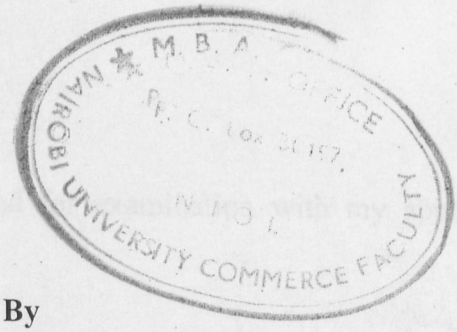
Creation and Implementation of Strategic Alliances among Non Governmental Organisations: A Case Study of Gedo Health Consortium



By

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DECLARATION

This management project is my original work and has not been presented for a degree in any other University.

Signed:---------- Date: 8/11/03

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This management project has been submitted for examination with my approval as University Supervisor.

Signed:---------- Date: 7/11/2003

Prof. Evans Aosa

DEDICATION

This study is dedicated to my family; my mother Grace Katumbi Musyoki and father Alexander Shem Musyoki, to my brothers Christopher Kimanthi and Benjamin Mutinda and my fiancé Jonathan Thomas.

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It was always my dream to have a master's degree, though the MBA programme turned out to be more demanding than I had initially visualised. I am deeply indebted to all those people who, either directly or indirectly, individually contributed to the successful completion of this project. I would like to express my sincere gratitude to all those who contributed in one way or another.

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ABSTRACT

Strategic alliances are often born out of the need of member organisations to position themselves better in terms of sourcing funds, and the need to share skills and resources that may be lacking in one organisation, if it were to stand alone. Such alliances give the organisation a better position in terms of image, shared experience and knowledge. Gedo Health Consortium was formed by an alliance of three NGOs and has become the management wing of the three partners Trocaire, Cordaid and AMREF.

This is a case study of Gedo Health Consortium carried out in July and August 2003. The objective of the study was to establish the nature of the strategic alliance and document the implementing experience of all three partners. The data was collected though an open-ended questionnaire and then analysed through content analysis, by comparing the data from the data collection instruments.

The study established that the three partners of Gedo Health Consortium had unsystematically undertaken certain steps towards the creation of the alliance. The partners had been collaborating in training and other areas of common interest for several years. The initiative was proposed by three programme managers working within the three organisations, who developed the idea from a concept into a proposal, which was acceptable to the three organisations.

The study also established that the initial stages of implementation have been filled with many teething problems, of which the alliance is still putting in place strategies to deal with. It was established that there is an urgent need to finalise and sign a comprehensive document, which binds the relationship of the three partner organisations and gives direction to the way forward. Further there is a need for co-operation, co-ordination and communication of the different organisational cultures, which affect the direction and decisions of the alliance.

It would be recommendable for the alliance members to have an external evaluation of the programme. This will address the management challenges, which affect attainment of the objectives of the alliance. The study found out that success of the working arrangement will depend heavily on strategically planning the overall management and direction of alliance. However, it was not established to what extent these deficiencies have affected the alliance. Therefore there is need for further study to be conducted on the long-term implementation process of the strategic alliance and its impact on the three partners. There is also need to study how the alliance management is influenced by the differences in organisational culture among the partners in the alliance.

FIGURES

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CHAPTER 1. INTRODUCTION

1.1 Background

1.1.1 Strategic Alliances

Hunger and Wheelen (1999:5) define a strategic alliance as a partnership of two or more corporations or business units to achieve strategically significant objectives that are of mutual benefit. Alliances between companies or business units have become a fact of life in modern business. Some alliances are very short term, only lasting long enough for one partner to establish a beachhead in a new market. Others are longer lasting and may even be the prelude of a full merger between two companies.

Companies or business units (organisations) may form a strategic alliance for a number of reasons, which include: to obtain technology and/ or manufacturing capabilities, obtain access to specific markets, reduce financial risk, reduce political risk and achieve or ensure competitive advantage. Co-operative arrangements between companies and business units fall along a continuum from weak and distant to strong and close. The types of alliances range from mutual service consortia to joint ventures and licensing arrangements to value chain partnerships (Hunger and Wheelen, 1999:5).

Further, according to Hunger and Wheelen (1999:13) strategic alliances involve developing co-operative ties with other organisations. Alliances are often used by not-for-profit organisations as a way to enhance their capacity to serve clients (target groups) or to acquire resources while still enabling them to keep their identity. Services can be purchased and provided more efficiently through co-operation with other organisations than if they were done alone. For example, four Ohio Universities agreed to create and jointly operate a new school of international business. Alone, none of the business schools could afford the $30 million to build the school.

1.1.2 NGO Working Alliances

This kind of partnership usually emerges from the informal networking that occurs within the non-governmental organisation (NGO) community in a given country or in a given sector. NGOs may find it in their common interest to design and implement programmes jointly. They may also commit or mobilise resources collaboratively. This partnership arrangement is based on the shared belief that the effort of the whole is greater and stronger than the effort of many separate parts (Soros, 1997).

Soros (1997) further emphasises that NGO working alliances often act as an important voice within the donor community. Together, NGOs may be able to influence the priorities and programmes of governments and major agencies. Through collaboration, NGOs can leverage additional resources from major donors. NGO working alliances therefore offer a powerful, credible, and well-grounded implementation structure. They often find it necessary and beneficial to incorporate the views and efforts of community-based structures and stakeholders in their alliances. NGO working alliances may be organised loosely or in more formal associations, counsels, or consortia.

In collaborative programme design and implementation, partners see a common problem, priority, or need. They conceptualise and design a programme together and divide among themselves the tasks of delivering the programme. This arrangement can work effectively when there is little happening in a given area of activity, but there are two or more donors interested in addressing a need. Collaborative programme design and implementation often requires a lead partner or designated co-ordinator. Facilitation, co-ordination, and regular communication of the partners are crucial. This arrangement is more difficult when numerous donors have already developed their own programmes and established their own ways of working in a given area (Soros, 1997).

Comprehensive programme strategy and multi-donor financing, is where there is an arrangement involving multiple donors committing their resources and programmes to a broad, strategic aim. Such partnerships emerge around large efforts, such as a

humanitarian emergency response, a national reconstruction programme, the systematic reform of a sector, or a regional initiative. This type of partnership requires a broad vision and comprehensive planning. All donor partners are not necessarily involved in designing the effort. Often, a large international agency - with technical expertise or major funding capacity - takes the lead in preparing the strategy and implementation plan, in co-operation with the national government(s) most concerned. There is usually quite formal co-ordination of the donors in this partnership arrangement. Donor partners may commit a part of the funding required, implement a defined project within the broader scheme, or develop their own programme, as long as they serve the common aim. An example of this is the trend towards like-minded donors supporting the funding of sectoral wide approaches (SWAPs) in much of sub-Saharan Africa. Generally, the partners are not categorised by their level of contribution, but rather by their status as donors – international organisations, governments or NGOs. A crucial element in this arrangement is confidence of the various donors in the broad strategy and plan, in the lead agency, and in the involved government(s). It also requires excellent co-ordination, communication, and Cupertino. There can be frustration among partners, especially NGOs, because broad co-ordination and consensus building often delays implementation. This partnership arrangement can, however, eventually have a high impact (Soros, 1997).

1.1.3 Gedo Health Consortium Strategic Alliance

Gedo Health Consortium (GHC) is a consortium of three International Non-governmental Organisations (INGOs) namely, Trocaire, CordAid and AMREF, initiated in April 2001. GHC sought to combine and integrate three former health programmes of the three agencies such that they no longer directly implement health activities but act through GHC. The alliance is a logical extension of each of the projects run by the three INGOs. Gedo Region lies in the extreme south west of Somalia with a predominantly arid landscape and borders both Kenya and Ethiopia. Below is a brief outline of what each of the three organisations did in Gedo Region before the initiation of GHC (GHC, 2001).

Trocaire is an INGO with a Catholic background and originates from Ireland. Its mission is to work in partnership and solidarity in order to meet long-term development needs in

developing countries. Trocaire initiated programmes in various sectors including primary health care (PHC), education, water, community development awareness and temporary veterinary activities in Bulla Hawa and Dolo Districts of Gedo Region in September 1992. Trocaire then managed a 50-bed referral hospital, a mother and child health (MCH) centre, a cold chain, a static point and one expanded programme of immunisation (EPI) mobile in Bulla Hawa town. In Dolo District they supported an MCH with static point and one EPI mobile, as well as a total of 11 health posts. There were also ten traditional birth attendants (TBAs) and a nutrition programme supported in both districts (GHC, 2001).

African Medical Research Foundation (AMREF) is an NGO that originates from Kenya and provides a network of health-oriented activities throughout eastern and southern Africa. AMREF has supported the health programme in Luuq District, Gedo Region since 1983 as part of a development project. AMREF started the implementation of PHC activities in Luuq district of Gedo Region in 1983. Since then, AMREF has been a key player in that district apart from a brief suspension of its programme activities between 1991 and 1992 during which the Somali civil war was at its peak. AMREF managed one district hospital and sixteen health posts in the district. In addition AMREF replicated the Luuq project in Abuduwak and Balanbale districts of Galgadud region in May 1997 (GHC, 2001).

Cordaid is a merger of three Dutch Catholic NGOs originating from the Netherlands and provides support in the field of emergency, rehabilitation and structural aid. Cordaid has supported the health programme in Garba Hare and Burdhubo Districts, Gedo Region as part of a relief programme since 1992. During 1999 Cordaid's programme assumed a low profile due to insecurities in the districts. In 2000 as the security situation improved Cordaid continued implementing the health activities with a forty bed capacity hospital, two MCHs, ten health posts and two EPI mobile teams located in Garba Hare and Burdhubo Districts (GHC, 2001).

In 2000 UNICEF was supporting these three organisations separately. UNICEF provided supplies and cash assistance to implement their projects in Bulla Hawa, Dolo, (Trocaire), Luuq (AMREF), Garba Hare and Burdhubo (Cordaid) Districts. In terms of funding they were also each in receipt of individual funding from their own organisations and other major back donors (GHC, 2001).

The three organisations had also been working in close collaboration since the beginning through the Somalia Aid Co-ordination Body (SACB). In 1997 they jointly hired a training co-ordinator for the five districts they worked in. This collaboration was further seen as a positive move that initiated exploration of other areas of joint effort. In light of the prevailing situation and scarcity of resources the three organisations decided to pull their programmes together in 2000. The idea was realised after a series of discussions and seminars involving the three NGOs, donor agencies, SACB, local staff and the community leaders of the five districts (GHC, 2001).

1.1.4 GHC Alliance Direction

The overall goal of the GHC initiative is to improve the health status of the people of Gedo by providing a better health service, ensuring greater co-ordination among INGOs involved and enabling communities to utilise, manage, own and sustain their own health care system. Setting up one management structure rather than the three separate ones of each of the participating agencies is the first stage in rationalising the above (GHC, 2001).

The programme serves a local population estimated at 271,000 people in the Gedo Region. The health problems facing the communities include those of high child, infant and maternal mortality (among the worst globally), low immunisation coverage, female genital mutilation and water borne diseases. Coupled with this are the lack of trained medical personnel and facilities to provide services to the population. In the absence of governmental structures, the three NGOs comprising the consortium are the major providers of health services in the region.

1.2 Statement of the Problem

Organisations need good strategies to enhance their success. There are various strategies that are open to the organisations. The strategies chosen for implementation depend on factors such as leadership, resources available to the firm, and changes in the environment. Studies in strategy suggest that organisations need to seek strategic fit between their internal resources, i.e. their strengths and weaknesses, and their external environment, i.e. opportunities and threats (Andrews 1971). The external environment includes influences from the political, economic, social and technological arena. The internal environment includes systems, policies, resource capacity and corporate culture. In order to remain competitive, relevant and sustainable, organisations need to formulate and implement strategies that will balance the two environments.

The GHC strategic alliance was established in April 2001 to act as the executive arm of an inter-agency coalition working in the health sector in five districts of Gedo Region. The coalition members Trócaire, Cordaid and AMREF wish to jointly address problems that were hitherto addressed by three organisations acting separately. It was felt that by collaboration better results would be achieved, establishing a clear vision and strategy for their work in Gedo Region. This research will focus on this collaborative arrangement. It poses several questions: What motivated the alliance? What process was followed to create the alliance? What problems were faced and how well were they addressed? What do the partners feel about the alliance now?

1.3 Objective of the Study

This study aims at: -

1) Documenting the process followed in the formation of the strategic alliance.
2) Documenting the implementation experience of the Gedo Health Consortium strategic alliance.

1.4 Importance of the Study

The findings of this study will assist Gedo Health Consortium and her partners, as it will assist in analysing the emerging relationships between the three partners and how these may be cemented. Secondly, it will be important to the partners of GHC, as it will help them replicate the experience in their operations in other sectors. Third, it will be important to other NGOs, as a guide in establishing strategic alliances. And lastly, it will assist researchers and policy makers of strategy management.

1.5 Organisation of the Study

This research is organised in five chapters.

Chapter 1 consists of the background, the statement of the research problem and objective of the study and the importance the study.

Chapter 2 consists of literature review on strategy and strategic alliances.

Chapter 3 deals with aspects of research methodology, namely the population of study, data collection methods and instruments of data analysis.

Chapter 4 deals with research findings after data analysis was carried out.

Chapter 5 includes a summary of findings, conclusions and recommendations resulting from the study. The limitations in this research are highlighted as well as recommendation for further research.

CHAPTER 2. LITERATURE REVIEW

2.1 Strategy

Johnson and Scholes (1999: 10) define strategy as "the direction and scope of an organisation over the long term; which achieves advantage for the organisation through its configuration of resources within a changing environment, to meet the needs of markets and fulfil stakeholders expectations". The key issues raised by this definition are one, the direction the firm intends to take; second, the scope in terms of products/services and geographical outreach; third, the long-term nature of strategies and therefore, uncertainties in the future. The fourth issue is achievement of advantage, which suggests that performance is benchmarked to competition, while configuration of resources suggests co-ordination and integration of all available resources. The changing environment suggests that there is a dynamic environment that could be full of challenges that need to be managed effectively, while meeting the needs of the market suggests that firms are responsive to market demands. Finally, meeting stakeholders' expectations suggests that firms should balance the expectations of the owners, customers, society at large, employees and all the other stakeholders.

Johnson and Scholes (1999) further identify strategy at three levels. Corporate level strategy is concerned with the overall direction of the business, the vision, mission and the geographical scope. Business level strategies are concerned with the different portfolios and how to manage them to ensure sustainability. Operational level strategies are concerned with the delivery systems, procedures etc. It is at the corporate level that a firm will decide which relationships and alliances would give the business a competitive edge.

Sometimes, firms can operate alone i.e. without formal relationships with others and remain successful. Certain developments in the environment are however making it attractive for firms to enter into collaborative arrangements (Yoshino and Rangan, 1995:3).

2.2 Strategic Alliances

Strategic alliances involve co-operation between two or more firms who pool resources together to create value proposition for their customers and for themselves. Strategic alliances afford partners a higher likelihood of success than if a firm had to go alone. Strategic alliances create synergy for the partners through sharing resources and capacities (Koigi, 2002).

The term "strategic alliances" is usually used interchangeably with "corporate coalition", "strategic partnerships" and "competitive alliances" in various literatures. For the purpose of this study however, we will use the term strategic alliance to mean co-operative arrangements between two or more firms. The partners in the alliance seek to add to their competencies by combining their resources with those of the other firm, with a commitment to reach agreed goals. This creates synergy (Yoshino & Rangan, 1998).

Channon (1999: 239) defines strategic alliances as coalitions and co-operative agreement, formed between a corporation and others in order to achieve certain strategic goals. Strategic alliances have been formed to facilitate entry to new markets or to reduce operational costs. Entry to new markets takes place where an overseas company makes an alliance with a home company while reduction of operational costs occurs due to sharing of resources and through economies of scale and scope.

Kanter (1997) argues that strategic alliances between companies, whether they are from different parts of the world or different ends of a supply-chain are a fact of life in business today. While some are short lived and others long term, Kanter argues that irrespective of the duration and objective of business alliance, being a good partner has become a key corporate asset and she calls this a company's collaborative advantage.

Kautz (2000) defines strategic alliance as partnership in which firms combine efforts of anything from getting a better price for goods by buying bulk or seeking business together with each firm providing part of the product. This is done to minimise risks

while maximising the company's leverage. Kautz further defines strategic alliances as business to business collaborations which could be entered for joint marketing, joint sales, product design collaborations, technology licensing and R&D. Strategic alliances can be vertical relations between customer and vendor, or horizontal between vendors, whether local or global. She distinguishes strategic alliances from mergers, acquisitions and outsourcing as these are permanent, structural changes in how a company exists and outsourcing is a way of purchasing functional service for the company. This differentiation is crucial, as usually there is confusion as to the scope of strategic alliances.

Another view of looking at strategic alliances is through the resource-based rationale by Das (2000), which emphasises value maximisation for a firm through pooling and utilising of valuable resources. The resource-based view suggests that valuable firm resources are usually scarce, imperfectly imitable, and lacking in direct substitutes. This therefore makes the trading and accumulation of resources a strategic necessity but when efficient market exchange of resources is possible, firms are more likely to continue alone without alliances. Therefore the resource-based approach "considers strategic alliances and mergers as strategies used to access other firms' resources, for the purpose of garnering otherwise unavailable competitive advantages and values to the firm" (Das, 2000: 5).

Contractor and Lorange (1988) give yet another theoretical definition of strategic alliance. Their definition is based on degree of interdependency between parties involved. Interdependence is found to be high in joint venture, mergers and acquisition where the options are hard to reverse due to the financial implications involved. Low interdependence alliances, i.e. informal co-operation or formalised co-operative ventures, are easy to reverse. Examples of low dependence temporal alliances are the seasonal holiday offers organised by airlines and hotels during off-peak seasons.

According to Lorange & Roos (1999), the normal trend is for strategic alliances to start from the less committed mode to a more binding relationship over time. In the final

analysis, the partners should benefit both financially and strategically from the relationship.

Johnson and Scholes (1997) summarised the different forms of alliance that exist and how different factors might influence the form of the alliance, (Figure 1).

Table 1: Types and Motives for Strategic Alliances

	Loose (market) relationships	**Contractual relationships**	**Formalised ownership/ Relationship**	**Formal integration**
Forms of Alliance	Networks Opportunistic alliances	Subcontracting Licences and Franchises	Consortia Joint ventures	Acquisition and Mergers
Influences Asset management	Assets do not need joint management	Asset management can be isolated	Asset needs to be jointly managed	
Asset separability	Assets cannot be separated	Assets/skills can be separated		Assets cannot be separated
Asset appropriability	High risk of assets being appropriated	Low risk of assets being appropriated		High risk of asset appropriation

(Source Johnson and Scholes (1997) pg. 311)

2.3 New Dimensions of Strategic Alliances - Competitiveness and Co-operation

In Yoshino & Rangan (1995), strategic alliance is defined through the facets that link businesses of two of more firms. At the core of this link is a trading partnership that

enhances the effectiveness of the competitive strategies of the partner firms by providing for mutually beneficial trade of technological skills or products.

In recognition that varied interpretation of the term exists, Yoshino & Rangan (1995) further define strategic alliance as possessing simultaneously the following three *necessary* and *sufficient* characteristics. First, the two or more firms that unite to pursue a set of agreed goals remain independent subsequent to the formation of the alliance. Second, the partner firms share the benefits of the alliance and control over the performance of the assigned tasks. This is thought to be perhaps the most distinctive characteristic of alliances and the one that makes them difficult to manage. Third, the partner firm contributes on a continuous basis in one or more key strategic areas e.g. technology, products etc.

By adding the above two characteristic of *necessity and sufficiency* to the definition of strategic alliance, relationships previously thought to be strategic alliances are now excluded, e.g. mergers, take-overs and acquisitions. Subsidiary companies are seen not to constitute strategic alliances because they do not involve independent firms with separate goals. The subsidiaries are seen more or less as tactical or reactive response by multinationals to host government pressures.

According to this new thinking, Yoshino & Rangan (1995) classify most of the strategic alliances of the 1990s as new alliances. New because even the big firms who earlier on thought they could go it alone found themselves entering into such alliances due to the increased rate of globalisation. Giants like International Business Machines (IBM) and General Motors (GM) realised that even giants need alliances in the new business environment. The strategic alliances required new managerial skills because they crossed national boundaries. These alliances were formed between rivals, which was previously unthinkable, and were also formed in areas that were thought to be unrelated. They required new managerial skills because they combined both co-operative and competitive elements in an environment of shared control.

This new thinking by Yoshino & Rangan (1995) on strategic alliances is refreshing because it brings out clearly the contradictions and confusion as far as the strategic alliance concept is concerned. Some other scholars view strategic alliances in terms of co-operation only, totally omitting the competitive elements in such relationships. Pelmutter and Heenan (1986), view strategic alliances in terms of co-operation. The work of managers is seen as working towards maintaining harmonious relationships. Ohmae (1989) sees strategic alliance in terms of harmonious relations and minimises the notion of competition in his studies about strategic alliances in Japan.

In Yoshino & Rangan (1995), the strategic alliance manager's key role is seen to be to learn from the alliance and to use this learning to gain in the market at the expense of the partner. Strategic alliance managers are therefore required to be alert and to view strategic alliances as "Trojan horses" to be avoided at all costs. There is a contradiction here as it is seen as a chance to gain competitive advantage but is to be avoided.

These definitions of strategic alliance assume that the prospective partners have a shared point of view. In reality however, each partner has its own perspective of the strategic situation or intent. Strategic intent differs from one firm to another even though the firms are in the alliance. This then brings challenges to strategic alliances and it therefore becomes important to study what drives firms to enter strategic alliances, and how they deal with differences in the strategic intent.

Again, Doz and Hamel (1998) see strategic alliances in terms of the "New Alliance Game" and value creation. They also view strategic alliances as not an option, but a necessity for firms who want to be at the cutting edge. They further identify "capacity to collaborate " as a core competence to be developed by all firms. A number of common characteristics of strategic alliances are identified. Initially there is great uncertainty and ambiguity; secondly, the manner in which value is created, and the way partners capture it, is not pre-ordained. Third, the partner relationship evolves in ways that are hard to predict. Fourthly, today's ally may be tomorrow's rival, or may be the current rival in some other market. Fifth, managing the alliance relationship over time is usually more

important than crafting the first formal agreement. Lastly, initial agreements have less to do with success than does adaptability to change. From the above, it is observed that strategic alliances are dynamic relationships and should be well managed.

2.4 Post Entrepreneurial Model

Among the new paradigms in organisation theory is what is called the post-entrepreneurial model propagated by Kanter (1989). Kanter calls for revolution in business management to create what she calls post-entrepreneurial organisation, mainly because it takes entrepreneurship a step further by applying entrepreneurial principles to the traditional corporation and creating a marriage between entrepreneurial creativity, corporate discipline, co-operation and team work.

Kanter argues that organisations have to be flexible enough - and even the big corporate giants need to learn how to dance - to form alliances if they have to, to survive in an increasingly competitive and rapidly changing world. Kanter argues further that the post-entrepreneurial organisation will pursue three main strategies. First, restructure and find strategies. Second, open boundaries to form strategic alliances, and finally, create new ventures from within, encouraging innovation and entrepreneurship.

When thinking of an organisation through restructuring and outsourcing of some functions, there will be a need to pool resources together and exploration of opportunities will take place in three forms. One, through service alliance - to take special projects with a limited life span e.g. R&D. Two, through opportunistic alliance, comprising of joint ventures to take advantage of an opportunity to enhance competencies - Kanter argues that such alliances are not always equally beneficial to all partners and are vulnerable to dissolution. Finally, stakeholder alliance, which is a more permanent arrangement made with key stakeholders like suppliers and customers working with the firm as partners. The result of these alliances is that structures and positions within the organisation change and managers see their roles and responsibility change to working

closely not only with internal colleagues, but also with external groups. These relationships influence cultural change.

Thomas & Strickland (1993) argue that the strategic alliance is one means of increasing resource capacity through external emphasis. They argue that this alternative facilitates a firm to extend its strength into competitive arenas that it would be hesitant to enter alone. A partner's functional capacity and contribution can reduce the firm's investment significantly, thus gaining more from little.

2.5 Generic Motives for Strategic Alliances

Lorange & Roos (1999) have provided a framework to analyse why firms enter into strategic alliances. One way of looking at the strategic importance of the particular business within which the alliance is being contemplated, within the overall portfolio of the firm, is to ask the question: Is the product a core business or a peripheral?

The second dimension is in regards to the firm's relative position in the industry, whether it is a leader or a follower. This results in four generic motives for strategic alliances as follows. Initially, defend the market when you are a leader and the business is core to the operations. Second, remain if a leader and the business is peripheral. Third catch up, if you are a follower and the business is core, and lastly, restructure if a follower and the business peripheral. Firms will therefore seek alliances depending upon the strategic position, direction and in whether the business is core or peripheral.

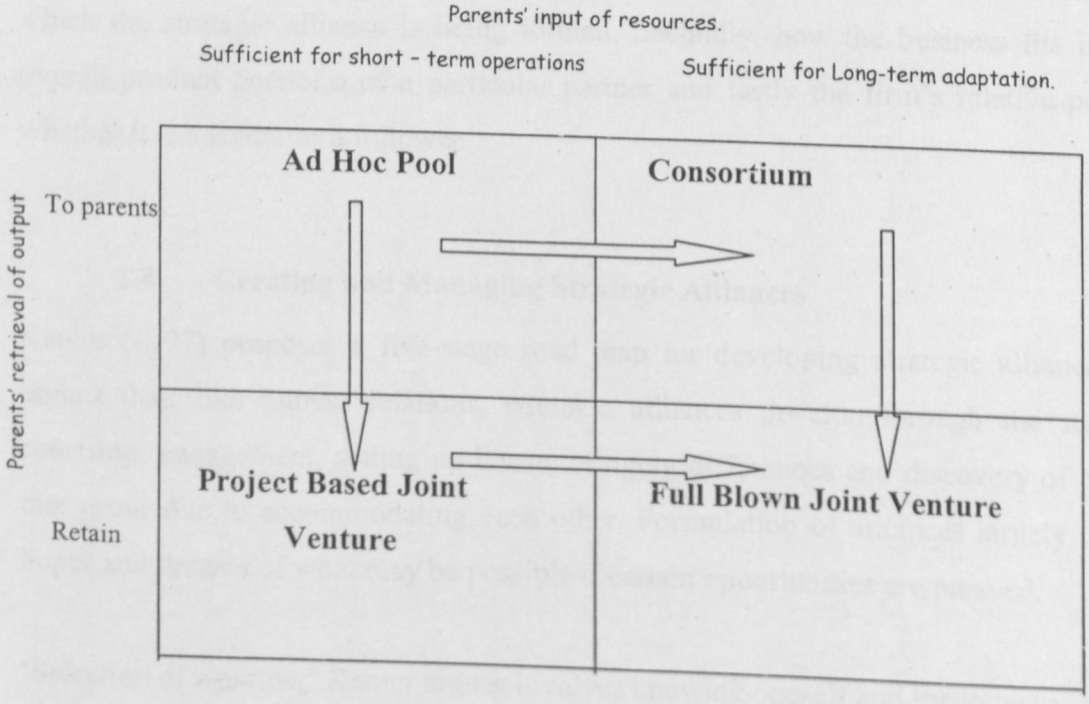
2.6 Evolution of Strategic Alliances – A Generic Model

Lorange & Roos (1999) argue that evolution of strategic alliance can be looked at from a generic model with four archetypes. First is the evolution of ad hoc pool strategic alliance, where only minimum resources are invested in the alliance. Second, evolution of consortium strategic alliances, where relatively more resources are given to the alliance and there is more commitment. Third, evolution of project based joint ventures, where resources in the alliance are restricted only to the project. And lastly, evolution of full-

blown, joint venture strategic alliances, where the alliance tends to be larger and involves accumulation of resources over time.

Evolution can also occur within alliance archetypes. The evolution can be from ad hoc pool to project based or from project based to full blown or consortium to full blown as shown in the Fig.2 below.

Figure 1: Strategic Alliance Evolution Within Archetypes.



(Source Lorange & Roos Pg. 11)

The strategic alliance partners are expected to manage this evolution well in order to maximise on benefits.

2.7 Objectives of Strategic Alliances

The primary purpose of any strategic alliance can be said to fall under the following objectives. These include co-option, co-specialisation, learning and internalisation. Co-

option turns potential competition into allies and effectively neutralises the potential rivalry. Firms with complementary goods to contribute are wooed into a network of economics. Co-specialisation is the synergistic value creation that results from combining previously separate resources, skills, knowledge source etc. Alliances can also become an avenue for learning and internalising skills especially those that are tacit, collective or embedded (Doz & Hamel, 1998).

Likewise, in order to understand the objectives of a particular strategic alliance we need to look at three factors. First, the strategic importance of the particular business within which the strategic alliance is being formed. Secondly, how the business fits into the overall product portfolio of a particular partner and lastly the firm's relative position, whether it is a leader or a follower.

2.8 Creating and Managing Strategic Alliances

Kanter (1997) proposes a five-stage road map for developing strategic alliances. She argues that, like human relations, strategic alliances develop through the stages of courtship, engagement, setting up house, bridging differences and discovery of changes that occur due to accommodating each other. Formulation of alliances largely rests on hopes and dreams of what may be possible if certain opportunities are pursued.

'Selection of a partner' Kanter argues involves knowing oneself and the industry well and evaluating the possible partners. This involves the rapport between executives within the prospective partners and their compatibility on strategic grounds, principles and hopes for the future.

'Getting engaged' refers to getting other people involved in the relationship that was started by top executives from the two (or more) organisations. The approval of other stakeholders at this stage is important to the continuity of the alliance. Specific joint ventures are incorporated in the relationship. This makes the relationship real.

With the initial courtship over, Kanter argues that the relationship goes through a third phase of 'setting up house' where more people at lower levels are involved and the day-to-day reality of the relationship starts manifesting itself. At this stage, differences may arise because staff at lower levels are less visionary and less experienced in working with people with different cultures. They may lack knowledge of the strategic importance of the alliance.

At the stage of 'discovery of differences' operational and cultural differences may emerge after collaboration is already underway. Experience opens the eyes of those involved and creates differences in the reporting authority and decision-making styles; learning to collaborate becomes critical. Some level of strategic, tactical, operational, interpersonal and cultural integration becomes necessary. Resolution of disputes becomes critical.

Lastly, productive partnerships and alliances stimulate change from within organisations. These changes may not have been anticipated at the onset of the alliances. This indeed attests to the uncertain and ambiguous nature of strategic alliances. The changes that occur include empowerment of relationship managers, creation of an infrastructure for learning and in managing the tradeoffs that arise from the relations. However, the question is how much should an organisation change for the sake of the alliance? What is the potential value of the alliance weighed against all other costs of the activities that demand time, resources and energy? Should the relationship take a different shape?

Kanter (1997) further identifies "eight Is" of a successful relationship. These are individual excellence, importance, interdependence, investment, information, integration, institutionalisation and integrity.

2.9 Challenges of Strategic Alliances

The increased competition arising from the fast-changing global market has resulted in a situation where companies are finding it increasingly difficult to go it alone. More than

ever before, many of the skills, capacities and resources that are essential to a firm's current and future prosperity are to be found outside the firm's boundaries and outside the management's direct control (Doz & Hamel, 1998).

Yoshin & Rangan (1995), argue that the key driving force for strategic alliances is competition that has made the market a global village. It should be realised that the world is moving so fast that firms must move with equal speed to form relationships that give them a competitive edge. In this new world order therefore, strategic relationships are a necessity, and are no longer an option. Synergies need to be created through collaborative efforts with other firms. To successfully forge these relationships, entrepreneurial skills are needed in order innovatively to develop competitive capacities with limited resources.

As such, strategic alliances are the fastest growing trend for business today. According to Kautz (1998), the numbers of alliances are growing by twenty percent a year, with ten thousand new alliances being reported in 1998 alone. Companies participating in alliances report that as much as eighteen percent of their revenues come from their alliances. That number is projected to climb to thirty five percent by 2004. The most active area for alliances is Europe where, according to a Booz-Allen Survey (1998), many companies report as much as forty two percent of their revenues coming from alliances with Returns on Investment (ROI) from their alliances of over twenty three percent. Many companies reported a higher ROI on their alliances than on their core businesses. The twenty-five companies most active in alliances achieved a seventeen point two percent return on equity - forty percent more than the average of the Fortune 500. Alliances clearly pay off for the participants. Strategic alliances have therefore becoming a more and more common tool for expanding the reach of your company without committing yourself to expensive expansions beyond your core business internally. Despite this, the rate of failure among strategic alliances is also considerably high.

These challenges can make the difference between success and failure of an alliance. Initially, there is a reluctance to give up autonomy over one's strategic resources. Second

is how to achieve operating momentum in a situation of cultural differences. Third is how to maintain focus on the external environment, i.e. competition and customers (target groups), instead of losing energies on internal friction points. Fourth, unnecessary politicking can also affect the implementation of strategic alliance. Fifth, is the challenge of maintaining organisational energy to continue co-operation over time as well as to increase the willingness to learn. Finally, there are those individuals who, despite their involvement become bottlenecks in the strategic alliance. The challenge in strategic alliances is how to balance all these issues and maintain a relationship that adds value to the partnership (Koigi, 2002).

While many studies have been conducted on the private sector strategic alliances this case study will provide a refreshing look into the case of three non-governmental organisations, which set out to create and implement an alliance, the Gedo Health Consortium. Established in April 2001 to act as management wing of the three NGOs (Trocaire, AMREF and Cordaid) working in the health sector in five districts of Gedo Region, it was felt that the consortium would achieve better results through collaboration, and therefore develop a clear vision and strategy for their work in Gedo Region. The rationale behind the alliance was to first help build the regional management and resource capacity through training and infrastructure development of the Regional Health Board (RHBs), the District Health Boards (DHBs), and the District Health Management Teams (DHMTs). Second, to rationalise the use of resources through improved efficiency and effectiveness. Third, to standardise salaries, incentives, infrastructure, management and administrative functions. Fourth, to regionalise expert inputs such as training, primary health care and medical co-ordination. And finally, to build a programme to increase cost-sharing in all aspects of the programme apart from essential public health initiatives.

CHAPTER 3. RESEARCH METHODOLOGY

3.1 Research Design

This is a case study on Gedo Health Consortium. It is said that case studies provide valuable insight for problem solving, evaluation and strategy. These details are secured from multiple sources of information, and allow evidence to be verified through in-depth probing (Cooper and Emory, 1996). This research aimed to provide an in-depth understanding of how Gedo Health Consortium entered into a strategic alliance, the need for the alliance, the process followed, milestones, problems encountered, their resolution, and the future of the alliance. Several persons were interviewed, in total thirteen (see the complete interview schedule appendix 3).

3.2 Data Collection

Both primary and secondary data was used in this study. Primary data was collected though in-depth interviews involving three partner representatives to the alliance were carried out. Those involved in the implementation and members of the steering committee were also interviewed. The research targeted those involved in the alliance in the creation, management or implementation of the programme.

The data was collected using an open-ended questionnaire. These types of questions are preferred because they give an opportunity for in-depth probing of issues. A sample questionnaire is attached in Appendix 2. The approach to data collection was through making appointments with the respondents. The researcher administered the questionnaire personally. An unstructured interview schedule was followed (appendix 3).

Secondary data was also used and provided additional useful information. This was obtained from the proposals to the several donors, the GHC in-house reports and GHC reports on the implementation to the partners.

3.3 Data Analysis

The data collected was analysed to establish the objectives of the strategic alliance between the three partners, the process followed in establishing the alliance, the challenges faced and how they were resolved and the future of the alliance. In case of inconsistencies in information clarification was sought through additional questioning.

The data was analysed through using content analysis. Content analysis aims at identify patterns that account for particular behaviours of a given unit, and its relationship with the environment. This method allows respondents to give a wide range of ideas about issues in much detail. Njau (2000), Kandie (2001), Kirui (2001), Koigi (2002) successfully used this method in past studies.

CHAPTER 4. RESEARCH FINDINGS

4.1 Introduction

This chapter presents the findings of the study. We set out to documenting the process followed in the formation of the strategic alliance and the implementation experience of the Gedo Health Consortium strategic alliance. Thirteen people were interviewed these were the representatives of the three organisations to the alliance, the director of GHC, implementing staff members, members of the steering committee and individual involved in the set-up or implementation of the alliance at one time.

In addition, the researcher also obtained useful data from secondary sources like the project proposals and in house reports. All information needed was obtained. The respondents were very co-operative and knowledgeable on the process followed in the creation and implementation of the alliance.

4.2 Creation and Process Followed in the Formation of the Strategic Alliance

4.2.1 Idea of Forming the Alliance

The initial concept of developing an alliance was born during an informal walk in the Ngong Hills of the three managers Erica Musch (Cordaid), Kathleen Fahy (Trocaire) and Basil King (AMREF) in 1999. However the three agencies had co-operated in a number of areas such as joint training as early as June 1997. This was therefore seen as a natural progression to develop a regional programme under the management of a Regional Health Board.

4.2.2 Identification and Selection of the Partners

Each of the three alliance members (AMREF, Cordaid and Trocaire) had been running broadly similar health programmes in different districts of Gedo Region for a number of years (AMREF since 1983 and 1992 for Trocaire and Cordaid). These worked through

District Health Boards (DHB) and District Health Management Teams (DHMT). All three agencies had a common development approach and capacity building strategies, had some collaboration with European donor agencies and covered the same region of Gedo.

In addition, at the time the office of Cordaid in Nairobi was in the AMREF Complex therefore encouraging both formal and informal contacts. The relation between the three organisations had been strengthened significantly through the recruitment of a joint training co-ordinator for the three programmes in June 1997. The three agencies also co-operated in a number of other areas such transport, workshops and lodging. It is important to note that there were other health agencies working in Somalia such as ACF and IRC but these were never considered as potential partners as they had different approaches to their health programmes.

4.2.3 Objectives of Forming the Alliance

The three programmes had received individual funding for approximately ten years, but Somalia was no longer a priority of major donors therefore they all realised that securing funding for the future would be difficult. In the case of Cordaid, the Dutch Government and Cordaid Head Office had expressed their wish to phase out of Somalia, as Somalia was not included in their strategic choice of targeted countries. For Trocaire, Ireland Aid had indicated that they were not willing to provide more funding without substantial change to the programme. AMREF was also having problems securing more funds for the programme. However it was common understanding that to terminate the programme would mean a setback to Gedo Region, as the local population would not have access to health care. An alliance leading to one programme was the most favourable option to ensure continuation of support for the three programmes and to be able to access greater funding.

The main objectives of the three partners as detailed in Table 1 were:

- to continue the provision of basic health care and improve on the quality of health care for the people of Gedo Region

- to ensure continuation of funding for the three programmes in the five districts of Gedo Region
- to reduce overhead costs of the three partners by consolidating offices and administrative support, leading to efficient use of funds
- To introduce a regional approach and standardised procedures within the three programmes (common approach to healthcare practices, capacity building, salaries, vehicle rental etc.)
- to strengthen and empower a Regional Health Board as a counterpart, with the aim of taking over responsibility for the health sector in Gedo Region in the future
- to build on the strengths of the three partners

Table 2: Objectives of the Partners in Forming the Alliance

Interest	AMREF	Trocaire	Cordaid	Remarks
Pursuit of funding	✓	✓	✓	
Continued provision of healthcare	✓	✓	✓	
Standardisation of health care	✓	✓	✓	
Same geographical coverage	✓	✓	✓	
Strengthen Regional/District HBs	✓	✓	✓	
Phasing out strategy	X	X	✓	Further details in the findings

(Source: Research Data)

4.2.4 *'Setting up House and Discovering the Differences '*

Though most of the respondents did not know the actual process followed, information was gathered from one of the initiators. After the initial "first thoughts", the three programme managers had a few informal meetings and lunches where the option of the alliance was further developed.

Earlier, before the development of the concept, there had been several meetings with members of the then existing District Health Boards of the five districts in Gedo. One of the first meetings concerned the Somalia Aid Co-ordination Body (SACB) travel ban on Gedo due to the murder of a veterinarian doctor in Bardera District in January 1999. The programme managers had indicated then that there were plans to strengthen the collaboration between the three partner organisations and also the collaboration between the five District Health Boards.

On February 18th 2000, in Kathleen Fahy's house, the three programme managers gave a preliminary presentation to representatives of Trocaire and Cordaid Head Offices. The initial response of the partners was positive. This was followed by the development of a comprehensive proposal, which was jointly written by the three programme managers. This took quite some time and a few formal meetings. Trocaire proposed to forward the proposal to the EU Co-financing Office. The format of the proposal was adapted to the required standard of the EU and was discussed with the Somali EU Health Representative. During the planning phase it was already agreed that Trocaire would be the Lead Agency for the first rotating period of 3 years. Trocaire Head Office and Regional Office took the responsibility to ensure that the proposal arrived in time (prior to 25th November 2000) in Brussels.

On 14th December 2000 the three programme managers gave an official presentation of the proposal. The presentation was held in the Fairview Hotel, Nairobi, to representatives of DFID, Dutch Government, SACB, EU Somalia Unit, WHO, and non-health NGOs working in Gedo. In general the project was considered positive, challenging and innovative for Somalia, however, there were also concerns about the ambitious target.

In February 2001 a last joint meeting was held with members of the five different District Health Boards in Bulla Hawa. The three managers gave a presentation about the proposed future of the programme. In general the changes were welcomed and approved by representatives of the five districts.

In April 2001 the three partners signed the MoU and GHC become the management wing of the three partner organisations. A head office was set up in Nairobi and a regional office in Mandera. The regional office became the link between the head office and the various districts' health programmes. All activities, supplies and reports were to be co-ordinated, distributed and submitted through this office.

The relationship between the three partner agencies was built up over a number of years, so in this sense it took long to form the alliance, as the partners grew closer. However, formalisation of the alliance was much briefer, as long as it took to write a joint proposal.

4.2.5 Challenges Encountered During the Formation Process

From the above descriptions it appears that there were no big problems during the process of forming the alliance. However, problems become apparent during the first two years of GHC and implementation of the programme, Gedo Regional Health Programme. These problems may be attributed in part to the shallow knowledge that each agency had of the others, e.g. organisational culture, policy, strategy, funding strategy and sources. This was compounded by insufficient funds, insecurity, and lack of clear strategic management.

Foremost, the bulk of the funding expected was delayed. For the first two years the programme operated on considerably reduced funding, approximately 35%. The bulk of this funding was to come from the EU (55%) and the rest from Ireland Aid (10%), Dutch Government (10%), DFID (10%) and each of the three agencies Trocaire, Cordaid and AMREF were to contribute an additional 5%.

The funds from the EU were delayed for two years (only approved early 2003 although backdated to the beginning of 2002). AMREF did not submit the proposal to DFID, therefore no funds were expected from them and AMREF announced in May 2000 at the GHC Partners meeting that it had always understood that its 5% would kick in at the time that EU funding was secured. Currently all funding from DFID has yet to be secured and Dutch Aid has refused to fund the programme.

As a consequence of the limited funding the implementation of the programme was enormously affected. All respondents stated it was remarkable how the management managed to operate the enlarged programme with the very limited funds available for a period of 2 years. This resulted in enormous strains on the Director and her team regarding the delivery of the programme objectives.

Security problems on the other hand did not make accessibility to the Gedo Region easy. This had a negative impact on the supervision and monitoring of the programme. Though three respondents (implementing staff) indicated that the Health Boards and Health Board staff have complained of a decline in field visits this should be considered in line with the security problems. The security problems were largely a result of clan-based clashes compounded by external Ethiopian influence, which resulted in sporadic and unpredictable outbursts of violence. However it is not clear how well GHC managed communication with the communities or promoted local ownership of the programme, which would assist in enhancing security.

The development approach of the programme was also mentioned by three of the respondents, who expressed that the long-term development approach of the programme in an insecure country was ambitious. Insecurity may even be considered a killer assumption, i.e. a factor that completely undermines the objectives of the programme. Four respondents also indicated the need to have an emergency component to the programme. This was subsequently taken on board in a revised planning framework and objectives.

Some of the respondents were aware of the details of the Memorandum of Understanding (MoU) signed by representatives of each of the three agencies. The MoU seeks to define the purpose of the consortium and the relationship between the three agencies. They expressed an opinion that, in light of experience, the MoU has proved to be inadequate. In particular it did not adequately predict how the partners would work jointly and the responsibilities of each partner in the alliance. It also did not predict the key role of the lead agency and the amount of work that the GHC would involve them in. It did not put in place contingency plans in case of partners failing to secure funds from the expected sources. Others stated that there was a need to have benchmarks of achievement for the partnership.

It appears that there are quite fundamental differences between the three partners, most crucially on their view and understanding of the lifespan and even purpose of the consortium. Was the consortium intended merely to be a vehicle for the implementation of one programme - Gedo Regional Health Programme - in which case the lifespan of GHC will be only 3 years from the start of EU funding (assuming no extension of funding)? Alternatively, was this in fact a more strategic alliance of the three agencies truly aimed at drawing on the strengths of each of the three partners to bring greater advantage to the people of Somalia? These issues have not been adequately addressed and there is a feeling that there may be differing opinions, even at the highest level. The respondents stated that insufficient thought was given to the legality of GHC.

Respondents also indicated that the problems are compounded by insufficient separation between the powers of the management, executive (partners) and the board (Steering Committee). They stated that the relationships remain ill defined. Some expressed the need for the Steering Committee role to be strengthened further. It was stated by some the need for the Steering Committee to take up an evaluation role.

The respondents indicated that the turnover of the key persons, either the initiators or partner implementers, created a gap and affected the urgency of implementation.

The respondents complained that the lack of documentation and reporting to partners and stakeholders had affected the perception the various stakeholders had of GHC. It was stated that this major shortfall could lead to closure of the programme. All stated the need to document the lessons learnt and to learn from them. It was also stated that the alliance partners had come together without a strategic approach in place, and that the alliance should not have started without a comprehensive MoU and without adequate finances.

4.2.6 Communication and Resolving the Challenges

There is ongoing dialogue between the three partner agencies through the regular meetings of the Steering Committee and through the initiation of an annual partner's meeting. The partners' meeting has discussed the MoU and recognised its weaknesses. A second draft has been prepared, defining in much greater detail the role of the lead agency and the communication links to other partners. Operational issues are dealt with through Trocaire (as lead agency) who manage the GHC Director.

It does not come out clearly from all respondents the extent to which staff, Health Boards and community members were involved in programme conceptualisation. As a consequence the respondents claimed a lack of understanding at community level of the changes. Communities had become used to the different approaches of each agency and many did not like the perceived decline in quality of service provision (a result of the above compounded challenges) of the programme.

4.3 Implementation of the Strategic Alliance

4.3.1 Intended Benefits from the Alliance

A successful relationship should have tangible and measurable benefits for all the partners. The study has established that benefits to the three partners are not easy to value nor to quantify. However the planned benefits to each of the partner agencies include: continuance of the programme; increased access to funding; enhancement of co-ordination in the Gedo Region; development of a strategic approach and strategies to standardise the programme. Additionally there is opportunity for considerable shared experience and learning to the three partners on the management of the alliance.

To the communities and target groups intended benefits include continued provision of health services, employment and source of living to the locals, and capacity building ongoing which will enable building of sustainable institutions (District and Regional Health Boards).

4.3.2 Materialized Benefits

The level to which expected benefits have not materialised has been the result of several problems and challenges mentioned above. It is very unfortunate that Gedo has suffered much from insecurity. Security problems in Gedo Region are reported to have worsened in the past two years. This has had a negative impact on management of the programme as access hampered supervision and monitoring of the programme on the ground. The beneficiaries have therefore also been affected negatively.

Some of the respondents have reported a decline in the standards of health facilities, this being attributed to the funding problems among others. The Regional Health Board has not materialised either; some of the blame for this is apportioned to the local militias who have caused instability, looting and threatening staff.

Shared learning has been limited. All respondents claimed that documentation of the programme to date has been poor and all partners have expressed dissatisfaction. This has resulted in a poor overall monitoring and assessment of the programme, as there is nothing being recorded from which to measure progress.

The various stakeholders, both in Nairobi and Somalia, have high expectations of GHC. Some of those who were interviewed claimed that there was a strong dissatisfaction among themselves and their counterparts in various institutions regarding the performance of GHC, though it is changing with the appointment of a Medical Co-ordinator. They indicated that the high profile of the organisation has been for negative reasons given the poor implementation record to date.

4.3.3 Increasing Benefits to the Target Group

Hopefully security in Gedo Region will improve, and the ongoing Somalia peace process at Mbagathi is welcome. The respondents stated that much depends on the local leaders on the ground. With improved security, access to the programme for monitoring and supervision will be enhanced and impact should improve.

The respondents were hopeful that with the bulk of funding secured the pace of implementation of the planned activities should increase. They hope that an increased sense of urgency will be given to implementation, monitoring of systems, supervision, timely reporting and sharing information with the partners. Furthermore, with the revision of the MoU, it is hoped that all issues which were troublesome and brought confusion and tension between the partners will be ironed out.

4.3.4 Implementing the Alliance

Among the stakeholders who have gained from the alliance are SACB, FSAU, WHO, UNICEF and other NGOs working in the area, who now have one agency to deal with in Gedo instead of three. However much needs to be done to strengthen these relations, especially with sharing of information.

In any change management, it is advised that a sense of urgency be exhibited so that opportunities are not lost as people analyse issues (paralysis by analysis syndrome) (Doz and Hamel 1998). The study found out there was a sense of urgency in setting up the strategic alliance. However most respondents expressed a lack of urgency in the implementation of the programme refer to Table 2. This can partly be attributed to severe constraints during the initial period of implementation.

Table 3: Implementation Urgency

Sense of urgency	Frequency	Percentage (%)	Cumulative(%)
Very Strong			
Not Strong	8	62%	62%
None at all	2	15%	15%
No Response	3	23%	23%
Total people	13	100	100

(Source: Research Data)

4.3.5 Transfer of Knowledge and Specialized Skills

The creation of the Alliance has been an "interesting lesson learned" for the three partners. It is worth mentioning that Cordaid provided valuable support to the programme in setting up financial management systems. AMREF provided the initial Medical Co-ordinator for 12 months and Trocaire, as the lead agency, has provided ongoing management support. A number of the DHMT staff who were previously employed by the three agencies separately are now working for the alliance.

On whether specialised skills were required to manage the alliance, respondents from the three organisations indicated that employees were doing tasks related to their area of competence. Their respective employer had trained them in whatever duties they were

charged with. However, most respondents expressed need for the management, partners and Steering Committee to have general knowledge of development, diplomacy and strategic thinking skills to manage the alliance.

4.3.6 Resource Management

4.3.6.1 Financial

Most respondents were not aware of the detailed financial management, though those who were aware noted that it was remarkable how the management of the alliance managed to run the programme on just 35% of the budget for the 2 first years. It was also expressed that the management of the resources can now be evaluated, since the programme is now operating with the full budget and with improved financial reporting improved to all partners.

There were varied responses regarding the adequacy of funding; this can be attributed in part to the unclear timeframe of the programme. Nevertheless, the respondents agreed that with the EU proposal approved and hopeful with funding from the three partners and the back-donor commitments, finances were secured for the next two years.

However some expressed uncertainty that the funding problems were over. This was mainly due to the uncertainty of back-donor funding like that of Dutch Aid which is decided on a year by year basis, and which could jeopardise the programme, and because Cordaid has no strategy for Somalia any more. Also not confirmed are the DFID funds, which AMREF is pursuing. Many of the respondents expressed uncertainty on funding after the three years of the EU contract.

The funding strategy is in place, as described above (pg27). One of the challenges mentioned was misunderstanding between the partners, where AMREF claimed that they had always intended that their 5% annual contribution would be tied into the same funding timeframe as the EU approval. As a consequence, the first two years of operation were funded by Trocaire, Cordaid and their respective back donors only. Two

respondents expressed fear that since Ireland Aid and Dutch Aid have funded since 2001 (one year before EU) they may refuse to fund the final year, leaving the programme once again short of funds (however this is speculation).

4.3.6.2 Physical Infrastructure and Human Resources

Most respondents could not comment on the physical infrastructure, and those who did could only report what they had heard from staff or community members, who complain of deterioration in the infrastructure due to looting and non-maintenance of health facilities. Construction and maintenance of facilities is a high capital cost activity and one of the priority cut backs suffered because of lack of finance.

The alliance human resources can be split into two, the programme staff and the Health Board staff. Due to the civil war in Somalia staff capacities are very low, and little training has been ongoing for the last ten and more years. This has affected the staff available. The programme has also had its own problems being understaffed due to funding problems. The respondents expressed need for the alliance to develop a comprehensive staff policy for the programme and Health Board staff.

4.3.7 Managing the Alliance and the Future of the Alliance

4.3.7.1 Organizational Strategic Policy and Management Commitment

The alliance is bound together by a MoU between the three partners. The MoU includes the roles, responsibilities and commitment of the three partners in the alliance for the period of the EU proposal, to the end of 2004. A Steering Committee meets 3-4 times a year, which advises the lead agency, the partners and the management of GHC.

A strategy was developed by the GHC management, involving the staff, District Health Management Teams, District Health Boards and the partners represented by the lead agency. Two respondents considered this a strategy for the Gedo Regional Health Programme only. It was expressed that if a strategy is to be developed for the alliance this must be done by the three partners.

Successful implementation of alliances requires team spirit in the respective partner institutions and in teams drawn from the three institutions. All three partners indicated that teamwork is encouraged in the individual institutions. In principal Trocaire, Cordaid and AMREF encourage collaboration, teamwork and participation in all their respective programmes. Trocaire as the lead agency involves all three partners in decision making through the Steering Committee, organising an annual Partners' Meeting and through setting up communication channels between partners.

4.3.8 Change Management and Management Commitment

Most respondents claimed that the three partners made their employees aware of the change through the three initiators who were the programme managers. Some former employees lost their jobs while others became employees under the new programme but with different conditions. The reaction has been varied; implementing staff questioned had received complaints from Health Board members of less direct support than previously. Others had complained that they were not aware of the change and outcomes. These respondents further declared that there is a level of dissatisfaction and that staff morale is low. This has had a number of consequences, amongst them that staff members on field visits have experienced threatening behaviour from their colleagues. The respondents claim that many of the Health Board staff still identify with and regard themselves as still working for their previous employers. For some time these staff continued to use the old systems of the individual agencies. Eight of the respondents expressed a continuing need to create awareness on the ground and to develop greater community ownership of the programme.

Trocaire is the lead agency and has delegated considerable power to the GHC Director who is answerable to the Trocaire Regional Director and to the Steering Committee. Seven of the respondents expressed a lack of total management commitment to oversee the programme and the projects' activities. However, some expressed that there were extenuating circumstances, namely the prolonged absences from work of the Director

following unfortunate accidents and convalescence over the last year of the alliance operation.

4.3.9 Performance Benchmarks and Partner Contribution

Majority of the respondents claimed there were no performance benchmarks set by the partners for the alliance. However, the programme has a logical framework, which set the performance objectives of the programme and the overall organisation, targets and indicators are defined in the logframe.

Trocaire as lead agency is more involved that the other two partners and has the biggest burden at the moment. They will hold this position for 3 years after which it passes to another agency, of which AMREF has expressed interest. The other agencies provide support, both technical and financial (see above), and through participation in the Steering Committee. All the three partners are represented in the Steering Committee and contribute accordingly. The financial contribution from all three partners is easy to value. However, ten of the respondents were aware Trocaire and Cordaid have made more financial input and greater commitment to the alliance.

4.3.10 Future of the Alliance

All respondents indicated there is uncertainty regarding the future of the alliance, though they were hopeful that the "teething problems" would fade away. With the bulk of funding now received, it was felt that GHC management should be able to implement the scheduled activities of the programme in the coming period. This, it was expressed, would reduce some of the tensions that existed between the partners of the alliance.

As it stands at the moment the MoU commits the three agencies to an alliance only for the length of the Regional Health Programme, i.e. to the end of 2004. Trocaire has expressed commitment beyond 2004. Cordaid has committed itself to support the Gedo Health Programme in line with the EU approved proposal to the end of 2004. AMREF's position is not clear. Half of the respondents were hopeful that the alliance would

continue but with a realignment of the funding partners. Ten of the respondents stated that management of the programme for the remaining two years of implementation will most likely determine the outcome of the direction taken by the partners.

4.4 Discussion

Formulation of alliances largely rests on hopes and dreams of what may be possible if certain opportunities are pursued. The Gedo Health strategic alliance was an opportunity for the partners to access funding, which was diminishing, and at the same time continue providing a healthcare programme for the Somali people.

It is debatable that some of the problems experienced could have been avoided if the Kanter (1997) five-stage road map had been followed. Kanter's road-map proposes as a first step the selection of partners; for the Gedo Health Consortium partners' identification of each other was fairly easy as they were working in the same geographical region and had already initiated some collaboration. No audit was performed to identify the organisational cultures or the resource capabilities of each partner. The second stage of Kanter's model is getting engaged, which refers to involving other people. In this case the Regional Representatives and the head offices were informed of the proposal and broadly approved. No details emerged as to strength of the approval, but the impression was gained that the discussions were not broad and did not look into the consequences of a partnership.

Setting up house is the third step, where more people at the lower level are involved. The research findings identified a lack of awareness by most staff and lack of ownership of the programme by the local people in the programme area. The fourth stage in Kanter's model is discovery of differences; the alliance partners differences in perception have resulted in tension as the partners realise their misunderstandings of the timeframe and legality issues among other things. Lastly according to Kanter, differences stimulate change within the organisations; this is likely to result in a change of structures into mutually acceptable ones and development of a comfortable working arrangement between the partners.

CHAPTER 5. SUMMARY, RECOMMENDATION AND CONCLUSION

5.1 Introduction

This study focussed on the creation and implementation of the Gedo Health Consortium. This chapter will contain a summary of the research findings, recommendations, conclusions, limitations of the study and suggestions for further study.

5.2 Summary of Results and Recommendations

5.2.1 Formation of the Alliance

The three partners established the alliance through an unplanned and unsystematic process as follows:

- Collaboration in the health sector over a number of years
- Initiation of the idea by the programme managers
- Informal meetings and lunches to develop the concept
- Presentation of the concept to their respective head offices
- Developments of a proposal, possibly development of the MoU by the three programme managers
- Presentation to donors and various stakeholders
- Establishment of the offices and set-up in April 2001

There was urgency in the formation of the alliance as funding for continuation of the individual programmes was uncertain. It is important to note that the three partners did not have any exit strategies in place in case of a need to terminate the programmes. It would be ideal for this to be considered for future situations.

The approach taken by the alliance partners was not strategic. During interviews it was mentioned that the three programme managers developed the MoU for the alliance, describing the nature of the relationship. This process should probably have included

greater involvement of regional and head offices to ensure total ownership and commitment from these parties. The MoU developed to bind the three partners was not comprehensive, and allowed for misinterpretation and misunderstanding.

5.2.2 Implementation Experience of the Alliance

Though it is not possible to predict and plan for unforeseen circumstances, the initial planning process should attempt to predict any risks in the programme design that might delay or prevent the achievement of objectives. The original logframe identified three potential risks including failure to secure funding, ongoing insecurity, and serious food insecurity. All three might be considered 'killer assumptions' that could completely derail the programme, and all three have occurred in the first two years of operation. The design process should have taken this into consideration and included contingency plans to minimise or mitigate such risks.

A considerable delay in the release of funding from the EU, which was the bulk of the funds needed, was a blow at the start-up phase. Partner agencies should have been aware from previous experience that the EU is slow in decision making. The lesson to be learnt is that the EU should not be relied upon for funding during a set up period.

Ongoing security problems have limited access of key programme staff for implementation and monitoring of the programme. As a result, some respondents claim that there has been a decline in the quality of health service provision. A combination of drought and insecurity exacerbated the already fragile food security situation in 2002 and required emergency nutrition intervention. As the leading health provider in the region GHC was forced to respond. This diverted human resources away from the main developmental programme. In Somalia recurring food insecurity is inevitable and emergency response should have been incorporated into the original programme design. This has been taken on board in the revised programme logframe.

5.2.3 Communication

The three partners entered into an alliance to pursue a set of agreed goals and have remained independent subsequent to the starting of the alliance. Initial programme

conceptualisation was followed by dialogue, agreement and development of a proposal. There were no changes within each partner organisation following the set-up of the alliance.

Given that the three partners have retained their individual identities and management structures, communication between the partners is perhaps the most important activity both in the creation and implementation process. The three programme managers were the key contact persons in the initial stages of set-up. The main channels of communication were through informal and formal meetings, emails, and presentations, resulting ultimately in proposals to the various stakeholders. It was established that despite the numerous communication channels established no clear understanding of the three partners' strategic intent was properly developed. The lack of proper understanding of the partners' intention in the strategic alliance can be attributed to the various misinterpretations of the expected roles and responsibilities of each partner.

Implementation has been underway for the last two years; communication channels established remain much the same with the addition of workshops and reporting to the various stakeholders. However, all the partners and most of the respondents were dissatisfied with the sharing of information and programme reporting. The anticipated opportunity for valuable learning experience to be shared within their organisations has not materialised. Improved communication should be seen as a way of creating awareness and a means to compare and measure progress. This should be highly encouraged and effective communication channels established to improve the relationships of the various stakeholders.

5.2.4 Benchmarks for the Alliance

A majority of the respondents claimed there were no performance benchmarks set by the partners for the alliance. As described in detailed in the literature review any alliance should have measurable benefits to all partners. It is recommendable for the three representatives of the partners to come together and establish benchmarks for the alliance. By so doing the partners will identify specific objectives the alliance is to

achieve. As is often said, "if you can't measure it, you can't manage it". It is through measures that the alliance can assess its performance effectively.

5.2.5 Experience and Perception

The alliance was established in order to access greater and continued funding for Gedo, among other reasons. To this extent it has, eventually, been successful. However, some of the respondents expressed an opinion that it was clear that the quality of services has declined in comparison with that formerly offered by each of the three agencies. This has strained the credibility both of the GHC but also of each of the three agencies. GHC must work hard to re-establish this credibility.

There may be an extension to the existing programme after the three years are complete. It will probably depend on what achievements and progress have been made with the programme (as measured through an external evaluation) and what security, social and economic improvements have been established in Gedo Region. The partners' individual strategic policies will also play a major role.

5.3 Conclusion

Establishing Gedo Health Consortium with the suitable partners was seen as providing a solution to the financial problems the three partners had. The alliance has created financial value and continuation of the Health programme in Gedo. The last two years have been a learning period where differences and difficulties have emerged. The challenge in the next two- three years for the partners will be to achieve operational momentum in a situation of different organisational cultures and to establish strategies to deal with the setbacks experienced in the past two years. The partners must start being comfortable with the way in which the alliance proceeds, through risk taking, learning and ambiguity. They must feel empowered to " break the rules" and to challenge long - standing assumptions within the alliance. Lastly the efforts of the partners must be directed at the key objectives and motivated to assure all the stakeholders that the goals are successfully implemented.

5.4 Limitation of the Study

This is a case study on only one alliance and therefore it may not be used in generalisations. The organisational cultures and values of the three partners may not be the same as other organisations. The study may also carry some of the weakness inherent in using questionnaires and interview techniques for data collection purposes. Apart from the possibility of misinterpretation of items and definitions by respondents, answers to the questions may reflect an ideal situation rather than what is on the ground. As with any other research, this study was undertaken within a fixed duration and the researcher did not have adequate time to seek the views of each and every stakeholder in the three organisations and the Gedo Region. The information was obtained only from the representative groups. This study also relied heavily of qualitative data, which is subjective. Similarly data analysis has been done mainly using qualitative methods i.e. content analysis.

5.5 Suggestion for Further Study

This study may be viewed as useful reference material for future researches on strategic alliances among non-governmental organisations.

Perhaps in future there will be need to conduct a complete study on the implementation process of strategic alliances and its impact on these organisations over a longer period.

A study can also be conducted to establish how relationships are influenced by differences in organisational culture among partners in an alliance.

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ABBREVIATIONS

ACF	Action Contre la Faim
AMREF	African Medical Research Foundation
Cordaid	Catholic Organisation for Relief and Development Aid
EC	European Commission
EPI	Expanded Programme of Immunisation
FSAU	Food Security Assessment Unit
GHC	Gedo Health Consortium
INGO	International Non Governmental Organisation
MCH	Mother and Child Health
MoU	Memorandum of Understanding
NCA	Norwegian Church Aid
NGO	Non Governmental Organisation
PHC	Primary Health Care
ROI	Return on Investment
SACB	Somali Aid Co-ordination Body
SWAP	Sectoral-Wide Approach
TBA	Traditional Birth Attendant
UN	United Nations
UNICEF	United Nations Children Fund
WFP	World Food Programme
WHO	World Health Organisation

Appendix 1: Letter of Introduction

Dear All,

I am working on my MBA thesis: "Creation and Implementation of Strategic Alliance among NGOs: A case study of Gedo Health Consortium. The objective of the study is to document the process followed in the formation of the GHC alliance and document the implementation experience of the GHC.

This paper will be important to GHC and her partners (Trocaire, Cordaid & AMREF) to evaluate the direction of the alliance and more so important to myself as a requirement to completion of my MBA. The focus is on the representatives of the three organisations, the director, the initiators of GHC and the persons involved in the implementation of the programme to answer all of the questions raised.

I plan to collect and concurrently compile the data in July03 and produce a draft in August03. I will be calling on you soon and would appreciate if you could give me some time to talk to you. The structure of the questionnaire is semi-structured, open-ended with all the data being provided by yourselves.

Please allow me to take up some of your time for this exercise.

With regards,

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Appendix 2: Questionnaire

Questionnaire on the Gedo Health Consortium Strategic Alliance

This questionnaire has been prepared in relation to the objectives of this study. Any issues that require clarification will be discussed with the researcher during or after the interview time.

A. Creation of the Gedo Health Consortium Strategic Alliance

Motivation of the strategic alliance

1. How did the idea of forming this strategic alliance come up?

2. How were the partners identified?

3. What were the interests of the partner in the alliance?

4. What are the objectives of forming the alliance?

5. Were the objectives communicated to people concerned?

6. Who communicated the objectives to you?

7. How were they communicated?

   Verbally

   Circular

   Other means

Process followed in the formation of the strategic alliance

1. Describe the process the partners went through in forming this alliance, ie. what steps were followed?

2. How long did it take to create the alliance?

3. Were there any problems/challenges encountered during the process of forming the alliance?

   a. Were these problems/challenges resolved (being resolved)?

   b. How they were addressed (being addressed)?

B. Implementation of the Gedo Health Consortium Strategic Alliance

Benefits from the Alliance

1. What are the benefits expected from the alliance for your organisation and your target beneficiaries?

2. Have the expected benefits materialised?

3. To what extent has your target group benefited from the alliance?

4. What should be done to increase the benefits to the target group (if any)?

5. Are there any other stakeholders who have gained from the alliance?

Implementation of the strategic alliance

1. How strong is the sense of urgency when implementing the alliance (during the during and with the implementation)?
   Very strong
   Not strong
   None at all

2. Has there been any transfer of knowledge/experience through the alliance?

3. Do you require specialised know-how in performance relating to the alliance? If Yes, explain how this have been acquired.

Resource Management

1. How does the alliance manage its resources (both cash and non-cash)?

2. Are you satisfied with the tools/techniques in placed for resources management?

3. Is the alliances adequately financed?

4. What strategies are in place to ensure adequate resources are available?

5. Is there a comprehensive funding strategy in place which has ensured all partners understand and agree a common level of commitment to obtain the funding necessary? Could you describe how this works in practice?

Managing the alliance and the future of the alliance

1. Does the organisation have a strategic policy (guidelines) that supports the strategic alliance? Is it comprehensive and effective?

2. Does your organisation encourage collaboration and teamwork between the partners and the alliance?

3. How did you prepare your employees for the change partners to alliance? Do employees respond quickly when changes occur?

4. Is there management commitment to provide continual oversight on projects started?

5. Are there performance benchmarks set relating to the alliance?

6. Do the partners make contributions that are easy to value?

7. Are there differences/shifts in the nature of individual partners participation in the alliance?

8. Is one partner putting in more effort and contributions to the alliance?

9. How do you see the future of the alliance?

Appendix 3: Unstructured Interview Schedule

	Interviewees	Post	Interview date or comments
1	Kathleen Fahy	Former Trocaire Somalia Programme Manger	x No response
2	Inge Leuverink	Cordaid Programme Manager	✓ Questionnaire returned
3	Erica Musch	Representative of Cordaid to GHC	✓ Questionnaire returned
4	Imanol - SACB	Steering Committee member and Health Coordinator SACB	✓27.06.03
5	Dr Kennedy Manyonyi	Medical Coordinator GHC	✓03.07.03
6	Abdullahi Mahat	Primary Health Co-ordinator GHC	✓07.07.03
7	Noreen Prendiville	Steering Committee Member and Co-ordinator Nutrition Project FSAU	✓08.07.03
8	Jo Thomas	Former Regional Representative Trocaire	✓10.07.03
9	Abdirahim A Farah	Acting Programme Manager GHC	✓14.07.03
10	Peter Ngatia	AMREF Representative to GHC and AMREF Programmes Manager	✓15.07.03
11	Dr Basil King	Former Medical Co-ordinator from AMREF	✓15.07.03
12	Simon Obosi	Head of Nairobi Office and former employee with Cordaid	✓07.08.03
13	Una MacAskill	Director GHC	✓12.08.03
14	Noel Molony	Trocaire Representative to GHC and Regional Representative Trocaire	✓27.08.03