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Community-Academic Perspectives in Partnership Development: Lessons from Rural Senegal

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Key Findings

- **Ongoing partnership evaluation is key to improving partnership functioning.**
- **The Partnership Self-Assessment Tool (PSAT) can be used to evaluate partnership processes and sustainability over time.**
- **Collaborative processes can be assessed based on several factors including: synergy; leadership effectiveness; efficiency; effectiveness of administration and management; and sufficiency of financial, non-financial, and other capital resources.**
- **Over the two-year reporting period, the Global Health Community Partnership (GHCP) showed improvements in all but the financial and non-financial resources factors.**
- **The leadership and administrative factors had the greatest improvements.**
- **The leadership and synergy factors ranked highest among all factors.**
- **Partners' self-reported participation over time indicates increasing satisfaction and benefits outweighing drawbacks.**
- **The GHCP has great opportunity to maximize its collaborative potential.**

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Background

Partnership Research Site in Kedougou Region of Senegal

Senegal, a low-to-middle-income country (LMIC) in West Africa, ranks 15th in incidence of cervical cancer worldwide with 4.43 million women aged 15 years and older at risk for disease development.[1] It is the most frequent cancer among all women, including women aged 15-44 years.[1] Annually, cervical cancer results in 1,482 new cases and 858 deaths.[1] Increasingly, LMIC health systems are leveraging health services and strengthening partnerships between academic centers and low resource community health systems to address capacity shortages and other barriers to health services access, including cervical cancer screening and treatment.[2] These global health partnerships can benefit health services quality, improve retention and attrition rates, and impact service sustainability.[2-7] Partnerships can benefit by incorporating monitoring practices, including reflection on partnership dynamics, as a way of ensuring equitability and reciprocity within the relationship.[8]

In 2010, the Global Health Community Partnership (GHCP) formed among the Kedougou Regional Medical Director in Southeastern Senegal; Peace Corps Senegal; the Institute of Health and Development at Cheikh Anta Diop University, Dakar, Senegal; and the University of Illinois at Chicago (UIC).[9] The purpose of this partnership was to improve access to quality primary health care services, including cervical cancer prevention, within the existing local health care system.[10] By identifying local priorities and health service gaps, Kedougou health leaders and health workers sought to improve access to quality cervical cancer prevention services by strengthening the health care workforce and delivery systems in the Kedougou region and informing the development and implementation of cervical cancer prevention programs in other rural regions of Senegal.[11] At the local level, GHCP was initially composed of a community advisory board comprised of representatives from the local health committee, women's groups, and other community leaders. This board dissolved in 2013, and was

replaced with bi-annual GHCP meetings. These meetings were attended by community and health service representatives from the project sites as well as local health system leaders, Peace Corps volunteers, and academic partners. Activities at the GHCP meetings included reporting of activities and findings, partnership evaluation, problem solving, strategic planning, and policy discussions.

Between 2010 and 2013, GHCP worked to build capacity across Kedougou to ensure access to an estimated 9,041 women in the targeted age group (30 to 50). By the end of 2014, the partnership implemented regional-level cervical cancer clinical guidelines, introduced the EngenderHealth-developed Client Oriented Provider Efficient (COPE®) quality improvement process for cervical cancer and general health services,[12-14] trained 63 health workers (mostly midwives) in the evidence-based screening technique of visual inspection of the cervix with acetic acid (VIA),[15] conducted a study to estimate the prevalence of cervical dysplasia in the region using VIA, and assessed risk factors for cervical cancer control.[16]

The objective of this research brief is to provide evaluation information on the partnership process and sustainability by examining the strengths, weaknesses and overall partnership quality over a two-year time period (September 2015-2017).

Data and Methods

The GHCP's processes and sustainability were evaluated based on the Partnership Synergy Framework's assessment tool, the PSAT.[17] The PSAT was utilized to collect partnership members' opinions of the process and collaborative functioning of the partnership. Indicators of success of the collaborative process were assessed through eight key areas using a 1-5 (low to high) point scale:

- Synergy
- Leadership
- Efficiency
- Admin & Management
- Sufficiency of Resources
- Decision-Making Processes
- Benefits vs. Drawbacks
- Satisfaction

Completion of the PSAT varied over time according to the attendance rate of participants at GHCP meetings. On average, 20 partners attended the two-day meetings. Data were collected five times between 2015-2017 at biannual GHCP meetings for a total of 110 responses. Scores were calculated using means and frequencies, which determined the overall score and placed the partnership factors into one of four domain zones. The zone category provides guidance for ways to improve the functioning of the partnership (See FIGURE 1).

FIGURE 1 **Key to zone findings/interpreting domain scores**

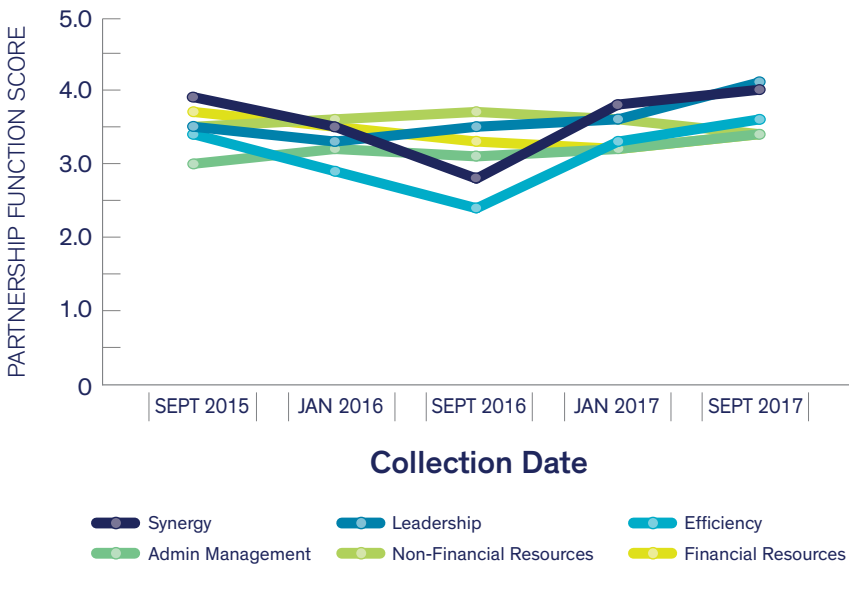
Danger Zone: (1.0-2.9)	Area needs a lot of improvement
Work Zone: (3.0-3.9)	More effort is needed to maximize collaborative potential
Headway Zone: (4.0-4.5)	Although the partnership is doing pretty well, it has the potential to progress further
Target Zone: (4.6-5.0)	Partnership currently excels in this area and should focus on maintaining current status

*Reproduced from the National Collaborating Centre for Methods and Tools.[17]

Partners' Views on Partnership Function

- Four of the six trend lines show change and improvement over time (synergy, leadership, efficiency, administrative management).
- The two 'resources-oriented' trend lines show a decrease over time with the financial resources factor decreasing more than the non-financial resources factor.
- The leadership factor had the greatest improvement, followed by administrative management, efficiency, and synergy factors.
- Over time, most trend lines were within the 'Headway' or 'Work' Zone domains. However, in September 2016, efficiency and synergy scores fell into the 'Danger Zone'.

FIGURE 2 **GHCP* Partners' views on partnership function factors over time**



*GHCP = The Global Health Community Partnership

Most recent GHCP PSAT Scores, Sept. 2017

- Both the leadership and synergy factors improved from the 'Work' Zone to the 'Headway' Zone category.
- The progress in the leadership and synergy factors suggests that the partnership is continuing to mature with productive interactions among participating members and organizations.
- The other four factors were categorized in the 'Work' Zone.

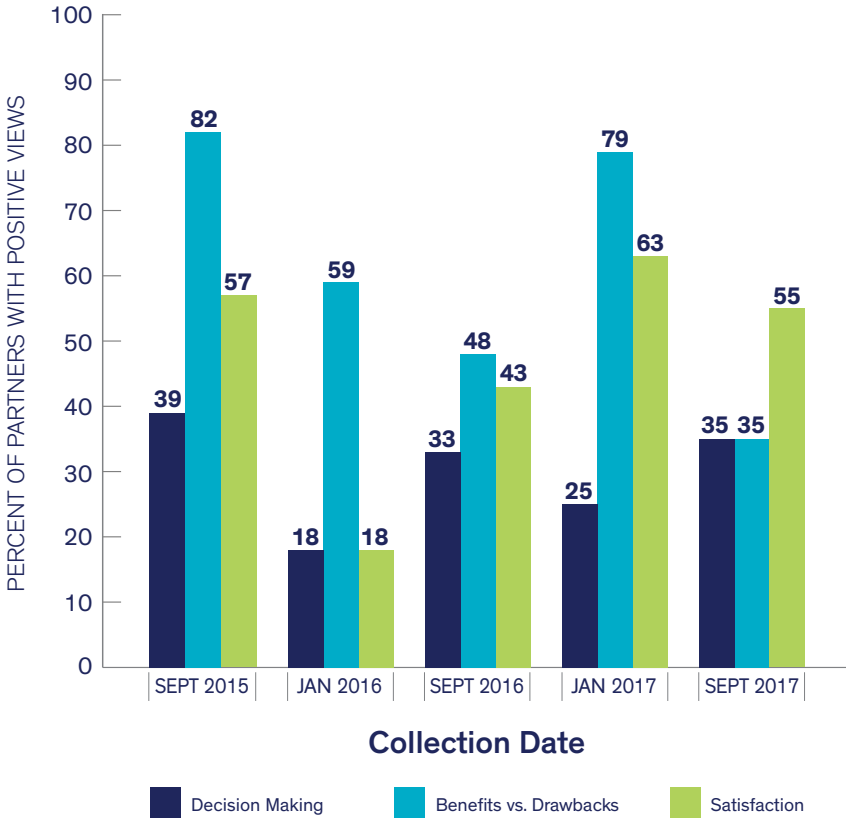
FIGURE 3 **Status of partnership functioning factors from latest GHCP* meeting, September, 2017**

Synergy Accomplishing more together than alone	**Headway Zone: (4.0)**
Leadership Promotion of productive interactions among diverse people and organizations	**Headway Zone: (4.1)**
Efficiency How well the partnership optimizes the involvement of its partners	**Work Zone: (3.6)**
Admin & Management Effectively facilitating activities such as communication, management of funds, analytic support, and minimizing barriers	**Work Zone: (3.4)**
Non-Financial Resources Sufficiency of resources including: skills and expertise; data and information; connections to particular people, organizations, and groups; and convening power	**Work Zone: (3.4)**
Financial Resources Sufficiency of financial and other capital resources including: space, equipment, and goods because they are essential for carrying out specific program activities	**Work Zone: (3.4)**

Partners' Views on Their Own Participation

- Overall, the highest percentages of partners' positive views occurred in the benefits vs. drawbacks category in three of the five partnership meetings (82%, 59%, 79%).
- Similarly, partners' positive views were reported in the overall satisfaction category in three of the five meetings (57%, 63%, 55%).
- However, participants consistently reported relatively low levels of positive views with respect to their individual decision-making in the partnership across all five partnership meetings (39%, 18%, 33%, 25%, 35%).

FIGURE 4 **GHCP* partners' views on their own participation over time**



*GHCP = The Global Health Community Partnership

Summary

This study provides evidence on the importance of conducting ongoing partnership evaluations to improve partnership functioning, strengthen partners' views of their participation, and ensure partnership equity. The PSAT is an evaluation tool that is user-friendly and provides the partnership with easy-to-understand status reports and areas for improvement. As partnerships work their way through the maturation process, partners' self-assessment of the collaborative process and their individual level of participation should change and improve. The evaluation of the current GHCP aligns with these expectations and reveals several areas for improvement, particularly with regard to both financial and non-financial resources. Turnover of partners and increasing demands put on the local health workforce due to malaria, Ebola, and diabetes shift focus away from cervical cancer. The local health workforce in Kedougou is also unstable as staff are often dispatched to other areas of the country in response to emergent health crises. Despite these workforce challenges, a majority of the GHCP partners have been with the project since 2010.

In September 2016, funding for all Prevention Research Center global health projects supported through the Global and Territorial Health Research Network was discontinued. The low 'Danger' zone scores and lower self-assessed participation views obtained at the September 2017 GHCP meeting may be related to this loss of funding. Likewise, the general concern about financial and non-financial resources identified in the evaluation are likely linked to the change in funding status. The increases in factors associated with leadership, synergy, efficiency, and administration and management are positive indicators for the GHCP leadership team as are the positive trends in partners' self-assessed satisfaction and benefits outweighing drawbacks. Finally, given that the GHCP has yet to achieve 'Target' Zone status using the PSAT, much work needs to be done. The partnership work continues, guided by the proverb: "If you want to go quickly, go alone. If you want to go far, go together."

References

1. Institut Catala d'Oncologia (ICO). 2016. Senegal: human papillomavirus and related cancers, fact sheet 2016. Retrieved April 17, 2016, from http://www.hpvcentre.net/statistics/reports/SEN_FS.pdf
2. Muir J, Farley J, Osterman J, Hawes A, Martin S, Morrison K. Global Health Programs and Partnerships: Evidence of Mutual Benefit and Equity. Rowman & Littlefield; 2016, p. 102.
3. Peters DH, Tran NT, Adam T. Implementation Research in Health: A Practical Guide [Internet]. World Health Organization; 2013. Available: http://who.int/alliance-hpsr/alliancehpsr_irpguide.pdf
4. Dieleman M, Shaw DM, Zwanikken P. Improving the implementation of health workforce policies through governance: a review of case studies. Hum Resour Health. 2011;9: 10. doi:10.1186/1478-4491-9-10
5. Gilson L, Mills A. Health sector reforms in sub-Saharan Africa: lessons of the last 10 years. Health Policy. 1995;32: 215–243.
6. Jeppsson A, Okuonzi SA. Vertical or holistic decentralization of the health sector? Experiences from Zambia and Uganda. Int J Health Plann Manage. 2000;15: 273–289. doi:10.1002/hpm.597
7. Smith BC. The decentralization of health care in developing countries: organizational options. Public Adm Dev. Wiley Periodicals Inc.; 1997;17: 399. Available: http://search.proquest.com/openview/8a0baaefc72c1d9a7e06b6f389991f4a/1?pq-origsite=gscholar
8. A. de-Graft Aikins, D. Arhinful, E. Pitchforth et al. Establishing and sustaining research partnerships in Africa: a case study of the UK-Africa Academic Partnership on Chronic Disease. Globalization and Health. 2012: 8: 29.
9. Huezo C, Diaz S. Quality of care in family planning: clients' rights and providers' needs. Adv Contracept. 1993;9(2):129-39.
10. Peace Care. (2015). Peace Care | Kedougou & Sedhiou, Senegal. Retrieved April 17, 2016, from http://peacecare.org/better-partnerships/cause-medium-witout-sidebar/kedougou-sedhiou-senegal/
11. Dykens, A., Hedrick, C., Ndiaye, Y., & Linn, A. (2014). Peace Corps partnered health services implementation research in global health: opportunity for impact. Global Advances in Health and Medicine Journal, 3(5), 8-15. DOI: gahmj/10.7453/2014.031
12. Alliance for Cervical Cancer Prevention (ACCP). 2004. Planning and implementing cervical cancer prevention and control programs: a manual for managers. Seattle: ACCP
13. EngenderHealth. COPE Handbook: A Process for Improving Quality in Health Services ® Revised Edition. EngenderHealth; 2003.
14. EngenderHealth. COPE for Cervical Cancer Prevention Services: A Toolbook to Accompany the COPE Handbook ® EngenderHealth's Quality Improvement Series. EngenderHealth; 2004.
15. Sauvaget C, Fayette JM, Muwonge R, Wesley R, Sankaranarayanan R. Accuracy of visual inspection with acetic acid for cervical cancer screening. Int J Gynaecol Obstet. 2011;113(1):14-24.
16. Dykens JA, Linn AM, Irwin T, Peters KE, Pyra M, Traoré F, et al. Implementing visual cervical cancer screening in Senegal: a cross-sectional study of risk factors and prevalence highlighting service utilization barriers. Int J Womens Health. 2017 Jan 27;9:59–67.
17. National Collaborating Centre for Methods and Tools. (2008). Partnership evaluation: The Partnership Self-Assessment Tool. Hamilton, ON: McMaster University. (Updated 04 January 2018) Retrieved from http://www.nccmt.ca/knowledge-repositories/search/10

SUGGESTED CITATION

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