Building effective public–private partnerships: Experiences and lessons from the African Comprehensive HIV/AIDS Partnerships (ACHAP)

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Abstract

This paper examines the processes for building highly collaborative public–private partnerships for public health, with a focus on the efforts to manage the complex relationships that underlie these partnerships. These processes are analyzed for the African Comprehensive HIV/AIDS Partnerships (ACHAP), a 5-year partnership (2001–2005) between the government of Botswana, Merck & Co., Inc. (and its company foundation), and the Bill & Melinda Gates Foundation. ACHAP is a highly collaborative initiative. The ACHAP office in Botswana engages intensively (on a daily basis) with the government of Botswana (an ACHAP partner and ACHAP's main grantee) to support HIV/AIDS control in that country, which had an adult prevalence of 38.5% HIV infection in 2000 when ACHAP was being established. The paper discusses the development of ACHAP in four stages: the creation of ACHAP, the first year, the second and third years, and the fourth year. Based on ACHAP's experiences over these four years, the paper identifies five lessons for managing relationships in highly collaborative public–private partnerships for public health.

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Introduction

While there is growing recognition about the role of public–private partnerships (PPPs) in addressing global health issues, researchers have emphasized that public and private organizations have significantly different goals, values and processes (Austin, 2000; Reich, 2002; Sagawa & Segal, 2000; Widdus, 2001). Partnerships are therefore advised to invest in extensive planning and learning, and then start a process of incremental engagement, beginning with arms-length philanthropic involvement and moving carefully towards highly collaborative models, which involve intensive and regular communication between partners, the exchange of multiple resources, and engagement at various levels of partner organizations (Austin, 2000; Barrett, Austin, & McCarthy, 2002; Sagawa & Segal, 2000).

But increasing numbers of corporations and foundations, seeking to increase the effectiveness of their philanthropy, are inclined to skip the step of cautious philanthropy and plunge directly into
highly collaborative PPPs with new partners (Center for Effective Philanthropy, 2003; Letts, Ryan, & Grossman, 1997). Influential writers such as Porter and Kramer (1999) recommend that partners be closely involved with the implementation of projects in order to create value. Others in international development have similarly sought to persuade private organizations to engage directly with public agencies through intensive partnerships, particularly for urgent issues like HIV/AIDS (WHO, 1999; World Bank, 2004).

This paper examines the dilemma between the growing desire for highly collaborative partnerships and the lagging capacity to manage the complex relationships that emerge in such partnerships. We analyze this dilemma as it evolved for the African Comprehensive HIV/AIDS Partnerships (ACHAP), a partnership initially intended for 5 years (2001–2005) between the government of Botswana, Merck & Co., Inc. (and its company foundation), and the Bill & Melinda Gates Foundation. With a commitment of $50 million each, Merck and Gates were Botswana’s largest foreign donors for HIV/AIDS at the time ACHAP was initiated. ACHAP’s involvement in Botswana has been important in initiating several major HIV/AIDS interventions. Botswana now has more people on antiretroviral treatment than any other country in sub-Saharan Africa and is the only country to provide free treatment for all. ACHAP has played an important role in achieving these outcomes (Ramiah & Reich, 2005).

ACHAP represents a highly collaborative initiative, seeking to engage intensively (on a daily basis) with the government of Botswana, both an ACHAP partner but also the main recipient of ACHAP funds, to provide considerable financial and technical support to address HIV/AIDS. This partnership was created despite the absence of past interactions among partners and the lack of substantial planning before establishing the partnership.

This paper analyzes the multiple challenges that ACHAP confronted in its first 4 years in building and managing its relationships with other organizations and among ACHAP partners (especially with the government). It examines these processes in four time periods: the creation of ACHAP; the first year; the second and third years; and the fourth year. Based on the ACHAP experience and drawing on the literature on PPPs, the final section identifies five lessons on relationship management in PPPs.

**Methods**

This study is based on published and unpublished documents collected in Botswana and the United States as well as over 60 semi-structured interviews conducted with a wide range of actors. In Botswana, interviews were conducted with senior and middle-ranking civil servants in various ministries and the National AIDS Coordinating Agency (NACA), political leaders including the President of Botswana and Botswana’s then Minister of Health, local NGOs, and international development partners. All senior and middle-ranking staff at the ACHAP office, including ACHAP’s first project leader, were also interviewed in Botswana.1 In the United States, interviews were conducted with Merck executives and officers at the Gates Foundation. In several instances, particularly with senior civil servants in Botswana, senior staff in ACHAP, and Merck executives, we conducted two or more interviews with the same interviewee, at different times during the research period (September 2003–August 2004). This made it possible to collect data on the responses of interviewees to important events (covered in the discussion of the fourth year in this paper) as they unfolded.

In the interviews, respondents were asked to discuss the performance of other individuals (sometimes their superiors), and the nature of relationships between individuals and between organizations. Due to the sensitivity of the questions, interviewees were assured of anonymity. When respondents agreed, interviews were tape-recorded, although some 50% of interviewees refused. Each direct quotation used in the paper was approved by the interviewee. Due to the sensitivity of some of the material, we decided not to use the names of any interviewees. Names have been used only where the quotation was drawn from a published source.

The research occurred over an extended period of time (about 2 years) and collected in-depth data from a wide range of interviewees; many of the respondents were approached more than once to discuss evolving issues. While the single case-study

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1The number of interviews in different agencies was as follows: Office of the President—3; National AIDS Coordinating Agency—3; Ministry of Finance—7; Ministry of Health—9; Ministry of Education—1; International Development Partners in Botswana—8; ATOS-KPMG Consulting Group—2; Local NGOs—4; ACHAP—16; Merck & Co., Inc.—7; Bill & Melinda Gates Foundation—2.
method provides depth and context, it also limits the potential applicability of lessons learnt. Further research on other cases of PPPs will be needed to establish and refine the broader applicability of the lessons presented in this paper.

Literature on building partnerships

The past decade has witnessed significant growth in PPPs in health issues around the globe. The Labor Government in the United Kingdom since its election in 1997 has emphasized PPPs as a core tool of governance for public policy for the social sectors (IPPR, 2001). In the United States, partnerships are increasingly viewed as an important approach for improving community health, as illustrated by the 25 partnerships in the Community Care Network Demonstration Program (Shortell et al., 2002). Public–private ventures are being adopted for disease management projects in Europe and the United Kingdom (Hunter, 2000). And in developing countries, PPPs are emerging as one component of efforts to provide public services and public infrastructure, as shown by the official policy of the Gauteng Department of Health in South Africa (Moorman, 2002).

As a result of these experiences, a growing academic literature has emerged on “partnership building”—the social processes of partnership work—as part of the effort to evaluate what these organizations achieve (Gillies, 1998; Shortell et al., 2002). While the benefits of partnerships are widely proclaimed, it is also increasingly recognized that bridging the different goals, values, and processes of public and private organizations is hard work. Some studies of PPPs have recommended extensive planning and learning about partner organizations, before starting highly collaborative relationships. For Sagawa and Segal (2000), planning and learning involve self-assessment by each partner, identification of a partner, connection with the partner, testing out a working relationship, and then launching a full-scale partnership. Similarly, Austin (2000) proposes that PPPs follow a “collaboration continuum”, which would allow for learning and planning. In this continuum, partners begin with philanthropic initiatives, move towards a transactional relationship, and eventually start highly collaborative projects. His detailed discussion of the characteristics of relationships and partnership initiatives at different stages of the continuum suggests that leapfrogging steps in this collaboration continuum is ill-advised if not implausible.

The realities of partnership work, however, can be far different from the theories. This case study on the creation and development of ACHAP illustrates an approach that differs from the linear models of partnership building proposed by Sagawa and Segal (2000) and by Austin (2000). The lessons on partnership building from the ACHAP case, which we discuss below, may have important implications for creating effective PPPs in other contexts.

The creation of ACHAP

ACHAP emerged from Merck’s prior experiences with other philanthropic projects on access to medicines, including the Mectizan Donation Program (for onchocerciasis or river blindness) and the Enhancing Care Initiative (ECI) (for HIV/AIDS) with the Harvard AIDS Institute. As one Merck executive explained, the company learned through these experiences that the donation of medicines alone is ineffective without support for strengthening the health care infrastructure to assure that medicines are used effectively. Although the particular model of engagement was not initially clear to Merck officials, they always intended ACHAP to be a highly collaborative project (Interview #2, 24/09/03).

Merck initiated the concept of ACHAP based on three key ideas. The first was that private-sector management and thinking (from Merck) could make a significant contribution in the fight against the HIV/AIDS epidemic. Second, the organization would be based on an equal partnership with a national government in a PPP, because national commitment was essential for effective intervention and the organization needed to work through the national government. Third, the initiative would invest a large sum of money in one location so that a comprehensive range of HIV/AIDS interventions could be implemented, to serve as a model that would demonstrate how private-sector resources could produce effective interventions (Distlerath & Macdonald, 2004).

In August 1999, Merck, realizing that it could not alone provide all the resources needed for an effective partnership, began to seek partners for additional funding as a first step towards ACHAP. Merck approached the Bill & Melinda Gates Foundation, which was optimistic about the project for three reasons. First, there was shared enthu-
siasm over the effort to leverage private-sector management and thinking to resolve social issues. Second, Merck had a personal connection with a key person in the Gates Foundation, who believed in Merck’s commitment to HIV/AIDS and had previously worked with Merck for 10 years on the Mectizan Donation Program (treatment of onchocerciasis) when he was at the Carter Center (Frost, Reich, & Fujisaki, 2002). He had also served as an adviser to Merck on its earlier HIV/AIDS initiatives, prior to accepting a position at the Gates Foundation as senior health adviser (ACHAP, 2003). After reviewing the Merck proposal, this senior health adviser recalled, “We (Gates Foundation) were soon in the position of wanting to push them faster than they wanted to go” (cited in Weber, Austin, & Barrett, 2001, p. 6). Third, the Gates Foundation was impressed with Merck’s high level of commitment to the partnership project. The senior health adviser noted that a key factor for Gates was that “Ray Gilmartin [then Merck’s Chairman and CEO] is involved” (cited in Weber et al., 2001, p. 6).

As enthusiastic as the Gates Foundation was about joining the partnership, other foundations (jointly approached by Merck and the Gates Foundation) were reluctant and skeptical. Several foundations expressed concerns about the propriety of having a pharmaceutical company become directly involved in designing and implementing a country’s HIV/AIDS program. Others felt that they did not want to become engaged in a large project in only one country, instead preferring pilot projects in several locations (Distlerath & Macdonald, 2004).

Merck and the Gates Foundation agreed that speed was of the essence in the HIV/AIDS epidemic and decided to start immediately. The first task was to select a location. In the spring of 2000, Merck and the Gates Foundation chose Botswana because of the country’s 38.5% adult prevalence of HIV infection in 2000, and the commitment of the country’s highest leaders to fight the HIV/AIDS epidemic. Botswana was also chosen for its small population of 1.6 million people, relatively well-developed health infrastructure, its stable and peaceful political environment, and its status as a middle-income country (ACHAP, 2003; Distlerath & Maedonald, 2004). These conditions suggested that the implementation of a comprehensive HIV/AIDS program in Botswana had good chances of success compared to other sub-Saharan African countries.

But neither Merck nor the Gates Foundation had any personal connections in Botswana. They turned for assistance to the executive director of the Harvard AIDS Institute (ACHAP, 2003; Weber et al., 2001). The director was working with Merck on the Enhancing Care Initiative, and the Harvard AIDS Institute was actively engaged in AIDS research in Botswana and had a positive reputation there. In addition, the director had a personal relationship with Botswana’s President and agreed to provide an introduction. Things moved quickly. Merck’s Vice-President of Global Health Policy recalled:

[The executive director of the Harvard AIDS Institute] called me on the last Thursday of June to say he had scheduled a meeting with President Mogae on the following Tuesday, July 4th [2000]. [The executive director of the Harvard AIDS Institute, another senior Merck executive] and I left the next day. On July 3rd, we were told we needed to have a document ready to be signed, so we patched something together from a draft press release describing the relationship between Merck and Gates. It was the first time we had put this in writing. President Mogae’s first reaction was that we should have started yesterday. He kept saying we must have a sense of urgency (cited in Weber et al., 2001, p. 10).

Several government officials in Botswana recalled mixed sentiments in this early period of ACHAP. The early conversations about ACHAP raised questions and sensitivities about trust. The President reported, “We (the government of Botswana) pride ourselves on our ability to manage donors, the Swiss, Norwegians, and others. We implement, and they monitor progress. But ACHAP was different. They thought they would strengthen our capacity and they would have their own program with us. We didn’t understand” (Interview #45, 26/03/04). The then Minister of Health said, “I understood that this kind of relationship should be done in some countries with poor financial management systems and endemic corruption. But this is not the case in Botswana” (Interview #3, 09/10/03).

At the same time, government officials were impressed by the enthusiasm of the Merck team. As one senior government official recalled, “We wanted to remain hopeful.” The government of Botswana decided to accept the proposed partnership and in July 2000 signed a statement of intent to initiate the project. This document detailed the
scope and objectives of the partnership, the equal relationship between the parties, administration of the project, and some short-term plans for programs.

**The first year (2001)**

At the start, the government of Botswana and Merck were the key partners in ACHAP. The Gates Foundation placed a representative on ACHAP’s board, but was not as involved as the other two partners, due partly to limited staffing at the foundation but also reflecting the foundation’s general approach to its grantees at the time. For the two core partners, however, the points of reference for the partnership differed considerably. For the government, the key point of reference was the agreement signed in July 2000. This agreement identified government as an equal partner in ACHAP. For Merck, final responsibility for ACHAP was located in the Board of Directors, which included only members from Merck, Gates, and the Harvard AIDS Institute. The board assumed primary responsibility for organizational decisions: authorizing budgets, approving proposals, and providing direction on strategy and operations of the ACHAP office. The central point of contact between the Board of Directors and the government was the ACHAP project leader, based in the ACHAP office in Gaborone.

Initially, the absence of a government representative in ACHAP’s Board of Directors was not regarded by government officials as an issue. The government viewed itself as a core partner in ACHAP but also as ACHAP’s main grantee. Moreover, all proposals for ACHAP funding for government programs and other activities were pre-approved by the Application Review Committee, which included representatives from the Ministries of Finance and Development Planning, Health, Local Government, Education, Labor and Home Affairs, and the Office of the President. Further, the formal agreement stated that ACHAP would primarily support government initiatives. The government interpreted “support” to mean that the ACHAP board would donate the necessary funds and then leave implementation to government agencies. The government also assumed that the ACHAP office in Gabarone would view government agencies as the primary point of contact in Botswana.

Merck was motivated by a different vision. To demonstrate the utility of private-sector thinking and skills, Merck promoted an active role for the ACHAP office in Botswana and suggested that the ACHAP Board of Directors hire the then Managing Director of Merck’s subsidiary in South Africa as ACHAP’s first project leader. The Board accepted this suggestion. ACHAP’s first project leader was a physician of Dutch origin, with extensive experience in the pharmaceutical industry in South Africa, but less experience in Botswana or AIDS control policy. The ACHAP office was dedicated, as one Merck executive suggested, to “doing whatever is necessary to solve the problem” (Interview #2, 24/09/03).

With these differing assumptions held by the two core partners, ACHAP began operations in Botswana. During the first months, the project leader was the only employee of the ACHAP office in Gabarone. He was based within Botswana’s NACA. In the first 6 months of operations, ACHAP provided financial and technical resources for government to write the National Strategic Framework for managing HIV/AIDS (ACHAP, 2004). This document was intended to provide ACHAP and other international development partners with a framework for assistance to government.

As the project leader gained more experience with government and as the ACHAP staff grew in number to include some 20 professional staff members, three factors contributed to tensions between government and ACHAP. First, ACHAP assumed an active role in identifying and promoting particular HIV/AIDS interventions. ACHAP’s project leader and his staff questioned the government’s priorities for HIV/AIDS interventions and also expressed concerns that priorities, once decided, were not implemented quickly. There was also growing pressure from Merck to spend and “get programs off the ground” quickly (Interview #2, 24/09/03).

One early example of disagreement over ACHAP’s role was its outreach to local non-governmental organizations (NGOs). ACHAP sought to diversify its portfolio and viewed government interventions as sometimes overly bureaucratic. Government officials viewed the outreach to NGOs as contrary to the signed agreement and demonstrating distrust in the government’s capacity to deal with HIV/AIDS. The President recalled, “They said they wanted to work with NGOs. ACHAP thought NGOs were better. We think we [the government] are better” (Interview #45, 26/03/04).
Government officials remained relatively silent about their misgivings over ACHAP’s increasingly pro-active behavior, because they did not wish to criticize the partnership and also because ACHAP’s outreach efforts quickly confronted major obstacles. But concerns about ACHAP’s deviation from a supportive role continued to grow over time. Serious disagreement occurred when proposals for ACHAP funding, already approved by government representatives on the Applications Review Committee, were rejected by ACHAP’s Board of Directors. An example of a proposal that the government supported but was not approved by the ACHAP Board, involved funding for the removal of clinical waste. ACHAP Board members felt that this was not specifically linked to AIDS control and was an issue for the broader health system. These cases, though few in number, were deeply etched in the memories of government officials interviewed.

The second factor that contributed to the growing rift between ACHAP and government was ACHAP’s project leadership. While the project leader was described by many in Botswana as “someone who got things done” and as deeply committed to the fight against HIV/AIDS in Botswana, some viewed his temperament as a major weakness (Interview #34, 22/03/04; Interview #44, 22/03/04; Interview #45, 26/03/04). His personality was seen as abrasive in Botswana’s cultural context, with its emphasis on consultation and consensus, resulting in sometimes productive and sometimes counterproductive consequences.

Tension also emerged with other groups working on AIDS in Botswana. For example, rifts arose with another major external development partner working towards AIDS control, the US Centers for Disease Control and Prevention (CDC), known as BOTUSA (Botswana–USA partnership). In one case, ACHAP initiated a condom marketing and distribution program in its first year of operation, but without involving BOTUSA, which was responsible for a smaller scale existing condom distribution program in Botswana. BOTUSA viewed ACHAP’s program as an attempt to overshadow BOTUSA’s own work (and territory) in Botswana (Interview #22, 06/12/04).

The third factor that added to tensions with government was perceptions and publicity about ACHAP’s large financial commitment ($100 million over 5 years). Some government officials recalled concerns about equality among partners. Other international development partners, such as BOTUSA and various UN agencies, had long been working on AIDS control in Botswana with much smaller budgets. ACHAP’s large financial commitment also produced resentment among some development partners. While ACHAP was not entirely responsible for these perceptions, several ACHAP staff recalled that the organization in its early phase did not actively seek to allay these concerns and sentiments (e.g., by establishing good working relationships with government, or by acknowledging the work being done by other international development partners).

Despite these difficulties in its first year, the ACHAP Board made a concerted effort to build relationships in Botswana. Board members made regular visits to meet with senior government officials, including the president and the permanent secretaries of key ministries, in order to establish and sustain personal and organizational connections. ACHAP was also able to deliver useful services to government. Among ACHAP’s early achievements was its assistance to government in starting up the national antiretroviral (ARV) treatment program (Ramiah & Reich, 2005). ACHAP’s project leader helped obtain the services of McKinsey & Company pro bono to conduct a feasibility study for starting ARV treatment in Botswana (McKinsey & Company, 2001). Several government officials agreed that ACHAP’s role in initiating the ARV program had been invaluable.

**The second and third years (2002–September 2003)**

Many of ACHAP’s program activities began in 2002. (ACHAP program activities are shown in Tables 1 and 2.) With more day-to-day involvement with government, two new factors led to tensions in the relationship between government and ACHAP. First, ACHAP tended to focus its attention on the most senior civil servants and political leaders and did not cultivate effective working relationships with middle-ranking civil servants and technical staff in government. This contributed to delays in the implementation of ACHAP-supported programs.

For example, in January 2002, the President of Botswana requested ACHAP’s assistance in building the treatment clinics, called the Infectious Disease Care Centers (IDCCs), necessary to start the national ARV program. In Botswana’s model of
ARV treatment in 2002, ARVs were provided by health care workers dedicated to this purpose and the ARV program functioned as a separate unit. In facilities where there was no existing space for a separate unit, new space had to be constructed in the form of IDCCs. To construct the facilities, ACHAP was asked to follow standard government procedures involving several civil service offices. Officials in these offices, however, were not fully informed of the initiative and had not been involved in earlier discussions between government and ACHAP (Interview #26, 10/12/03; Interview #32, 01/12/03). This gap led to a protracted process of negotiating the construction of the IDCCs, which eventually had to be resolved by presidential intervention.

The second factor that contributed to tension was ACHAP's difficult relationship with NACA. NACA was established in 1999, shortly before ACHAP. While ACHAP was organizing itself, the

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Table 1
Key ACHAP contributions to HIV/AIDS prevention and care interventions in Botswana (2003)

<table>
<thead>
<tr>
<th>Program</th>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coping Centers for People Living with HIV/AIDS</td>
<td>Financial support</td>
</tr>
<tr>
<td>Resource Centers at District Hospitals</td>
<td>Financial support</td>
</tr>
<tr>
<td>Botswana Christian AIDS Intervention Program (BOCAIP)</td>
<td>Financial support</td>
</tr>
<tr>
<td>Counseling Centers</td>
<td></td>
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<tr>
<td>Teacher Capacity Building Program</td>
<td>Financial support</td>
</tr>
<tr>
<td>Condom Marketing and Distribution</td>
<td>Financial support and contracting consultants</td>
</tr>
<tr>
<td>Highly Mobile Populations Sexually Transmitted Infections (STIs)/HIV Prevention Program</td>
<td>Efforts to encourage government to initiate program and technical advice from ACHAP staff in developing program</td>
</tr>
<tr>
<td>Capacity building and strategic planning with government institutions</td>
<td>Efforts to encourage government to initiate program and technical advice from ACHAP staff in developing program</td>
</tr>
<tr>
<td>Alcohol abuse and HIV prevention</td>
<td>Efforts to encourage government to initiate program and technical advice from ACHAP staff in developing program</td>
</tr>
<tr>
<td>Dula Sentle (orphanage for HIV/AIDS Orphans)</td>
<td>Efforts to encourage government to initiate program and technical advice from ACHAP staff in developing program</td>
</tr>
<tr>
<td>Botswana Network of AIDS Service Organizations (BONASO)</td>
<td>Efforts to encourage government to initiate program and technical advice from ACHAP staff in developing program</td>
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<tr>
<td>Small Grants Program</td>
<td>Efforts to encourage government to initiate program and technical advice from ACHAP staff in developing program</td>
</tr>
<tr>
<td>Botswana Network of People Living with HIV/AIDS (BONEPWA)</td>
<td>Efforts to encourage government to initiate program and technical advice from ACHAP staff in developing program</td>
</tr>
<tr>
<td>Routine HIV Testing</td>
<td>Efforts to encourage government to initiate program and technical advice from ACHAP staff in developing program</td>
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</tbody>
</table>

Table 2
ACHAP contributions to the ARV program

<table>
<thead>
<tr>
<th>Aspects of the ARV program</th>
<th>ACHAP contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy, planning and project management (central and facility level)</td>
<td>Recruitment and salaries of key staff</td>
</tr>
<tr>
<td>Information, Education and Communication (IEC) and community mobilization</td>
<td>Recruitment and salaries of key staff</td>
</tr>
<tr>
<td>Training of health professionals (in ARV therapy, IT, monitoring &amp; evaluation)</td>
<td>Financial support for KITSO, management and financial support for preceptorship program, recruitment and salaries of some key staff for monitoring and evaluation and IT training</td>
</tr>
<tr>
<td>Healthcare worker recruitment</td>
<td>Recruitment and salaries for up to 52 healthcare workers for a period of two years</td>
</tr>
<tr>
<td>Drug logistics</td>
<td>Donation of two ARV drugs (Stocrin and Crixivan) from Merck</td>
</tr>
<tr>
<td>Laboratory and testing logistics</td>
<td>Financial support</td>
</tr>
<tr>
<td>Information technology for nationwide tracking and monitoring of patients, laboratory samples and medication utilization</td>
<td>Financial support for purchase and installation of hardware, recruitment and salaries of key staff managing the program.</td>
</tr>
<tr>
<td>Procurement and upgrading of space for provision of treatment</td>
<td>Contracting and financing the building of 16 clinics for ARV treatment</td>
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</tbody>
</table>

*aSource: adapted from ACHAP, 2004.
agency was also responsible for processing and approving all HIV/AIDS expenditure in Botswana, including funds for ACHAP-supported programs. ACHAP staff, along with government officials and civil society organizations, expressed frustration with NACA’s inefficiencies, which left several HIV/AIDS interventions unfunded for extended periods of time, hindering ongoing programs and delaying the implementation of new ones (Interview #45, 26/03/04; Interview #28, 08/12/03; Interview #43, 23/03/04; Interview 34, 22/03/04; Interview #26, 10/12/03). These tensions between NACA and ACHAP were compounded by an initially difficult personal relationship between the leaders of the two organizations.

One source of tension in ACHAP’s second year was a growing concern that ACHAP was overstepping its role as facilitator and becoming an implementer. This concern emerged, e.g., around ACHAP’s attempt to establish programs addressing the influence of alcohol consumption and mobile populations on the transmission of HIV/AIDS. One senior official in the Ministry of Local Government said, “They wrote the mobile populations proposal themselves, and then said, ‘You should do this and that. That attitude doesn’t go down well here’ (Interview #27, 10/12/03). Another official from the Ministry of Health noted, “ACHAP has ideas, and there is nothing wrong with having ideas. But in a partnership no one must be made to feel that a new idea is one person’s idea” (Interview #26, 10/12/03).

Continuing pressure from ACHAP to launch these two programs (for alcohol and mobile populations) created stress for both government officials and ACHAP staff. At the same time, however, ACHAP staff were learning from these experiences. One ACHAP manager said, “We could have stayed just as a facilitator for funding. But we believed that we had to get involved in implementation. We should have involved people [in government] more in the process” (Interview #4, 03/12/03).

Government frustrations about ACHAP’s role were echoed by other partners in Botswana. Larger civil society organizations, which had initially worked well with ACHAP, began in the second and third years to resent what they saw as ACHAP’s interference in organizing some of these groups (Interview #18, 05/12/03; Interview #19, 05/12/03; Interview #20, 05/12/03).

Another source of irritation was ACHAP’s pursuit of media coverage, which was viewed as overly assertive. The director of another development organization attributed the media attention to the corporate sponsors, saying, “Merck has gone on an unattractive media frenzy which almost serves to prove everyone’s suspicions about private-sector involvement. It is ridiculous how every month they have journalists over to Botswana and then get them to write about how adherence is high and prevalence is falling, all things for which there is absolutely no evidence” (Interview #23, 06/12/03). The nature of media coverage resulted in part from ACHAP’s employment of communications staff who regularly encouraged reporting about ACHAP’s activities.

In the third year of ACHAP’s operations, several factors contributed to improved relationships for the partnership. One important event was the visit of Bill and Melinda Gates to Botswana in September 2003. Until this point (as mentioned earlier), the Gates Foundation participated in ACHAP in a less direct manner, in sharp contrast to Merck’s multi-dimensional hands-on approach. The high-profile visit of Bill and Melinda Gates changed the foundation’s relationship to ACHAP and improved staff morale at the ACHAP office in Gabarone. Government officials were also deeply appreciative of the visit, which bolstered ACHAP’s reputation in Botswana and helped balance Merck’s involvement in ACHAP.

ACHAP’s positive contributions to HIV/AIDS programs in Botswana during its second and third years also added to the organization’s public face. One widely cited example, noted above, was ACHAP’s role in building the clinics for the ARV program. Government reports indicated at the time that it would have taken 18 months for government agencies to build the first clinic. After the president issued his directive, ACHAP completed the first clinic in 3 months. Senior officials, including the president, agreed in interviews that without ACHAP there would have been a great delay in constructing the treatment centers (Interview #34, 22/03/04; Interview #44, 22/03/04; Interview #45, 26/03/04).

A final factor that strengthened the partnership, particularly by the end of 2003, was ACHAP’s learning about the importance of relationships and how to nurture them. For example, the relationship between the ACHAP project leader and NACA’s coordinator improved considerably over time, through efforts on both sides. ACHAP staff also began to hold regular meetings with key govern-
ment officials to encourage two-way communication. These meetings improved mutual understanding between government and ACHAP.

After 2 years of intense activity and interaction with government, the last months of 2003 began a period of reflection for ACHAP, as ACHAP partners and staff started to consider the potential end of Merck/Gates funding and commitment in 2005. Botswana’s HIV/AIDS crisis showed no signs of abating or even coming under control, and government officials became concerned about a future without ACHAP. These reflections led to important changes within ACHAP and in the relationship between the core partners at the beginning of the fourth year.

The fourth year (November 2003–April 2004)

By the fourth year of ACHAP’s operations, the partnership had evolved and achieved some maturity. The core partners had reached greater mutual understanding and comfort with each other. The most important change during this period was the transition in ACHAP’s project leadership. ACHAP’s Board, as well as ACHAP’s project leader, sought to assure the partnership’s sustainability (in organizational and financial terms), even as Merck and the Gates Foundation expressed reluctance to provide financial assistance beyond the initial $100 million commitment. Further, government’s emphasis on local participation for all foreign endeavors had been noted by the ACHAP Board and staff. ACHAP’s Board of Directors recognized the importance of local leadership in consolidating ACHAP’s achievements during the next 2 years and began to consider a possible transition away from funding by Merck and the Gates Foundation.

In late 2003, the ACHAP board hired ACHAP’s second project leader. A Botswana citizen, the second project leader had previously worked for Debswana (the DeBeers–government of Botswana partnership for diamond mining), as the director of a widely praised HIV/AIDS workplace program. During interviews conducted just after the appointment of the second project leader, government officials expressed optimism about the consequences of this leadership change (Interview #49, 22/03/04; Interview #34, 22/03/04). One senior official noted, “I have not worked with her, but she is Motswana. She understands our ways. I know her socially and have heard of her professionally” (Interview #44, 22/03/04). The appointment was widely viewed as a positive step in enhancing local knowledge in the leadership of ACHAP, with the expectation that this change would make ACHAP more effective in its interactions with the government and civil society in the fight against AIDS in Botswana.

ACHAP’s next move delivered some of the promise of a new phase. Prior to leaving, ACHAP’s first project leader laid the groundwork for the first joint meeting between ACHAP’s Board of Directors and Botswana’s senior government officials. Previously, board members had mainly met with government officials individually. This meeting was designed as an off-site retreat and included all board members, permanent secretaries from the five ministries involved in reviewing ACHAP funding proposals, and the coordinator of NACA. The meeting was organized and facilitated by ATOS-KPMG, a management consulting firm based in Botswana, which was hired by ACHAP. Before the meeting, ATOS-KPMG consultants conducted interviews with board members and government officials, and analyzed the relationships and their impact on performance, in order to structure the meeting and present issues for discussion. Their analysis of ACHAP helped identify problems that needed attention and facilitate decisions among the key players about how to improve both relationships and performance.

A key outcome of the meeting was the decision that the ACHAP Board of Directors would no longer approve proposals for funding. A new committee to approve proposals was created, including a member of government. It was agreed that this format was better than placing a government official on the board of directors. For all partners, the desire to engage more closely was matched by the desire to maintain a degree of independence.

These developments in ACHAP’s fourth year represented significant progress for ACHAP’s relationships, especially with government. In late 2004, the government appointed a new Minister of Health and a new director for NACA, which provided an opportunity to reconstruct those critical relationships, in concert with the new project leader for ACHAP. These changes in organizational leadership along with the improved relationships among the core partners encouraged Merck and the Gates Foundation in December 2004 to extend their commitments to ACHAP for another 5 years, with the continued donation of two ARV drugs from
Merck and the remaining, unspent portion of the original $100 million financial commitment, which exceeded $56.5 million at the end of 2004 (Donnelly, 2005).

Lessons from the ACHAP experience

Theories and realities of building PPPs

The challenges faced by ACHAP in its first 4 years confirm the concerns of partnership studies about the vastly different values and practices of public and private agencies and the difficulties of building and sustaining multi-organizational collaborations (Austin, 2000; Barrett et al., 2002; Frost et al., 2002; Sagawa & Segal, 2000). We observed above how these differences created tensions in the ACHAP experience of becoming engaged with partners in Botswana’s fight against HIV/AIDS.

The ACHAP experience, however, highlights three difficulties with the significant planning and learning periods advised by various writers about partnerships, as discussed earlier in this paper. First, depending upon the urgency and importance of an issue, partners may want to accelerate the establishment of a PPP (and to adapt their behavior). For a small country such as Botswana, the adult HIV/AIDS prevalence of 38.5% (in 2000) was debilitating for the nation and its economy. In 2001, an estimated 110,000 people in Botswana were eligible for ARV treatment (NACA, 2003). The government received multiple forms of assistance in starting the ARV program.

A highly collaborative project seemed necessary to the three core partners, and they made special efforts to initiate the partnership. As discussed above, although the government had doubts and misgivings about ACHAP at various points, officials chose not to raise their concerns in the interest of making progress in the fight against HIV/AIDS. High-level Merck executives became closely involved in the overall management of ACHAP, especially in the project’s first year.

Second, the step-by-step planning approach does not take into account the sudden changes that can occur within partner organizations and working environments. Partnerships are subject to surprises, especially in dealing with complex issues such as HIV/AIDS, where much knowledge remains unknown about the disease process and social responses. For example, ACHAP focused substantial energy on supporting the government’s ARV program, which unexpectedly met with subdued enthusiasm from the general population. Further, NACA was set up only a short time before ACHAP and was following its own learning curve and organizational growth. The interaction between NACA and ACHAP would have been difficult to plan with certainty, as NACA and its leadership were new to government as well.

Third, the emphasis on step-by-step planning ignores the potential for organizations to learn and adapt as they proceed. “Learning organizations” have mechanisms for knowledge acquisition, information distribution, and information interpretation and can thereby change their strategies and activities over time (Huber, 1991). The capacity of ACHAP to learn and adapt to the government and to HIV/AIDS in Botswana is central to explaining its ability to implement a wide range of programs and make positive contributions, particularly in ACHAP’s second, third, and fourth years. It also explains the current positive relationship between ACHAP and government (based on new leadership, new structures, and new commitment) and the hopes for ACHAP in the future.

ACHAP’s efforts at managing relationships provide an important set of experiences for the field of PPPs. Below, we identify five potential lessons, based on the ACHAP experience, about how partners can build more effective collaborative relationships.

Understand your partner’s values

A first key lesson is for partners to understand the key values that motivate other partners. A substantial literature on building partnerships in the field of international business emphasizes the importance of understanding the culture of one’s business partner (Hofstede, 1994; Trompenaars & Hampden-Turner, 1997). The same holds for PPPs in health. Yet private corporations engaged in partnerships have not always understood the complex social realities and value systems of public-sector organizations. Similarly, Asthana, Richardson, and Halliday (2002, p. 789) found that differences in organizational culture contributed to delays in making joint decisions in Health Action Zone partnerships in the United Kingdom. In Botswana, the government, as we noted above, gives great attention to consultation and consensus-building in the process of decision-making. Botswana’s own colonial experience and the history of Southern Africa have left the people of Botswana
wary of foreigners who do not show an appreciation of local values and ways. ACHAP learned about these social realities over time. The meeting between ACHAP’s Board of Directors and high-ranking government officials in 2004 and the change of project leadership to a local person both reflected this learning about values.

Commit to building relationships at the technical and operational levels

A second lesson is that partners need to make a firm commitment to building relationships at the technical and operational levels relevant to the partnership. Senior-level engagement in partner organizations is critical to establish credibility, initiate collaboration, and demonstrate commitment. At the same time, strong relationships with technical and operational staff, at the middle and lower levels of an organization, are critical for successful implementation of programs and ongoing continuity. This lesson finds resonance in the broader literature on PPPs. The study by Asthana et al. (2002, p. 790, 792), e.g., noted the importance of involving frontline staff in planning and decisions, in order to promote consensus about implementation, and the role of informal networks among key strategic actors, as a means of addressing big issues that are difficult to address in formal settings.

Construct the partnership as a learning process

Partners must understand collaboration as a learning process rather than an organizational structure (Widdus, 2001). Each partner needs to be willing to develop and utilize mechanisms for learning about the partnership and be willing to adapt behavior. Formal or informal mechanisms that promote regular information-sharing within each partner organization as well as between partner organizations are critical. Shortell et al. (2002) include the ability to “take corrective action or change direction as needed” as one of the six key governance and management characteristics of partnerships. ACHAP could have made greater efforts to institute such learning mechanisms. ACHAP’s shortcomings in its early phases were partly influenced by the lack of awareness among some ACHAP staff of the particular values of government in Botswana, as we noted above. ACHAP also received little support from government officials on comprehending and navigating the government’s processes and thinking, partly because of the absence of appropriate mechanisms for sharing information at different levels of partner organizations.

Build a portfolio of diverse activities

A fourth lesson, particularly where partners have little prior experience with each other, is to initiate a range of different activities within the partnership. A broad portfolio of activities can improve the chances for success, since some activities may work while others will fail for reasons external to the partnership. ACHAP’s comprehensive approach to HIV/AIDS, enabled by its vast resources, allowed it to engage in different kinds of interventions. The achievements in high-profile government programs (such as the ARV program) helped build government’s trust in ACHAP and helped create relationships of collaboration and trust.

Expect stress in partnership relationships

Finally, partners must expect stress in highly collaborative PPPs. Indeed, while the above lessons can improve the quality of relationships among partners, public and private organizations are still motivated by different values and operational procedures. In their analysis of 25 community partnerships, Shortell et al. (2002, p.75) found that the more successful organizations were those with the ability to anticipate, manage, and channel conflict. As ACHAP’s present project leader stated, even at a time when the environment in Gaborone is hopeful about ACHAP’s prospects, “It is a daily challenge to get government to think differently and more like us.”

Conclusions

The ACHAP experience shows how the core partners became increasingly sensitive over time to the importance of partnership relationships as a central element in planning and implementing ACHAP activities in Botswana. This paper does not systematically link the processes of relationship management to particular program outcomes for ACHAP. We believe, however, based on this in-depth study of ACHAP’s experiences, that constructive relationships among partners can contribute positively to effective programs and that difficulties in these relationships can hinder the planning and implementation of effective AIDS control efforts. Building constructive relationships is central to the effectiveness of partnerships, but is not easy. It requires ongoing, conscious planning.
and continuing efforts, including the creation of a partnership learning process. Additional research on the experiences of building relationships in other public–private partnerships for health will be useful in confirming findings presented here and in identifying a much-needed set of lessons on how to build effective relationships applicable to a wide range of public–private partnerships for health.

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