SAVING MOTHERS, GIVING LIFE: AN ASSESSMENT OF A PARTNERSHIP FOR MAKING PROGRESS TOWARD SUSTAINABLE REDUCTIONS IN GLOBAL MATERNAL MORTALITY

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ABSTRACT

ANGELI PRAKASH ACHREKAR: Saving Mothers, Giving Life: An Assessment of a Partnership for Making Progress Toward Sustainable Reductions in Global Maternal Mortality
(Under the direction of Edward Baker, Jr.)

On June 1st 2012 former U.S. Secretary of State, Hillary Clinton, launched the *Saving Mothers, Giving Life* partnership to reduce global maternal mortality. Ensuring the partnership's success and sustained impact is a priority for the U.S. Government as it moves from Phase 1 (Year 1, June 1, 2012 to September 30, 2013) to Phase 2 (Years 2-5, October 1, 2013 to September 30, 2017). This study systematically assessed the strengths and weaknesses of the *Saving Mothers, Giving Life* partnership and offers recommendations for strengthening the partnership to ensure progress in Phase 2 and sustained impact over time.

A literature review identified key factors that contributed to the success and/or failure of global health partnerships. Semi-structured interviews were conducted among 22 leaders representing: (1) the U.S. Government, (2) global-level partners, and (3) countries, Zambia and Uganda – who were instrumental in the development and/or implementation of *Saving Mothers, Giving Life*.

Key findings include: (1) Its membership is comprised of high-caliber partners, but the country representatives are not engaged as leaders at the global-level; (2) It enjoyed the political support from the highest levels of leadership, but caused concern as this leadership transitioned; (3) It began with a shared vision for Phase 1, but differing visions of success exist for Phase 2; (4) It focused on results and strengthened local capacities, systems and ownership at the district-level, yet resulted in opposing strategies for scaling at national-levels; and (5) It established a comprehensive governance structure, but inadvertently created a Headquarters echo-chamber.

Recommendations for strengthening the partnership include: (1) Recreating a sense of urgency by renewing the commitment of a senior-level champion, (2) Creating and sharing a common vision with short- and long-term strategies, (3) Reconfiguring the governance structure to be less

cumbersome, while expanding it to include country representatives; and (4) Developing processes and guidance to institutionalize country-level efforts for sustained reductions in maternal mortality.

This work is dedicated to the women and their children around the world that we are privileged to serve - the leaders of today and the future of the next generation.

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LIST OF ABBREVIATIONS

CDC	Centers for Disease Control and Prevention
DOS	Department of State
DOD	Department of Defense
EMC	Every Mother Counts
GHI	Global Health Initiative
GHP	Global Health Partnership
HHS	Department of Health and Human Services
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MOH	Ministry of Health
OGAC	Office of the Global AIDS Coordinator
PEPFAR	President's Emergency Plan for AIDS Relief
PPP	Public-Private Partnership
SMGL	Saving Mothers, Giving Life
UN	United Nations
USAID	U.S. International Agency for International Development
USG	United States Government
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

Early maternal mortality has significant family, societal, economic, and public health consequences, causing stress on communities and societal structures and services. A mother's death is a tragedy in and of itself, but it also weakens the family structure and can render children without a parent or caregiver. Her death reduces family income and core necessities, including food, driving families into poverty and reducing productivity. Ensuring a safe delivery and birth is one step closer to ensuring healthy and economically secure families and communities.

On June 1st 2012 *Saving Mothers, Giving Life,* potentially the U.S. Department of State's largest public-private partnership in global women's health, was born. Former U.S. Secretary of State, Hillary Rodham Clinton, announced in Oslo, Norway that she is "*very pleased that the United States will be a part of the Saving Mothers, Giving Life partnership, along with [the Government of Norway], Merck for Mothers, Every Mother Counts, and the American College of Obstetricians and Gynecologists. We're not focusing on a single intervention, but on strengthening health systems ...the United States is committing $75 million to this partnership."*

A confluence of unprecedented global commitment and leadership among key organizations within the public and private sectors resulted in the formation of this global health partnership to help reduce global maternal mortality. At the time of launch, founding partners included the U.S. Government, the Government of Norway, Merck, the American College of Obstetricians and Gynecologists, and Every Mother Counts. Through partnership, these organizations have begun to work collectively towards the goal of supporting countries where women are dying at high rates during pregnancy and childbirth to aggressively reduce maternal mortality.

Three phrases come to mind when thinking of the formation of the *Saving Mothers, Giving Life* partnership: *"building the ship as we sail it"; "baking with passion and guidance, not a recipe"; and "attempting to move mountains in record time".* Despite the uncertainties, the partnership

formed, was launched, and is currently functioning among global partners, with implementation underway in target districts in Uganda and Zambia.

The launch of the *Saving Mothers, Giving Life* partnership is considered by the Obama Administration to be among its key achievements in global maternal health. Supporting this partnership to help ensure its success and sustained impact is a priority for the U.S. Government, particularly for the U.S. Department of State (DOS), the Office of the Global AIDS Coordinator (OGAC), the U.S. Agency for International Development (USAID), and the U.S. Centers for Disease Control and Prevention (CDC).

I have seized a unique opportunity, both as part of the team that helped create *Saving Mothers, Giving Life* and as a researcher working to complete my doctoral degree, to help ensure that the partnership maintains its strength and viability from the start as it has a strong potential to make real public health impact now and in the future. My doctoral research and findings are particularly relevant because *Saving Mothers, Giving Life* is at a critical inflection point as the partnership moves from the Phase 1 (Year 1 proof-of-concept or pilot that occurs from June 1, 2012 to September 30, 2013) to Phase 2 (Years 2-5, scale-up that occurs from October 1, 2013 to September 30, 2017). My hope is that the key findings and recommendations of this research will inform the health of the partnership as it moves forward.

DISSERTATION AIMS AND RESEARCH QUESTIONS

My dissertation topic is: *Saving Mothers, Giving Life*: an assessment of a partnership for making progress toward sustainable reductions in global maternal mortality. The aims of my dissertation are threefold, to: (1) document the core elements of the *Saving Mothers, Giving Life* partnership so that they can be analyzed systematically against factors of other global health partnerships; 2) conduct an assessment of the strengths and weaknesses of the *Saving Mothers, Giving Life* partnership; and (3) make recommendations for strengthening the partnership for ensuring progress toward its sustained impact. To make this assessment, my dissertation research examined the following questions:

- Which factors characterize successful and unsuccessful global health partnerships? How have these factors been assessed?
- Which partnership strategies have succeeded and which have failed? What are the reasons for this success or failure?
- What are the key elements of the *Saving Mothers, Giving Life* partnership, including membership, goals of the partnership, and the conditions in which it was developed and exists (social, organizational, political and economic context)?
- How do the elements of the *Saving Mothers, Giving Life* partnership compare to those critical factors associated with success and failure of other global health partnerships?
- What are the strengths and weaknesses of the *Saving Mothers, Giving Life* partnership?
- What opportunities and barriers exist to strengthen the *Saving Mothers, Giving Life* partnership?
- What are key recommendations to assist the partnership in progress toward achieving its mission in reducing global maternal mortality?

SIGNIFICANCE OF THIS RESEARCH

Global Health Partnerships (GHPs) bring together multiple organizations across diverse sectors under a common vision to leverage complementary resources and expertise. *Saving Mothers, Giving Life* is a global health partnership that has the potential to make a substantial contribution to the reduction of maternal mortality around the world. It is a public-private partnership that engages the whole of the U.S. Government (USG), leveraging the USG-supported President's Emergency Plan for AIDS Relief (PEPFAR) and Maternal and Child Health (MCH) platforms, expertise, partners, and infrastructure for maximizing efficiency and impact. It also builds upon the investments and platforms that the Government of Norway has supported. The partnership simultaneously draws on complementary private sector skills, resources, and expertise to address the persistent, though preventable, global problem of maternal mortality.

A systematic assessment of the *Saving Mothers, Giving Life* partnership for making progress toward sustainable reductions in global maternal mortality may yield important information for

organizational and program improvement of the partnership and field implementation. The partnership is at a critical inflection point - as it moves from Phase 1 (Year 1, pilot - June 1, 2012 to September 30, 2013) to Phase 2 (Years 2-5, scale-up - October 1, 2013 to September 30, 2017) - to really assess the health not only of the program, but also of the partnership itself. Lessons learned may also inform the design and development of other global public-private partnerships seeking to improve global maternal health or global health more broadly.

BACKGROUND ON MATERNAL MORTALITY

Childbirth is a normal part of the human life cycle. However, complications during pregnancy, childbirth, or in the 42 days after birth are the leading causes of death among women of reproductive age. Despite advancements in public health, technology and medicine, nearly 30 women die every hour, 800 women die each day, and an estimated 287,000 women die each year due to pregnancy and childbirth related causes. An additional 15-20 million women suffer debilitating infections and disabilities annually as a result of pregnancy. A critical window is during labor, delivery, and the first 24- to 48-hours postpartum when an estimated two out of every three maternal deaths and 45% of newborn deaths occur.

Sub-Saharan Africa has the highest maternal mortality ratio in the world with an average of 640 maternal deaths/100,000 live births (although rates differ significantly between countries). Maternal mortality in this region is decreasing at a rate much lower than in the rest of the world. Similarly, according to WHO estimates, the probability that a 15-year-old girl will die from pregnancy related causes during her lifetime is highest in sub-Saharan Africa (one in 31) and lowest in developed regions (one in 4,300). This difference in death rates and lifetime risk for young, healthy women is the greatest disparity in health between rich and poor countries today (WHO, 2010).

Most maternal deaths are preventable. More than 80 percent of maternal deaths are caused directly by treatable obstetrical complications, such as severe bleeding before or after delivery, infections, hypertensive diseases of pregnancy resulting in convulsions, and obstructed labor. Co-infection with HIV is increasingly one of the most common causes of pregnancy-associated deaths in Africa (ranging from 15-40 percent) (WHO, 2010). Mothers are dying for reasons that are well understood and almost always preventable, even in the poorest countries. Almost 90 percent of the

complications that lead to death can be prevented when women in need have access to quality and timely basic and emergency obstetrics services delivered by skilled attendants at birth in equipped health facilities.

Despite the fact that most maternal deaths can be prevented, a cultural acceptance persists that maternal deaths are "the will of God" (as a mother in Zambia explained to me) or an expected outcome, particularly in resource-limited countries that lack functioning health systems and have inadequate infrastructure. The research is clear that mothers' lives cannot be saved by any one intervention alone—maternal mortality reduction requires a comprehensive health delivery systems solution. Interventions delivered in a fragmented manner often lack evidence of effectively reducing maternal risks during delivery. For example, women have been provided with safe birth kits, including soap, a new razor to cut the umbilical cord, plastic sheeting on which women can give birth— but kits are not enough and often do not reduce maternal sepsis. Women have also been recipients of birth planning information about complications of pregnancy through community-based interventions— but this information often does not always lead to behavior change for their families. In some countries, laws have been established to require women to give birth in a facility without the commensurate effort to improve the quality and accessibility of care at those facilities.

While advocacy efforts to raise resources to improve maternal health have been successful, these resources must be linked to implementation of comprehensive, effective programs. Implementation of one-complication or one-component programs to reduce maternal mortality (e.g., those that address only post-partum hemorrhage or only training) provides only partial solutions to the problem (Maine, 2007). Reducing maternal mortality requires an integrated approach. De Cock et. al. state that "reducing maternal mortality does not depend on a single intervention but on the availability, access, and acceptability of a number of complex services, which include timely transport for a woman to a safe place to deliver, adequately equipped facilities, appropriately trained health care workers, and provision of safe delivery and emergency obstetric services around the clock." (De Cock, et al, 2011).

In 2000 the global community, represented by the United Nations including 189 heads of state, established the Millennium Development Goals (MDGs) to improve key outcomes that impact

health and development by its target date of end of 2015. MDG 5 focuses on reducing the maternal mortality rate by 75% from 1990-2015 (Hogan, 2010). Momentum to reduce maternal mortality has been mounting over the decades and has reached a pinnacle, with less than 3 years (or less than 1,000 days) left to achieve MDG 5. While substantial progress has been made to drive down maternal mortality globally in the past 20 years, the declines are insufficient. MDG 5 continues to lag furthest behind all MDGs with only 13 countries in the developing world expected to achieve MDG 5 by 2015, none of which are in sub-Saharan Africa.

There was a surge by the global community to improve maternal and child health on a broader, more visionary level. For example, in September 2010 U.N. Secretary-General Ban Ki-moon launched *Every Woman, Every Child* to mobilize and intensify international and national action by governments, multilaterals, the private sector and civil society to save the lives of 16 million women and children by 2015. In November 2010, the Norwegian Government, under Prime Minister Jens Stoltenberg, renewed its commitment to maternal and child health, specifically to ensure safe delivery, for both the mother and the newborn child. Later in September 2011, Merck launched the 10-year *Merck for Mothers* initiative that brings together Merck's scientific and business expertise to making proven solutions more widely available, developing new game-changing technologies, and improving public awareness, policy efforts and private sector engagement to save women's lives during pregnancy and childbirth. Then later in 2012, the U.N. launched the Commission on Life-Saving Commodities, as part of the *Every Woman, Every Child* movement to increase access to life-saving medicines and health supplies for the world's most vulnerable women and children.

OVERVIEW OF SAVING MOTHERS, GIVING LIFE

The *Saving Mothers, Giving Life* partnership is a concerted response by the U.S. Government to harness the global momentum of these separate efforts, as well as President Obama's and former Secretary Clinton's emphasis on impacting women's lives, to reinvigorate and accelerate the reduction of maternal mortality in a comprehensive and integrated manner. Through *Saving Mothers, Giving Life*, the U.S. Government invited significant support from key public, private and non-governmental groups in the global health field and brought them together to help reduce maternal mortality. In addition to the U.S. Government, the founding partners of the partnership

include: the Government of Norway, Merck, the American College of Obstetricians and Gynecologists, and Every Mother Counts. To date, the Governments of Uganda and Zambia are also central members of the partnership at the country level.

The *Saving Mothers, Giving Life* partnership works collectively towards the goal of supporting countries where women are dying at high rates during pregnancy and childbirth to aggressively reduce maternal mortality. The global partnership seeks to leverage respective strengths, experience, methodologies, and resources of each partner to address strategic gaps for successful implementation of the initiative. The effort intends to help mothers during labor, delivery, and the first 48-hours postpartum by supporting countries to implement a fully functioning network of health delivery systems, including: (1) skilled attendance at birth; (2) safe facilities and hospitals for delivery; (3) supplies and provision of basic and emergency obstetric services; (4) systems for communication, referral, and transportation; and (5) quality data, surveillance and response – all provided and accessible, 24 hours/7 days a week.

The founding partners have pledged more than $200 million USD in financial resources and additional in-kind resources to support the implementation of *Saving Mothers, Giving Life* over the course of 5 years. Their goal is to support countries to reduce maternal deaths by up to 50 percent in targeted districts in resource-limited countries by accomplishing the following three objectives, to:

(1) Develop models of quality maternal health services through district health network strengthening to achieve maximum, sustainable impact;

(2) Galvanize the American public to create a domestic constituency to support saving mothers' lives around the world; and

(3) Engage new public and private partners around the world to co-invest in saving mothers' lives.

Saving Mothers, Giving Life is intended to focus in countries with the political will and commitment to reduce maternal mortality in a significant way. Implementation has begun in select districts in Uganda and Zambia, which are among the countries with the highest maternal mortality ratios in the world. In Uganda, *Saving Mothers, Giving Life* focuses on the districts of Kabarole,

Kamwenge, Kibaale, and Kyenjojo. In Zambia, the initiative focuses on the Lundazi, Kalomo, Nyimba, and Mansa districts.

CHAPTER 2: LITERATURE REVIEW

An essential starting point to begin the assessment of the *Saving Mothers, Giving Life* partnership was to conduct an initial review of the literature focused on exploring key factors that contribute to the success and failure of building and maintaining global health partnerships. This review of the literature examined global health partnerships that were broader than global maternal health, as there was sparse published literature on maternal health partnerships that compared in scope and magnitude to that of *Saving Mothers, Giving Life*. Also, drawing on information from global health partnerships that address a variety of topics, beyond maternal health, revealed important crosscutting information and lessons that are applicable to maternal health partnerships alike.

DESCRIPTION OF SEARCH METHODS

A systematic review of published and unpublished literature was conducted examining an array of global health partnerships and best practices or critical factors that contributed to or hindered the building of effective global health partnerships and alliances. Relevant global health partnerships addressing a variety of topical areas were reviewed to supplement and/or validate findings.

Multiple publication sources were used in this literature review, including reports, syntheses, and research articles accessed from: (1) PubMed; (2) OVID Global Health; (3) WHO reports; and (4) recommended textbooks from leading experts in global health. The PubMed database provides the most comprehensive access to health-related literature. It comprises more than 22 million records and citations of biomedical literature from the MEDLINE database, life science journals, and online books. The OVID Global Health database provides access to community- and international-level research on public health. Every year over 70,000 records are added to the database from over 125 countries. A combination of these databases and textbooks yielded a comprehensive list of program and policy resources that helped elucidate the critical factors for success and/or failure of effective

global health partnerships from both public and private sectors as well as from resource-privileged and resource-limited countries.

DEFINITION OF VARIABLES

- *Partnership Inputs* - For the purpose of this literature review, the primary facilitators and barriers, including best practices, critical factors for success and failure of global health partnerships were examined.
- *Partnership Domains* – The number and types of organizations and sectors engaged in health partnerships has increased exponentially over the last two decades. The terms used for these partnerships or collaborations are also diverse. For the purpose of this inquiry, the terms, 'global health partnership', 'public-private partnership' and 'global health alliance' were used as the units of analysis.
- *Partnership Outputs* - Assessing the effectiveness of a partnership can be broadly defined as the ability (or lack there of) of the partnership to "produce a decided, decisive, or desired effect" as defined in the Merriam-Webster Dictionary. Exploring facilitators and barriers to establishing the partnership is ultimately whether or not the partnership was deemed effective, or had success (or conversely, had barriers or limitations) to its desired outcomes. For the purpose of this foundational review, literature concerning any of the terms qualifying partnership outcomes as 'effective' or 'successful' was explored. Partnerships deemed 'ineffective' and 'unsuccessful' were also examined and analyzed.
- *Classification of Countries* - The terms 'resource-limited country', 'low-income country', and 'developing country' are often used interchangeably. While there is no internationally recognized definition or classification of 'resource-limited country', these terms are used broadly to characterize a nation with a low level of financial well-being. However, the preferred term in global contexts includes 'resource-limited' as it speaks to the range of objective economic, health, and development measures or indicators (e.g., Gross National Income, mortality rates, literacy rates, etc.) that contribute to the well-being of a nation according to the World Bank and United Nations. For the purpose of this inquiry, literature concerning any of the terms 'resource-limited

country', 'low-income country', and 'developing country' in addition to countries that fall into "middle-to-upper income countries" were explored.

SEARCH TERMS AND STRATEGIES

Table 2.1 summarizes terms for the constructs or variables delineated above. A combination of the terms within each category was used to initiate the primary literature search. Specifically, for the PubMed and OVID Global Health searches, the following combination of terms was used across the categories: (critical success factor OR critical failure factor) AND (global health partnerships OR public-private partnerships OR global health alliances) AND (effective OR ineffective).

Table 2.1: Partnership Constructs Used for Literature Search

Partnership Input		Partnership Domain		Partnership Output
Critical Success Factor OR Critical Failure Factor	AND	Global Health Partnerships OR Public-Private Partnerships OR Global Health Alliances	AND	Effective OR Ineffective

The WHO reports were searched by accessing the following website: http://www.who.int/en/ and entering the term 'global public-private partnerships' into the search function for all WHO publications through this site.

INCLUSION AND EXCLUSION CRITERIA

Inclusion Criteria

- Types of Studies – Systematic reviews, descriptive, relational, and causal studies in English and across all years were considered in this review.
- Publication Sources - (1) electronic databases (i.e., PubMed and OVID Global Health) from the year 1980 to present and (2) WHO reports from the year 1980 to present. This timeframe was selected to accommodate many of the earlier public-private partnerships. However, most of the global health partnerships were established in the later years, particularly when the large influx of

foreign assistance entered the global health landscape (e.g., global HIV/AIDS through PEPFAR in 2003).

- Literature examining global health programs in resource-limited, upper- or middle-income countries (e.g., United States, Sweden, Denmark, England, etc.)
- Unit of Analysis – Organization-level

Exclusion Criteria

- Reports and articles written in non-English languages.
- Unit of Analysis – Individual-level

PROCESS FOR ARTICLE REVIEW

The primary literature sources were reviewed and articles were examined for final analysis utilizing the inclusion and exclusion criteria outlined above. Findings extrapolated from the literature review were managed as follows:

- All articles retrieved from search strategies were scanned on the basis of their titles to determine if they warranted further examination.
- Abstracts of select articles that related to the research question were pulled for further analysis.
- Full text articles of those selected, available publicly or from the UNC or CDC library systems through electronic journals or PDFs, were printed and saved electronically for use in the final analysis.
- Relevant findings on critical factors for success and failure were abstracted from each key article and assembled into a table.

The search strategies resulted in over 400 articles through PubMed, 60 articles through OVID Global Health and more than 10 WHO reports. Additionally, 3 key textbooks were found.

KEY FINDINGS AND THEMES

The review of the literature provided information to further explore factors that contribute to the success and/or failure of global health partnerships. Key definitions, general themes and main literature review findings drawn across all articles and textbooks, in terms of factors contributing to effective or ineffective partnerships, are summarized below.

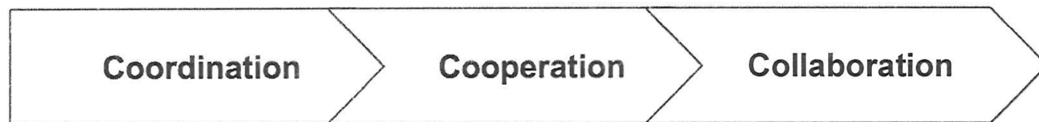
- *Definition of Critical Success and Failure Factors* – The concept of critical success factors originated from the business sector and has been readily documented related in the health sector. For the purposes of my dissertation, 'Critical Success Factors' are defined as "specific activities, procedures or areas that a partnership, organization, or project depends on to achieve its mission [improved health]" (Freund, 1988). Critical failure factors or factors that contribute to failed efforts are much less apparent in the literature. However, drawing from limited publications, for the purposes of my dissertation, 'Critical Failure Factors' are defined as "key aspects or areas where "things must go wrong" that results in a higher level of failure" (Wong, 2005).
- *Definition of Global Health Partnership* – Drawing on the USG Global Health Initiative (GHI) guidance and the findings of this literature review, a partnership is defined as "a collaborative relationship between two or more parties characterized by shared goals and decision-making, coordination or combination of resources, and some degree of shared accountability to achieve a specific goal".
- *Definition of Effective and Ineffective Partnership* – The literature review suggests a number of different ways to define whether or not a partnership is effective or ineffective. For the purposes of my dissertation, a general working definition of 'Effective or Successful Partnerships' is an acceleration, improvement, or reduction of the cost of the initiatives aimed at reducing disease burdens in comparison to what could be accomplished on a solitary basis. Essentially, the "whole is greater than the sum of its parts" (Aristotle). Further, 'Ineffective or Unsuccessful Partnerships' is a reduction, weakening, or increase of the cost of the initiatives aimed at reducing disease burdens in comparison to what could be accomplished on a solitary basis.

General Theme 1: Global health partnerships are heralded as an innovative policy tool for collaboration in the global health arena. Global health partnerships are becoming increasingly important as a key tool to address public health challenges. This is particularly true in an era of limited financial resources and continued complex public health challenges, where solutions require diversity and shared strengths, experience, methodologies, and resources across multiple sectors. In a Bill and Melinda Gates Foundation-supported report, the critical importance or "dominance" of partnerships in global health is framed as, "simply put, there are few global public health challenges

where any single player has the funding, research, and delivery capabilities required to solve the problem on a worldwide scale" (Rosenberg, 2011). In fact, global health partnerships represent 80% of the investments made by the Bill and Melinda Gates Foundation.

General Theme 2: Partnerships exist along a spectrum from coordination, cooperation, to close collaboration. Research shows that partnerships that are integrated and practice 'close collaboration' **result in the greatest success.** The degree to which a partnership is integrated is one of the key facilitators or barriers to its effectiveness or ineffectiveness. While the terms 'coordination', 'cooperation' and 'collaboration' may seem to be synonymous with one another, there are important distinctions in in this terminology as it relates to how partnerships function. For example, Rosenberg et. al. describe a spectrum of levels of partnership integration (see Figure 2.1).

Figure 2.1: Degrees of Partnerships Integration



On the left side of the spectrum—coordination—organizations or entities within a partnership may exist and operate independently for the most part, but share information or a common purpose. In the middle of the spectrum—cooperation—organizations or entities within a partnership strive to align efforts and have a more coordinated and targeted response. On the right side of the spectrum and a more rare phenomenon—collaboration—organizations or entities within a partnership align and coordinate efforts by forming an integrated team. This type of partnership integration is considered "real collaboration" and can result in the greatest success. Both 'Coordination' and 'Cooperation' are key enablers for healthy partnerships; but optimal partnerships ensure 'Collaboration'.

General Theme 3: Astute leadership skills and competencies are paramount to establishing and maintaining successful global health partnerships; without it, partnerships fail. Among the key facilitators for effective partnerships is leadership and governance. Collaborative leadership plays a central role in global health partnerships, which typically involves multiple partners from various sectors with differing perspectives. While important, collaborative leadership is difficult to achieve. For instance, the head of the Fetzer Institute, Rob Lehman, appropriately and eloquently

desribes collaboration on the surface as, "bringing together resources, both financial and intellectual, to work toward a common purpose." He further continues that, "the inner life of collaboration is about states of mind and spirit that are open—open to self-examination, open to growth, open to trust, and open to mutual action...the practices of true collaboration are those practices of awareness, listening, and speaking that brings us into openness and receptivity" (Rosenberg, 2010). Close collaboration often takes place between individuals, not between the organizations they represent. Therefore, among the critical success factors in global health partnerships, establishing an integrated, collaborative team with complementary leadership skills and roles among individuals appear to be the most essential.

General Theme 4: All global health partnerships reviewed share commons elements that contribute to success along the various stages of the partnership. Dr. Bert Peterson, a leading global maternal and child health expert, recommended that I read the book, *Real Collaboration – What it Takes for Global Health to Success*, by Dr. Mark Rosenberg et. al with key contributions by Dr. William Foege and other leading global public health experts. This book has become foundational to my dissertation as a cornerstone in my thinking as I continue to explore real, practical, application to improve public health work through partnership. The authors examined seven of the largest and more impactful global health partnerships addressing smallpox, childhood immunizations, polio, river blindness, tobacco, road-traffic injuries, and TB. These global health partnerships were analyzed by a group of experts and supplemented by interviews and consultations (Rosenberg et. al., 2010). The result was a simple framework or construct—the Partnership Pathway, illustrated below (see Table 2.2)—outlining key elements of success along each stage of a partnership as shown below. The full table with sub-critical factors is shown later (see Table 2.5).

Table 2.2: Partnership Pathway –Key Elements that Contribute to a Partnership's Success (Rosenberg, 2010)

Genesis	The First Mile	The Journey	The Last Mile
• Contextualize problem • Identify need for partnership	• Choose right membership • Develop shared goal • Select appropriate structure • Shape big-picture strategy	• Bring discipline and flexibility to management • Apply discipline in research and planning • Deliberately launch, measure, and communicate	• Adapt approach to sustain momentum • Transfer control in a supportive way • Capture and communicate lessons learned • Dissolve

	• Clarify organizational role	• Continuously engage partners in problem-solving • Revise operating plan based on learning • Develop complementary leadership • Fill critical team leadership roles	partnership when goal is achieved

During the literature review, eight key reports and articles were gleaned from the search output, since they were directly relevant to the question under inquiry. Each document was reviewed comprehensively to better define the critical factors to the success or failure of global health partnerships. I examined each report and documented all of the critcal success factors or best practices. The comprehensive review of the literature yielded very few critical failure factors; they are noted where relevant. In Table 2.3, a summary of the key findings from each document is provided. I analyzed all critcal success factors and then grouped them into logical categories: (1) Political Will, Health Need, Scope; (2) Membership, Complementary Skills; (3) Alignment to Local Systems; (4) Governance/Leadership and Management Structure; and (5) M&E, Performance, Communication. I then assigned every critical success factor to one of the five categories of critical success factors, as shown in Table 2.3.

To examine how the key elements of the Partnership Pathway compared to the key findings from the literature review of essential critical success factors for global health partnerships, I mapped the critical success factors of the Partnership Pathway against the categories of critical success factors synthesized from the literature review (see Table 2.4). The mapping process, in effect, validated the Partnership Pathway as a "gold-standard" framework that can be used to analyze the *Saving Mothers, Giving Life* partnership against. Therefore, I used the Partnership Pathway (focusing in on the First Mile) as a framework to compare elements of the *Saving Mothers, Giving Life* partnership to those critical success factors of other global health partnerships and examine its strengths and weaknesses.

The *Saving Mothers, Giving Life* partnership maps directly to the stages along the continuum of the Partnership Pathway. For example, the 'Genesis Stage' is essentially pre-launch (prior to June

1, 2012) of the *Saving Mothers, Giving Life* partnership during the development. The 'First Mile' maps directly to Phase 1 or Year 1 of the *Saving Mothers, Giving Life* partnership (June 1, 2012 to September 30, 2013). The *Saving Mothers, Giving Life* partnership is at a critical inflection point as it moves to Phase 2 or Years 2-5 (October 1, 2013 to September 30, 2017) where key recommendations can really help shape the 'Journey' an the 'Last Mile'. To further understand the Partnership Pathway, I disaggregated each key element for success into its subcomponents that the research indicated contributed to its success (see Table 2.4).

QUALITY AND LIMITATIONS OF REVIEW

Both program and policy resources were reviewed to facilitate a more comprehensive review of the literature. The majority of the articles analyzed in the review were descriptive studies or a justification of personal opinion with qualitative data. A handful of articles provided comprehensive syntheses of information and lessons learned on specific partnerships or aspects of partnerships. While these publications provide a wide range of contextual information about partnerships, a causal relationship cannot necessarily be drawn between the variables. However, the conceptual Partnership Pathway Framework provides a comprehensive, practical construct for identifying elements that contribute to success at each stage of the partnership. Despite the dearth of literature on factors that contributed to the failure of partnerships, it was clear that many of the elements that contributed to the effectiveness of partnerships, when not present, contributed to their failure.

This literature review serves as a basis for exploring key factors in building global health partnerships, including factors that contribute to their success and/or failure. Overall, the literature review revealed a critical overarching finding - the confirmation that there is still limited literature documenting how global health partnerships work and what were the active ingredients of their success and failure.

Table 2.3: Summary of Findings and Categorization of Critical Success Factors for Global Health Partnerships.

	Source	Summary of Key Findings: Critical Success Factors for Global Health Partnerships	Category
1	*Working toward Transformational Health Partnerships in Low- and Middle-Income Countries*; BSR, September 2012 Accessible at: https://www.bsr.org/reports/BSR_Working_Toward_Transformational_Health_Partnerships.pdf	BSR is a global network of nearly 300 member companies from the private sector focused on building a just and sustainable world. This report summarized the contribution of GHPs to meeting global health needs with a focus on low- and middle-income countries and provides perspectives on how to increase the impact and scale of GHPs going forward. The findings are based on interviews with leaders from the private sector and stakeholder groups, an assessment of more than 220 partnerships, a survey of 30 pharmaceutical industry executives, and a multi-stakeholder roundtable convened in Geneva in December 2011.	
		Adoption of an approach based on health needs and clear outcomes • 78 percent of respondents identified taking a health-needs-based approach as critical to the impact of GHPs. Targeted partnerships for a particular health issue (e.g., HIV/AIDS) or broader issues (e.g., maternal health) are useful.	Political Will, Health Need, Scope
		Emphasis on broad-based, multi-company partnerships • Partnerships that involve more than one industry partner can leverage greater resources, facilitate greater knowledge sharing, and lead to greater scaling of programs.	Membership, Complementary Skills
		Alignment of partnerships • 89 percent of respondents identified aligned partners as a critical success factor of effective GHPs. Aligned partnerships reflect clearly defined roles and responsibilities, agreed-upon objectives and targets, and clear communication lines between all partners. Partnership alignment is critical to ensuring that all parties share a common set of expectations, that partner assets are used to their greatest potential, and that the partnership is built for sustainability and scale.	Membership, Complementary Skills
		Emphasis on existing country systems and local ownership • These partnerships are more likely to develop sustainable activities and knowledge that are often far more efficient and therefore sustainable and	Alignment to Local Systems

	Source	Summary of Key Findings: Critical Success Factors for Global Health Partnerships	Category
		scalable.	
		<u>Implementation of tracking and measurement of programs to evaluate impact</u> • 79 percent of respondents identified impact measurement as one of the factors most critical to the success of GHPs. Partnerships that emphasize measuring impact have shown to increase industry commitment and can lead to the scaling of successful programs. • Ultimately, impact measurement should move from measurement of intermediate or process outcomes to highlighting the end or outcome impacts as it relates to saving or improving lives. The report underscores the importance of involving organizations that have the capability to measure and report on impact.	M&E, Performance, Communication
2	*Assessing the Impact of Global Health Partnerships.* Karen Caines and Kent Buse; Cindy Carlson; Rose-marie de Loor; Nel Druce; Cheri Grace; Mark Pearson; Jennifer Sancho and Rajeev Sadanandan. DFID Health Resource Centre, 2004 Accessed at: http://www2.ohchr.org/english/issues/development/docs/WHO_synthesis.pdf	DFID commissioned an evidence-based assessment of the impact of the GHPs with which DFID engages at both global and country level to determine best practice principles to guide DFID's future engagement in partnerships. This synthesis report summarizes key findings from a series of component studies, which in practice covered a wider range of GHPs. Further, this report identified several factors or determinants within the below categories that contributed to effective partnerships.	
		<u>Goal and scope</u> • Clear rationale & evidence base; appropriate choice of partners; consultation involves appropriate and influential stakeholders. • Agreed simple and compelling goal; clearly defined and focused scope, priorities and vision for success. • Scope, objectives and strategies tailored to current need.	Political Will, Health Need, Scope
		<u>Structure/organization</u> • Clear and transparent governance, legal and institutional arrangements; understanding of risk and risk management. • Suitable incentives for involving range of partner types. • Clear definition of roles and functions, and sufficient resources allocated. • No more than 1 or 2 primary governance structures with smaller number of members, involving constituencies and relevant skill base. • Strategic board with clear decision making rights for 10-20 most	Governance/ Leadership and Management Structure; Membership, Complementary Skills;

Source	Summary of Key Findings: Critical Success Factors for Global Health Partnerships	Category
	important decisions. • Constituency management and methods to involve stakeholders. • Accountable, strong leader (skills, networks) • Delegated executive and strong project management (focused team to structure, launch and manage the GHP). • Mechanisms for involving national partners, delivering technical assistance and other inputs at country level • Procedures established for governance, management and administration cope effectively with GHP issues. • Inclusive structures perceived to be working by all partners, including developing countries. • Senior champions in partner organizations, actively engaged and delegating appropriately to secretariat. • Inclusivity and representation of constituencies, including countries, NGOs, people affected • Effective use of resources (e.g., % administrative costs). <u>Process/ways of working</u> • 'Trust but verify' – managing open debate and transparency; understand and respect cultural differences; build trust. • Mechanisms for managing debate and achieving consensus on policy and strategic issues • Framework agreement or MOU that includes partner conflict resolution. • SMART business plan setting out objectives, strategies and roles for partners (international and national levels). • Agreed partner roles and commitments (people, money, technology), including national level. • Communication plan and mechanisms. • Detailed operating, reporting and financial/fundraising plans and progress reports publicly available. • Partners understand roles and processes; make, and deliver on, commitments (financial, technical assistance, etc). • Reported spirit of partnership (transparent, collegial). • Communication of partnership position and individual commitments	Governance/ Leadership and Management Structure

	Source	Summary of Key Findings: Critical Success Factors for Global Health Partnerships	Category
		within partner organizations (taken forward among partners at country level) • Active linkages at international through to national levels, coordinated activities taken forward with other GHPs as appropriate. • Active country ownership at national level. • Operational and monitoring process effective at all levels.	
		Environment • Flexible approach and mechanism in place to detect and respond to changing environment (e.g., regular reviews undertaken). • Flexible partnership that is monitoring and responding to environment changes. • Partners aware of changes and take action. • Scenario planning – entrepreneurial thinking. • Strategic alliances and joint working undertaken where needed.	Political Will, Health Need, Scope
3	*Public-Private Investment Partnerships for Health: An Atlas of Innovation*; The Global Health Group University of California, San Francisco. August 2010 Accessed at: http://globalhealthsciences.ucsf.edu/sites/default/files/content/ghg/hsi-ppip-atlas.pdf	This report provides an overview of innovative Public-Private Investment Partnerships (PPIPs) worldwide, all of which were established to systematically address healthcare challenges in a particular setting. The Atlas is a working document that serves as a snapshot of the PPIP landscape at one point in time. The information included was collected in late 2009 and early 2010. Case studies of 12 key PPIPs in seven countries, using a standardized format are documented in this report.	
		Political Will and Capacity • In all PPIPs, the government takes on tremendous role (e.g., business partner, contract manager, informed purchaser, while remaining responsible for leadership, regulation and monitoring) and their commitment is essential. Governments must have or commit to acquiring these skills and must also ensure the support of the community.	Political Will, Health Need, Scope
		Commitment from the Private Sector • Commitment from the private sector is also critical. Though a profit incentive may exist for the private sector, their commitment to serving its	Membership, Complementary Skills

	Source	Summary of Key Findings: Critical Success Factors for Global Health Partnerships	Category
		clients, both government and patients, must be maintained for success.	
		<u>Ensuring Trust Between Sectors</u> • Trust between the private and public sectors are important in forming a successful partnership. The report describes that PPIPs can draw on mechanisms to overcome challenges to effective collaboration including: supporting an open tender process, utilizing third-party facilitators, and maintaining continuous open dialogue and transparency by all parties.	Governance Leadership and Management Structure
		<u>Independent Monitoring and Evaluation</u> • An independent should be established to collect and validate performance data and ensure all contractual obligations are met. Monitoring and evaluation is also important in maintaining public confidence in the PPIP and in ensuring iterative learning and course correction as the partnership develops.	M&E, Performance, Communication
4	*Global Public-Private Health Partnerships: lessons learned from ten years of experience and evaluation*; Kent Buse and Sonja Tanaka UNAIDS, Geneva. International Dental Journal 2011; 61 (Suppl. 2): 2–10	The authors of this article synthesize and present lessons learned from global public-private partnerships from over the past ten years, including from eight independent evaluations of GHPs, a number of independent research projects, and 20 key informant interviews with 'partnership pioneers' who have founded or led major partnerships or served on their Boards.	
		<u>Identify and play to the partnership's comparative advantage</u> • Partnerships must define their value not only by ambitious goals, but also by their distinctive contribution and comparative advantage in reaching those goals. This articulation of comparative advantages should be defined and synthesized in a unifying partnership strategy towards a shared vision. • "What distinguish successful from unsuccessful partnerships are common vision, shared commitment, and partners that bring together complementary skills and resources to attack a problem. They do it in a way that places it at a comparative advantage." - Jeffrey Sturchio, Senior Partner at Rabin Martin, Former President and CEO of the Global Health Council; Former President of the Merck Company Foundation • William Foege "an effective coalition is able to define what the last mile	Membership, Complementary Skills

Source	Summary of Key Findings: Critical Success Factors for Global Health Partnerships	Category
	looks like."	
	Adequately resource partnership secretariats • Size of a partnership's secretariat is a critical factor in determining its success. Research shows that small secretariats promote the tendency to advocate 'one size fits all' attitudes in country operations due to the lack of capacity to respond to local contexts. Conversely, large secretariats may not be feasible or desirable, either. The key is that the partnership should consider the secretariat size and structure in a deliberate fashion.	Governance Leadership and Management Structure
	Practice good management • Practicing good management can take different forms at different stages for the partnership. Research shows that at the outset, maintaining a flexible, loose-knit structure requires some degree of ambiguity regarding roles and responsibilities. • As the GHPs mature, more formal professional management structures and strategies become increasingly critical to optimize partnership performance, monitoring and accountability. Partnership agreements and organizational structures should be established and defined through strategic and operational (or business) plans as the partnership develops. • SMART (Specific, Measureable, Attainable, Relevant, Time-bound) objectives, performance management and continuous internal assessment were found to be a key driver of effective partnerships.	Governance Leadership and Management Structure
	Practice good governance • Adequate representation of relevant stakeholders or members from within the partnership is critical. The research shows that processes to select board members should be transparent, fair and inclusive, with explicit selection criteria based on an agreed balance of diversity and expertise. • Good governance can ensure both public accountability and internal efficiency. Therefore, the findings indicate that all GHPs should publish	Governance Leadership and Management Structure

Source	Summary of Key Findings: Critical Success Factors for Global Health Partnerships	Category
	key governance, financial, operational, and performance documents and decisions on the Internet. • Further, a formal system of accountability of partners—including work plans, deadlines, deliverables, and sanctions for non-performance—is critical as the partnership continues to develop.	
	Acknowledge and respect partners' divergent interests • Another key factor to the effectiveness of GHPs is understanding or appreciating the pressures and incentives faced by different partners, particularly private sector partners. For example, private sector partners often engage in GHPs as a corporate social responsibility, separate from their core activities. But increasingly, private sector partners are entering GHPs to contribute their unique expertise to a global health cause as well as expand networking opportunities, exposure to knowledge and best practices, a more satisfied workforce and access to new markets.	Membership, Complementary Skills
	Ensure operations impact positively on national and local systems • The research indicates that while GHPs have been highly successful in mobilizing resources, more attention should focus on building capacity and ownership and increasing longer-term financing commitments within countries. For example, GHPs should work towards a more coordinated approach and systematic investment to strengthen country health information systems as a basis for monitoring progress, enabling performance- based funding mechanisms and designing evidence-informed responses.	Alignment to Local Systems
	Strive for continuous improvement • Chris Elias, of PATH suggests that "the focus needs to be on the process of how you develop a partnership rather than saying here is a template and this is how you should do it." • The research also suggests that GHPs should consider themselves as a learning process rather than an organizational structure and continually invest in identifying and agreeing upon the biggest opportunities for partnership impact and the actions required to realize these	M&E, Performance, Communication

	Source	Summary of Key Findings: Critical Success Factors for Global Health Partnerships	Category
		opportunities.	
5	*Public-Private Partnerships and Collaboration in the Health Sector: An Overview with Case Studies from Recent European Experience.* Irina A. Nikolic and Harald Maikisch. October 2006. The International Bank for Reconstruction and Development / The World Bank Accessed at: http://miha.ef.uni-lj.si/_dokumenti3plus2/192328/JZP-2011-LIT-6.pdf	This report provides an overview of public-private partnerships and public-private collaboration in the health sector in Europe. The key types of PPPs and PPC encountered in practice, the associated benefits and risks, and good practices for ensuring success are described. It includes in depth case studies of the following partnerships from the European experience: Privatization of outpatient dialysis services (Romania); Catering at the Charity Clinic (Germany); Shared regional hospital sterilization services (Austria); National E-Health Portal (Denmark); Holistic care center Waldviertel (Austria); Privatization of St. Goran's Hospital (Sweden); Build, own, and operate PPP at Berlin-Buch Hospital (Germany); and Comprehensive PPP program (Portugal). This report is produced by the Health, Nutrition, and Population Family of the World Bank's Human Development Network. However, the findings, interpretations, and conclusions expressed in the report are entirely those of the author(s). The authors present some key success factors, listed below, that should considered in planning PPPs and PPC. They categorize findings (much more project-oriented) in terms of the preparation, implementation, and monitoring phases of partnership development.	
		Preparation • Ensure adequate legal and fiscal capability (e.g., capacity, framework, regulations) • Establish a dedicated taskforce, advisory board, and/or a project management office close to the decision-making authority (e.g., Ministry of Health, Ministry of Finance) • Identify and review options against a clear set of pre-defined project objectives and quality standards • Assess risks and develop risk mitigation plan • Prepare a transparent and effective bidding process • Set up an effective monitoring and evaluation framework	Political Will, Health Need, Scope; Governance Leadership and Management Structure
		Implementation • Select partner(s)	Membership, Complementary Skills; Governance

	Source	Summary of Key Findings: Critical Success Factors for Global Health Partnerships	Category
		• Review judicial and audit capacity and adjust contract accordingly (e.g., procedural reliability and length, arbitration clause, auditing body) • Develop detailed quality and performance standards and targets • Ensure ongoing cooperation and communication between all the key stakeholders throughout the project • Implement change management and communication strategy • Pilot the project in stages, whenever possible to allow for needed and timely adjustments Monitoring and adjustment • Ensure ongoing monitoring according to the pre-agreed criteria and targets: Internal (conducted by the public partner through on- site monitoring and reporting); and External (conducted by an outside authority, e.g., certification authorities, audits) • Adjust any element of the project, including monitoring component as needed based on the lessons learned and in discussion with all the partners and key stakeholders • Build any lessons learned into the body of public-private collaboration/partnership expertise (e.g., government's center of excellence)	Leadership and Management Structure M&E, Performance, Communication
6	*Public–private health partnerships: a strategy for WHO*; Bulletin of the World Health Organization, 2001, 79 (8). Kent Buse & Amalia Waxman Accessed at: http://cdrwww.who.int/bulletin/archives/79(8)748.pdf	This article explores WHO's involvement with commercial sector partnerships. The paper presents opportunities and risks in these public-private partnerships and proposes a strategy, with specific governance requirements (listed below), for WHO in its role in partnerships for the promotion and protection of public health. Governance requirements • The findings indicate that partnerships involving WHO should: • Be governed by bodies that are widely representative yet give WHO adequate decision-making power so as to reflect its position as the premier health organization with universal representation. • Maintain mechanisms for ensuring the participation of constituencies in the partnership that might otherwise lack the material resources needed in order to participate	Governance Leadership and Management Structure

	Source	Summary of Key Findings: Critical Success Factors for Global Health Partnerships	Category
		• Establish clear goals, roles, responsibilities, and decision-making structures, and the means of monitoring and enforcing decisions • Establish systems of communication whereby information about decision-making structures, funding, resource allocation and results is regularly conveyed to all concerned, and should provide for consultation with stakeholders. • Document and publicize details of the process and outcomes of the partnership.	
7	*Public-Private Partnerships for Public Health.* Michael R. Reich. 2002, President and Fellows of Harvard College Accessed at: http://harvardschoolofpublichealth.com/faculty/michael-reich/files/Partnerships_book.PDF#page=12	This book presents the results of a workshop convened in April 2000 by the Harvard School of Public Health and the Global Health Council to examine questions about public-private partnerships in international public health. The format of the workshop was a two-day meeting, which brought together 50 people from international agencies, private corporations, development banks, consumer advocacy groups, private foundations, non-governmental organizations, developing country government officials, and academics institutions. Participants discussed problems and benefits of public-private partnerships seeking to expand the use of specific products with the potential to improve health conditions in poor countries. A key contribution of this book is the framing of the critical factors in establishing strategic collaboration (Austin, 2000): The Seven C's of Strategic Collaboration • Clarity of purpose • Congruency of mission, strategy, and values • Creation of value • Connection with purpose and people • Communication between partners • Continual learning • Commitment to the partnership The author of the book emphasizes the importance of GHPs needing to address these "Seven C's" to assure a sustainable collaboration among the partners and for impact within society.	Governance Leadership and Management Structure

	Source	Summary of Key Findings: Critical Success Factors for Global Health Partnerships	Category
		Austin, J. (2000). The Collaboration Challenge: How Nonprofits and Businesses Succeed Through Strategic Alliances. San Francisco: Jossey-Bass Publishers.	
8	*Seven habits of highly effective global public–private health partnerships: Practice and potential.* Kent Buse, Andrew M. Harmer. Social Science & Medicine 64 (2007) 259–271	The authors systematically reviewed the governance structures of over 100 initiatives involving representatives from both the public and private sectors on decision-making bodies. This paper outlines seven contributions made by GHPs to tackling diseases of poverty. It then identifies and discusses seven unhealthy habits (listed and summarized below) many GHPs practice that result in ineffective or sub-optimal performance.	
		Unhealthy habit 1: GHP alignment is 'out of sync' • Findings indicate that GHPs often, as a result of seeking quick results, do not align their assistance and resources with recipient countries' national priorities nor do they make use of, or develop, recipient countries' systems. • The authors recommend that GHPs should identify mechanisms to involve themselves in sector-wide policy and planning dialogues to align with country systems and priorities.	Alignment to Local Systems
		Unhealthy habit 2: GHPs are not representative of their stakeholders • Findings show that GHPs often fail to provide adequate representation of stakeholders in decision-making on governing bodies. • For instance, the findings of this assessment indicate that constituencies from low- and lower- middle-income countries (LMICs) are underrepresented on governing bodies with an average of 17% of the membership across their sample actually represented on the leadership or governing board. Further non-government organizations (NGO) that are engaged in implementing are least represented (5%) while the corporate sector has the greatest representation on leadership or governing bodies of GHPs (23%).	Membership, Complementary Skills
		Unhealthy habit 3: Poor governance • Findings reveal that many GHPs fail to clearly specify partners' roles and responsibilities; conduct inadequate performance monitoring; provide	Governance Leadership and Management Structure

Source	Summary of Key Findings: Critical Success Factors for Global Health Partnerships	Category
	insufficient oversight of corporate partner selection; and lack of transparency in decision- making. • Further, the authors note that poor specificity of partner roles and responsibilities can be assured through Memoranda of Understanding, if adequately they are sufficiently detailed.	
	<u>Unhealthy habit 4: Vilification of the public sector</u> • The authors indicate that there has been a "diminished sense of the 'public' nature of global public health initiatives.…Underfunding of publicly mandated international organizations, such as the WHO, presents one manifestation". • The authors underscore the importance and necessity of public–private interaction, but also encourage a more systematic consideration of the costs, benefits and risks of not adequately engaging the public sector, particularly in engendering a sense of public responsibility and developing capacity in public sector institutions to respond.	Membership, Complementary Skills
	<u>Unhealthy habit 5: Inadequate finance</u> • GHPs often lack the necessary resources to carry out planned activities or to finance the true costs of required for operationalizing the partnership, for example of the secretariat or coordinating bodies where program implementation is occurring.	Governance Leadership and Management Structure
	<u>Unhealthy habit 6: Poor harmonization</u> • Partners within GHPs also often have failed to harmonize their procedures and practices with one another and with other donors working in the same space, leading to duplication and waste. • For example, the article notes studies that illustrate examples of duplication among GHPs in planning, project-specific M&E, missions and financial management, and parallel systems for health service delivery (e.g., drug procurement and distribution).	Membership, Complementary Skills
	<u>Unhealthy habit 7: Inadequate incentives to partner faced by staff</u> • GHPs require sustained commitment by the partners. Research shows	Governance Leadership and Management Structure

Source	Summary of Key Findings: Critical Success Factors for Global Health Partnerships	Category
	that this level of organizational commitment diminishes over time. In some cases, staff are not supported or inadequate incentives are provides to have staff participate in “outside” interests. • Further, secretariat staff are required to span organizational boundaries to represent the entirety of the partnership. At times this role often extraordinary time and energy to partnership activities, often at the expense of corporate interests.	

Table 2.4: Partnership Pathway Critical Success Factors (CSFs) Mapped to Categories of CSFs Synthesized From Literature Review

Partnership Pathway Critical Success Factors	Political Will, Health Need, Scope	Membership, Complementary Skills	Alignment to Local Systems	Governance/ Leadership and Management Structure	M&E, Performance, Communication
The First Mile					
Choosing the right membership		X		X	
Developing a shared goal	X		X		
Selecting the appropriate structure				X	
Shaping a big-picture strategy	X				
Clarifying organizational role	X			X	
The Journey					
Bringing discipline and flexibility to management				X	
Applying discipline in research and planning				X	X
Deliberately launching, measuring, and communicating				X	X
Continuously engaging partners in problem-solving		X		X	
Revising operating plan based on learning		X		X	X
Developing complementary leadership		X			

Partnership Pathway Critical Success Factors	Political Will, Health Need, Scope	Membership, Complementary Skills	Alignment to Local Systems	Governance/ Leadership and Management Structure	M&E, Performance, Communication
Filling critical team leadership roles (i.e., Convener, Visionary, Strategist, Team Builder)		X			
Serving external leadership roles (i.e., Advocate, Political Influencer, Networker)		X			
The Last Mile					
Adapting approach to sustain momentum			X		X
Transferring control in a supportive way			X	X	
Capturing and communicating lessons learned					X
Dissolving the partnership when the goal is achieved					X

Table 2.5: Summary of Critical Success Factors of the Partnership Pathway (Rosenberg, 2010)

	The First Mile
Choosing the right membership	Existing and future membership should be chosen such that they can become an integrated team and achieve high performance by: (1) Defining stakeholder groups critical to the effort and determining whether their representatives should participate as members or in other forums. Stakeholder groups that should be considered depend on the type of partnership - partnerships designed for general advocacy and education could include all segments of society; partnerships designed for research and development could include organizations with technical or scientific expertise; partnerships designed to generate political will could include government officials and those who influence them; and partnerships designed to implement interventions or services could include representatives from the partner country's government, civil society, and private sector. (2) Seeking individuals with the leadership skills needed to accomplish the tasks of the partnership. The partnership can improve its effectiveness by choosing the appropriate organization as well as the leaders within the organization that can provide the following qualities and skills: alignment of personal agendas with the goals of the partnership; experience and technical or functional skills; positive attitude and team orientation; influence and authority, particularly within their own organizations so they can tap in to needed resources; and emotional intelligence. (3) Limiting membership to a size that allows for interaction, decision-making, and trust building. Partnership with integrated teams limit the size of membership (ranging between 5 and 30 people) to increase the likelihood that every person will participate in discussion and decision-making.
Developing a shared goal	A clear vision, goal, and articulation of the 'Last Mile' should be defined by the partnership. The findings point to two activities that can help partners develop a shared goal: (1) discuss and come to agreement on the vision behind the effort; and (2) refine the language of the goal together. A collective vision is what transforms the partnership from a collection of individual organization to an inspired, integrated team. Discussing the language of the goal is also important, particularly because language and organizational cultural differences can create misunderstandings.
Selecting the appropriate structure	An early, time-limited discussion of the structure of the partnership is critical to its success and ability to form close, integrated collaboration. Two governance models that have emerged from the research as those that facilitate real collaboration: (1) the lead partner model involves a member from one agency that serves as convener and or administrator of the partnership; and (2) the secretariat model involves a head of the secretariat that serves as the convener (with staff) as the administrator. The 'structure' may include deciding how the secretariat would function and focus and composition of working groups. The partnership structure also includes the structures that facilitate input (e.g., technical teams and working groups), decision-making (e.g., steering committee, senior champions, or stakeholder forums), and implementation (e.g., country coordinating bodies).

Shaping a big-picture strategy	In the formation of the partnership, the discussion should focus on the strategy, which could include where the partnership will focus (e.g., geographic location, target population), what the partnership will do, and how it expects to achieve the goal.
Clarifying organizational role	Developing a shared understanding and acceptance of organizational roles. This involves overcoming individual and organizational challenges, including individual styles that can create conflict and different language interpretations that can lead to misunderstandings. Organizational roles may include: technical advice, formal endorsement of decisions, field implementer, fund raising, management of surveillance network, provision of technology, policy advice, standard or norm setting, communication with stakeholders and public, or provision of financial resources.
The Journey	
Bringing discipline and flexibility to management	The appropriate balance should be met in bringing discipline to the operational processes of the partnership and also maintaining flexibility to respond to changes in the political, social, or economic environment.
Applying discipline in research and planning	The discipline in conducting research to understand the scope and context of the problem or health need from an epidemiologic and community perspective is important. The key principles for the research process include: involving local communities to identify social factors and political influencers; establishing an early relationship with key influencers (including those with budget authority); and incorporating the research into the planning process. The discipline of carrying out research and planning processes related to developing objectives and strategies for reaching those objectives, monitoring for quality improvement, and mid-course correction. The key principles for the planning process include: agreeing on supporting strategies; establishing project and operational work plans around those strategies; and incorporating planning into the research with iterative learning.
Deliberately launching, measuring, and communicating	A deliberate approach should be considered in launching the program, measuring its progress, and then communicating its progress. The key principles of launching the partnership include: tapping community volunteers; securing high-level commitment and engagement; and supporting early adopters. The key principles of measuring the progress include: measuring impact (not simply input or outputs); including sustainability indicators (e.g., donor satisfaction and country funding commitments). The key principles for communicating with key stakeholders include: addressing concerns and attitudes of key stakeholder groups before developing communication and advocacy plans; and sharing credit.
Continuously engaging partners in problem-solving	This element is particularly important for partnerships seeking integrated, or close collaboration. Holding productive meetings and communicating frequently with partners are ways to ensure partners are engaged in problem solving. The key principles for holding productive meetings include: sending materials in advance; and shaping agendas around issues instead of reports or updates. The key principles for communicating regularly with partners include: deciding as a group on the best method for partner communication; seeking partner feedback on issues; and utilizing interagency coordinators, if challenges persist across agencies or organizations.

Revising operating plan based on learning	Including a process for assessing failures and successes of the partnership and using those findings to modify and improve the operating plan of the partnership is key. The key principles for revising the operating plan include: establishing a shortfall team; periodically reviewing shortfalls to learn from mistakes; and incorporating those lessons into revisions of the operating plan.
Developing complementary leadership	Success depends on the ability of the partners to assume complementary and essential individual leadership roles (as distinct from organizational roles).
Filling critical team leadership roles	Complementary leadership roles are imperative for the critical or core team of the partnership. The leadership roles, each with unique and complementary skills, include: Convener, Visionary, Strategist, and Team Builder. The role of the Convener is to create space for open dialogue among the partners—this role requires skills that suppress the ego, while drive towards the shared goal. The role of the Visionary is to inspire partners with what can be accomplished—this role requires skills that focus on the big picture and motivate others to believe in the goal. The role of the Strategist is to help the partnership determine the value it provides—this role requires rational thinking, with the ability to draw on and frame strategic options. Finally, the role of the Team Builder is to help the partners understand the varying perspectives and aligns these under the common goal—this role requires a persuasive and compelling style.
Serving external leadership roles	External leadership roles are just as important as those internal to the partnership. The external leadership roles include: Advocate, Political Influencer, and Networker. The Advocate is important in changing attitudes and behaviors and requires a leader that can convey sincere passion for the cause. The Political Influencer taps in to the right people at the right time, requiring a leader that understands decision-making. The Networker contributes to generating wide support for the partnership, and requires a wide network of relationships.
The Last Mile	
Adapting approach to sustain momentum	Highly successful partnerships are adaptive and change their approach related to surveillance, stakeholder involvement, or strategy to sustain momentum. Shifting the approach to surveillance often becomes more intensive as the number of cases declines as the partnership nears its goal. Involving more local stakeholders and resources, are important to sustain the momentum of the partnership. Adapting the strategy to accommodate significant changes in the political or economic environment is critical as well.
Transferring control in a supportive way	Transferring the leadership and management of the project and partnership to local leaders is important for sustaining the effort. Also, connected to transferring control, is giving credit to in-country partners and others involved in the effort.
Capturing and communicating lessons learned	Documenting and sharing lessons learned (through reports, articles, and internet briefs) from the partnership process and outcomes of the partnership are important so other global health partnerships can benefit from the lessons learned.
Dissolving the partnership when the goal is achieved	One of the most difficult elements of the partnership pathway is deciding to terminate when the project is or even if it is "limping along".

CHAPTER 3: METHODOLOGY

STUDY DESIGN

My research applied a descriptive, non-experimental design for the purpose of assessing the *Saving Mothers, Giving Life* partnership for making progress toward sustainable reductions in global maternal mortality. I aimed to: (1) document the core elements of the *Saving Mothers, Giving Life* partnership so that they can be analyzed systematically against factors of other global health partnerships; 2) conduct an assessment of the strengths and weaknesses of the *Saving Mothers, Giving Life* partnership; and (3) make recommendations for strengthening the partnership for ensuring progress toward its sustained impact. Specifically, I examined:

- Which factors characterize successful and unsuccessful global health partnerships? How have these factors been assessed?
- Which partnership strategies have succeeded and which have failed? What are the reasons for this success or failure?
- What are the key elements of the *Saving Mothers, Giving Life* partnership, including membership, goals of the partnership, and the conditions in which it was developed and exists (social, organizational, political and economic context)?
- How do the elements of the *Saving Mothers, Giving Life* partnership compare to those critical factors associated with success and failure of other global health partnerships?
- What are the strengths and weaknesses of the *Saving Mothers, Giving Life* partnership?
- What opportunities and barriers exist to strengthen the *Saving Mothers, Giving Life* partnership?
- What are key recommendations to assist the partnership in progress toward achieving its mission in reducing global maternal mortality?

DATA COLLECTION PROCEDURES

I collected primary and secondary data for this study. Primary, qualitative data were obtained from semi-structured key informant interviews. I conducted semi-structured key informant interviews in-person (one by phone) with key leaders who played a critical role in the development of the *Saving Mothers, Giving Life* partnership. Purposive sampling was used to identify the key 24 leaders that were a part of the development of the *Saving Mothers, Giving Life* partnership. These leaders served as key senior-level decision-makers within the respective organizations who participated in the development of the partnership or currently participate on the partnership leadership council or committees. As part of the team that helped create the partnership, I was familiar with those leaders, internal and external to the U.S. Government, who played a critical role in the partnership's development. The size of this sample is sufficient in that it provided a feasible number of informants to be interviewed, with 6-8 participants from each category to reflect diverse perspectives. These leaders were categorized based on their relationship, internal or external to the U.S. Government, and their confirmed role in *Saving Mothers, Giving Life*. The following categories of leaders are described below, from:

(1) The U.S. Government from agencies that played a key role in the development of *Saving Mothers, Giving Life* partnership;

(2) Outside the U.S. Government and that played a key role in the development of *Saving Mothers, Giving Life* as founding members of the partnership; and

(3) Zambia or Uganda, including from the U.S. Government and the Government of Zambia and the Government of Uganda, that are engaged in implementing *Saving Mothers, Giving Life*.

Key informants were recruited through purposive sampling and sent an introductory e-mail explaining the study and inviting selected individuals to provide perspectives through scheduled semi-structured key informant interviews. A total of no more than 24 participants were invited to serve as key informants for the study. After scheduling interviews, each key informant was given the consent

form (see Appendix A) for review and signature, prior to interviewing. For those who consented, I conducted a 30 to 45-minute in-person or phone interview using the semi-structured interview guide (see Appendix B) held in the privacy of their offices or in another private place.

DATA ANALYSIS

All interviews were electronically recorded with a digital recorder and transcribed verbatim following the interview. Simultaneously, I took hand-written field notes during the interviews and made a brief summary note after each interview, recording main points and my observations about the interview itself. I managed and organized the interview data using ATLAS.ti qualitative data analysis software. Each of the transcribed interview records was uploaded to ATLAS.ti and I created codes to label every string of text captured through the interviews. This process enabled me to identify themes or patterns and to compare and contrast responses across interviews. Using ATLAS.ti, I was able to create networks among the coded text, which could then be linked and also quantified either by frequency of mention or extent of a theme common across interviews.

The data obtained in the semi-structured interviews were triangulated with the key historical documents of the *Saving Mothers, Giving Life* partnership (see Appendix C), including the Memorandum of Understanding between the global partners (Merck, ACOG, and EMC with the USG) and the letter of commitment from the Government of Norway, signed by the Minister of Foreign Affairs, Jonas Gahr Støre, to former Secretary of State Hillary Rodham Clinton. I also used observational data that I gathered from two key *Saving Mothers, Giving Life* partnership meetings: (1) April 15-19, 2013 in Livingstone, Zambia and (2) July 11-12, 2013 in Oslo, Norway. These additional historical documents and observational records from the key meetings created a more robust source of data to be analyzed to help provide more depth to the primary sources of data.

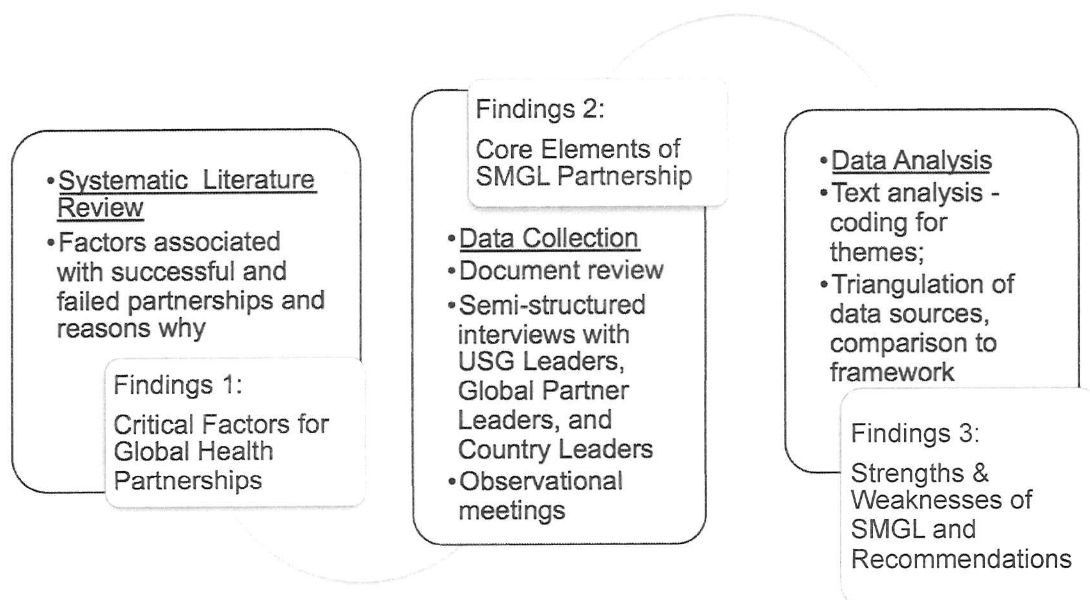
The following table links the identified research questions with the specific data collection methods used to answer those questions.

Study Research Question	Data Collection
Which factors characterize successful and unsuccessful global health partnerships? How have these factors been assessed?	Literature Review

Study Research Question	Data Collection
Which partnership strategies have succeeded and which have failed? What are the reasons for this success or failure?	Literature Review
What are the key elements of the *Saving Mothers, Giving Life* partnership, including membership, goals, and the conditions in which it was developed and exists (social, organizational, political and economic context)?	Historical Document Review; Qualitative Interviews
How do the elements of the *Saving Mothers, Giving Life* partnership compare to those critical factors associated with success and failure of other global health partnerships?	Qualitative Interviews; Observational Data from Meetings
What are the strengths and weaknesses of the *Saving Mothers, Giving Life* partnership?	Qualitative Interviews; Observational Data from Meetings
What opportunities and barriers exist to strengthen the *Saving Mothers, Giving Life* partnership?	Qualitative Interviews; Observational Data from Meetings
What are key recommendations to assist the partnership in progress toward achieving its mission in reducing global maternal mortality?	Qualitative Interviews; Observational Data from Meetings

The diagram below depicts the process flow that was used in collecting and analyzing the data and formulation into recommendations.

Figure 3.1: Process for Data Collection and Analysis



I analyzed the core elements of the *Saving Mothers, Giving Life* partnership unearthed through the historical document review and key informant interviews against the critical success factors of the Partnership Pathway, which through the literature review was validated as a "gold-standard" framework. Specifically, I focused on analyzing elements of the 'First Mile' of the Partnership Pathway, since the partnership is at a critical inflection point - as it moves from Phase 1 (Year 1, pilot - June 1, 2012 to September 30, 2013) to Phase 2 (Years 2-5, scale-up - October 1, 2013 to September 30, 2017) - to assess the health of the partnership itself.

IRB AND CONFIDENTIALITY ISSUES

Both the CDC and University of North Carolina—Chapel Hill IRBs approved this study in April 2013. This study was approved by the CDC IRB as category IC, noting that this activity is not human subjects research, but program evaluation and that the results may lead to program improvement. This study (#13-1716) was also subsequently approved by the UNC IRB and determined to be exempt from further review according to the regulatory category cited above under 45 CFR 46.101(b).

All electronic data for this study were stored on secure U.S. Government-networked computers that are password protected. All transcription files were also stored on these secure U.S. Government-networked computers that are password protected. Key informant interviews took place within a private phone call or within the privacy of the informant's personal office or another private space. Digital recordings of the interview were transferred to my computer within a day of being recorded. The digital files were then destroyed one month after the interview. Consent was obtained before any interview was conducted and participants had the option of stopping the interview at anytime, if they wished. I assured key informants that any information received during the interview would be described only as group summaries and any quotes used would remain anonymous, unless permission was granted to use otherwise. This research presented only very limited risks to study participants for being a part of the research.

CHAPTER 4: ANALYSIS AND DISCUSSION

This chapter begins with a description of the key informants that were interviewed as a part of this research, followed by a description of the key elements of the *Saving Mothers, Giving Life* partnership gathered from the study: membership, goals, and governance. Next, the key findings are described, along with an analysis of strengths and weaknesses of each comparing them against those critical factors associated with success and failure of other global health partnerships, specifically in relation to the 'First Mile' of the Partnership Pathway Framework from the literature review. Finally, opportunities and barriers to strengthen the *Saving Mothers, Giving Life* partnership are presented.

Quotations used in this section were excerpted from the interviews and are attributed anonymously to the person (or organization they represent) referenced in the text. To avoid pronouns that would disclose the gender, name of a person, or specific organizational entity, pronouns and personal nouns in quotations have been substituted to help ensure anonymity. Substituted nouns and other clarifying words are placed in brackets.

DESCRIPTION OF KEY INFORMANTS

Twenty-two (or 91.6%) of the 24 key informants that were invited to participate in the study were interviewed as key informants. The key informants represented organizational-, not individual-level perspectives. All key informants are senior-level leaders with decision-making authority within their respective organizations and were (or are) also leaders in the development and/or implementation of *Saving Mothers, Giving Life.* The key informants also reported serving in leadership positions, described as Executive Directors, Directors, Leads, or Senior Advisors within their respective organizations or area of work (i.e., clinical or public health focused maternal and child health, and/or HIV) for 5-30+ years.

Organizational categories of the key informants of this study are described below:

- 8 key informants are from the U.S. Government/Headquarters. Leaders represented diverse perspectives from the USG, coming from various departments or agencies from the USG, including from the State Department's former Global Health Initiative Office, State Department's Office of the Global AIDS Coordinator, the U.S. Agency for International Development, and the Department of Health and Human Service's Centers for Disease Control and Prevention.
- 6 key informants are global-level partners from outside the U.S. Government and represent organizational entities that are considered the founding partners, as well as the secretariat, of the *Saving Mothers, Giving Life* partnership. These organizations include the Government of Norway's Ministry of Foreign Affairs, Merck for Mothers, the American College of Obstetricians and Gynecologists, and Every Mother Counts.
- 8 key informants are country-level leaders residing in Zambia or Uganda from the U.S. Government or the Governments of Zambia or Uganda (district-level Ministry of Health officials) that are leading the implementation of *Saving Mothers, Giving Life*.

DESCRIPTION OF KEY PARTNERSHIP ELEMENTS

Membership

The current membership of the *Saving Mothers, Giving Life* partnership is comprised of the U.S. Government, the Government of Norway, Merck & Co., Inc. (Merck), the American College of Obstetricians and Gynecologists (ACOG), Every Mother Counts (EMC), and most recently also includes Project Cure. For the purposes of my dissertation, I completed an in-depth analysis of only the founding partners (all except Project Cure) that were part of the original design and development of the partnership, given my area of focus was on the development and Phase 1 (or First Mile) of the partnership. These once disparate entities formed a public-private partnership solidified in verbal and written agreements signed by organizational leads in December 2011 (between the USG and the Government of Norway) and in March 2012 (between the USG, Merck, ACOG, and EMC). Comprehensive descriptions of each of the founding partners, including their roles and commitment or contribution are presented below.

USG

The U.S. State Department's former Global Health Initiative Office coordinated the U.S. Global Health Initiative (GHI) through which multiple U.S. agencies and departments, including the Centers for Disease Control and Prevention, Department of Defense, Peace Corps, State Department's/Office of the Global AIDS Coordinator (OGAC), and U.S. Agency for International Development were brought together, as one USG, as a member of the *Saving Mothers, Giving Life* partnership. The USG's roles in support of the *Saving Mothers, Giving Life* partnership are to:

- Link with in-country programs led by the Chief of Mission and the interagency health team, including coordinating USG activities to support *Saving Mothers, Giving Life* implementation, and by bringing to bear the innovation and complementary strengths of the USG's implementing agencies for international health programs,
- Drive U.S. diplomatic efforts to bring attention to and support for maternal health,
- Convene non-USG partners with the *Saving Mothers, Giving Life* partnership (e.g. private companies, foundations, and non-profit and faith-based organizations) with an interest in supporting *Saving Mothers, Giving Life* activities,
- Participate with the other key members of the Partnership in providing strategic planning and policy direction for the *Saving Mothers, Giving Life* partnership, and
- Coordinate with relevant USG agencies, the USG contribution of financial, human, and material resources to support *Saving Mothers, Giving Life* implementation, subject to the availability of funds, and in accordance with the internal approval processes of the USG.

The USG's contribution to the *Saving Mothers, Giving Life* partnership is documented and described through financial and in-kind resources that reflect its additive value in the partnership. Financially, in addition to the $17.65 million USD that HHS/CDC initially contributed to catalyze the implementation of Phase 1 (Year 1) programming of *Saving Mothers, Giving Life* in Uganda and Zambia, the USG contributed an additional $75 million USD ($60 million from PEPFAR/HIV funds and $15 million from USAID/MCH funds) to support program implementation for Phase 2 (Years 2-5). In-kind resource contribution by the USG included its expertise in program implementation related to

HIV, maternal health, and systems strengthening in-country; its long-standing relationships with country governments through the USG's in-country presence; existing mechanisms with implementing partners; and infrastructures or platforms that could be leveraged for *Saving Mothers, Giving Life* that had been strengthened through USG-supported President's Emergency Plan for AIDS Relief (PEPFAR) HIV/AIDS efforts and USAID's maternal and child health efforts over a number of years.

Partners, through in-depth interviews, further confirmed and qualified these commitments and contributions made by the USG. For example, one informant reported, "In Phase 1 the only partners who actually did something were the USG agencies – not in terms of thinking ... but in actual practical action and commitment of money". Another partner noted, "There would be no Phase 1 without the USG. They are showing leadership in the field...I still think going forward that they will be the backbone of SMGL. They are the ones with the relationships with the governments and implementers in country and it is going to be really hard for anyone else to come in and play that role". To further support this statement, another partner shared, "The sheer power of our USG is stunning - CDC is phenomenal. USAID is an implementer. The power of boots on the ground is overwhelming.... [sometimes] with a huge amount of inefficiency and unnecessary bureaucratic in-fighting and neglect, but no one does it like them. When the USG decides to move, it's a pretty powerful thing to watch". Another informant shared that the "Greatest contribution was the platform of the USG, in particular of PEPFAR – a massive global health program built across a number of countries that could be utilized for other diseases". Another informant highlighted the USG's "brand" as a key contribution by describing, "The USG's ability to convene different actors, stakeholders, and interests around a particular issue...not just the USG, but the State Department, in particular. The State Department has a brand and a credibility that is like no other."

Government of Norway

The Norwegian Government has a deep commitment to improving maternal health globally and wide-ranging experience in addressing complex development issues. The Government of Norway is mobilizing advocacy efforts and supporting program implementation, focusing in particular

on sustainability and scalability of the *Saving Mothers, Giving Life* program. The Norwegian Government's roles in support of the *Saving Mothers, Giving Life* partnership are to:

- Provide advocacy and co-leadership globally, including by engaging with African leaders and with other donor governments, and link to other global and regional initiatives such as the UN Secretary-General's "Every Woman, Every Child" initiative and the East African Community's "Open Health Initiative,"
- Host a meeting/event on women's and children's health in Norway, seeking to enhance momentum for reducing maternal mortality among donor and recipient countries, and to advance innovative solutions and scientific underpinnings,
- Co-invest financial resources to support *Saving Mothers, Giving Life* program implementation,
- Facilitate technical assistance on sustainability and scalability, including through results-based financing, and
- Participate with the other key founding partners in providing strategic planning and policy direction for the *Saving Mothers, Giving Life* Partnership, and contribute to working groups and strategic planning efforts where Norway can add value.

The Government of Norway's contribution to the *Saving Mothers, Giving Life* partnership is primarily defined by their credibility and focused expertise in sustainability of global efforts, which has essentially been seen as their "brand". Their financial commitment and contribution was made during a public speech given by former Minister of Foreign Affairs, Jonas Gahr Støre, where he states, "Now, we need to be equally creative in finding ways to make these initiatives more interactive and to promote better consolidation. Norway and the United States will work together to make this happen. Norway welcomes and endorses the *Saving Mothers, Giving Life Partnership*, under the U.S. Global Health Initiative, led by you, Secretary Clinton. *Saving Mothers, Giving Life* is widening the focus of the biggest global health initiative, the U.S. President's Emergency Plan for AIDS Relief, which initially focused entirely on HIV/AIDS issues, and now also works to save mothers from dying in childbirth. I am pleased to announce today that Norway will join the *Saving Mothers, Giving Life*

partnership, and that – subject to the Storting's consent – we intend to provide an allocation of up to 500 million kroner (that is to say, 80 million dollars) over five years, for developing long-term, sustainable solutions in this important area".

Partners, through in-depth interviews, further confirmed and qualified these commitments and contributions made by the Government of Norway. The single most important contribution shared by partners, in some ways similar to the "brand" of the U.S. State Department, is the Norwegian Government "brand". One partner described the Norwegian contribution in that, "They have brought credibility. Enormous imprimatur of respectability – calling card for certified, "organic" – certified, "Norway approved". If Norwegians believe this works, then it works – because everyone knows that Norwegians have high standards…". The majority of partners expressed that while Norway has committed to contribute significant financial resources (i.e., $80 million USD) to *Saving Mothers, Giving Life*, there is a lack of clarity about how those resources will specifically help advance the partnership's goals. For example, one partner stated that, "Norway's biggest contribution is they've contributed a lot of money, but the biggest challenge is they have not engaged in SMGL…".

Merck & Co., Inc.

Merck is a global health care company that provides innovative medicines, vaccines, and consumer health and animal products to make a difference in people's lives. In September 2011, Merck announced "Merck for Mothers," a 10 year, $500 million initiative to make proven solutions more widely available, by developing new technologies and improving public awareness, policy efforts and private sector engagement for reducing maternal mortality in line with MDG 5. Merck's roles in support of the *Saving Mothers, Giving Life* partnership are to:

- Establish and maintain an organizational unit (or Secretariat) with staff, an office (to be located at a U.S.-based Merck facility), and a website to support the *Saving Mothers, Giving Life* partnership,
- Convene non-USG partners (e.g., private companies, foundations, and non-profit and faith-based organizations) with an interest in supporting *Saving Mothers, Giving Life* activities, mapping their interests with the menu of needs and partners on the ground, as articulated in

country plans, and receiving and disbursing funds for program implementation, in accordance with the plans and decisions of the *Saving Mothers, Giving Life* partnership,

- Be a leader in innovation and implementation science, advocacy and policy, including by supporting the impact evaluation of the initial implementation for Phase 1 (Year 1),
- Provide opportunities for Merck employees to support the goals of the *Saving Mothers, Giving Life* partnership through volunteer recruitment, and
- Co-invest Merck funds and resources in *Saving Mothers, Giving Life* operational plans and activities that are targeted to reducing maternal mortality, through private sector engagement in-country that is in line with MDG 5 and Merck for Mothers access plans, subject to funding availability and approval in accordance with Merck internal processes.

Merck's contributions and commitments to the *Saving Mothers, Giving Life* partnership are documented and described through financial and in-kind resources that reflect its additive value in the partnership. Financially, Merck contributed $50 million USD in addition to $8 million in-kind to the *Saving Mothers, Giving Life* partnership. Other partners within the *Saving Mothers, Giving Life* partnership recognized and appreciated Merck's private sector skill-set and clarity of commitments. One partner expressed that "[Merck is] one of the few partners that has done completely what it said it would do". Further, another partner felt that, "They have filled in so many gaps without which we would not have a functioning partnership". However, it was also noted that, "It is not clear that they are actually filling gaps that have been identified in the field as opposed to gaps that they [Merck] feel are in country".

<u>American College of Obstetricians and Gynecologists (ACOG)</u>

ACOG is a private, voluntary membership organization of over 55,000 professionals providing health care for women. ACOG works to advocate for quality health care for women, maintain the highest standards of clinical practice and continuing education for its members, promote patient education, understanding, and involvement in medical care, and increase awareness among its members and the public of changing issues facing women's health care. ACOG's roles in support of the *Saving Mothers, Giving Life* partnership are to:

- Provide scientific and technical leadership for the *Saving Mothers, Giving Life* partnership and participate in addressing key implementation challenges of programs and interventions to reduce maternal mortality,
- Galvanize other key professional membership associations to support the *Saving Mothers, Giving Life* partnership, and
- Support and sustain the public awareness and resource mobilization campaign through its members and the women they serve.

ACOG's commitments have primarily been described in terms of its technical credibility, not in financial contributions. One partner, when describing ACOG said, "They bestow a high degree of credibility and should be the cornerstone for validating the [SMGL] model." They also went on to say, "They [ACOG] haven't unleashed the power of their network or the individuals. So, if they have the expertise but are not able to leverage it, what use is it?". Specifically, a handful of other partners pointed to the potential and power of ACOG to also bring together other American professional associations to help with African associations. One partner expressed that, "ACOG's real potential will come out...by strengthening country professional associations of OBGYN, nurses, midwives. They may need to bring in the American Association of Nurse and Midwives".

Every Mother Counts (EMC)

EMC is an advocacy and mobilization campaign to increase education and support for maternal mortality reduction globally. EMC seeks to engage new audiences to better understand the challenges and the solutions while encouraging them to take action to improve the lives of girls and women worldwide. As a key founding partner, EMC's role is to assist *Saving Mothers, Giving Life* with one of its three key objectives: to "galvanize the American public around the shared experience of motherhood and childbirth, increasing awareness of maternal mortality and individual donations to support *Saving Mothers, Giving Life* country-level program implementation". EMC's roles in support of the *Saving Mothers, Giving Life* partnership are to:

- Incorporate *Saving Mothers, Giving Life* into broader EMC-driven national maternal health public awareness and fundraising activities, such as by: providing messaging that includes

the 24-hour window and providing opportunities for individuals, families, and groups to donate funds to benefit *Saving Mothers, Giving Life* and other programs,

- Contribute to *Saving Mothers, Giving Life* partnership public relations, public awareness, communications, resource mobilization, and media engagement that helps develop a movement of 'mothers helping mothers,' and
- Contribute an allocation of funds from EMC-driven resource mobilization activities to the *Saving Mothers, Giving Life* partnership for in-country programs. These resources may be designated for particular interventions as discussed amongst the Partnership and allocated directly to implementing partners within designated countries.

Similar to ACOG, the commitments of Every Mother Counts were not linked to contributing substantive financial resources, but really focused on their technical expertise. The key limitation was the size of their organization. One partner aptly described that "Of all partners, [EMC] has the best ability to tap the emotional quotient in the U.S. They are the craftiest, closest to consumer in social media than of any of the partners, they know how to mobilize it, but they are hampered with being too small. Their instinct for modern technology and communication to help build a domestic constituency is enormous. I don't think they add anything in the field, except to convey why Americans should care". Another informant commented, "They are more poised to make a major contribution, but they don't have the band-width to do it".

<u>Goals and Strategies</u>

The overarching goal of *Saving Mothers, Giving Life* is to accelerate the partnerships' collective work to reduce global maternal mortality. Specifically, the focus of the partnership's work is to support countries where women are dying at significant rates during pregnancy and childbirth to aggressively reduce maternal mortality during labor, delivery, and the first 24- to 48- hours postpartum.

As articulated in the Memorandum of Understanding between the global partners (USG, Merck, ACOG, and EMC) and other internal and public documents and records, the *Saving Mothers,*

Giving Life partnership shares the following goals in the Phase 1 (Year 1 - proof of concept phase) and if successful in the Phase 2 (Years 2-5) scale up of this effort to:

(1) Reduce maternal deaths in targeted districts in select countries by up to 50%;

(2) Catalyze cost effective, system-wide health delivery solutions at the district level that can be scaled-up nationally; and

(3) Galvanize the American public around the shared experience of motherhood and childbirth, increasing awareness of maternal mortality and raising private funds to support *Saving Mothers, Giving Life* country-level program implementation.

Strategies documented within the MOU to help advance the first goal to reduce maternal deaths in targeted districts in select countries by up to 50%, include to: (A) Strengthen district health networks for comprehensive, integrated maternal health care during the critical period of labor, delivery, and 48 hours post-partum; and (B) Support the development and implementation of country operational plans for delivering a core set of integrated and systems-level solutions at the district level. The core set of integrated and systems-level solutions include: Adequate human resources, including skilled health personnel at all levels to support safe labor and delivery, task-shifting, and supportive supervision; safe health facilities for women to deliver; high quality basic and emergency obstetric care and other services, and available supplies and systems at health facilities; innovative and integrated systems of incentives, communication, transportation, and lodging facilities to improve facility-based births in a timely manner; and Strengthened information systems to register 100% of women who deliver and their pregnancy outcome.

Strategies documented within the MOU to help advance the second goal to catalyze cost effective, system-wide health delivery solutions at the district level that can be scaled-up nationally, include to: (A) Support implementation science and conduct rigorous impact evaluation of district level activities to determine effective models that can be brought to scale nationally and internationally; and (B) Apply lessons learned and the evidence base in the design of the *Saving Mothers, Giving Life* program as it expands to additional countries.

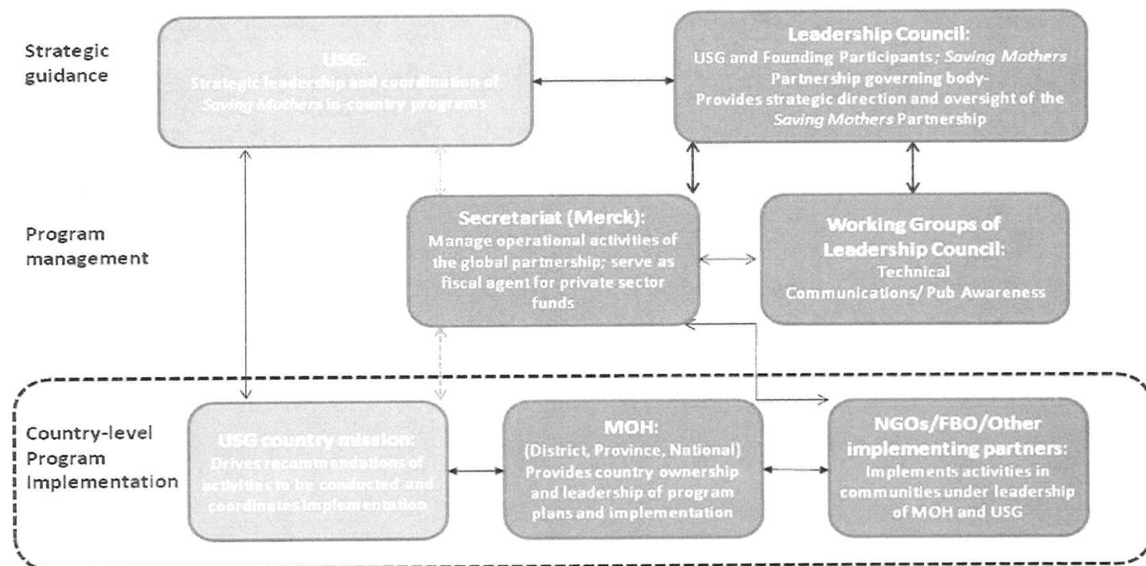
Finally, strategies documented within the MOU to help advance the second goal to galvanize the American public around the shared experience of motherhood and childbirth, increasing

awareness of maternal mortality and raising private funds to support *Saving Mothers, Giving Life* country-level program implementation, include to: (A) Conduct a national awareness-raising and mobilization campaign for maternal health, which features *Saving Mothers, Giving Life* as a key initiative in improving maternal health and cites examples, content and stories from *Saving Mothers, Giving Life* programs; (B) Support the national maternal health awareness-raising campaign by providing opportunities for the public to participate in events, fundraisers, online actions, and other activities, including a mechanism for mothers who deliver babies in the United States to donate to the *Saving Mothers, Giving Life* Partnership; and (C) Mobilize additional private sector, foundation, government, non-profit, and faith-based partners, by agreement of the Participants, to become engaged in support of the goals and objectives of *Saving Mothers, Giving Life*.

Governance and Operating Structures

The conceptual and theoretical design of the governance structure that guides operation of the *Saving Mothers, Giving Life* partnership was developed with input and feedback from all founding partners of the partnership. After the formal launch of the partnership in June 2012, the conceptual framework was put to practice by the partnership. The governance structure is comprised of three levels of architecture to support strategic guidance, program management, and country-level program implementation (see Figure 4.1).

Figure 4.1: *Saving Mothers, Giving Life* Governance, Conceptualized by the Partnership



Leadership Council

The strategic guidance function of the partnership is supported by a Leadership Council that includes 1-2 senior leaders from the key founding organizations (i.e., USG -OGAC, USAID; Government of Norway, Merck, ACOG, EMC, and also now includes the newest partner, Project Cure). The role of the Leadership Council, as the governing body of the *Saving Mothers, Giving Life* partnership, is to provide strategic planning, policy direction and oversight in the implementation of the goals and objectives of the effort. Specific responsibilities of the Leadership Council, as previously conceptualized and documented internally, include to: Establish program goals and core principles; Develop, as necessary, *Saving Mothers, Giving Life* Partnership procedures and criteria (e.g., membership, governance, communications and decision-making procedures); Provide input and support and participate in the development, assessment, implementation and evaluation of innovative strategies at the *Saving Mothers, Giving Life* program level to improve maternal health and reduce maternal mortality; Develop the criteria to be utilized in evaluating the impact of the initial implementation phase and at the conclusion of the *Saving Mothers, Giving Life* program; Review, provide input and participate in the development and implementation of *Saving Mothers, Giving Life* operational plans and on-the-ground *Saving Mothers, Giving Life* program implementation and other activities; Allocate *Saving Mothers, Giving Life* Partnership resources and make funding decisions (excluding Norwegian and USG funding decision-making); Approve and oversee public awareness, branding and marketing campaigns; Lead advocacy efforts, and Issue an annual report, an impact evaluation of the initial implementation phase in three countries and an end-of-program evaluation.

Secretariat

The program management function of the partnership is coordinated by a Secretariat. Until July 12, 2013, the Secretariat (led by a Director of the *Saving Mothers, Giving Life* Partnership) operated under the management of Merck and was responsible for the day-to-day activities, representing the collective interest of the partners. Currently, the Secretariat is operated under the management of the USG through USAID. Specific responsibilities of the Secretariat, as previously conceptualized and documented internally to guide the partnership, include to: Establish, maintain, and direct an organizational unit with staff, an office (to be located at a U.S.-based Merck facility), and

a website; Develop, as necessary, procedures (e.g., membership, governance, communications and decision-making procedures) for consideration by the Council; Manage the day-to-day activities of the *Saving Mothers, Giving Life* Partnership consistent with the program goals, core principles, and Council direction and decisions; Identify and recommend private sector partners to the Council, mapping their interests with the menu of needs and partners on-the-ground, as articulated in country plans; Manage, allocate and disburse non-governmental funds donated to *Saving Mothers, Giving Life*, in accordance with Council decisions; Produce appropriate financial reports describing the receipt and use of non-governmental funds; Assist in implementing public awareness and marketing campaigns and developing key communications materials for the *Saving Mothers, Giving Life* program, Facilitate and support the activities of the committees (described below), as needed; Create progress reports, briefing papers, fact sheets and other material summarizing the activities and impact of the *Saving Mothers, Giving Life* program; Develop the criteria for and upon approval by the Council implement the impact evaluation of the proof of concept phase and of the *Saving Mothers, Giving Life* program at its conclusion, and Develop and recommend to the Council an annual report and such other reports as determined by the Council.

Technical Committees

The program management function of the partnership is primarily supported by a series of technical committees. There are six technical committees comprised of various representatives from the global partners (USG/HQ, Merck, ACOG, EMC and Government of Norway): (1) Advocacy and Communications Committee; (2) Phase 2 Planning Committee; (3) Scientific and Technical Committee; (4) Monitoring and Evaluation Sub-Committee; (5) Implementation Science Committee; and (6) Partnership Development Committee. Each committee has nominated co-chairs, who also represent their respective committee on an Operations Committee. Specific responsibilities of these technical committees, as previously conceptualized and documented internally to guide the partnership, include to: propose decision points for review, deliberation, and vetting by the Operations Committee and finally for distillation and synthesis for the Leadership Council.

Program Implementation

In-country program implementation is governed and operated through a network of representatives from the Ministry of Health (at the district, provincial, and national levels), USG field teams comprised of management and technical staff, and program implementing partners in Zambia and Uganda. The program work of *Saving Mothers, Giving Life* is facilitated by a district coordinator (from the MOH) that is situated in each district where the program is implemented. Together, these entities are part of the MOH's technical working group on maternal health. These comprehensive program implementation teams attempt to meet monthly convening everyone who is present and working in the district on *Saving Mothers, Giving Life*, including district medical teams. These monthly district meetings are designed so that information (both progress and challenges with implementation) can feed into the quarterly national-level planning meetings among the MOH working group and USG taskforce. While the frequency of the monthly and quarterly meetings is not as consistent, the effort is still made for them to take place.

KEY FINDINGS AND DISCUSSION

In this section of the chapter, key findings are presented along with an analysis of strengths and weaknesses of the key elements of the *Saving Mothers, Giving Life* partnership (Membership, Goals, and Governance), in relation to the 'First Mile' of the Partnership Pathway Framework identified in the literature review. The key findings are fundamentally related to the vision, strategy, operations, and tactics of the *Saving Mothers, Giving Life* partnership. Ultimately, strengths and weaknesses of the partnership are assessed to assist the partnership in progress toward achieving its mission in reducing global maternal mortality. During the 'First Mile' or Phase 1 of the *Saving Mothers, Giving Life* partnership, the following factors are critical in determining the success or failure of a partnership: (1) Choosing the right membership; (2) Developing a shared goal; (3) Shaping a big-picture strategy; and (4) Clarifying organizational roles. Finally, opportunities and barriers to strengthen the *Saving Mothers, Giving Life* partnership are described.

Membership

Key Finding #1: *Saving Mothers, Giving Life* membership is comprised of high-caliber partners, but the country representatives are not engaged as leaders at the global-level.

'Choosing the right membership' is a critical factor for the success or failure of a partnership. The research shows that existing and future members should be chosen such that they can become an integrated team and achieve high performance by: (1) Limiting membership to a small size (ideally ranging between 5 and no more than 20 people) that allows for interaction, decision-making, and trust building; (2) Seeking individuals with the leadership skills needed to drive and accomplish the tasks of the partnership; and (3) Defining stakeholder groups critical to the effort and determining whether their representatives should participate as members or in another forum. In analyzing the membership of the *Saving Mothers, Giving Life* partnership, I examined the extent to which the *Saving Mothers, Giving Life* partnership 'Chose the right members', per these definitions.

A key strength of the *Saving Mothers, Giving Life* partnership was its limited membership size with 6 organizational members – the USG, the Government of Norway, Merck, ACOG, EMC, and most recently Project Cure. Each organizational member has 1-2 key leaders, that exemplify a complementary skill set, that are represented on decision-making bodies for the partnership. However, it should be noted that there were a few comments made by key informants about the USG (with all its agencies) and its inability to represent one singular entity. For instance, one informant challenged the USG, "[They] need to think about this – are they the USG as a whole or are they USAID, the CDC, the Peace Corps, the DOD, etc. I would have hoped that more of the internal business between the USG agencies would be dealt with within the USG and they came to the table as a single partner". Despite this, the relatively limited number of representatives for the *Saving Mothers, Giving Life* partnership has facilitated the ability for interaction, decision-making and trust-building. One partner expressed that, "All of this is so personality dependent and trust dependent so people don't feel like they are out to get them, or bust them, or belittle them – [in this partnership] we are building rapport and understanding."

Another key strength of the *Saving Mothers, Giving Life* partnership is that its members have a unique and complementary leadership skill set. Partners confirmed this statement in their interviews. The majority of partners felt that the *Saving Mothers, Giving Life* partnership did attract a unique set of leaders described as, "Very willing to commit the time up front, to engage with the program and partnership. This was almost a unique time. The ability for people to get along so well socially was important."

Further, the diversity of the *Saving Mothers, Giving Life* partnership's membership is another strength. By design, the partnership was constituted to be diverse, including multiple stakeholders from the public and private and sectors – with governments from the U.S. and Norway, industry with Merck, professional associations with ACOG and non-profit, public awareness with EMC. Research indicates that stakeholder groups that should be considered depend on the type of partnership that is being intended to form. For instance, Rosenberg asserts that that, "Partnerships designed to generate political will could include government officials and those who influence them; and partnerships designed to implement interventions or services could include representatives from the partner country's government, civil society, and private sector." (Rosenberg, 2010).

When taking all three sub-factors for successes into account (size, leadership skills, and stakeholder definition), it is clear that the single greatest strength about the membership is the high caliber of its partners. The single greatest weakness, however, in terms of membership of the *Saving Mothers, Giving Life* partnership is the lack of country representatives engaged as leaders in the leadership and decision-making of the global partnership as a whole. Because the membership currently does not include all essential stakeholders at the global level, 'real collaboration' – or the ability to have a fully integrated team for partnership success – seems unlikely. The *Saving Mothers, Giving Life* partnership, while effective in many ways, could be approaching a donor-recipient relationship versus a truly collaborative one. At most, 'cooperation' – to align efforts for a more coordinated response - may possible.

Key informants representing the USG, global-level partners, as well as both countries noted this country-level void in the member leadership in the global level of the *Saving Mothers, Giving Life* partnership. One informant emphasized that, "The Governments in Zambia and Uganda must play a

leadership role more visibly. It still feels like a Washington, DC, New York, New Jersey partnership". Still further, one informant asked, "Where do our host governments fit in, who are contributing far more than can even be measured against additional resources [the partnership] has put toward this effort? …If we walk the walk of country ownership isn't it important to consider them on equal footing to any corporate or any other partner?".

Interestingly, informants from the country perspective emphasize that they are in the leadership position; however, this is separate from the decision-making of *Saving Mothers, Giving Life* that occurs on behalf of the partnership at the global-level. One informant stated, "They [the country] had provided the necessary leadership…SMGL is run through our government systems- our staff, our infrastructure. We are putting things together – for example antenatal outreach – SMGL partnership must have a beginning and an end - so we are integrating. We don't want to sit back and say these activities are SMGL. No, these are our activities and SMGL has helped us on top of what we are already doing. So, we want to continue to contribute to these areas through our own [government] budgets. So for example, in my district, we are planning 7 billion Kwacha for all health services in Lundazi, from there 30% of those funds will be for maternal health services".

As we think about what it means to have sustained impact – one that countries can lead and carry forward on their own – it is imperative that the notion of country ownership be part of the *Saving Mothers, Giving Life* partnership from every level from designing, planning, implementing, managing, and monitoring the effort in country, but also as it interfaces with the leadership and decision-making of the partnership as a whole. Critical to all these aspects is membership or an equal seat at the partnership table at the formation of the partnership.

Key Finding #2: *Saving Mothers, Giving Life* enjoyed the political support from the highest levels of leadership, but caused concern as this leadership transitioned.

In further analyzing the partnership's membership, I examined contextual factors to better understand why the members joined the *Saving Mothers, Giving Life* partnership to begin with – what was their motivation? I hoped that this deeper understanding of motivation or intention to join would

inform ways that the partnership could be sustained as it moves from Phase 1 to 2. By and large, the motivation for joining expressed by every single key informant was because of the political interest of former Secretary of State, Hillary Rodham Clinton. There were resounding statements made by informants that reinforced this political interest as the key motivating driver for joining the partnership to begin with. For example, one informant eloquently stated that, "At the broadest level [the motivation] was Secretary Clinton and there is no doubt about it. She was known for her domestic health, as a woman's advocate, and so she created the strategic space for this tactical application. It [*Saving Mothers, Giving Life*] wouldn't have happened otherwise." Another informant explained that, "There was a lot of interest that was generated [in *Saving Mothers, Giving Life]* by virtue of the political support generated by someone that has as much power, influence, and charisma as Hillary Clinton." My research confirmed what some might consider the obvious, that the political interest of Secretary Clinton was critical in the genesis of the partnership. But, hearing this confirmation from every single key informant from the USG, global partners, and the field is what surprised me.

Along with the political interest of former Secretary of State Clinton in the *Saving Mothers, Giving Life* partnership, came a level of power and urgency that in some ways was the critical factor to enable the partnership to come to life. Some informants equally shared these motivational drivers of political interest expressed by the Secretary and the urgency. This propelled programming and country selection for catalytic implementation – a great strength of the partnership. One informant stated clearly that their organization's interest in joining the partnership was, "Two things. Two of them equally important. Hillary Clinton and leap-frogging. If [the invitation to join] hadn't come from Hillary Clinton's office and if it hadn't allowed me to leap frog, we wouldn't have joined." This informant went on to say that this was a "win, win".

Given this overwhelming sense of attribution to the Secretary's engagement in the *Saving Mothers, Giving Life* partnership, there is concern about the continuity of high-level leadership in the partnership. One informant expressed the concern about continuity in leadership from many levels within the USG, explaining that, "Leadership is changing on so many levels – Secretary Clinton leaving, Secretary Kerry coming on board, Lois Quam leaving, no GHI office, State handing

leadership over to USAID, no public expression of commitment from USAID leadership." Another reinforced this concern by sharing that, "There is a change in the visibility of SMGL and we're not quite clear how Secretary Kerry will embrace this". Another leader questioned whether, "We can have the same level of ambition without the same caliber of leader associated with the partnership?" And another informant emphasized, "The leadership has to come from America – from somewhere in America…. Someone at a high-level has to say I am going to do it. I am going to build the network and the links and assuage the fears, create the momentum to say it is going to be big, coordinated, and effective". This political interest and engagement has been and will continue to be very important as we move to Phase 2.

Similar to the above key finding, a void in a senior-level leader or champion may make attempts of 'real collaboration' difficult. The existing partners may question the trust they place in the partnership as it proceeds into the future, without a commensurate commitment from senior leadership that was enjoyed at the beginning of the partnership. Therefore, in this case, 'real collaboration' – or the ability to have a fully integrated team for partnership success – also seems unlikely.

Goals and Strategies

Key Finding #3: *Saving Mothers, Giving Life* began with a bold and shared vision for Phase 1, but differing visions of success existed for Phase 2.

'Developing a shared goal' is also a critical factors for successful partnerships. The research indicates that a clear vision, goal, and articulation of the 'Last Mile' should be defined by the partnership—this would translate to Year 5 of the *Saving Mothers, Giving Life* partnership. Rosenberg, in articulating the key factors in the Partnership Pathway Framework, notes that a collective vision is what transforms the partnership from a collection of individual organizations to an inspired, integrated team.

A key strength of the *Saving Mothers, Giving Life* partnership as it relates to developing a shared goal is that there was consistency across the board in terms of informants' views on the goal

for Phase 1 (Year 1 – pilot) of the partnership. When asked to define the vision of success at Year 1 of the *Saving Mothers, Giving Life* partnership, there was little variation in responses among informants and most informants also qualified that definition as being expressed as already being achieved. The overwhelming definition of success was expressed as some version of "50% reduction of maternal mortality in targeted districts".

One informant stated that, "We already are at success for Year 1—we are going to be able to show success in creating demand for women to deliver in facilities, success in equipping those facilities…at a much higher level, and that will translate to improved maternal mortality. I don't have any question about having achieved success in Year 1. You measure success if you have achieved your objectives you have set out to accomplish in one year. It may not be 100% achievement, but it can still be successful of you have moved forward, better than not going anywhere". Another informant explained, "Year 1 is already successful because the partnership is working through a series of major struggles and not just getting through it, but thriving through it. There's good will, frank discussions, a lot of enthusiasm, little ego." This informant further articulates, "Another indication of success is that we had to do a lot of things very quickly in a short time frame and if we weren't jumping in with both feet with appropriate, ambitious, visionary goals we would have failed". With a cautiously optimistic stance, another informant shares that it was this ambitious goal that effectively, "Puts us into a certain position a year into this that we find ourselves almost predictably."

A fundamental weakness in the *Saving Mothers, Giving Life* partnership in terms of goals and strategy development is the lack of consistency in defining visions of success at the end-state or Year 5 of the partnership. When asked to define the vision of success at the end of the *Saving Mothers, Giving Life* partnership, responses were all over the board. Some immediately translated "success" to the number of countries (ranging from 2-10 to well over 10) that would embrace *Saving Mothers, Giving Life*. Most expressed "success" in two different ways – one more operationally in terms of impact on maternal mortality at Year 5; and the other more visionary in terms of an approach to scale the program at Year 5. For example, one informant shared that 'success at Year 5' is defined as, "Significant strides at meeting MDGs with health systems that, for mothers, function at a significant higher level across the majority of the country". Another said that success is defined as, "Sustained

results that we can point to clear investments –by investing in these 5 [interventions] we have been able to reduce maternal mortality".

Alternatively, still other informants defined success at Year 5 much more broadly in terms of approach to scale. For instance, one informant defined success at Year 5 as, "Showing the world a new way of tackling public health by cracking the code - engaging the golden triangle – local governments, public sector (including citizens) and the private sector". Another informant shared that success at Year 5 would be expressed with, "The partnership having generated more resources to sustain the global attention on maternal health than directly on SMGL".

A collective vision is essential for 'real collaboration' to exist. Again, this is what Rosenberg articulates as an essential element that transforms the partnership from a collection of individual organizations to an inspired, integrated team. Without a shared vision of definition of success 'real collaboration' may be very difficult to achieve.

Key Finding #4: *Saving Mothers, Giving Life* focused on results and strengthened local capacities, systems and ownership at the district-level, yet resulted in opposing strategies for scaling at national-levels.

'Shaping a big-picture strategy' is a critical factor for successful partnerships that is also related to 'developing a shared goal'. A deliberate discussion focused on the strategy is a key component in the formation of the partnership. The strategy or strategies could span from anything from, where the partnership will focus (e.g., geographic location, target population), to what the partnership will do, to the model it expects to follow, to how it expects to achieve the goals. The strategic model currently employed by the *Saving Mothers, Giving Life* partnership is a health systems approach focused at the district level to ensure that every pregnant woman has access to clean and safe delivery services and, in the event of an obstetric complication, life-saving emergency care within 2 hours (see Appendix D). The model serves to strengthen the existing health network (both public and private) within each district to address the "Three Delays" that lead to maternal deaths: the delay in seeking appropriate services; the delay in reaching services; and, the delay in

receiving timely, quality care at the facility. The model and approach employed by the *Saving Mothers, Giving Life* partnership in Phase 1 has resulted in extraordinary impact and local capacities and systems that have been strengthened – the likes of which are arguably, unparalleled.

A key weakness revealed during the analysis of the *Saving Mothers, Giving Life* partnership in terms of strategy development was the lack of consistency (and in some cases directly opposing) strategies for scaling-up the programs to national-levels in Phase 2 (Years 2-5). For example, responses about strategies for Phase 2 scale-up to national-levels varied substantially from one that described a service delivery strategy at a district-level to another that described a political strategy at a national- or global-level. The former service delivery strategy is "downstream" and places a greater emphasis operationally on direct impact on the lives of women and children, while the latter is "upstream" with a greater political focus that may not necessarily be tied to impact in the nearer term. One informant explained these conflicting strategies, "If we start moving away from a service delivery model – we will be in trouble – because everything we do has to be laser light focused on improving the services and the access to these women to prevent these deaths. If we move to an advocacy model it will not work. It is a combination of figuring it out, where we are trying to go, the leadership to get us there, and the management to make it happen – and we will have challenges on all these levels." Another informant stressed that, "Ultimately, SMGL will win or lose based on the political connection at the local level. Scale is not going to come from money, scale is going to come from politics".

Some partners have expressed their concern out-right that there is disagreement in the model and this is resulting in a sense of stagnation of the partnership. And in some cases, this disagreement or opposing views of the strategic model has resulted in some key misinterpretations and key problems. For example, an informant explained that, "[One global partner] seems to have a global agenda and I'm not sure that it will sync with the district model. They are not buying in to our model and they are not bringing any resources. They talk about sustainability - but sustainability of what?" The partner in question states, "We see a whole range of our investments as being germane and relevant to *Saving Mothers, Giving Life.* There was this operational expectation that the partnership would mean that all the partners would come in with financing and finance USG budget

lines of their projects – because the model was that they would do this at the district level with a number of partners. This is not a value added".

Finally, another informant brought the focus to the woman we are trying to serve by declaring, "[The model] has to be a pull model not a push model. A lot of aide in this world is a push model, we haven't actually asked the woman what she wants and give it to her and nobody does that and nobody is talking about that even today…nobody's ever talked to the woman and asked her what she wants. Nobody. We just presume we know what they want, or we presume they will take what we give, worst still we don't care". With a lack clarity and agreement on the strategy for national-scale up, 'real collaboration' may prove to be difficult, yet again. In this case, 'cooperation' – to align efforts for a more coordinated response - or even a lesser degree of partnership integration (i.e., 'coordination') may only possible.

Governance and Operating Structures

Key Finding #5: *Saving Mothers, Giving Life* had a comprehensive governance structure, but inadvertently created a Headquarters echo-chamber.

As articulated in the 'First Mile' of the Partnership Pathway Framework, 'selecting the appropriate structure' and 'clarifying the organizational role' are both critical factors for the success or failure of partnerships. Both of these factors relate to the governance elements of a partnership. Rosenberg notes that two governance models have emerged from the research as those that facilitate real, integrated collaboration. The first governance model – the lead partner model – involves a member from one agency that serves as convener and or administrator of the partnership. The second governance model – the secretariat model - involves a head of the secretariat that serves as the convener (with staff) as the administrator. In addition to the overall governance structure, the partnership structure also includes the structures that facilitate input (e.g., technical teams and working groups), decision-making (e.g., steering committee, senior champions, or stakeholder forums), and implementation (e.g., country coordinating bodies). 'Clarifying organizational roles'

involves specificity of roles, which may include leadership, management, technical, or implementer roles.

As detailed in the previous section of this chapter – Description of Key Elements - the governance structure of the *Saving Mothers, Giving Life* partnership is quite complex with levels of architecture to support strategic guidance, program management, and country-level program implementation. The *Saving Mothers, Giving Life* partnership employs the secretariat model (as noted above) along with a complex array of management and technical committees. There was a resounding saturation of responses from informants related to how rigid and cumbersome the governance structure of the *Saving Mothers, Giving Life* partnership was, in practice. This complex governance structure ultimately led to its ineffectiveness and inability to make progress – as defined by partnerships that exhibit 'real collaboration'. One informant stated simply that, "It [the organizational structure of *Saving Mothers, Giving Life*] is not yet an effective organization".

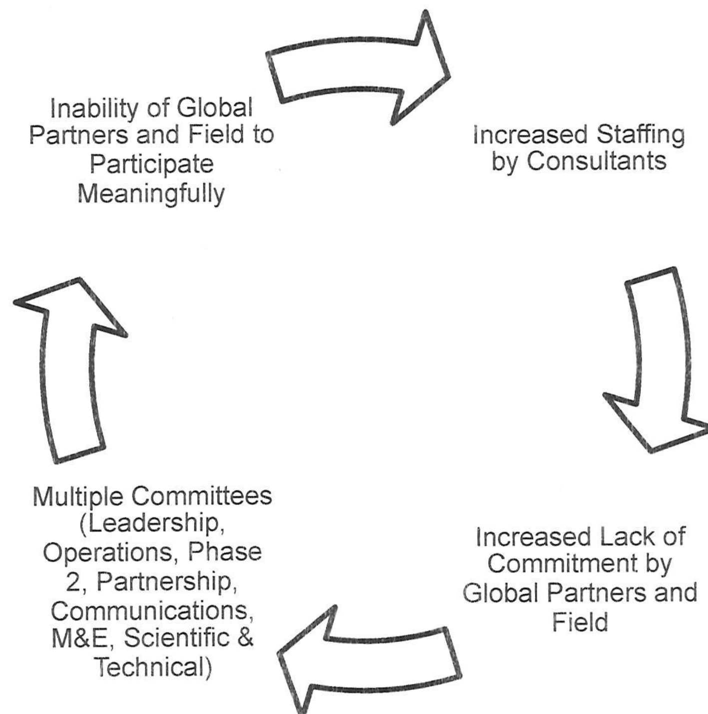
Further, one informant suggested that, "We set it [the governance structure of Secretariat and Committees] up too process-orientated, too rigid, I think we need to step back and find a way that will allow us a way to achieve our goal, for us to put the woman back in the center, rather than putting our process in the center." Another informant stressed that, "We simply cannot participate in all these different levels of committees. Also, we don't think that is the way to go. Any partnership that requires so much process that outweighs the impact of the work – completely negates the benefits of the partnership. We just find that there are too many meetings, too many discussion forums, go over same ground, not making decisions."

The key finding, that the governance structure inadvertently created an unintended Headquarters echo chamber (see Figure 4.2), resulted in an underlying weakness in the entire partnership. By disconnecting the leadership of the partnership from the leadership of the program implementation in the field, there was no ground-truthing of the partnership at the global-level. Nearly every possibility that the partnership had in making progress toward sustainable reductions in maternal mortality was diminished. Effectively, the complexity of the governing structure with its multiple layers (Leadership Council, Secretariat, Operations Council and 6 Committees) resulted in the inability of the global partners and country representatives to participate meaningfully together

and collaboratively. In response to this lack of participation, yet the need to progress, the Secretariat increased the staffing on the committees by hiring consultants who were external to the *Saving Mothers, Giving Life* effort. The lack of commitment by global partners and particularly the field was exasperated, ultimately resulting in a full disconnection between the global partners and the field leaders.

One informant reinforced the need for the direct link between the global partners and the field by stating that, "Because all global partnerships are implemented locally…there is a need for a very strong communication system and a very clear governance system between Headquarters and the field. It has to be very clear from all the partners how decisions are made, when they are made, and by whom they are made and that then has to filter and engage seamlessly to all the people in the field". Another informant explained that, "Rather than having a convening hub around the table – we should create more of an operational hub around a function that necessarily links the field and Headquarters, and necessarily links implementers and scientists, and necessarily links the different components that the partners bring".

Figure 4.2: Unintended Headquarters Echo Chamber



KEY OPPORTUNITIES AND BARRIERS

The key opportunities and barriers that exist to strengthen the *Saving Mothers, Giving Life* partnership have the concept of 'leadership' as a common denominator. An important opportunity is the vary stage of development that the *Saving Mothers, Giving Life* partnership is in. As described earlier, the partnership is at a critical inflection point as the partnership changes or moves from the Phase 1/Year 1 proof-of-concept or pilot that occurs from June 1, 2012 to September 30, 2013 to Phase 2/Years 2-5, scale-up that occurs from October 1, 2013 to September 30, 2017. Therefore, this is a critical moment for the leadership of the partnership to seize the opportunity to take stalk of its health - the health of the partnership. Closely examining the partnership's strengths and weaknesses to inform and make adjustments (however large or small) to the partnership will help enable it to make progress toward sustainable reductions in maternal mortality.

Furthermore, there were a series of leadership transitions that impacted the *Saving Mothers, Giving Life* partnership. First, one month after the partnership's launch on June 1, 2012, the leadership and coordination of the *Saving Mothers, Giving Life* effort was transitioned from the GHI Office within the State Department (led by GHI Executive Director, Lois Quam) to USAID (led by Administrator, Rajiv Shah) on July 2, 2012. This transfer in leadership was handled openly and transparently with all the global partners. The USAID Deputy Administrator, assumed full responsibility and was actively engaged, gaining the trust and respect of the global partners. However, the functional USG lead for the *Saving Mothers, Giving Life* was not in place at USAID until December 2012. Second, in February 2013, leadership at the highest level of the State Department changed from Secretary Hillary Rodham Clinton (who launched *Saving Mothers, Giving Life*) to Secretary John Kerry (whose engagement with *Saving Mothers, Giving Life* is yet to be determined). Third, USG representation on the leadership council of the partnership changed in April 2013, when the position representing S/GHI was transitioned to a position representing S/OGAC—coordinating the PEPFAR global HIV efforts. This was also a transparent and welcome shift, given the extensive PEPFAR-supported contributions and platform being leveraged for *Saving Mothers, Giving Life*. Around the same time, Lois Quam, the founder (or mother) of the *Saving Mothers, Giving Life* partnership began to transition from her primary role associated with the partnership.

Many partners expressed that the change or transition in leadership, organizationally and individually, associated with the *Saving Mothers, Giving Life* was a key barrier in strengthening the partnership. For example, one informant expressed that by changing organizational leadership, "We confused the corporate non-USG partners when they believed they were negotiating in good faith with the U.S. Department of State. It doesn't matter what the name of the office is – people came to partner with the U.S. Department of State and then at some point someone said there is another agency that will lead – this unintentionally, inadvertently weakened the trust between the partners and ultimately of the initiative." Another partner described that this change, like any change, was difficult because, "We had to get to know new people, new personalities, new organizational cultures – and those same people did not have the same level of authority, same level of agency, they did not have the same power". One informant commented on changes at the individual level, "All you have to do is change a few leaders and we are all back to square one".

Despite these expressed barriers, I believe there are ways to view this change in leadership in a positive manner and as a critical opportunity to strengthen the partnership. From my perspective, during a time of 'change' there is window of opportunity. The key is being able to see the window and align elements to get through the window. First, the organizational change in leadership from State Department to USAID could be a strategic opportunity to consolidate operational accountability and ensure better integration of the *Saving Mothers, Giving Life* effort with the $170 million per year maternal health portfolio that USAID manages. This would be possible if the highest levels of leadership at USAID assume ownership of *Saving Mothers, Giving Life*. An informant shared that, "At one level, I don't care who takes ownership of [*Saving Mothers, Giving Life*], but I don't want to slip into the situation where we do same old stuff—we have been doing same old stuff for the past 30 years—but we don't have a lot to show for it. The only reason we are successfully utilizing resources across agencies and partners is because of our local commitment of working together".

Next, change is good – change generates new people and with new people come new ideas and new ways of creating and collaborating. One informant commented, "Partnerships evolve. They literally live and breathe. You have to take the time to make sure that the partners are evolving with

the program and the thinking. The best way to do that is to use data to get feedback from what is happening on the ground. And you can't be afraid to course-correct". This is our moment in the *Saving Mothers, Giving Life* partnership for celebration of our initial successes and course-correction, where necessary.

STUDY LIMITATIONS

This study resulted in an extensive, in-depth, description and assessment of key elements as well as key strengths and weaknesses of the *Saving Mothers, Giving Life* partnership. While this is useful in better understanding how to support the partnership in facilitating progress toward sustained impact, there are several potential limitations to this study. For example, findings are not necessarily directly generalizable to other global health partnerships; however, they may provide useful information in the development of other global health partnerships. Also, given my role as part of the team that helped create *Saving Mothers, Giving Life*, and now as a researcher, I am a participant observer. While, this perspective may lead to some level of bias, such insider knowledge is often necessary for the type of in-depth analysis conducted in this case (C.V. Patton, 2012). Additionally, I have existing relationships with all the key informants, as I had to work closely with each of them to help establish the partnership. I acknowledge that this may have resulted in some aspects of response bias where key informants may have responded to questions in a manner in which I would want to hear.

CHAPTER 5: PLAN FOR ACTION

This is the most exciting chapter for me to write, as I am no longer reflecting in the past on what was, but influencing the present of what is and dreaming to the future of what can be. In this chapter, key recommendations are presented through an action plan to assist the *Saving Mothers, Giving Life* partnership in making progress toward sustainable reductions in global maternal mortality in Phase 2. The action plan described herein (summarized in Table 5.1), is active; it describes actions that I have already taken, actions I plan to take, or actions I hope others will take on.

LEADERSHIP FRAMEWORK

The action plan is designed as a leadership guide to help the *Saving Mothers, Giving Life* partnership facilitate sustainable reductions in global maternal mortality as the partnership transitions from Phase 1 to Phase 2. The health of the partnership is at a critical inflection point and recommendations for action are timely. John Kotter's 8-steps to transforming organizations was used as the leadership framework underpinning this action plan. The 8 essential steps to leading change are to: 1) Establish a sense of urgency, 2) Form a powerful guiding coalition, 3) Create a vision, 4) Communicate the vision, 5) Empower others to act on the vision, 6) Plan for and create short-term wins, 7) Consolidate improvements and produce still more changes, and 8) Institutionalize new approaches.

SPECIFIC RECOMMENDATIONS AND PLANS FOR CHANGE

(1) Establish a Sense of Urgency

Recommendation 1: Recreate a sense of urgency by renewing the political commitment of a senior-level champion in global maternal mortality reduction.

Seizing opportunities and creating momentum or a sense of urgency for action is critical to success. A leader must closely examine the facts and the data, including political realities, to

understand what the right thing is and needs to be done for the population and the organization (E. Baker, UNC leadership class 2009). The *Saving Mothers, Giving Life* partnership needs a boost, momentum to show commitment from a high-level leader. To address the key concern expressed unanimously by all informants and a critical factor to ensuring the continued success of the *Saving Mothers, Giving Life* partnership, I recommend renewing the political commitment of a senior-level champion or champions as a means to recreating a sense of urgency in global maternal mortality reduction.

For example, this senior-level champion could be from the USG such as, the Secretary of State, John Kerry and/or the Secretary of Health and Human Services, Kathleen Sebelius. Secretary Sebelius as currently the only Secretary-level woman, mother and leader with authority that spans both domestic and global health programs within the Obama Administration, may be the right champion to help push this effort forward. For Mother's Day 2013, I helped facilitate engagement of Secretary Sebelius in promoting domestic and global public-private partnerships related to maternal health, specifically Text4Baby and *Saving Mothers, Giving Life*. A press release (See Appendix E) was disseminated across the globe and a personal text message was sent from the Secretary to over 600,000 pregnant women in the United States. This effort only initiated the attention and possibility of the Secretary as a key political champion for both domestic and global maternal mortality.

Another specific action would be to formally request Secretary Sebelius to serve as the U.S. political champion for domestic and global women and maternal health. This request could come from a push from key senior level USG leaders, including PEPFAR Ambassador Eric Goosby, USAID Administrator Raj Shah, CDC Director Tom Frieden, and Assistant Secretary of Health and Human Services Nils Daulaire. By doing so, the power of the domestic and global networks and public affairs machinery that HHS and DOS supports through HIV, MCH, and health reform could be leveraged. This cross-Departmental level champion (i.e., Secretary Sebelius from DHHS serving as a champion for this partnership in which USAID leads on behalf of the USG) could reinforce and emphasize the interagency support and nature of the partnership.

Another specific recommendation would be for the senior-level global champion to come from outside of (or in addition to) the USG. For example, a natural champion in the public arena could be from an existing *Saving Mothers, Giving Life* partner, Every Mother Counts. Specifically, Christy Turlington-Burns, who has both star appeal and a credible voice in the women's health arena, could be ideal. Already a champion for girls' and women's health, her skills set and broad reach to the general public could further be leveraged for a greater impact. Another non-USG champion could be from one of the partner countries. For example, First Lady of Zambia, Dr. Christine Kaseba-Sata, could also be a powerful champion of *Saving Mothers, Giving Life.* As a practicing OB/GYN and a champion at the country level for *Saving Mothers, Giving Life*, Dr. Kaseba-Sata could have a significant impact to help drive focused attention on sustainable, country-led efforts to reduce maternal mortality.

(2) Form a Powerful Guiding Coalition

Recommendation 2A: Expand the *Saving Mothers, Giving Life* partnership to engage country representatives as leaders in the partnership at the global, decision-making level.

Recommendation 2B: Reconfigure the governance structure of the *Saving Mothers, Giving Life* partnership to more strategically link the field and Headquarters, as well as implementers and scientists.

To address the key concerns expressed by informants that country representatives are not engaged as leaders in the global *Saving Mothers, Giving Life* partnership and that the partnership has created a Headquarters echo-chamber that is not linked to the countries, I recommend two key actions. The first is to necessarily engage country representatives as leaders in the global partnership. The second is to create a structure that strategically links the countries to Headquarters as well as the program implementers to the scientists.

In my first leadership class at UNC (leadership, 2009), the professor shared that "It is the relationships with people, and the right people, that is primary—all else is derivative". The people are always an essential ingredient. Part of building a powerful guiding coalition, includes a clear focus on assembling the appropriate mix of individuals adept at vision, strategy, operations and tactics necessary to carry out all of the leadership and management functions that are essential to any healthy organization (Baker, 2010). As we think of Phase 2 of the *Saving Mothers, Giving Life* partnership and maintaining its progress toward sustained reductions in maternal mortality, country leaders (with the appropriate mix of visionary and strategy development skills) must absolutely and intentionally be invited to join as leaders in the partnership. Country representatives with operational and tactical skills are already engaged at the program level. After country leaders are engaged in the partnership the governance function and structure should be re-evaluated to strategically focus around implementation, linking the countries to Headquarters as well as the program implementers to the scientists.

Expanding the membership to include country-level representatives in the global-level decision-making will help lead to a more collaborative, and thus more successful, partnership. While the membership of the partnership will increase, this would include a necessary and central stakeholder – the country. Deliberately including the country representatives (i.e., from the partner governments) would strategically link the function and focus of the partnership directly to policy- and program-level implementation. This is the key to ensuring that collaborative efforts are practical, feasible, culturally appropriate, based on the need of the beneficiary (e.g., the Zambian or Uganda woman), and ultimately effective in saving lives.

(3) Create a Vision

Recommendation 3: Develop a shared vision that incorporates both short- and long-term strategies to make progress toward sustained reductions in global maternal mortality.

Clearly and concisely articulating a central, compelling vision and purpose is absolutely a critical factor to ensuring a successful partnership. Also important is the need to be flexible, resilient,

and adaptive to the environment to accomplish goals. Flexibility includes the ability to accept what comes, adapt to change, remove obstacles, and modify systems to make relevant and appropriate decisions to continue to move toward attaining the vision.

To address the fundamental concern, arguably the fatal flaw, in the *Saving Mothers, Giving Life* partnership of differing visions of success for Year 5, I recommend that the partnership, after engaging the countries as leaders, revisit the vision. The partnership should have a retreat specifically focused on developing and documenting a shared vision that incorporates both short- and long-term strategies to make progress toward sustained reductions in global maternal mortality. This process may benefit by engaging an external facilitator to help the partners define and come to consensus on a common vision and key strategies.

Because, as confirmed by my research, partners are interested in both impact as well as sustainability, the partners should consider key systems that must be strengthened and sustained locally to result in impact, including for example: Pooled procurement of equipment and other relevant supplies; Reliable supply chain for essential commodities; Data generation from SMGL-supported HMIS changes national policy; Health care workers are financed through national governments or insurance schemes. Once final, the Memorandum of Understanding should be amended to incorporate the vision for success and re-signed by all parties, including the Government of Norway and the newly engaged country leaders from Zambia and Uganda.

(4) Communicate the Vision

Recommendation 4: Share Phase 1 results and Phase 2 vision at a forum specifically organized to convene former Secretary Clinton and a current senior-level champion with founding partners and key country leaders.

It will be important for the *Saving Mothers, Giving Life* partnership to seek opportunities to communicate this vision. This also relates to prior recommendations about creating a sense of urgency with re-engaged political and country leaders. One way to communicate the vision is to tie it to the public release of Phase 1 results. This link to Phase results of the pilot effort allows for the

documentation and communication of prior efforts and positioning for the future of the partnership. Phase 1 results will be available September 30, 2013. The data are trending in a very positive way and we have already started to discuss potential opportunities at the UN General Assembly for this time of dissemination, which could be linked to the communication of the vision for Phase 2. Alternatively, another public event later in the year - organized with full partner input and engagement – could be initiated.

(5) Empower Others to Act on the Vision

Recommendation 5: Issue guidance to USG on appropriate use of PEPFAR funds for integrating MCH activities into HIV programming.

A vision can only be successful if it can be acted upon. The key is to empower others to carry on the vision. From a USG perspective, there currently does not exist much guidance on how USG funds can be used appropriately to integrate HIV and maternal and child health activities. This lack of guidance has hampered the USG's ability to use resources effectively for integrated services for women. In order to empower the USG to act on the vision, I recommend that that the USG issue guidance on how the USG through its implementing partners can appropriately – according to all the legal statues - use PEPFAR funds for integrating maternal and child health (MCH) activities into HIV programming at the country-level. I propose that an interagency technical group representing MCH and prevention of HIV from mothers to children transmission (PMTCT) as well as health systems strengthening experts from across the USG – from USAID, CDC, OGAC, Peace Corps, and DOD, convene to define specific technical interventions that can be supported with HIV funding—which amplify maternal mortality reduction and PMTCT efforts in a synergistic manner.

(6) Plan for and Create Short-Term Wins

Recommendation 6: Establish a prestigious annual reward system for country action.

Success breeds success. Demonstrating visible performance and health impact has been a key feature of PEPFAR and a fundamental reason why this global HIV/AIDS Presidential initiative that was first launched by the Bush Administration, is also supported in the Obama Administration. PEPFAR enjoys bi-partisan support. *Saving Mothers, Giving Life* also has a results-orientation and positive results are expected with the conclusion of Phase 1. I recommend that once these gains are achieved, and successes shared widely, that we celebrate the success among all those who helped contribute to it. I recommend instituting a high-level *Saving Mothers, Giving Life* award for country action resulting in impact as well as for innovative interventions and approaches to strengthening capacity and systems. This could facilitate a healthy dose of competition and focus on achieving sustainable impact.

(7) Consolidate Improvements and Produce Still More Change

Recommendation 7: Incorporate evidence-informed interventions and comprehensive programming lessons from *Saving Mothers, Giving Life* into USAID's $170 million per year maternal health portfolio

In an effort to consolidate improvements and produce still more change in sustainable reductions in global maternal mortality, I recommend that USAID incorporate key lessons learned from *Saving Mothers, Giving Life* programming into their maternal health portfolio. USAID is currently in the process of creating global momentum to end preventable maternal deaths. USAID has been convening a process with global health and development stakeholders to set an ambitious, yet realistic goal for reducing maternal and newborn deaths post MDGs. Consensus on that 'bold endgame' is coalescing: Ending Preventable Maternal Deaths Worldwide by 2035. Their efforts can be more targeted by making *Saving Mothers, Giving Life* a key pillar of this agenda to end preventable maternal deaths. Another area of incorporation could be creating synergy between USAID's multiple and significant MCH public–private partnerships and initiatives.

For example, USAID, in partnership with the Government of Norway, the Bill & Melinda Gates Foundation, Grand Challenges Canada, The World Bank, and the U.K. Department for International

Development (DfID), supports groundbreaking prevention and treatment innovations for pregnant women and newborns in poor, low resource communities around the 48 hours of delivery through the Saving Lives at Birth effort. These tried and tested innovations could be brought to scale at a full district-level with effective systems of delivery through *Saving Mothers, Giving Life*. A policy directive from USAID leadership for their bi-lateral programs to incorporate evidence-informed interventions and comprehensive programming lessons learned from *Saving Mothers, Giving Life* will help with more effective and impactful programming.

(8) Institutionalize New Approaches

Recommendation 8: Incorporate *Saving Mothers, Giving Life* program commitments into formal country health partnership plans (e.g., partnership frameworks), delineating USG, global partner, and country government financial commitments.

The absolute key to this endeavor is sustainability—sustainability of systems, capacities, and motivation to sustain reductions in global maternal mortality. The efforts of *Saving Mothers, Giving Life* is already well on its way of incorporating sustainability principles. In order to institutionalize long-term wins—that is, continuing to save mothers' lives around the world over time, the partnership must inspire countries to continue pressing forward, moving in the right direction—in their desired direction, despite the obstacles. Ensuring that partner countries have the capacity and determination to lead, manage, implement, and sustain these programs financially and politically for continued health impact is essential for this. A part of this is also to develop processes together to help facilitate institutionalization of key sustainability approaches. To institutionalize *Saving Mothers, Giving Life* programming in countries, I recommend that negotiations about *Saving Mothers, Giving Life* with country governments occur at the earliest possible point. An open, transparent discussion about financial and system-wide commitments, contributions, and expectations made by the USG, global partners of *Saving Mothers, Giving Life,* and country governments should occur by all relevant parties and be documented. Using a formal country health partnership plan (e.g., partnership frameworks) would facilitate this.

Table 5.1: Summary of Key Reccomendations Organized by 8-Step Action Plan

Action Step	Specific Recommendations	Key Issues Addressed
1. Establish a sense of urgency	• Recreate a sense of urgency by renewing the political commitment of a senior-level champion in global maternal mortality reduction.	• Concern about continuity of high-level political leadership in the partnership.
2. Form a powerful guiding coalition	• Expand the *Saving Mothers, Giving Life* partnership to engage country representatives as leaders in the global partnership. • Reconfigure the governance structure of the *Saving Mothers, Giving Life* partnership to more strategically link the field and Headquarters as well as implementers and scientists.	• Country representatives are not engaged as leaders in the global partnership. • Creation of an unintended Headquarters echo chamber.
3. Create a vision	• Develop a shared vision that incorporates both short- and long-term strategies to make progress toward sustained reductions in global maternal mortality.	• Differing visions of success in Year 5 of the partnership.
4. Communicate the vision	• Share Phase 1 results and Phase 2 vision at a forum specifically organized to convene former Secretary Clinton with founding partners and key country leaders.	• Differing visions of success in Year 5 of the partnership.
5. Empower others to act on the vision	• Issue guidance to USG on appropriate use of PEPFAR funds for integrating MCH activities into HIV programming.	• Differing visions of success in Year 5 of the partnership.
6. Plan for and create short-term wins	• Establish a prestigious annual award system for country action.	• Creation of an unintended Headquarters echo chamber.
7. Consolidate improvements and produce still more changes	• Incorporate evidence-informed interventions and comprehensive programming lessons from *Saving Mothers, Giving Life* into USAID's maternal health portfolio.	• Opposing strategies for scaling-up to national levels in Phase 2.
8. Institutionalize new approaches	• Incorporate *Saving Mothers, Giving Life* program commitments into formal country health partnership plans (e.g., partnership frameworks), delineating USG, global partner, and country government financial commitments.	• Differing visions of success in Year 5 of the partnership. • Opposing strategies for scaling-up to national levels in Phase 2.

CONCLUDING REMARKS

I played a part in helping to conceive of and give birth to *Saving Mothers, Giving Life*. As such, I care about its health and want to help it grow in the future. The partnership is at a critical inflection point - as it moves from Phase 1 (June 1, 2012 to September 30, 2013) to Phase 2 (October 1, 2013 to September 30, 2017). My dissertation research came from my desire to help the partnership grow and to help it successfully move in to its next phase. My hope is that by crystallizing key issues that are faced by the partnership and providing targeted recommendations, that the *Saving Mothers, Giving Life* partnership can make progress towards sustainable reductions in global maternal mortality. Ideally, these recommendations may also inform the design and development of other global public-private partnerships seeking to improve global maternal health or global health more broadly.

I feel so fortunate to have been able to participate in the conceptualization and application of a global partnership. I have learned a tremendous amount, both in knowledge and experience, about partnerships in general and specifically about creating *Saving Mothers, Giving Life* and also in researching ways that it can be improved. I think the single most important thing I have taken away from this is what a respected colleague shared, like most things in life, and I quote from an African proverb: “If you want to go quick, go alone. If you want to go long, go with others.”

APPENDIX A: SEMI-STRUCTURED INTERVIEW CONSENT FORM

University of North Carolina at Chapel Hill
Consent to Participate in a Research Study
Adult Participants

Consent Form Version Date: April 13, 2013
IRB Study # 13-1716
Title of Study: *Saving Mothers, Giving Life*: An Assessment of a Partnership for Making Progress Toward Sustainable Reductions in Global Maternal Mortality

9. **Principal Investigator**: Angeli Achrekar
   Principal Investigator Department: Health Policy and Management
   Principal Investigator Phone number: 770.639.2436
   Principal Investigator E-mail Address: AAchrekar@cdc.gov
   Faculty Advisor: Dr. Edward Baker
   Faculty Advisor Contact Information: 919.357.7213 or elbaker@email.unc.edu

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What are some general things you should know about research studies?
You are being asked to take part in a research study. To join the study is voluntary.
You may refuse to join, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. This new information may help people and/or programs in the future. You may not receive any direct benefit from being in the research study. There also may be risks to being in research studies.

Details about this study are discussed below. It is important that you understand this information so that you can make an informed choice about being in this research study.

You will be given a copy of this consent form. You may ask the researcher named above, or staff members who may assist them, any questions you have about this study at any time.

What is the purpose of this study?
The purpose of this study is to assess the *Saving Mothers, Giving Life* partnership for making progress toward sustainable reductions in global maternal mortality. Specifically, it will aim to: (1) document the core elements of the *Saving Mothers, Giving Life* partnership so that they can analyzed systematically against factors of other global health partnerships; 2) assess the strengths and weaknesses of the *Saving Mothers, Giving Life* partnership at each stage of the partnership's development; and (3) make recommendations for strengthening the partnership for ensuring progress toward its sustained impact. Analysis of the development and implementation of the partnership may yield important information for program improvement. Lessons learned may also inform the design and development of other public-private partnerships seeking to improve global maternal health or global health more broadly.

You are being asked to participate in the study because you are (see the checked item):

_____ A leader from within the U.S. Government who helped in the formative development of the *Saving Mothers, Giving Life* partnership
_____ A leader from within the U.S. Government who is currently, actively engaged in the *Saving Mothers, Giving Life* partnership
_____ A leader from outside the U.S. Government and founding member of the *Saving Mothers,*

Giving Life partnership

_____ A leader residing in Zambia or Uganda, including from the U.S. Government or the Local Government, who is engaged in the programmatic implementation of the *Saving Mothers, Giving Life*

Are there any reasons you should not be in this study?

You should not be in this study if you do not fit into one of the categories above.

How many people will take part in this study?

A total of approximately 20-25 people will take part in this part of the study.

How long will your part in this study last?

Your part in this study will take approximately 45 minutes to one hour for the interview.

What will happen if you take part in the study?

The study involves a one-time interview/dialogue with the principal investigator and is anticipated to last approximately 45 to 60 minutes. The interview questions will be about your and your organization's involvement in the development of the *Saving Mothers, Giving Life* partnership and your thoughts for ensuring effective partnership collaboration for making progress toward sustained impact.

Your participation in this research study is voluntary. If you decide to participate, you may withdraw at any time or choose not to answer any question(s). You may also choose not to participate. You will not be penalized if you decide not to participate or if you withdraw from participating in this study at any time.

What are the possible benefits from being in this study?

The research is designed to benefit other global health collaborations for impact. Ultimately, society may benefit by gaining new knowledge. There is little chance you will benefit, personally, from being in this research study.

What are the possible risks or discomforts involved from being in this study?

There are no known risks to your participation in this study. There may be uncommon or previously unknown risks. You should report any problems to the researcher.

How will your privacy be protected?

We will do our best to keep your information confidential. All data will be stored in a password protected electronic format. A code will be used to identify your interview data. The file linking your code with your name will be stored in a separately password protected file only accessible to the principal investigator.

With your permission, your interview will be audio recorded. You may request to stop the recording at any time. Your interview will be transcribed word for word. Electronic recordings will be destroyed within one month after transcription. If you do not give permission for your interview to be audio recorded, written notes will be taken during the interview.

Check the line that best matches your choice:

_____ OK to record me during the study

_____ Not OK to record me during the study

Information that you provide in your interview will be released only as group summaries and any quotes used will not be connected to you personally or written in any manner that would allow someone to identify them as coming from you.

Participants will not be identified in any report or publication about this study, unless permission is given by the participant to do so. Although every effort will be made to keep research records private, there may be times when federal or state law requires the disclosure of such records, including

personal information. This is very unlikely, but if disclosure is ever required, UNC-Chapel Hill will take steps allowable by law to protect the privacy of personal information. In some cases, your information in this research study could be reviewed by representatives of the University or government agencies for purposes such as quality control or safety.

What if you want to stop before your part in the study is complete?

You can withdraw from this study at any time, without penalty.

Will you receive anything for being in this study?

You will not receive anything for taking part in this study.

Will it cost you anything to be in this study?

It will not cost you anything to be in this study.

What if you have questions about this study?

You have the right to ask, and have answered, any questions you may have about this research. If you have questions about the study, complaints, concerns, or if a research-related injury occurs, you should contact the researchers listed on the first page of this form.

What if you have questions about your rights as a research participant?

All research on human volunteers is reviewed by a committee that works to protect your rights and welfare. If you have questions or concerns about your rights as a research subject, or if you would like to obtain information or offer input, you may contact the Institutional Review Board at 919.966.3113 or by e-mail to IRB_subjects@unc.edu.

Participant's Agreement:

I have read the information provided above. I have asked all the questions I have at this time. I voluntarily agree to participate in this research study.

____ ____________

Signature of Research Participant Date

____

Printed Name of Research Participant

____ ____________

Signature of Research Team Member Obtaining Consent Date

____

Printed Name of Research Team Member Obtaining Consent

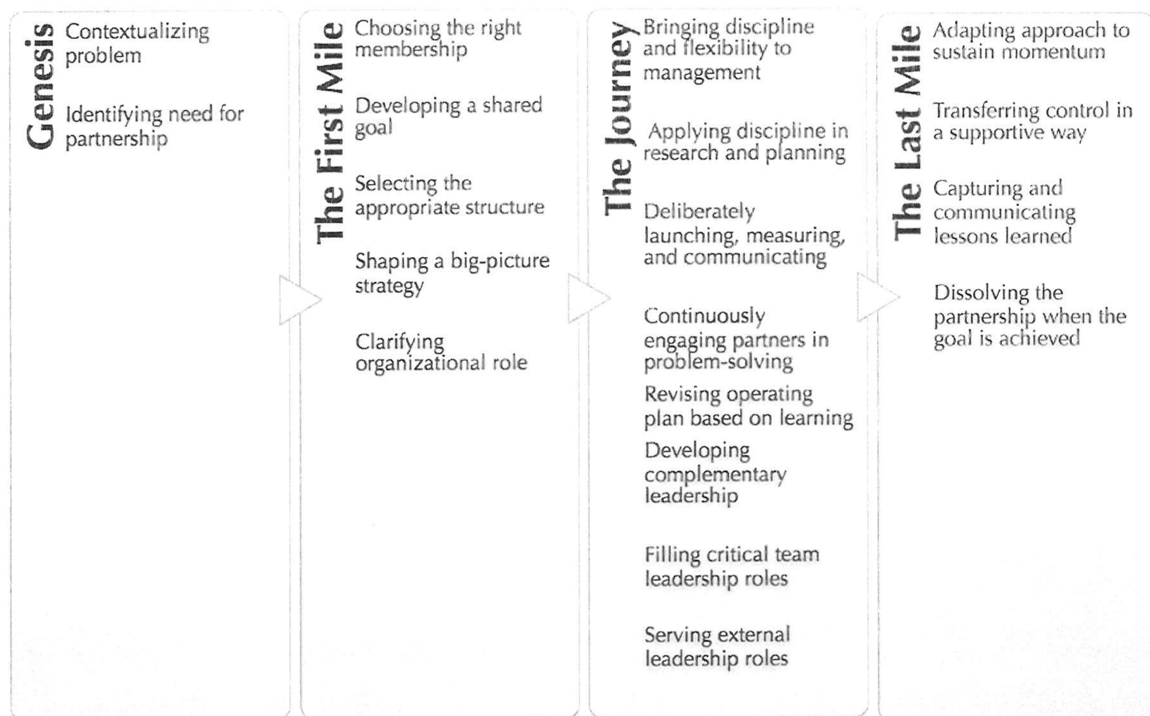
APPENDIX B: SEMI-STRUCTURED INTERVIEW GUIDE

Q = Question
P = Possible Probing Question
OBTAIN CONSENT (Collect Signed Consent Form)

Welcome
Hi, (insert name). Thanks so much for making time to meet with me today. It's been such a pleasure to be a part of developing *Saving Mothers, Giving Life* partnership with you. I have appreciated your leadership in this effort and hope to learn more from you in a systematic way as part of completing my doctoral work.

Introduction
The purpose of our interview today is for me to learn more about your thoughts on the strengths and weaknesses of the *Saving Mothers, Giving Life* partnership at each stage of the partnership's development and opportunities for improvement to help improve its progress toward sustainable reduction of maternal mortality.

Also, the questions are structured around aspects of a simple, illustrative framework—the Partnership Pathway, which frames each stage of a partnership (i.e., the Genesis, the First Mile, the Journey, and the Last Mile)—see figure below.



As part of my doctoral program at University of North Carolina in Chapel Hill, I plan to systematically document the development of the *Saving Mothers, Giving Life* partnership and publish findings (with you, if you are interested) and to improve the *Saving Mothers, Giving Life* effort, itself, and to also inform the design and development of other public-private partnerships seeking to improve global maternal health or global health more broadly.

As a reminder, our interview should take about 45 minutes. The interview will be completely confidential. Information that you provide will be released only as group summaries and any quotes used will not be connected to you personally or in any manner that would allow someone to identify them as coming from you.

Before we start the interview, do you have any questions about the research study or the interview? (If there are no questions and the participant indicated that I may record the interview then, I will start the recorder now.) I will also be taking handwritten notes during the interview and will summarize our conversation at the end to make sure I have captured and understood your main points.

Background Questions

1. How long have you been with (insert name of organization)?

2. What is/was your position?

3. What role did you play, personally, in establishing or developing *Saving Mothers, Giving Life*?

'Genesis' Questions - Intention

4. Were there any particular social, political and/or economic reasons why your organization wanted to be a part of Saving Mothers, Giving Life?—what was your motivation?

5. What was the single most important reason why your respective organization considered joining the *Saving Mothers, Giving Life* partnership?

6. How does participation in *Saving Mothers, Giving Life* partnership align with your organization's mission?

'First Mile' Questions - Commitment

7. What ultimately lead to your organization's commitment to joining the *Saving Mothers, Giving Life* partnership?

8. Was there a particular catalyst (champion, policy directive, etc.)? If so, please describe.
    a. What did the champion do that contributed to the commitment?

9. How committed are staff or employees within your organizations to *Saving Mothers, Giving Life?*

10. How will your organization define the success of the *Saving Mothers, Giving Life* partnership? After the first - Year 1? After the final - Year 5?

11. How would you describe your organization's key commitment or contribution to *Saving Mothers, Giving Life*?
    a. Has this evolved over time?
    b. What is your organizations financial commitment?
    c. How did this commitment happen?

12. What is it that other existing partners are committed or contributing to?

13. Are you involved in the current governance or operating structures?
    a. What is your role?
    b. What do you feel is working/not working about this structure?

14. What are your functional expectations for the Secretariat?

15. What are your functional expectations for the USG?
    a. How are the field teams and the Headquarters teams working together?
    b. What can be improved?

'Journey' Questions – Field Perspective (Interview Questions only for Key Informants from Zambia or Uganda)

1. Were there any particular social, political and/or economic reasons why Zambia/Uganda wanted to be a part of Saving Mothers, Giving Life?

2. What was the single most important reason why Zambia/Uganda considered joining the *Saving Mothers, Giving Life* partnership?

3. How does participation in *Saving Mothers, Giving Life* partnership align with Zambia's/Uganda's mission?

4. What ultimately lead to your organization's commitment to joining the *Saving Mothers, Giving Life* partnership?

5. Was there a particular catalyst (champion, policy directive, etc.)? If so, please describe.
    a. What did the champion do that contributed to the commitment?

6. How committed are staff or employees within your organizations to *Saving Mothers, Giving Life?*

7. What is the leadership and/or management structure for implementation in Zambia/Uganda?

8. What is the accountability and decision-making structure within the country? How does this interface with Headquarters?

9. What are the complementary roles of the USG agencies in Zambia/Uganda? How can this be improved?

10. What are the complementary roles of the implementing partners in Zambia/Uganda? How can this be improved?

11. How is the link between HIV and maternal mortality being made?

12. How do country commitments (political or financial) factor in to the implementation?

13. How are the partner commitments being realized in country?

14. Are there local champions that facilitate the implementation?

15. What are opportunities and barriers to improving the implementation in country?

Other Important Information

16. Is there anything else you would like to share about the *Saving Mothers, Giving Life* partnership in terms of facilitators or barriers of success?

Closing

I will transcribe my notes for all the details. In summary, I am taking away the following main themes from our interview: (insert themes). Are these correct? Am I missing anything or is there anything you want to add that we have not talked about?

Thank you for your time today.

END

APPENDIX C: KEY HISTORICAL DOCUMENTS

MEMORANDUM OF UNDERSTANDING

MEMORANDUM OF UNDERSTANDING
On Cooperation to Reduce Global Maternal Mortality
Between the

Global Health Initiative Office, U.S. Department of State
and
Merck & Co., Inc.
and
American College of Obstetricians and Gynecologists
and
Every Mother Counts

I. Purpose

The Global Health Initiative Office, U.S. Department of State (hereinafter referred to as "S/GHI[1]") on behalf of the U.S. Government global health agencies, including the President's Emergency Plan for AIDS Relief (PEPFAR), the U.S. Agency for International Development (USAID), the U.S. Department of Health and Human Services (HHS), and in particular the U.S. Centers for Disease Control and Prevention (CDC), and other U.S. agencies, Merck & Co., Inc. (hereinafter referred to as "Merck"), the American College of Obstetricians and Gynecologists (hereinafter referred to as "the College"), and Every Mother Counts (hereinafter referred to as "EMC"), (hereinafter each referred to as a "Participant" and collectively as the "Participants"), have a common interest in reducing maternal mortality and saving mothers' lives during childbirth globally. As described in this Memorandum of Understanding ("MOU"), and consistent with all policies and regulations of the Participants, the Participants seek to share their respective strengths, experience, methodologies, and resources in order to pursue a public -private partnership (herein referred to as "*Saving Mothers* Partnership") focused on making change in local health systems of targeted geographic areas in the developing world, with an aim to reduce maternal mortality by up to half in those targeted areas and countries.

The purpose of this MOU is to establish a strategic alliance between S/GHI and the operating agencies that it coordinates, Merck, the College, and EMC, to further the goals set forth below, and to outline the understandings and intentions of the Participants with regard to these shared goals. The Partnership will actively seek out new partners in order to more rapidly save women's lives. This MOU is not intended to affect the separate and unique missions, mandates, and accountabilities of the Participants. Unless specifically provided otherwise, the cooperation between the Participants as outlined in this MOU shall not be construed as a partnership or other type of legal entity or personality. Each Participant accepts full and sole responsibility for any and all expenses incurred by itself relating to this MOU. Nothing in this MOU is to be construed as superseding or interfering in any way with any agreements or contracts entered into among the Participants, either prior to or subsequent to the execution of this MOU. Nothing in this MOU should be construed as an exclusive working relationship, or as an endorsement of a specific private entity. The Participants specifically acknowledge that this MOU is not an obligation to offer, commit, or provide funds or resources, nor does it constitute

[1] S/GHI is the coordinating office which works through PEPFAR, CDC, and USAID to achieve the U.S. government's goals in maternal mortality and other areas of global health. S/GHI also works closely with other U.S. agencies, as the coordinator of the agencies' global health efforts.

a legally binding commitment by or among any Participants or create any rights in any third party.

II. **Background**

The Global Health Initiative established targets for the reduction of maternal mortality in 2009. Saving Mothers, Giving Life (*Saving Mothers*) is a signature program initiated by S/GHI in pursuit of those targets, which will be launched by this *Saving Mothers* Partnership to accelerate the Participants' collective work to reduce global maternal mortality, and to help meet the Millennium Development Goals (MDGs) 4 and 5. MDG 4 aims to reduce the under-5 mortality rate globally by two-thirds and MDG 5 aims to reduce the maternal mortality rate globally by three-quarters by 2015.

Saving Mothers country-level programs are designed to strengthen the district health network to ensure the delivery of focused and high impact interventions during the most critical 24-hour period around labor, delivery, and post-partum. *Saving Mothers* focuses on the 24-hour period around childbirth, while recognizing the importance of the continuum of care and will be linked to comprehensive strategies necessary to improve women's lives before and during pregnancy, during labor and delivery, and post-partum.

As a first step, *Saving Mothers* has launched an initial implementation phase that aims to reduce maternal mortality by up to 50% in targeted districts in three countries. The change in mortality of up to 50% sought through this Partnership will be measured against a country-specific baseline in each intervention district, produced through a pre-implementation assessment. After this proof of concept in three countries is evaluated after 12 months, the goal is to scale-up more broadly and sustainably in countries with high burdens (such as Kenya, Ethiopia, Tanzania, Nigeria, and others) that are willing to make political and financial commitments to address their maternal mortality challenges. *Saving Mothers* will align fully with national country plans, and emphasize local partnerships and technical assistance that equip host country governments and local organizations with the capacity to lead and manage the interventions proposed.

A key feature of this program is to bring the collective action of the United States government global health agencies and U.S. Government interagency health teams (under the leadership of the Ambassador), coordinated by S/GHI, with the Participants, to build on and leverage existing strengths and resources of multiple U.S. Government (USG) programs, including the PEPFAR, USAID, CDC, the National Institutes of Health (NIH) and other HHS agencies, the Department of Defense (DoD), and Peace Corps. The impact of resources will be maximized by building on a foundation of relationships, infrastructure, partners, and expertise established through these existing program platforms. This approach also strengthens health delivery systems that will immediately impact maternal and neonatal mortality and accelerate the potential to address multiple other public health issues.

The *Saving Mothers* Partnership will have global reach to galvanize the American public around the shared experience of motherhood and childbirth, and to roll out effective country programs through strengthened district health networks for comprehensive, integrated maternal health care. The *Saving Mothers* Partnership will also leverage the complementary strengths and reach of the Participants and their stakeholders. The Partnership will actively seek out new partners in

order to more rapidly save women's lives, in consultation with the existing Participants and subject to USG internal legal and ethics review.

III. **Principles of *Saving Mothers***

a. **Focus on "The 24 Hour Imperative":** Reduce maternal mortality by up to half in targeted districts, with up to 12 districts in Phase 1, by focusing on the most vulnerable period: labor and delivery and the first 24 hours postpartum
b. **Support Functional Health Facilities at All Levels:** Every pregnant woman has the ability to deliver in a functional health care facility (health post or clinic, health center, or hospital) as close to her home as possible, attended by skilled birth attendants, and backed by emergency obstetric care
c. **Encourage Mobilized, Engaged Communities:** Every pregnant woman has access to facility-based delivery through: mobilization of her family and community for birth preparedness, a network of appropriate transport and communication, a system of financial or non-financial incentives, and respectful care
d. **Ensure Effective Surveillance and Response:** Identify and register each pregnant woman, each birth and each death. For each death, conduct maternal mortality audits or verbal autopsies. Strengthen systems for health information, monitoring and evaluation

IV. **Goals & Objectives**

The Participants share the following goals in the proof of concept phase and if successful in the scale up of this effort:

a. **Reduce maternal deaths in targeted districts in select countries by up to 50%**
   - Strengthen district health networks for comprehensive, integrated maternal health care during the critical period of labor, delivery, and 24 hours post-partum
   - Support the development and implementation of country operational plans for delivering a core set of integrated and systems-level solutions at the district level, which include:
     - Adequate human resources, including skilled health personnel at all levels to support safe labor and delivery, task-shifting, and supportive supervision
     - Safe health facilities for women to deliver
     - High quality basic and emergency obstetric care and other services, and available supplies and systems at health facilities
     - Innovative and integrated systems of incentives, communication, transportation, and lodging facilities to improve facility-based births in a timely manner
     - Strengthened information systems to register 100% of women who deliver and their pregnancy outcome

b. **Catalyze cost effective, system-wide health delivery solutions at the district level that can be scaled-up nationally**
   - Support implementation science and conduct rigorous impact evaluation of district level activities to determine effective models that can be brought to scale nationally and internationally
   - Apply lessons learned and the evidence base in the design of the *Saving Mothers* program as it expands to additional countries

c. **Galvanize the American public around the shared experience of motherhood and childbirth, increasing awareness of maternal mortality and raising private funds to support *Saving Mothers* country-level program implementation**
   - Conduct a national awareness-raising and mobilization campaign for maternal health, which features *Saving Mothers* as a key initiative in improving maternal health and cites examples, content and stories from *Saving Mothers* programs
   - Support the national maternal health awareness-raising campaign by providing opportunities for the public to participate in events, fundraisers, online actions, and other activities, including a mechanism for mothers who deliver babies in the United States to donate to the *Saving Mothers* Partnership
   - Mobilize additional private sector, foundation, government, non-profit, and faith-based partners, by agreement of the Participants, to become engaged in support of the goals and objectives of *Saving Mothers*

V. **Expected Roles of the Participants**

The general roles of the *Saving Mothers* Participants under this MOU are as follows:

a. **S/GHI:** The U.S. Department of State's Global Health Initiative Office coordinates the U.S. Global Health Initiative (GHI) on behalf of PEPFAR, HHS/CDC, and USAID, and other U.S. agencies, with a unified strategy to save lives and maximize investments to address the most challenging global health issues, advance America's values, and strengthen our national security. This unified strategy aims to build upon existing health platforms, such as PEPFAR and maternal and child health programs supported by USAID and HHS, to improve overall health impact. On behalf of the U.S. agencies, principally PEPFAR, USAID, and CDC, S/GHI intends to support the *Saving Mothers* Partnership by:
   1. Assuming primary responsibility for linkages with in-country programs led by the Chief of Mission and the interagency health team, including coordinating USG activities to support *Saving Mothers* implementation, and by bringing to bear the innovation and complementary strengths of the USG's implementing agencies for international health programs,
   2. Driving U.S. diplomatic efforts to bring attention to and support for maternal health
   3. Convening non-USG partners, with the Partnership (e.g. private companies, foundations, and non-profit and faith-based organizations) with an interest in supporting *Saving Mothers* activities
   4. Participating with the other key Participants in providing strategic planning and policy direction for the *Saving Mothers* Partnership, and
   5. Coordinating with relevant USG agencies the USG contribution of financial, human, and material resources to support *Saving Mothers* implementation, subject to the availability of funds, and in accordance with the internal approval processes of the USG.

b. **Merck & Co., Inc.:** Merck is a global health care company that provides innovative medicines, vaccines, and consumer health and animal products to make a difference in people's lives. In September 2011, Merck announced "Merck for Mothers", a 10 year, $500 million initiative to make proven solutions more widely available, by developing new technologies and improving public awareness, policy efforts and private sector engagement for reducing maternal mortality in line with MDG 5. Merck , as a key Founding Participant,

intends to bring financial and in-kind resources, and business and scientific expertise to *Saving Mothers* to:

1. Establish and maintain an organizational unit with staff, an office (to be located at a U.S.-based Merck facility), and a website to support the *Saving Mothers* Partnership, which will be further developed in consultation with the Participants,
2. Convene non-USG partners (e.g. private companies, foundations, and non-profit and faith-based organizations) with an interest in supporting *Saving Mothers* activities, mapping their interests with the menu of needs and partners on the ground, as articulated in country plans, and receiving and disbursing funds for program implementation, in accordance with the plans and decisions of the *Saving Mothers* Partnership,
3. Be a leader in innovation and implementation science, advocacy and policy, including by supporting the impact evaluation of the initial implementation phase (year one),
4. Provide opportunities for Merck employees to support the goals of the *Saving Mothers* Partnership through volunteer recruitment, and
5. Co-invest Merck funds and resources in *Saving Mothers* operational plans and activities that are targeted to reducing maternal mortality, through private sector engagement in-country that is in line with MDG 5 and Merck-for-Mothers access plans, subject to funding availability and approval in accordance with Merck internal processes.

c. **The College:** The American College of Obstetricians and Gynecologists is a private, voluntary membership organization of over 55,000 professionals providing health care for women. The College works to advocate for quality health care for women, maintain the highest standards of clinical practice and continuing education for its members, promote patient education, understanding, and involvement in medical care, and increase awareness among its members and the public of changing issues facing women's health care. The College intends to serve as a key Founding Participant to:

1. Provide scientific and technical leadership for the *Saving Mothers* Partnership and participate in addressing key implementation challenges of programs and interventions to reduce maternal mortality,
2. Galvanize other key professional membership associations to support the *Saving Mothers* Partnership, and
3. Support and sustain the public awareness and resource mobilization campaign through its members and the women they serve.

d. **Every Mother Counts:** EMC is an advocacy and mobilization campaign to increase education and support for maternal mortality reduction globally. EMC seeks to engage new audiences to better understand the challenges and the solutions while encouraging them to take action to improve the lives of girls and women worldwide. As a key Founding Participant, EMC intends to assist *Saving Mothers* with its goal to "Galvanize the American public around the shared experience of motherhood and childbirth, increasing awareness of maternal mortality and individual donations to support *Saving Mothers* country-level program implementation", by:

1. Incorporating *Saving Mothers* into broader EMC-driven national maternal health public awareness and fundraising activities, such as by: providing

messaging that includes the 24-hour window and providing opportunities for individuals, families, and groups to donate funds to benefit *Saving Mothers* and other programs,

2. Contributing to *Saving Mothers* Partnership public relations, public awareness, communications, resource mobilization, and media engagement that helps develop a movement of 'mothers helping mothers', and
3. Contributing an allocation of funds from FMC-driven resource mobilization activities to the *Saving Mothers* Partnership for in-country programs. These resources may be designated for particular interventions as discussed amongst the Partnership and allocated directly to implementing partners within designated countries.

Nothing in this MOU shall preclude Participants from pursuing consumer oriented activities related to their unique mandates. However, explicit reference to *Saving Mothers* in consumer and product-related public awareness and fundraising efforts shall be undertaken in consultation with the *Saving Mothers* Partnership.

VI. Implementation Strategy

Implementation of *Saving Mothers* efforts in-country is led by the Chief of Mission and the interagency health team, who are also responsible for implementing the baseline assessment to measure impact. During the initial proof of concept phase, up to three countries will be invited to submit '*Saving Mothers* operational plans' that summarize how the Ministries of Health (MOH), the *Saving Mothers* Partnership, and other implementing organizations will implement the core set of integrated and systems-level solutions in select districts, with the aim to reduce maternal mortality in those targeted areas by up to 50%. These operational plans will be submitted by Ministries of Health, and will align with existing MOH health policy and strategy. S/GHI, working with the global health agencies and interagency technical team, will coordinate the U.S. government review of the country operational plans. S/GHI will also work with the Participants to review and provide technical and programmatic input into the country operational plans as well.

After implementation of the proof of concept, the *Saving Mothers* Partnership will conduct an impact evaluation with metrics of each of the first three country *Saving Mothers* activities, to identify successful and cost effective models. Findings of the evaluation will determine to what extent *Saving Mothers* should be continued and scaled in Phase 2 at a national level and in other countries. If the proof of concept is successful, we envision that during the scale-up phase in years two and beyond, additional countries will be invited to submit proposals to implement successful *Saving Mothers* interventions for the accelerated reduction of maternal mortality in resource-limited countries. The U.S. government, through the appropriate agencies and the Chief of Mission authority, will coordinate communication with countries as well as the disbursement and oversight of U.S. government funds. Participants of the *Saving Mothers* Partnership will assist to mobilize awareness and additional funds in support of country plans for program implementation. Together, Participants are to provide direction and oversight over the *Saving Mothers* partnership in the proof of concept phase and, if successful, in the scale up of this work thereafter.

a. **Communications**
Participants, as appropriate, intend to develop a communications and branding strategy for *Saving Mothers* activities. S/GHI is required to comply with USG communications protocols, and intends to work to align as appropriate with the communications strategy of the *Saving Mothers* Partnership. The use of the official name, seal, emblem and/or logo, trademarks, or trade names ("Marks") of any Participant by the other Participants shall be allowed only with the prior written permission of the Participant who owns or has legal right to such Marks, or pursuant to an implementing instrument or implementing document signed by such Participant. All press releases referencing this MOU or the *Saving Mothers* Partnership, or any implementing instrument or implementing document hereunder, must be approved by all Participants, in writing, prior to release or disclosure.

b. **Reporting & Evaluation**
The *Saving Mothers* Partnership intends to produce an annual report, and an impact evaluation of the initial implementation phase in the three pilot countries. Additional implementation science and innovation may be conducted by *Saving Mothers* Participants per mutual agreement.

VII. General Provisions

a. **Effective Date and Duration.** This MOU shall take effect upon the signature of all Participants effective as of the date signed by the last of the Participants and shall have an initial duration of five years from that date. The duration of this MOU may be extended by agreement of the Participants in writing.

b. **Amendment and Modification.** This MOU may be amended or modified by written agreement of the Participants.

c. The Participants expressly acknowledge that they are independent contractors and that this Agreement does not create a joint venture, agency or employee relationship with any other Participants for any purpose whatsoever. Nothing hereunder shall be deemed to authorize any Participants, their agents or employees to act for, represent, or bind any other Participants or their affiliates. Unless otherwise expressly authorized in writing by any Participants, no Participants shall have a right or authority to assume or create any obligation or other responsibility, express or implied, on behalf of or in the name the other Participants, or to bind in any manner whatsoever, or to accept payment from any person on behalf of the other Participants.

d. **Termination.** Any Participant may terminate this MOU at any time upon at least 30 days written notice to the other Participants with such termination becoming effective upon the date set forth in such written notice.

LETTER OF COMMITMENT FROM NORWEGIAN GOVERNMENT

20112345

ROYAL NORWEGIAN MINISTRY
OF FOREIGN AFFAIRS

Minister of Foreign Affairs

2011 DEC 22 P 3:04

Date: 13 December 2011

Dear Madame Secretary, dear Hillary!

Following our substantive discussions on global health back in 2009 and the meeting between President Obama and Prime Minister Stoltenberg on 20 October, I am very pleased to see that US-Norwegian cooperation on global health is gaining momentum. I warmly welcome your invitation to take part in the ***Saving Mothers, Giving Lives*** partnership, and look forward to fruitful cooperation in this regard. I am also pleased to see that our joint ***Open Health*** initiative, discussed by President Obama and Prime Minister Stoltenberg, is moving forward. This Initiative is being developed by Norway and the US in collaboration with a set of countries, and draws on current work on accountability, innovation, results-based financing and vaccination. ***Open Health*** will be an integral part of the ***Open Government Partnership***. These initiatives, together with the successful collaboration between our two countries on ***Saving Lives at Birth: A Grand Challenge for Development***, and our fruitful cooperation within the framework of the UN Secretary-General's ***Every Woman, Every Child*** campaign, constitute a robust and effective partnership for accelerating progress in maternal, neonatal and child health. We are enthusiastic about the US initiative ***Saving Mothers, Giving Lives***, and look forward to playing a prominent role. Together we will work out a more detailed collaborative plan including financial commitments, partner countries and concrete, evidence-based approaches based on lessons learned from the US pilot programme. We are particularly interested in sustainability and scalability, and are therefore looking at key elements of the programme that we could focus on in the next phase.

The Honourable Hillary Rodham Clinton
Secretary of State
U.S Department of Sate
Washington, D.C

In this collaboration, the Norwegian Government, with the particular engagement of Prime Minister Stoltenberg and myself, will provide advocacy and co-leadership globally, to bring more attention, partners, and resources to the initiative, including by engaging with African leaders and with other donor governments.
The UN Secretary-General's *Every Woman, Every Child* campaign will be pivotal in this regard. Further, we will host a conference on women's and children's health in Norway. This will seek to enhance momentum for reducing maternal mortality amongst donor and recipient countries, and advance innovative solutions and scientific underpinnings. We will also provide funding for the initiative, and facilitate technical assistance on sustainability and scalability through results-based financing.
I hope to see rapid advances in this field, and would be very pleased to welcome you to Norway in connection with the conference on women's and children's health in 2012.

Yours sincerely — Warm regards

Jonas Gahr Støre

APPENDIX D: SAVING MOTHERS, GIVING LIFE MODEL

To accelerate saving the lives of mothers and newborns, the Saving Mothers, Giving Life (SMGL) model employs a systems approach focused at the health district level to ensure that every pregnant woman has access to clean and safe normal delivery services and, in the event of an obstetric complication, life-saving emergency care within 2 hours. The model serves to strengthen the existing health network (both public and private) within each district to address the "Three Delays": delay in seeking appropriate services; delay in reaching services; and, delay in receiving timely, quality care at the facility.

Attention is also focused on the most vulnerable period for mother and baby—labor, delivery, and the first 48 hours post-partum. The SMGL approach further integrates maternal and newborn health (MNH) services with HIV services (e.g., HIV counseling and testing and PMTCT services), and post-partum family planning. Linkages with other reproductive health services are strengthened. Based on global best practices with evidence-based MNH and HIV interventions, and on implementation experiences in Uganda and Zambia, this model recommends that each health district strive to integrate the following:

- A sufficient number of public and private facilities with appropriate geographical positioning to provide—24 hours per day/7 days a week—clean and safe normal delivery services, quality HIV testing, counseling and treatment (for woman, partner, and baby as appropriate), and essential newborn care for all pregnant women in the district.

- At a minimum, five emergency obstetric and newborn care (EmONC) facilities (public and private), including at least one facility that can provide comprehensive emergency obstetrical and newborn care (CEmONC), for a population of 500,000 or per 20,000 births, accessible within two hours from a normal delivery site after the development of a severe obstetric or newborn complication, and for post-abortion care.

- A sufficient number of skilled birth attendants to provide, on a consistent basis, quality respectful normal delivery care, diagnosis and stabilization of complications, and if needed, timely facilitated referral for EmONC. Performance-based EmONC-trained personnel to provide required signal functions at BEmONC and CEmONC designated facilities. WHO guidelines recommend 1 midwife per 120 deliveries/year; 1-2 doctors and 6 medical personnel (midwives, clinical officers, and nurses) for every 1000 births.

- Availability and maintenance of necessary infrastructure and equipment, and reliable supplies of commodities and drugs to perform the seven (BEmONC)/nine (CEmONC) signal functions, and provide newborn essential and special care, as well as quality HIV testing and treatment, and PMTCT services as appropriate to the level of the facility, on a continuous basis.

- A 24-hour/7 day per week, consultative, protocol-driven, quality-assured, integrated (public and private) communication/transportation referral system that ensures women with complications reach emergency services within 2 hours. This includes providing, where appropriate, temporary lodging for women with high-risk pregnancies or who live greater than 2-hours travel time to an EmONC facility.

- A government-owned HMIS data-gathering system that accurately records every birth, obstetric and newborn complication and treatment provided, and birth outcomes at public and private facilities in the district. A timely, no-fault, medical death review performed in follow-up to every institutional maternal and neonatal death with cause of death information used for ongoing monitoring and quality improvement. Prospective enumeration of maternal and newborn deaths in the community with verbal autopsies. Where appropriate, m-health approaches to facilitate the reporting process.

- Community outreach to counsel women, families, local leaders, and community organizations on the importance of birth planning, 4 ANC visits, HIV testing and treatment, pre- and post-partum homecare for mother/newborn and danger signs, and the value of facility delivery. Postpartum family planning methods also discussed.

- As feasible, incorporate demand- and supply-side financial incentives to promote and facilitate women seeking, accessing and utilizing quality care (eg. vouchers, user-fee reductions, and Conditional Cash Transfers), and the provision of quality services.

- Sound managerial practices utilizing 'short-loop' data feedback and response, to ensure reliable delivery of quality essential and emergency maternal and newborn care.

The Saving Mothers, Giving Life Model builds on:

- The leadership, health systems, policies/national and district plans and aspirations of partner governments

- Synergies derived from the investment and unique expertise of private and public organizations for the common purposes of preventing maternal and newborn deaths and creating an AIDS-free generation

- A foundation of relationships, infrastructure, partnerships, expertise and services supported through PEPFAR, USAID, HHS/CDC, Peace Corps and other US government agencies

- Other donor- and private sector-funded maternal, neonatal and child health efforts in countries, including those targeting HIV-infected and affected families and communities

- Local and global expertise in maternal and neonatal health, HIV/AIDS, and evidence-based quality improvement processes

APPENDIX E: MOTHER'S DAY MESSAGE FROM SECRETARY SEBELIUS

A Special Message from Secretary of the Department of Health and Human Services Kathleen Sebelius (May 13, 2012)

Happy Mother's Day!

As a mom, I am honored to have the opportunity to recognize mothers around the world and celebrate their contributions to our families and communities. As Secretary of the U.S. Department of Health and Human Services, it is important for me to take a moment and reflect on our responsibility to support safe motherhood for everyone, everywhere. Every woman – no matter where she lives – deserves a safe pregnancy and birth, and all babies- no matter where they are born- deserve a healthy start to life.

Our work at the Department is to ensure all Americans live healthier lives. This is a responsibility that I take very personally. A cornerstone of this work is making certain all women have access to the care they need. The Affordable Care Act offers important benefits for women and their families. Today, women have access to important preventive services like mammograms, contraception, and a well-woman visit, with no out-of-pocket costs. Soon, insurance companies will no longer be allowed to deny coverage to women due to pre-existing conditions, such as cancer or having been pregnant; nor will they be allowed to charge women more just because they're women. It's a new day for women's health care. When the new Health Insurance Marketplace opens for enrollment in October, every plan will be required to cover prenatal and maternity care, a welcome change from today's market where this comprehensive coverage may not have been included for the very women who need it. Women will also have financial assistance to help them afford coverage. But, they cannot take advantage of this opportunity if they don't know it exists.

That is why we are pursuing innovative, public-private partnerships, both domestically and internationally, to help mothers gain access to the knowledge and services they need. In an effort to reach more women with important information related to the Health Insurance Marketplace, we are collaborating with text4baby, the nation's largest and only free mobile information service designed to

promote maternal and child health through text messaging. Through this program, women in the U.S. receive free text messages, timed to their due date or their baby's birth date, on topics such as prenatal and postnatal care, developmental milestones, immunizations, nutrition, safe sleep, and much more. Pregnant women and moms with babies under one year can sign up for text4baby by texting "BABY" (or BEBE for Spanish) to 511411. Today, on Mother's Day, text4baby is launching the 2013 State Enrollment Contest – a friendly competition among states – to connect even more women to critical health and safety information. Visit text4baby.org for more information.

We are also engaging with global partners to ensure all women around the world have a safe and healthy pregnancy and delivery. *Saving Mothers, Giving Life* is a public-private partnership that seeks to help countries aggressively reduce maternal mortality. Currently, the program is working in sub-Saharan Africa where women are dying at alarming rates during pregnancy and childbirth. The initiative helps countries build capacities to ensure mothers receive the essential care and resources they need during labor, delivery, and the first 24-hours after birth – the most vulnerable period for mothers and their newborn children. The work is underway in targeted districts in Zambia and Uganda, and in less than a year, we are already seeing tremendous increases in the number of women delivering in health care facilities, where they have the best chance for a safe and healthy delivery. In addition, hundreds of health workers have been trained in emergency obstetric care, birthing centers and operating rooms have been renovated or upgraded, emergency transportation has been subsidized and HIV testing and treatment have been provided to expecting mothers. Thanks to the coordinated efforts of many dedicated partners, and the generosity of the American people, we are already making a dramatic impact on mothers' lives.

Today on Mother's Day, I am happy to celebrate these amazing collaborations, which are succeeding to make pregnancy and childbirth healthier and safer for women here in the U.S. and around the world. The best chance we have for ensuring the health of our loved ones is by working together as partners. Together, we can go further in supporting safe motherhood. Safe and healthy motherhood is possible – especially when we work in partnership. There are several ways you too can get involved:

Enroll. Pregnant women and moms with babies under one year can to sign up for text4baby by texting "BABY" (or BEBE for Spanish) to 511411.

Learn the facts. Understand the devastating impact the death of a mother can have on a family and community and what you can do to make a difference globally. Learn more at www.SavingMothersGivingLife.org.

Spread the word. Tell your friends about this important cause and help raise awareness. Go to www.EveryMotherCounts.org for more ways to get involved.

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