the system of donors and agencies involved with global health, and end the coexistence of uncoordinated parallel strategies with similar goals.

At the national level, GHPs present several advantages as compared to single agencies or donors working in isolation. As GHPs bring several actors together, they can have more leverage and power to advocate for neglected health problems in a country, help build political commitment, and support stable and technically sound health agendas that can survive political and administrative changes in governments (Bryce, Coitinho, Darnton-Hill, Pelletier, & Pinstrup-Andersen, 2008). GHPs can also pull in a larger source of resources that can be used to support the scaling up of effective health interventions.

The Lancet Series on Undernutrition reflect on the role of global health actors in advancing nutrition at the country level. Recognizing that each country is a world of its own, it encourages global health actors to assess the level of readiness each country has to act at scale, to identify gaps, and to build sufficient capacity at national level to develop a system capable of delivering effective health interventions to its entire population (Bryce et al., 2008; Morris et al., 2008). This recommendations is particularly relevant for GHPs as they engage various countries with different health problems and capacity to address them.

The on-going discussions on the post-2015 health agenda provide a window of opportunity to debate the success and failures of GHPs and lessons for their improvement. This dissertation presents evidence that can inform this debate, and

demonstrates that attention should be placed on the process of development of GHPs, including the perspectives of the involved partners and power dynamics.

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APPENDIX A

Interview guide: Multilateral agency

Module 1. Perspectives on Maternal and Child Health (MCH) problems in country

X (where they are working on)

- What do you think are the key MCH problems in country X?
- What do you think are the causes of these problems?
- What do you think have hindered the solutions to these problems?
- What do you think some solutions to these problems might be?
- What role do you see for an organization like yours in implementing these solutions?
- How could it be that your organization would be able to perform this role?

Module 2. Health systems

- What do you think is the capacity of the health system in country X to deliver MCH interventions to the population?

Probes

- Can you tell me about the resources available to deliver MCH interventions to the population?

- Can you tell me about the staff available to delivery MCH interventions to the population
- Can you tell me about how decisions about the MCH interventions and strategies are made?

Module 3. GHP and political context

- How did you find out about RHI? How did you get involved with it?
- Have you worked with the persons and organizations members of RHI in the past?
- What are the objectives of RHI? Are these objectives similar to the ones of the country?
- I would like to talk about the communication among members of RHI... When did the members of RHI interact? How was the communication among members of RHI during the x situation (characterization of the communication dynamics)
- Is RHI similar to the agency's usual operations? If so, in what way? How is it different?
- RHI has particular characteristics. Can you talk about your experience with...
 - Technical Master Plans?
 - RBF model?
 - Policy dialogue?
 - Monitoring and evaluation?

Formulation of country's action plan

- How many meetings did RHI have with the country partners? What were the objectives of each of these meetings?

Probes

- How did you find it working with the other members of RHI during these meetings? Were these objectives accomplished? How were these objectives planned to be achieved? Were there any other things accomplished during these meetings that were not originally planned? Were there any unintended negative consequences of these meetings?
- How were the meetings usually developed? Can you describe the level of participation of the country partners during these meetings? Were there different levels of participation? If so, who participated the most? Who participated the least? Were there any strategies used to motivate the participation of other members?
- How were decisions usually made? Who usually participated in the decision making process?
- How were the levels of involvement/commitment of the members of RHI?
- How was the level of trust among members of RHI?

Probes

- What do you think help built this (un)trust? Have there been changes in the level of trust? What do you think have caused these changes?
- Was there a established leadership? How would you describe this leadership?
- Can you tell me about the resources such as time, funds, and information available for the accomplishment of the objectives of RHI?
- What were some political and social factors that may affect the development of RHI?

- What are some political and social factors that might positively affected the development of RHI?
- What are some political and social factors that might negatively affect the development of RHI?
- What do you think are the strengths of the RHI?
- What do you think are some challenges that RHI will face?
- What do you think can help improve the development of similar initiatives in the future?

APPENDIX B

Interview guide: Country partner

Module 1. Perspectives on Maternal and Child Health (MCH) problems in this country?

- What do you think are the key MCH problems in the country?
- What do you think are the causes of these problems?
- What do you think have hindered the solutions to these problems?
- What do you think some solutions to these problems might be?

Module 2. Health systems

- What do you think is the capacity of the health system in the country to deliver MCH interventions to the population?
- Probes
- Can you tell me about the resources available to deliver MCH interventions to the population?
- Can you tell me about the staff available to delivery MCH interventions to the population?
- Can you tell me about how decisions about the MCH interventions and strategies are made?

Module 3. GHP and political context

- How did you find out about RHI? How did you get involved with it?
- Have you worked with the persons and organizations members of RHI in the past?
- What are the objectives of RHI? Are these objectives similar to the ones of the country?
- I would like to talk about the communication among members of RHI... When did the members of RHI interact? How was the communication among members of RHI during the x situation (characterization of the communication dynamics)
- How many meetings did the country team have with RHI ? What were the objectives of each of these meetings?

Probes

- How did you find it working with the other members of RHI during these meetings? Were these objectives accomplished? How were these objectives planned to be achieved? Were there any other things accomplished during these meetings that were not originally planned? Were there any unintended negative consequences of these meetings?
- How were the meetings usually developed? Can you describe the level of participation of the country partners during these meetings? Were there different levels of participation? If so, who participated the most? Who participated the least? Were there any strategies used to motivate the participation of other members?

- How were decisions usually made? Who usually participated in the decision making process?
- How were the levels of involvement/commitment of the members of RHI?
- How was the level of trust among members of RHI?

Probes

- What do you think help built this (un)trust? Have there been changes in the level of trust? What do you think have caused these changes?
- Was there a established leadership? How would you describe this leadership?
- Can you tell me about the resources such as time, funds, and information available for the accomplishment of the objectives of RHI?
- What were some political and social factors that may affect the development of RHI?
- What are some political and social factors that might positively affected the development of RHI?
- What are some political and social factors that might negatively affect the development of RHI?
- What do you think are the strengths of the RHI?
- What do you think are some challenges that RHI will face?
- What do you think can help improve the development of similar initiatives in the future?

APPENDIX C

Interview guide: Donors

Module 1. Perspectives on Maternal and Child Health (MCH) problems in countries

C and D

- What do you think are the key MCH problems in country C and D? (probe for differences and similarities)
- What do you think are the causes of these problems?
- What do you think have hindered the solutions to these problems?
- What do you think some solutions to these problems might be?
- What role do you see for an organization like yours in implementing these solutions?
- How could it be that your organization would be able to perform this role?

Module 2. Health systems

- What do you think is the capacity of the health system in countries C and D to deliver MCH interventions to the population?

Probes

- Can you tell me about the resources available to deliver MCH interventions to the population?

Module 3. GHP and political context

- How did you find out about RHI? How did you get involved with it?
- What was the motivation of creating this new Initiative?
- Have you worked with the persons and organizations members of RHI in the past?
- What are the objectives of RHI? Are these objectives similar to the ones of the countries?
- I would like to talk about the communication among members of RHI... When did the members of RHI interact? How was the communication among members of RHI during the x situation (characterization of the communication dynamics)
- RHI has particular characteristics. Can you talk about your experience with...
 - Technical Master Plans?
 - RBF model?
 - Policy dialogue?
 - Monitoring and evaluation?

Formulation of country's action plan

- How many meetings did RHI have with the country partners? What were the objectives of each of these meetings?

Probes

If you attended any of the meetings...

- How did you find it working with the other members of RHI during these meetings? Were these objectives accomplished? How were these objectives planned to be achieved? Were there any other things accomplished during these

- meetings that were not originally planned? Were there any unintended negative consequences of these meetings?
- How were the meetings usually developed? Can you describe the level of participation of the country partners during these meetings? Were there different levels of participation? If so, who participated the most? Who participated the least? Were there any strategies used to motivate the participation of other members?
 - How were decisions usually made? Who usually participated in the decision making process?
 - How were the levels of involvement/commitment of the members of RHI?
 - How was the level of trust among members of RHI?

Probes

- What do you think help built this (un)trust? Have there been changes in the level of trust? What do you think have caused these changes?
- Was there a established leadership? How would you describe this leadership?
- Can you tell me about the resources such as time, funds, and information available for the accomplishment of the objectives of RHI?
- What were some political and social factors that may affect the development of RHI?
- What are some political and social factors that might positively affected the development of RHI?
- What are some political and social factors that might negatively affect the development of RHI?

- What do you think are the strengths of the RHI?
- What do you think are some challenges that RHI will face?
- What do you think can help improve the development of similar initiatives in the future?