The targeted “Solution” in the spotlight: how a product focus influences collective action within and beyond cross-sector partnerships

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The Targeted “Solution” in the Spotlight: How a Product Focus Influences Collective Action within and beyond Cross-Sector Partnerships

Abstract: Based on a comparative case study of six cross-sector partnerships (CSPs) in global health we illustrate how a CSP’s aim to address a social issue on the basis of products influences the governance of collective action within the partnership and beyond, at the field level. We show how such product focus, through specialization, influences a CSP’s structures and interaction culture and, as a reflection of the partners’ underlying logics, generates different CSP-field effects. Specifically, if conceived as self-contained and without considering the implications for other field players and programs, a product focus may expedite collective action within the CSP, but spur fragmentation and disruption at the field level. Conversely, if designed to strengthen field capacity and integration at the product-field interlinkages, a product focus may take longer to form, but helps avoid the above field effects. On this basis, we advance theory on CSPs’ product focus as a multilevel coordination mechanism and elaborate on the implications for designing product-based CSPs.

Keywords: Collective action, cross-sector partnerships, issue field, governance, global health
With roughly half of the world’s population having no access to essential health services (United Nations, 2017), improving the health of the poor is a major global objective. While critical to building prosperous societies, as goal no. 3 of the United Nations Sustainable Development Goals underscores, it requires a coordinated effort by numerous actors from different parts of society. Cross-sector partnerships (CSPs) have emerged as one way to enable more concerted action by aligning and leveraging different actors’ interests and commitments (Clarke & Crane, 2018). In this article, we examine CSPs as voluntary initiatives in which companies, public-interest entities, and civil society organizations collaborate to address a societal challenge, share the risks and required resource contributions, and actively engage on an ongoing basis (Selsky & Parker, 2005; Utting & Zammit, 2009).

We are interested in the specific solution – namely, the type of focal output (Van Tulder et al., 2016) that a CSP develops to tackle the societal challenge. Prior research has illustrated the processes of agreeing on and defining the targeted solution (e.g. Gray, 1989; Cloutier & Langley, 2017) and identified different CSP types that are focused, for example, on developing policy and standards, mobilizing resources and raising awareness, or delivering products and services (e.g. Bryson, Crosby, & Stone, 2015; Liese & Beisheim, 2011). While scholars have examined standard-based CSPs in particular (de Bakker, Rasche, & Ponte, 2019; Dentoni, Bitzer, & Schouten, 2018), we focus on CSPs that develop and disseminate products, such as drugs, technologies, or equipment. We posit that their product focus requires further examination for two reasons.

First, given the partners’ operational interactions and interdependencies that unfold around a product (Bull & McNeill, 2007), the latter may form a “mechanism of social coordination by which (…) actors interact with one another in predictable ways” (Zietsma et al., 2017, p. 392). In this role, the product focus may mirror and carry forward the assumptions or logics that guide the CSP partners (Scott, 2003). Second, the products typically transcend
the partnership and pass through markets or public service systems to reach their beneficiaries (e.g. citizens or, in a health setting, the patients). Through these market and public system links, collaborative solutions may affect other actors working on the same or a related societal issue and eventually trigger field-level change (Lawrence, Hardy, & Phillips, 2002). However, we know little about how a CSP’s product focus shapes the allocation of resources and coordination of joint actions, hence the governance of collective action (Provan & Kenis, 2008), at the CSP and field levels. The term “field” here relates to the larger community of actors that “frequently and fatefully” interact (Scott, 1995, pp. 207-208). We focus on fields in the context of societal challenges, i.e. issue fields (Hoffman, 1999), where the interaction of multiple actors may help ensure an effective use of field resources while avoiding unnecessary duplication and deadlocks.

With the term collective action we thus refer to “actions taken by a group of people or organizations for a common cause” (Bowen, Bansal, & Slawinski, 2018, p. 1412) whereas governance addresses “the structure of collective action” (Powell et al., 2005, p. 1135) that “enables actors to direct, coordinate, and allocate resources for the collaboration” (Vangen, Hayes, & Cornforth, 2015, p. 8). We posit that research on the product focus, as a so far neglected means of social coordination, first offers an opportunity to enrich extant research on CSP governance (e.g. Alonso & Andrews, 2019; Caldwell, Roehrich, & George, 2017). Second, it addresses recent calls to investigate the interactions between CSPs and the wider systems or fields in which they are embedded (Clarke & Crane, 2018; Dentoni, Pinkse, & Lubberink, 2020) with a view on a CSP’s product focus as a link between these levels. We thus ask: How does a CSP’s product focus influence the governance of collective action at the partnership and field levels?

We address this question with a comparative case study of six product-focused CSPs in global health and find that, depending on the lack or existence of suitable products for the
targeted health issue and beneficiary group, the CSPs specialized in either product development or delivery. This specialization influenced the agility of collaborative structures and cultures, as well as the role of business partners. Our findings further illustrate how five CSPs followed a combination of market and social logics in defining a “detached” product focus. Such a focus built on self-contained collaboration templates, largely neglected the interdependencies with other field players and programs, and thereby accelerated the partnership formation. However, once their products started to be disseminated, the CSPs faced criticism for their products absorbing scarce local resources and spurring field fragmentation. Thus, the CSPs were challenged to better “anchor” their interventions in the field by helping build local capacity at the product-field interfaces and by coordinating with other CSPs and initiatives that worked on the same or related issues. Their resulting evolution from a detached to an anchored product focus contrasts with the sixth case in which the partners took the time to conceive their product focus as a combination of a social, market, and an additional field-anchoring logic from the outset, thereby avoiding contestation and negative field-level effects.

These insights expand research on CSP solutions (de Bakker et al., 2019; Dentoni et al., 2018; Stadtler & Lin, 2019) by exposing the role of a CSP’s product focus in governing collective action within and beyond the partnership. We clarify the implications for relational (Caldwell et al., 2017; Huxham & Vangen, 2004) and structural (Alonso & Andrews, 2019; Rivera-Santos & Rufin, 2010) views on CSP governance and advance insights at the CSP–field interface (Dentoni et al., 2020; Gray & Purdy, 2018; Lawrence et al., 2002; Vurro & Dacin, 2014) by outlining how the inclusion of a field-anchoring logic (i.e. focused on strengthening field capacity and integration) helps facilitate collective action at this level. By linking CSP and field considerations, however, our study suggests that enhancing the effectiveness of collective action at the field level comes at the cost of speed and independence at the partnership level.
In developing these arguments, we first summarize the literature on CSPs’ targeted solutions and their implications, introduce our case-study design, and show how the product focus of six CSPs influenced CSP- and field-level collective action and evolved over time. We then analyze our findings with a view on the drivers, nature, and multilevel effects that the CSPs’ different product foci implied. We conclude our study by discussing the theoretical contributions to the CSP literature and by outlining the CSP design implications.

**Research into CSPs and the “Solutions” They Pursue**

CSPs are formed to address a societal problem (Clarke & Crane, 2018; Selsky & Parker, 2005; Van Tulder et al., 2016), which prompts the question of how they attempt to do so. Directing our attention to CSPs’ output, we use the term “solution” in a non-normative way, meaning we focus on the partners’ targeted means of addressing a societal issue, regardless of its eventual contribution to solving it. Agreeing on the CSP’s solution is part of the partners’ initial negotiation of what Eden and Huxham (2001) and Cloutier and Langley (2017, p. 105) define as the partnership purpose: “the overarching ends that collaboration partners seek to achieve through collaboration, and the legitimate means whereby such ends might be reached.” We focus on this second element: the output or means the partners use as they seek to reach their collaboration goal.

Based on the targeted solution, different CSP types can be identified (Bryson et al., 2015; Bull & McNeill, 2007; Liese & Beisheim, 2011). For example, CSPs can focus on resource mobilization (e.g. fundraising) and advocacy (e.g. campaigns to raise awareness) (Bull & McNeill, 2007; Liu & Ko, 2011). Alternatively, they can address a common issue via voluntary standards to guide the behavior of the member organizations (e.g. de Bakker et al., 2019) or address it by jointly developing and disseminating products and services (Bull & McNeill, 2007; Liese & Beisheim, 2011). Partnerships may combine these solutions but
typically focus on one (Liese & Beisheim, 2011) that allows them to overcome key hurdles and reach their specific beneficiary group (Stadtler & Lin, 2019).

Distinguishing between CSPs in line with the targeted solution matters because the central challenges and conditions for success tend to differ. For example, resource mobilization and advocacy partnerships need to design campaigns that effectively mobilize influential and resource-rich stakeholders while passing a clear but not simplistic message (Bull & McNeill, 2007; Liu & Ko, 2011). In standard-centered CSPs, key challenges unfold around developing standards and ensuring that each member organization adheres to the standard in its unilateral operations (de Bakker et al., 2019; Schouten & Glasbergen, 2011). Conversely, in product-focused partnerships that aim to develop and disseminate articles or substances to targeted beneficiaries, central challenges emerge around designing and governing the joint operations and interdependence structures (Alonso & Andrews, 2019; Stadtler & Van Wassenhove, 2016; Quélin, Kivleniece, & Lazzarini, 2017). In this respect, coordination is critical to bringing together partners’ contributions, dividing up the labor, and ensuring proper coordination to integrate joint and individual tasks (Gulati, Wohlgezogen, & Zhelyazkov, 2012).

Research by Liese and Beisheim (2011) states that product-based CSPs with greater clarity of procedural rules and delegation are more effective. Bryson et al. (2006) suggest that, compared with standard-based CSPs, a product focus may be less prone to conflict because of the (public) line staff’s greater experience with cooperation. We are interested in having a more systematic understanding of how the product focus as such – and in different forms – influences the governance of collective action when forming and implementing the CSP.

CSPs’ Product Focus and the Governance of Collective Action

In the CSP literature, governance of the partners’ collective action is described with structural and relational dimensions (Bryson et al., 2015). The former relates to questions of designing decision-making committees (Rivera-Santos & Rufin, 2010), procedures, and formal
agreements (Alonso & Andrews, 2019). The relational dimension concerns questions of communication (Koschmann et al., 2012), trust (Caldwell et al., 2017; Huxham & Vangen, 2004), and shared values, norms, and interaction cultures (Bryson et al., 2015) to coordinate and monitor behavior. Designing these governance dimensions is difficult since the partners’ different interests and views have to be aligned, and a shared understanding of the issue, the required contributions, and a joint way of working have to be developed (Cloutier & Langley, 2017; Gray, 1989).

Little is known about the role of a product focus in this process, as a result of the partners’ alignment of interests and issue views (Cloutier & Langley, 2017; Eden & Huxham, 2001) and in light of its central position in the partners’ interdependence structure and operational interactions. For example, insights from institutional theory suggest that material artifacts, such as products, can embody the assumptions and worldviews (i.e. logics) that guided their development (Scott, 2003). In a CSP, the partners thus may turn their product focus into a carrier of a specific logic combination (Pache & Santos, 2013). For instance, it can represent a market logic (e.g. favoring cost-efficient approaches) combined with a social logic (e.g. favoring approaches that best serve the beneficiaries’ needs and their empowerment) and/or a public service logic (e.g. favoring bureaucratic approaches and control) (Battilana & Dorado, 2010; Jay, 2013; Pache & Santos, 2013; Thornton, Ocasio, & Lounsbury, 2012).

Besides influencing preferred collaborative approaches and interactions within the partnership, the partners’ targeted solution may also have ripple effects at the field level. For example, Lawrence et al. (2002) expose how collaborative solutions in terms of new practices, rules, and technologies may become proto-institutions and be adopted among a broader group of actors outside the collaboration. We similarly suggest that when products pass through markets and public systems to reach their beneficiaries (Lawrence et al., 2002; Stadtler & Lin,
As a connection between the CSP and other actors embedded in the same issue field, a CSP’s product focus may thereby vary in the extent to which it promotes an effective use of field resources and avoids unnecessary duplication and deadlocks. As the literature of organizational fields stresses (Hoffman, 1999; Maguire, Hardy, & Lawrence, 2004), coordination is required also at this broader level, to ensure that actors “engage in collective and mutually supportive action and that [field] resources are acquired and utilized efficiently and effectively” (Provan & Kenis, 2008, p. 231). How a CSP’s product focus influences the governance of collective actions at this field level, as well as within the partnership, has not been systematically addressed, yet offers an opportunity to illuminate CSPs’ governance and their larger societal impact (van Tulder et al., 2016) from a new angle.

**Methods**

To explore our research question, we chose a qualitative, inductive research design that would allow us to acknowledge the specific context and dynamic evolution (Lee, 1999) of a product focus role and its implications. We are interested in an interpretive analysis of patterns and views across levels and time. To identify more robust patterns, we opted for a comparative case study design (Eisenhardt, 1989; Eisenhardt & Graebner, 2007).

**The Empirical Setting: CSPs for Global Health Solutions**

To have better comparability, we chose CSPs that all addressed global health issues. At the beginning of the 2000s, over 1 billion people suffered from diseases that placed a huge burden on developing countries in particular (World Health Organization, 2006). Public programs and other local systems were not adequately equipped to provide solutions, and often the medical products (e.g. drugs, vaccines, diagnostics, and control products) did not exist or could not reach the affected communities. However, with the introduction of the Millennium
Development Goals (MDGs), financial commitments strengthened and CSPs emerged as a new approach to fight prevailing diseases.

Our starting point was a 2004 report on mapping global health partnerships (Carlson, 2004) that sought to “redress health problems of significance for the poor in low and middle-income countries” (p. 5). We screened the 75 mentioned CSPs (1) for a global product focus, (2) for ongoing activities in 2018, and (3) for having several cross-sector partners at their origin. Criteria 1 and 3 were applied to enhance comparability, while criterion 2 allowed us to analyze the product focus’s evolution over a long timeframe. As such, its (potentially) evolving impact on the governance of collective action within and beyond the partnership would be more comprehensive (i.e. “extreme cases,” Flyvbjerg, 2006). We identified six CSPs (here called Push-P, Vacc-P, Eradi-P, Forti-P, Med-P, and Drug-P) that, besides fulfilling the above criteria, also had several similarities (see below and Table 1).

These CSPs were established around the beginning of the new millennium with cross-sector boards uniting public, private, and civil society organizations to jointly oversee the partnership’s operations. To meet their health-related goals, the CSPs sought donation-based funding and built on collaborative, cross-sector implementation models (see Table 1). The six CSPs operated at a major scale (e.g. leveraging between €49 million and €4.6 billion in 2016-17), which meant the partners’ operations and resource commitments required more formal structures than bilateral CSPs would. Except for Eradi-P, the sample CSPs were registered as foundations and hired CSP staff to coordinate between the partners and help with the administrative tasks. Based on the CSPs’ scale, their product focus would affect not only multiple partner organizations but also multiple field actors, and facilitate or challenge their collective action.

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When we started to analyze these CSPs, we realized that one case did not show the field-level effects we identified in the other cases. As our analysis further suggested differences in the CSP’s formation and initial design, we decided to use this case as a contrast or polar case (Eisenhardt & Graebner, 2007). Specifically, investigating questions such as “what was similar in the apparently dissimilar context of our contrast case and what was different and why?” can help identify the patterns underlying the focal phenomenon and relationships and enforce the probing of identified reasons and implications (Eisenhardt, 1989; Eisenhardt & Graebner, 2007).

**Data Collection**

We collected data from several sources: archival data, videos, and semi-structured interviews (see Table 2). We first analyzed the CSPs’ annual reports, board meeting minutes, websites, and videos, which allowed us to track the development of the product focus’s role in the CSPs over time. We further captured the partners’ views by examining their words in press articles, their press releases, and external partnership evaluation reports commissioned either jointly by the partners or by donors. To gain more specific insights in line with our research question, we interviewed five to 11 CSP employees per case. Tasked with coordinating at the interface between various partner organizations, they were the most knowledgeable about the product focus’s different implications.

To avoid bias from a functional perspective, we selected interview partners in various positions, such as employees working in the private sector engagement, donor engagement, and implementation coordination. In our findings, we refer to these interviewees by using codes that correspond to our CSPs’ working names (see Table 2). Following our interview guidelines, we asked the interviewees about the health issue and the CSP’s strengths and weaknesses when it came to addressing the issue. In this way, we steered the conversation toward the product focus. The number of interviews per CSP varied according to the CSP’s complexity and the
richness of the secondary data. We audio-recorded and transcribed the interviews and asked follow-up questions when clarification was needed.

To identify product focus–related patterns outside the partnerships, we investigated the external CSP evaluations and explored how experts in other disciplines have portrayed the focal CSPs over time. To this end, we examined academic articles and case studies featured in medical, health, nutrition, and international relations outlets. We continued our data collection alongside our analysis until we had a rich understanding and triangulated evidence of our inductively emerging constructs. Our final database included 517 documents, 24 videos, and 51 interviews.

Data Analysis

In our analysis, each CSP formed a separate case with its product focus as the central point of analysis. We followed a three-step process. First, we examined the multiple data sources per case with a focus on the partnership’s roots, operations, and evolution. To deepen our analysis of the product focus, we conducted within-case coding, which allowed us to identify patterns across different data sources and over time. Initially, we engaged in open coding: We sorted the interviews and archival documents into data incidents, thereby identifying sets of sentences conveying insights into the product focus and its implications. To move from mass descriptive codes to fewer and more encompassing ones, we derived first-order categories from recurring data incidents (Van Maanen, 1979). For each case, we then regrouped these multiple first-order codes into more conceptual second-order codes, which, in turn, clustered around a handful of temporally ordered aggregation dimensions. This process allowed the unique patterns of each case to emerge before patterns were generalized across cases (Eisenhardt, 1989).
Second, building on the case-specific data structures, we examined and compared patterns across our cases (Eisenhardt & Graebner, 2007). This process helped us integrate and condense the different data structures to similarities and recurring patterns among the five baseline CSPs and to juxtapose them with the contrast case. Through this comparative process, we obtained a final set of 15 first-order codes for the five cases, which we regrouped into seven more conceptual second-order codes. The latter clustered around three temporal periods, which we used as aggregations. Conversely, the data structure of the contrast case centered entirely on the “initially anchored product focus” aggregation dimension, based on ten first-order and four second-order codes (see Figure 1, differences in italic).

Third, we compared our evidence with insights from extant CSP literature. To develop an in-depth understanding of what our concepts implied and how they related to each other, we also used visual and conceptual templates. We integrated the emerging patterns into two process models (i.e. baseline vs. contrast models) illustrating the roles of the CSP product focus for governing collective action at the partnership and field levels. Comparing where and how the models aligned and converged helped us probe our understanding of different types of product focus, including their drivers and governance implications.

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Findings

We now illustrate how the CSPs formed around a product focus, explain how this focus guided the partner interactions, and depict the criticism that five CSPs received for their initial field-level impact. We capture the partners’ reactions to this feedback and juxtapose these patterns with the contrast case. Figure 2 depicts the central processes, and an appendix with further evidence complements our findings.

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Forming Partnerships with a Product Focus

The absence or existence of suitable products. The five baseline CSPs had roots in global, sector-spanning discussion forums, most of which formed around the end of the 1990s to address the growing scale of specific health challenges and the insufficiencies of extant structures. Here, “global” refers to the scale of the health challenges (i.e. global infectious diseases and insufficient immunization, drug availability, or access to nutrition) and to the assembled actors (i.e. international companies and industry associations, United Nations agencies, international civil society organizations, multilateral organizations, bilateral aid organizations, and international private foundations).

Two notions recurred: First, there was an appreciation that suitable health tools, prevention and immunization articles, and/or treatments existed for the focal health challenge (hence “preventable and treatable,” Push-P) but could not reach their beneficiaries in remote and low-income regions. Alternatively, if such products were insufficient or lacking, the required knowledge existed but needed to be leveraged in a new way (e.g. “deploy new solutions on the same scale as the known problems,” Forti-P). Second, the idea of establishing independent, cross-sector partnership organizations rather than supporting existing multilateral institutions gained traction, especially among private donors and bilateral aid agencies. Encouraged by technological advances, previous partnership experiences, and new donor resources, the discussion forums thus provided a platform for subgroups to advocate and eventually create new, product-based CSPs.

Drug-P’s founding context slightly differed in that it was conceived and financially kick-started by an international humanitarian organization that repeatedly faced a “paucity of effective drugs in the world’s poorest regions where they worked” (website). It created an international, and especially disease-endemic country-focused, cross-sectoral think tank to
identify an appropriate partnership model that would allow combining different sectors’ capacities, expertise, and resources in new ways of developing drugs.ii

**Catalyzing actors promoting their solution vision.** However, also in the other cases, our evidence points to the influential role of specific catalyzing actors (here, mostly private foundations), who leveraged substantial financing and promoted a partnership in line with their solution visions. For example, the idea behind Push-P of financially supporting disease-affected countries had “numerous owners,” whereas its final focus on supporting the purchases of drugs, vaccines, and other commodities resonated strongly with major donors (health book, 2012, p. 219). Vacc-P was established largely thanks to a private foundation that praised the “high cost-effectiveness” of vaccines to save children’s lives (press release, 2002). “We have some very strong visionaries, like [donor X] who launched and funds [Vacc-P] and has very clear ideas about what he wants to achieve,” explained an interviewee (V4). Eradi-P started with assistance from a global, business sector–based association that had managed its own vaccination program to combat a widespread disease. It subsequently “catalyzed [Eradi-P] to bring together the different public and private mandates and skills that were needed” (E1) and offered financial support.

Forti-P followed a similar path, where “Western donors, companies, and private foundations decided to (...) provide significant funds” (health article, 2010, p. 29) to focus on food fortification. For Med-P, two individuals, in particular, led the partnership discussions, both of whom favored “product development and (...) a portfolio approach (...) [based on] their prior experience in the pharmaceutical industry” (health article, 2004, p. 4). Thus, the catalyzing actors came from or had close links to the business sector. For example, one of them became “the largest single contributor to more than 60% of the funds provided to global health CSPs” while following a “striking faith in the transformative power of new technologies” (health book, 2012, p. 216).
Defining the product focus. Receiving financial support, the founding partners crystallized as a sub-group of the larger discussion forums or think tank and jointly acknowledged that successful products – or at least related knowledge to address the focal health issues – existed but needed to be adapted and scaled in developing countries. However, critical differences emerged in the ways they approached the product focus.

Among the five cases, products like vaccines, drugs, and other physical treatments were considered relatively “easy” solutions that would also offer important health benefits. For example, Push-P’s partners realized there were well-proven medical interventions for the focal diseases that, in turn, would allow for a “most cost-effective use of resources” (P2). Vacc-P’s partners reckoned that “for less than US$30 [a treatment], we can save three million lives. Where else can we make such an important difference so quickly?” (Vacc-P, first annual report, p. 3). “Get the needle into that child’s arm; that’s it. You can show the results right there,” said one interviewee (V5). Eradi-P similarly built on the recognition of vaccines as “one of the most affordable and effective means of reducing child mortality” (health article on Eradi-P, 2007, p. 185).

The promoters of Forti-P stressed that “no other technology available today offers as large an opportunity to improve lives and accelerate development at such a low cost and in such a short time” (press release, 2002). Med-P’s partners underscored the opportunities to apply extant product development knowledge to the context of neglected diseases in poor countries: “Resistance has wiped out the effectiveness of most affordable drugs. There is an urgent need to leverage extant knowledge and bring forward new, effective substitutes” (first annual report, p. 5). Thus, the product focus satisfied the desire for fast and cost-effective solutions. While this focus prevailed, the narrow focus on purchasing and disseminating drugs and vaccines sparked controversy at Push-P. “Historical tensions between funding and technical agencies” surfaced, which led to the dedication of a small proportion of funding to
supporting health systems (evaluation, 2009, p. 12). Similarly, Forti-P’s partners recognized that with the product focus there was also a need to strengthen related markets.

Product availability (i.e. whether treatments for the focal disease or health issue were available for massive dissemination or a more specific target group) subsequently formed a reference point for the partners’ joint actions to concentrate on. Forti-P and Med-P *specialized* in product development, whereas Push-P, Vacc-P, and Eradi-P did so in product delivery. Across these cases, the goal of the collaborative operations was to fill a particular gap in the market environment. For example, Push-P invested in national programs to purchase drugs, vaccines, and other treatments where the markets were too weak to respond. Vacc-P and Eradi-P sought to ensure that also children in underserved or remote areas were immunized against specific diseases. To this end, the pooling of vaccine demands would help bring costs down and scale the dissemination of innovations, such as fractional immunization doses, which incurred lower costs for the countries.

Conversely, Med-P and Forti-P focused on situations where market inefficiencies prevented the effective development of product-based solutions. Forti-P “work[ed] with the food industry to develop food fortification schemes, and use[d] existing food marketing channels to deliver better nutrition” (annual report, 2007-8, p. 18). Developing new business models was at the center of the partners’ collective actions. Med-P focused on supporting companies’ research and development (R&D) projects in the search for affordable, high-quality, and robust drugs designed for special target groups. “Working in partnership (…) means companies can share the cost and risk of drug development (and) create a functioning market for new products,” according to its website.

In shaping their product focus, the partners acknowledged that their solutions required *social adaptation* to meet the beneficiaries’ needs. For example, Push-P also financed and promoted “outreach and prevention-related interventions” (P2), which included the shaping of
disease-related communication and behavioral change strategies (report, 2003). Likewise, the partners encouraged the adaptation of distribution strategies, such as the use of motorbikes to reach the most remote beneficiaries (webpage). Vacc-P’s partners also promoted “broad education programs to inform a range of audiences about the efficacy of vaccination, from grassroots public information campaigns, to targeted briefings for opinion leaders and health officials at all levels of government; and educational seminars that […] expand the knowledge of local health care workers” (report, 2002, p. 25).

Eradi-P’s accounts pointed to major adaptations for more patient-tailored vaccines and delivery to remote areas, such as reducing the needed doses, negotiating tranquility days in war zones, and massively leveraging social media to overcome “logistic, geographic, social, political, cultural, ethnic, gender, and other barriers to [reach] the most-marginalized […] children and communities” (health article, 2012, p. 542). Forti-P promoted the local adaptation of fortified food to the beneficiaries’ needs, and “social mobilization (…) with local nutrition champions” (F5) and more “door-to-door sales models” (F6). Med-P fostered product adaptation to its target groups’ specific needs and social contexts, for example, by using a “better tolerated dosage form for small children who are unable to take tablets” (report, 2003, p. 15).

Drug-P also approached its product focus by specializing and seeking cost-effectiveness and social adaptation as it aimed to advance “research and development of new treatments for pressing diseases via a cost-effective, innovative, not-for-profit drug development model” (website). In this respect, social adaptation meant considering not only the disease characteristics but also the particularities of the beneficiaries, safety and tolerance requirements, and issues relating to stability, route of administration, dosing and treatment, and costs. However, Drug-P’s product approach differed in that its founding organization wanted
to develop a model that would consider not only diseases affecting the most neglected patients but also the local field contexts in terms of socio-economic challenges and health capacities.

Consequently, while its primary purpose would be to develop new treatments for global application, Drug-P’s development platforms would be “designed from the outset to strengthen local skills and to prepare access to treatment for the greatest number of people, consolidate new skills, and strengthen local infrastructure” (health article, 2019, p. 8). Such field-level capacity strengthening would include activities such as renovating and re-equipping health sites and clinical laboratories, as well as training health service personnel, for example, for building expertise in clinical trial methodology. The think tank worked hard to design a suitable product-focused CSP concept that would incorporate a strong field anchoring. “It took four years to develop the idea. We looked at different models and were convinced that we could create a new one” (D1). To this end, the founding partners “play[ed] a crucial role in anchoring [the CSP] in the urgency and reality of neglected […] actors in the field” (report, 2013, p. 4).

Product focus as a collaboration template. Across our sample, we found that when moving to the CSP design, the focus on products – whether on their delivery or their development – helped guide the partner configuration in terms of peripheral and central positions and respective tasks. Moreover, it shaped the partners’ interaction structure and culture. Specifically, with health access being predominantly a public service, product delivery called for multilateral, governmental, and civil society partners to leverage their distribution capacities for the focal vaccines and treatments (see Table 1). The delivery-focused CSPs mostly influenced companies via interventions in product offer and demand and collaborations on selective delivery innovations.

For example, Push-P’s partners highlighted that the “delivery of health-care services should be rooted firmly in local capacity” (annual report, 2002, p. 4), which typically related to local public health agencies or multilateral organizations delivering the treatments financed
by Push-P. Similarly, Eradi-P and Vacc-P primarily built on local public health systems to deliver vaccines and, if this was insufficient, used alternative, civil society, and multilateral organization–based models. The large, sophisticated, and volume-oriented delivery work thereby required enhanced levels of formality. For example, according to the Push-P accounts (P8), “we can never completely eliminate red tape because of the nature and complexity of [the CSP].” Similarly, Vacc-P interviewees emphasized that “it’s like a big machine to get the vaccines out” (V3). In Eradi-P’s context, our accounts suggested: “There’s perhaps too much of a reporting burden there, too many task teams and working groups. We’re now trying to find that balance” (E1).

Conversely, the central partners for the two product development CSPs were companies. Forti-P reached its target groups by adopting “a private sector lens focused on business models” (F2) but also helped governments as much as possible in their monitoring capacity and civil society’s awareness work for food fortification. Med-P’s model was about “breaking the common pharma mindset” (M1) and connecting them with public actors. The focus on product development, in turn, required lighter structures that allowed for experimentation and nurtured an innovation-centered interaction culture (see Appendix). Our interviewees talked about Forti-P as being “agile and dedicated to testing models and innovating” (F9). Similarly, a Med-P employee compared it to “working in a kitchen or a film studio: You’re working with extremely creative, highly temperamental people” (M2).

Moreover, in terms of CSP design, we find that the five baseline CSPs followed a self-contained collaboration model that would operate largely independently of existing field programs and local capacity building measures. Proponents of such design stressed the prospects of “speed, ownership, accountability, and effective management,” “shaking up the status quo,” “remaining extremely flexible,” and “guarantee[ing] independence” (first annual reports). In this respect, our accounts for Drug-P differed as they emphasized a more locally
anchored design that, whenever possible, would support the strengthening of local capacity and interact with existing programs. For example, in designing what they called an “alternative model to develop drugs,” Drug-P’s R&D networks would prioritize “South-South and North-South collaborations” and support existing capacity in countries where the diseases were endemic (report, 2006, p. 3).

However, in terms of specialization, Drug-P showed a similar pattern as the baseline cases in that the product development focus spurred flexible collaborative structures and an innovative collaborative culture. In terms of partner configuration, Drug-P eventually also engaged with biotech and pharmaceutical companies via their social responsibility programs as the latter provided essential drug development expertise and capacities.

**Local Repercussions**

Compared with Drug-P, the other CSPs moved quickly toward implementation and soon reached important milestones in terms of product development and delivery (see Table 1 for 2005 and 2015/16 achievements). Despite these accomplishments, their product focus turned into a key point of external criticism. Donor- and partner-commissioned evaluations, along with academic health articles, warned of the CSPs’ disruptive field-level implications. We found no such criticism for Drug-P.

*Local disruptions (1).* The first point of criticism related to local resource absorption and negative side effects with the product focus causing significant coordination and opportunity costs for poorly equipped local health systems. For example, several stakeholders criticized Push-P’s “process [for creating] too much [of an] additional burden for recipients” (evaluation, 2004, p. 21). Another evaluation (2006, p. 3) cautioned that Push-P was “geared to support discrete disease projects rather than strategic programs (…) and [was] a major source of disharmony for national planning and implementation.” For instance, specialists left the more general public sector programs to pursue better-remunerated CSP health positions, which
had a negative impact on the availability of generic healthcare services in Zambia and South Africa (health article, 2010).

Similarly, Vacc-P’s partners faced criticism for having “failed to [better acknowledge the] priorities of the assisted countries” (health article, 2004, p. 1922) while succumbing to a tendency to “reinforce […] technical solutions to health” (health article, 2014, p. 866). As such, there was a risk that it would “undermine the [national] implementation capacity” (health article, 2004, p. 1923) with its disease-focused programs “distracting governments from coordinated efforts to strengthen health systems” (health article, 2014, p. 866). Eradi-P’s critics suggested that the focal disease was “not a priority for many developing countries” and warned that its exclusive focus on a single disease sometimes had an “adverse effect on the routine immunization programs” (health article, 2005, p. 377).

For Forti-P, a health article (2008, p. 407) suggested that “on-the-ground nutrition solutions and implementation options need to be identified by local authors rather than international systems.” Moreover, critics warned that “a possible negative side effect of [Forti-P] is the exclusion of small and medium-sized domestic food producers and companies that lack the fortification knowledge and technology” (health article, 2010, p. 18). Med-P had only a few of its drugs at an advanced development stage, which triggered little criticism at the local level. However, health experts warned about the “costs of changing the operating systems” (health article, 2000, p. 470) for affected communities once the partners’ drugs moved closer to delivery.

*Local disruptions (2).* While the abovementioned point of criticism surfaced early in the CSPs’ operations, the second point of criticism emerged later and concerned the *fragmentation of health solutions* and lack of coordination with other initiatives. Specifically, the CSPs’ solutions focused on addressing a specific health concern through drugs, vaccines, or some other product-based treatment. This narrow approach had an impact on the governance
of collective action – especially the coordination of resources – in the health field more broadly. A health article analyzing Push-P (2014, p. 55) warned about a “lack of harmonization of programs […] and the creation of parallel structures leading to inefficiencies and ‘doubling up’.” An earlier health article (2004, p. 99) had found that “[Push-P] was just one of several initiatives in these countries, which were superimposed on pre-existing funding and partnership processes.” Similar accounts emerged for Vacc-P and warned of a “conceptual distortion of health systems” at local levels (health article, 2014, p. 871) and that, regarding Eradi-P, there was “concern that the pure focus on [disease X] vaccination was problematic” (health article, 2014, p. 870).

We found comparable warnings in a health article mentioning Med-P (2004, p. 470), which stressed that “the international health landscape appear[ed] increasingly fragmented with diverse players in overlapping coalitions and partnerships.” Fragmentation was another issue raised in an evaluation of Forti-P (2014, p. 9): “The essential action for adequate food fortification initiatives is their integration into comprehensive and effective national food and nutrition security policies, strategies, and programs that also address the possible risks of food fortification and the complex causes of hidden hunger.” Because of this fragmentation, there were calls for greater collaboration between CSPs, and with other initiatives. Such calls included the need “to identify best implementation practices and opportunities for fruitful collaboration across disease programs” (evaluation of Push-P, 2004, p. 5) to avoid “critical gaps and missed opportunities” (evaluation of Push-P, 2009, p. 37). For Vacc-P, an evaluation (2014, p. 24) suggested that “health systems strengthening represents a clear opportunity for collaboration.” Others called on “the international food system [to act] in a coordinated way” (health article, 2008, p. 407).
Toward an Anchored Product Focus

In response to these points of criticism, the partners of the five CSPs embarked on adaptations: by agreeing on a better anchored solution focus and by adapting the CSP design.

Local field anchoring and design adaptations (1). First, the five CSPs decided to add product-centric measures to strengthen local field capacity, including workstreams with support teams and structures to guide these activities. For example, although Push-P, since its inception, had been involved in some health systems strengthening (HSS) work, these efforts had small outcomes (evaluation, 2009). Consequently, the Push-P partners clarified and extended the scope of their HSS activities and created two new technical partnership positions and a cross-functional technical working group “as a coordinating mechanism to more effectively implement […] the HSS activities” (board report, 2009, p. 27).

Vacc-P began supporting HSS activities in 2005/6 (board meeting minutes) and added an HSS partnership task team to “provide technical input and oversight at the global level and to coordinate communication between partners and global and regional levels” (evaluation, 2009, p. 41). Similarly, Eradi-P continuously expanded its support for local health systems, which later led to considerations such as “for a long time, people were saying that [we] take all this funding and don’t leave enough for other immunizations. But now they see [we’ve] supported a whole range of additional activities and some reinforcement of the health system” (E5). Forti-P’s partners added programs to “improve the nutrition and health of farmers, workers, and their families in supply chains,” to bring more suppliers on board, and to help “small and medium enterprises in Africa to scale up their production and delivery of healthy foods” (website). At Med-P, supporting access to health systems was long viewed as “well, that’s somebody else’s job,” but in 2007, it “really became part of the work we do” (M2), including a separate partnership work unit.
**Global field anchoring and design adaptations (2).** Second, the five CSPs started to foster *global field integration* and added related *field-level coordination mechanisms* to their CSP design. For example, Push-P and Vacc-P began collaborating around HSS via an umbrella partnership and funding platform in 2009. Relocating their global secretariats to a single building would also “intensify collaboration” (press, 2018), especially with respect to sharing knowledge and coordinating political advocacy. Vacc-P joined Eradi-P’s supervisory board to enhance coordination and synergy between the CSPs, for example by helping strengthen routine immunization programs. Forti-P worked with a multilateral organization to “enable inclusive and efficient agricultural and food systems” (press release, 2019) and collaborated with a consumer goods forum to “raise nutrition standards for workforces across the globe” (website). In 2009, Med-P joined a consortium of 11 CSPs to seek collaboration opportunities, and in 2011 it became a member of a coalition around regulatory resources and fostered consultation with a delivery-focused global CSP.

These adjustments thus required adaptations to the CSP design through additional teams and positions. But most importantly, they produced a conceptual shift from a detached product focus to better anchoring it in the local and global health fields. Our contrast case in turn shows that when focusing on capacity building at the product-field interfaces and coordinating across CSPs from the outset, the above disruptions to local field actors and systems can be avoided. Drug-P’s anchored product focus with its local network approach made the CSP more receptive to local field challenges and helped meet the need to collaborate across initiatives. Thus, it was formed by integrating capacity-building measures in the product focus and seeking cross-initiative coordination. For example, it transferred one of its drug ideas to Medi-P as it saw a better fit there. Moreover, when it moved toward implementation, it could strengthen collaboration with other CSPs (e.g. identify synergy and alignment opportunities and jointly gather stakeholder input; report, 2009).
Discussion

We set out to understand how a CSP’s product focus influences the governance of collective action at the partnership and issue-field levels. By comparing the evolution of five health CSPs over time and with a contrast case, we showed how – through specialization and as a reflection of the partners’ logic combination – the product focus functions as a means for social coordination at both of these levels. Specifically, depending on the availability of suitable products, the analyzed CSPs specialized in product development or delivery, which, in turn, influenced the preferred partner configuration and agility of the collaborative structures and culture. Furthermore, by reflecting a specific logic constellation, the partners’ product focus was initially either detached or field-anchored and expedited or delayed the move toward implementation by suggesting self-contained or field-anchored collaboration templates. At the issue-field level, we however find that a detached product focus risked diverting resources away from other, typically resource-poor field actors and spurred the fragmentation of health solutions. Conversely, an anchored product focus facilitated field-level collective action by strengthening local capacities and promoting field integration at the product–field interlinkages.

These insights contribute to extant literature by enriching the relational and structural views (Alonso & Andrews, 2019; Caldwell et al., 2017; Huxham & Vangen, 2004) on CSP governance with insights into the implications of CSPs’ targeted “solution,” and help link CSP governance to issue field considerations (Gray & Purdy, 2018; Vurro & Dacin, 2014; Dentoni et al., 2020) by acknowledging the CSP’s impact on field-level collective action. We elaborate on these contributions by considering the nature, drivers, and multilevel implications of CSPs’ product focus (see Figure 3).

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Different Product Foci and Their Respective Drivers

Our study interest in the specific solution, namely, the type of focal output (Van Tulder et al., 2016) that a CSP develops to tackle the societal challenge, brought to light different product foci. First, depending on the lack or existence of suitable products for the targeted health issue and beneficiary group, the studied CSPs focused mainly on product development or delivery. Second, the partners’ product focus reflected different ways in which they combined underlying logics in terms of assumptions, values, and priorities. Logic combinations are known as influencing behavior (Scott, 2003) and, depending on how they combine logics across different items, create patterns (Goodrick & Reay, 2011), such as different product foci and their governance implications in our study (see Figure 3).

A “detached” product focus comprised a strong market logic (i.e. a focus on cost-effectiveness, speed, and measurability), which centered on products as technical outcomes. In line with a social logic (i.e. a focus on the beneficiaries’ social needs and their empowerment), the products would yet be adapted in composition and in dissemination practices (see also Battilana & Dorado, 2010; Pache & Santos, 2013; Thornton et al., 2012). These logics combined in segmentation (Goodrick & Reay, 2011), meaning that the market logic influenced the partners’ overall interactions, while the social logic guided actions at the CSP-beneficiary interface. On this basis, a detached product focus would build on self-contained collaboration templates and largely neglect the interdependencies with other field programs and the need to strengthen local capacities.

Conversely, the “anchored” product focus added such a “field-anchoring logic” which focused on strengthening field capacity and integration. This logic served local health fields in the public interest but differed from what is commonly considered a public service logic (i.e. a focus on more bureaucratic and hierarchical approaches, Jay, 2013; Thornton et al., 2012). The field-anchoring logic acknowledged the important interdependencies not just among CSP
partners but also with the social-ecological systems (see Dentoni et al., 2020) in which they were situated. Similar to what McKague et al. (2015) introduced as contextual bridging in developing markets when actors transfer new meaning, practices, and structures in a context-sensitive way (i.e. sensitive to the norms, practices, knowledge, and relationships existing in that context), our study reveals a field-anchoring logic to transfer products in a way that is sensitive to their effects on other field players and programs. While extant literature on introducing new solutions, and especially products, to social causes highlights the need to socially contextualize and adapt these products in the form of “on the ground involvement” in interaction with beneficiaries and direct partners (Purtik & Arenas, 2019; van Wijk et al., 2019), we show how the task of contextualizing also requires the operational coordination with other field initiatives and programs and the supporting of local field capacities.

However, such operational field anchoring seems to come at a trade-off with pursuing a market logic in view of efficiency-effectiveness tensions (Provan & Kenis, 2008). Specifically, at the level of the partnership, efficiency ambitions enabled by CSP independence, simplicity, and speed conflict with the greater complexity, interdependencies, and long-term approaches necessary to enhance the effectiveness of field-level collective action. In five of the study cases, concessions to the market logics were eventually made when critics flagged the field-disruptive effects of their initially detached product focus. Conversely, the contrast case illustrates how a balance between the three logics can be crafted early on. The anchored product focus built on an integrative constellation (Goodrick & Reay, 2011) of market, social, and field-anchoring logics, in which each dominated in a specific area.

At the root of an initially detached or anchored product focus, our study elucidated the role of funding-providing CSP catalysts. Business sector–related catalysts supported a detached product focus, whereas the contrast case presented a humanitarian organization with ample experience with local health challenges and programs as the driver behind an initially
anchored product focus. In all cases, however, these catalysts neither acted as neutral conveners (Gray, 1989) nor built on an established legitimacy (Maguire et al., 2004) or a central field position (Zietsma et al., 2017) as studies on field dynamics would suggest. Instead, they adopted the roles of “backstage actors” (Litrico & David, 2017) at a time where the MDGs opened up public, disease-related health fields to multiple sectors for the first time. Roles and influence were to be shaped (Maguire et al., 2004), and new actors could channel and promote subgroups that corresponded to their solution vision.

Thus, the CSPs did not emerge around open-ended deliberations considering multiple solution alternatives (Gray, 1989; Van Tulder & Keen, 2018). Rather, our findings exemplify what Eden and Huxham (2001) introduced as pragmatic group processes: An actor with significant resources to offer the group influences the collaborative agenda, and the other partners pragmatically accept it. Consequently, in addition to influencing a CSP design through increased accountability requests (Kolk, 2014) and suggesting specific corporate partners (Osei-Amponsah, van Paassen, & Klerkx, 2018), donors may act as CSP catalysts and assert their product-based solution vision.

While creating momentum, such an influential role can be problematic when the catalysts are “deeply committed and morally energized” people who still “lack familiarity with the details on the ground” (health article on Vacc-P, 2004, p. 1923). By showing how a detached product focus may engender disruptive field-level effects, our study suggests it is not enough for such catalysts to be emotionally involved and interact with others (van Wijk et al., 2019): They also need to develop a deep understanding of extant field-level initiatives, structures, and systemic challenges.
A CSP’s Product Focus and the Interplay of Collective Action at the Partnership and Field Levels

As a key contribution, our study shows how a view on different CSP product foci matters as we illustrate their partnership and field-level implications. In terms of specialization, we found that with a focus on product delivery (development), CSPs were more likely to use sophisticated (light) structures, to develop a formal (innovative) interaction culture, and to incorporate businesses as peripheral (core) partners. While one may assume these CSP characteristics result from the sectors involved (Bryson et al., 2015; Selsky & Parker, 2005), our contrast case confirms the influence of the CSP’s specialization: While the Drug-P partners initially did not intend to collaborate with companies for drug development, their CSP structure was still perceived as flexible and its interaction culture as innovative before they ultimately added companies to the partner configuration. These insights suggest that, in addition to the partners’ sectoral background (Bryson et al., 2015; Rivera-Santos & Rufin, 2010; Rufin & Rivera-Santos, 2012; Selsky & Parker, 2005), questions of power and trust (Bryson et al., 2015), and partnering experience (Alonso & Andrews, 2019), a CSP’s specialization in either product development or delivery shapes how collective action is governed. Specifically, it influences how the partners align their interactions and, as such, shapes the coordinative dimensions of CSP governance (Gulati et al., 2012).

Besides this direct impact, we found the specialization to influence when the limitations of an initially detached product focus may surface: Criticism regarding field-level ripple effects tended to emerge earlier for product delivery CSPs, whereas for product development CSPs criticism emerged later when the first product pilots were to be scaled. This links to the second facet of a product focus’s social coordination function, here as a carrier of a specific logic constellation (Scott, 2003). At the partnership level, we found a detached product focus to suggest self-contained collaboration templates and, thus, to accelerate the move toward CSP
implementation. Our contrast case, however, suggested that not all the studied CSPs fit this pattern and that there is merit in taking an anchoring perspective from the start – even if searching for new, better field-anchored collaboration templates draws out a CSP’s formation period. In this way, Drug-P’s partners were able to anticipate and avoid disruptive tensions – not between different partners, as frequently reported (Bryson et al., 2015; Vangen et al., 2015), but at the field–CSP interfaces.

Our view on a CSP’s product focus hence helps reveal critical interlinkages between the governance of collective action at the partnership and field levels. Prior studies on CSP–field interactions have focused on how fields may change and further institutionalize as a result of partnerships (Gray & Purdy, 2018), for example, by expanding governance arrangements such as standards (de Bakker et al., 2019) or offering a proto-institution that has the potential to be emulated and spread through the field (Lawrence et al., 2002). Moreover, they highlight how the socio-ecological systems in which a CSP is embedded may either reinforce or cancel out a CSP’s impact (Dentoni et al., 2020). Our study indicates that a CSP’s product focus can either promote integrated field-level actions or cancel out the capacity and impact of other programs and actors in the issue field.

Specifically, we illustrate how a detached product focus may risk disrupting the governance (especially coordination) of collective action at the field level by absorbing scarce local resources and spurring field fragmentation that enhances complexity and inefficiencies. These insights resonate with recent empirical studies that draw attention to CSPs’ unintended negative effects on beneficiaries (Vestergaard et al., 2020) or resource and interest alignment opportunities in other CSPs (Arslan & Tarakci, 2020). We demonstrate field-level negative ripple effects that affect other field actors, especially resource-poor market players (e.g. smallholder farmers in the case of nutrition) or public systems (e.g. local health programs).
An anchored product focus, in turn, helped avoid (address) such detrimental effects and facilitated the governance of collective action at the field level in two ways. First, it promoted capacity-building activities in product-disseminating public systems (Push-P, Vacc-P, Eradi-P, and Drug-P) and/or market systems (e.g. Forti-P, partly Med-P) at the local field level. For the former, capacity building includes, among others, product-related infrastructure support and local staff training. For the latter, it may revolve around promoting sustainable market structures and supporting local companies and institutions (e.g. farmers and laboratories). These activities matter because “in the poorest countries, success will be limited unless the more fundamental causes of poverty and inequity are also addressed” (Push-P related health article, 2004, p. 52), and CSPs help build the local (health) infrastructure and promote local ownership (Buse & Harmer, 2007; Utting & Zammit, 2009).

Moreover, an anchored product focus promoted field integration by coordinating with other initiatives and programs, and by establishing CSP interlinkages at the global field level. These insights expand a recent study that introduced the need for cross-CSP coordination as a result of funding requirements or CSP staff’s experiences (Caldwell et al., 2017) as we expose the ripple effects (e.g. overloading resource-scarce local actors and public programs) if such coordination is missing. Our study suggests that such coordination may involve the sharing of knowledge and insights (i.e. strengthening across all sample CSPs), aligning development or delivery standards and practices (Med-P and Drug-P; and Vacc-P and Push-P), pooling voice and influence to bring about a change in policy (i.e. strengthening across all sample CSPs), and having formal governance interlinkages (Eradi-P and Drug-P).

**CSP Design Implications**

Based on the different product foci and their effects on governing collective action at the partnership and field levels, we can elaborate on specific design implications. First, as our findings contrast the agile structures and innovative culture of CSPs specialized in product
development with the more formal and rigid design of product delivery ones, they prompt the question of whether CSPs per se are a flexible organizational form, as is often suggested (Utting & Zammit, 2009). Moreover, specialization may bring about specific challenges. For example, how do the more rigid product-delivery CSPs or “well-oiled engines” (V6) ensure the continuous learning and recalibration of partner roles that CSPs require to adapt to changing environments (Caldwell et al., 2017; Dentoni et al., 2020; Le Ber & Branzei, 2010)? And how do the more agile product-development CSPs align the need for waterproof partner contracts with the use of light structures and agile processes?

Second, our findings suggest that, in order to overcome the shortcomings of a detached product focus, CSP partners may need to move from a self-contained to a better field-anchored CSP design by adding field-level capacity-building workstreams and field coordination mechanisms. The latter two mechanisms expand what Dentoni et al. (2020, p. 13) suggest are “zooming out practices” – establishing communication channels and adopting complex frames. Deeper interlinkages may be necessary in the form of establishing capacity-building CSP responsibilities and teams interacting with local field actors, as well as CSP-spanning task forces and coordination structures anchored in the global issue field.

However, when moving towards a more field-anchored CSP design our accounts noted that “measuring the impact of those [field-strengthening] interventions is difficult” (V8) and that a more anchored product focus may thus run counter to some donors’ preference for quick, technology-oriented solutions. Diversifying the funding basis towards more long-term oriented donors may be one solution, as shown by Drug-P, whose policies stipulate that at least 50% of its budget must be publicly funded while no one donor can contribute over 25% of all donations. Likewise, greater CSP coordination and collaboration may be challenged by “working together but bidding for the same funds” (F1) and by “adding complexity” as the Eradi-P quotation in the appendix shows. These trade-offs constitute an interesting avenue for
future research. For example, how can CSP partners manage to develop and agree on comprehensive, field-strengthening solutions while simultaneously securing sufficient funding? Furthermore, what are the particularities of collaboration between CSPs rather than individual organizations? And how do CSPs manage competition for donors and resource-rich partners when collaborating?

Conclusions

Our study expands research on CSP solutions (de Bakker et al., 2019; Dentoni et al., 2018; Liese & Beisheim, 2011; Stadtler & Lin, 2019) by exposing the role of a CSP’s product focus as a multilevel social coordination mechanism and delineates the implications for governing collective action within and beyond the partnership. We posit that a view on the CSP’s targeted solution, here its product focus, advances our understanding of CSP’s multilevel interlinkages (Dentoni et al., 2020; van Wijk et al., 2019) as it helps explain the relationships between individual catalysts (micro level), the partner interactions and CSP governance (meso level), and the CSP’s local and global field-level implications (macro level).

In adopting such a view, our study contributes new insights into the coordination-related component of CSP governance (Gulati et al., 2012) with implications for the relational (Caldwell et al., 2017; Huxham & Vangen, 2004) and structural (Alonso & Andrews, 2019; Rufin & Rivera-Santos, 2012) views. Our study also adds to extant understanding of CSPs’ impact on larger systems (Clarke & Crane, 2018; Dentoni et al., 2020; Van Tulder et al., 2016) by linking CSP and field considerations (Gray & Purdy, 2018; Vurro & Dacin, 2014) beyond a CSP formation (Lawrence et al., 2002), and by uncovering different facets of a CSP’s field anchoring.

In reaching these insights, our study remained explorative and thus calls for further research. For example, we limited our analysis to six global product-focused health CSPs that, by the end of the study, had operated for nearly 20 years. More research is needed to explore
the implications of a CSP’s product focus – for example, by examining it (1) in other issue areas, such as access to education and water (Selsky & Parker, 2005), (2) in CSPs that are less institutionalized, such as bilateral, project-based partnerships, (3) with a comparison between failed and ongoing CSPs to overcome our study’s potential survivor bias, and (4) in more recently formed CSPs that might have learned from millennial CSPs.

Future research may also draw on a larger database, such as the global health partnership directory of International Federation of Pharmaceutical Manufacturers and Associations, and (1) quantitatively explore the influence of catalyzing actors in CSP formation processes and (2) test the suggested implications of a product focus’s specialization and underlying logic combination (see Figure 3). Together with the questions outlined in the discussion, we hope our study encourages more research into the role of a CSP’s product focus and the governing of collective action at the partnership and field levels.

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https://apps.who.int/iris/bitstream/handle/10665/69367/WHO_CDS_NTD_2006.2_eng.pdf?sequence=1

Figure 1: Data Structure
Figure 2: Process Models of CSPs’ Product Focus and its Multilevel Implications
Figure 3: The Drivers, Nature, and Implications of a CSP’s Product Focus
Table 1: Case Partnerships

<table>
<thead>
<tr>
<th>Founding partners</th>
<th>Push-P</th>
<th>Vacc-P</th>
<th>Eradi-P</th>
<th>Forti-P</th>
<th>Med-P</th>
<th>Drug-P</th>
</tr>
</thead>
<tbody>
<tr>
<td>• United Nations (UN) agencies • developing countries, donor governments • foundations • companies • civil society organizations</td>
<td>• two UN agencies • an international financial institution • a private foundation</td>
<td>• a national public health institute • an international service organization • a UN organization • an international financial institution • a private donor foundation</td>
<td>• an industry initiative • a UN agency • a private foundation • four donor governments</td>
<td>• a UN agency • a related partnership • a private foundation • research donors • three public, one private, and one international research institutions • a ministry • a civil society organization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focal solution</td>
<td>• Address a small set of priority diseases by enabling the delivery of product-based solutions</td>
<td>• Address a larger set of priority diseases by fostering the delivery of vaccines</td>
<td>• Address a focal disease with global vaccination programs</td>
<td>• Address a focal health problem by developing sustainable product solutions</td>
<td>• Address a focal disease by jointly developing new and/or improved drugs</td>
<td>• Address a set of priority diseases by jointly developing new and/or improved drugs</td>
</tr>
<tr>
<td>Collaborative governance: Cross-sector board with representatives</td>
<td>• … from civil society, affected communities, business, foundations, and implementing and donor governments</td>
<td>• … from the UN, the vaccine industry, aid agencies, major foundations, and independent experts</td>
<td>• … in line with the founding partners</td>
<td>• … of key donors, industry, and experts from leading development and scientific organizations</td>
<td>• … of the public sector, academia, and the business sector</td>
<td>• … of founding partners and other organizations, e.g. pharma, based on required skills</td>
</tr>
<tr>
<td>Operational model</td>
<td>• Pool global resources and support partnerships to deliver product-based disease solutions. Based on an independent expert review’s input, resources are disseminated to locally crafted, multi-stakeholder delivery programs</td>
<td>• Ministries and international organizations estimate vaccine demands, an international partner tackles procurement, and in-country health systems, international organizations, and civil society organizations collaborate in delivery</td>
<td>• Advocate global resources for implementing a joint disease program focused on public and civil society organizations’ vaccination campaigns and professional, coordinate disease surveillance</td>
<td>• Promote national food fortification programs governed by national cross-sector alliances (e.g. help companies add micronutrients, increase nutrition awareness, and enable public food fortification monitoring)</td>
<td>• Solicit donor funding and co-finance drug development projects with public laboratories and industry partners. Civil society and international organizations help deliver drugs to countries where market mechanisms do not work</td>
<td>• Solicit donor funding and co-finance drug development projects with disease-endemic public laboratories and industry partners. Civil society and international organizations help deliver drugs where market mechanisms do not work</td>
</tr>
<tr>
<td>• CSP employees* • Partners</td>
<td>• Approx. 700 • Approx. 250</td>
<td>• Approx. 200 • Approx. 100</td>
<td>• No secretariat • Approx. 150 • “hundreds”</td>
<td>• Approx. 120 • Approx. 150</td>
<td>• Approx. 100 • Approx. 180</td>
<td>• Approx. 200 • Approx. 180</td>
</tr>
<tr>
<td>Resources*</td>
<td>Approx. £4.6 billion</td>
<td>Approx. £1.5 billion</td>
<td>n/a</td>
<td>Approx. €51 million</td>
<td>Approx. €64 million</td>
<td>Approx. €49 million</td>
</tr>
<tr>
<td>Donors</td>
<td>• Governments, private foundations, corporations, others</td>
<td></td>
<td></td>
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<tr>
<td>2005/6 (2015/16) results</td>
<td>• Accumulated ca. 10 (823) million people reached</td>
<td>• Accumulated ca. 114 (277) million core beneficiaries reached</td>
<td>• Disease remaining in 28 (2) countries</td>
<td>• 600 (768) million people pro year reached with fortified food</td>
<td>• 19 (26) projects with 0 (10) treatments delivered</td>
<td>• 0 (6) treatments delivered</td>
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*FY2016/17 based
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<tr>
<th>Tab 2: Archival Documents and Interviews</th>
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<tr>
<th>Push-P Interviewees</th>
<th>Eradi-P Interviewees Code</th>
<th>Documents</th>
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<tbody>
<tr>
<td>Finance Specialist</td>
<td>P1</td>
<td>• Webpage • Annual reports (16) • Videos (2) • Strategy &amp; governance docs (7) • Board meeting minutes (40) • Academic studies and commissioned external evaluations (19) • Brochures (3) • Case studies (4) • Press articles and releases (39)</td>
</tr>
<tr>
<td>Program Manager*</td>
<td>V1</td>
<td>Webpage (3), Annual reports (13) • Book chapter • Brochure • Case study material • Advocacy tool book • Academic studies and commissioned external evaluations (12) • Videos (11) • Press articles and releases (52)</td>
</tr>
<tr>
<td>Legal Manager</td>
<td>V2</td>
<td>Webpages (3), Annual reports (13) • Book chapter • Brochure • Case study material • Advocacy tool book • Academic studies and commissioned external evaluations (12) • Videos (11) • Press articles and releases (34)</td>
</tr>
<tr>
<td>Senior Project Manager</td>
<td>V3</td>
<td>Webpages (3), Annual reports (13) • Book chapter • Brochure • Case study material • Advocacy tool book • Academic studies and commissioned external evaluations (12) • Videos (11) • Press articles and releases (34)</td>
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<tr>
<td>Relationship Manager</td>
<td>V4</td>
<td>Webpages (3), Annual reports (13) • Book chapter • Brochure • Case study material • Advocacy tool book • Academic studies and commissioned external evaluations (12) • Videos (11) • Press articles and releases (34)</td>
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<tr>
<td>Fund Manager</td>
<td>V5</td>
<td>Webpages (3), Annual reports (13) • Book chapter • Brochure • Case study material • Advocacy tool book • Academic studies and commissioned external evaluations (12) • Videos (11) • Press articles and releases (34)</td>
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<tr>
<td>Partnerships Manager</td>
<td>P7</td>
<td>Webpages (3), Annual reports (13) • Book chapter • Brochure • Case study material • Advocacy tool book • Academic studies and commissioned external evaluations (12) • Videos (11) • Press articles and releases (34)</td>
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<tr>
<td>Country Team</td>
<td>P8</td>
<td>Webpages (3), Annual reports (13) • Book chapter • Brochure • Case study material • Advocacy tool book • Academic studies and commissioned external evaluations (12) • Videos (11) • Press articles and releases (34)</td>
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<tr>
<td>Communications</td>
<td>P9</td>
<td>Webpages (3), Annual reports (13) • Book chapter • Brochure • Case study material • Advocacy tool book • Academic studies and commissioned external evaluations (12) • Videos (11) • Press articles and releases (34)</td>
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<td>Human Relations</td>
<td>P10</td>
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<tr>
<td>Partnerships Manager II</td>
<td>P11</td>
<td>Webpages (3), Annual reports (13) • Book chapter • Brochure • Case study material • Advocacy tool book • Academic studies and commissioned external evaluations (12) • Videos (11) • Press articles and releases (34)</td>
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<tr>
<th>Vac-P Interviewees</th>
<th>Documents</th>
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<tbody>
<tr>
<td>Program Consultant</td>
<td>(2 interviews)</td>
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<tr>
<td>Project Management</td>
<td>(2 interviews)</td>
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<tr>
<td>Technical Manager</td>
<td>(two interviews)</td>
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<tr>
<td>Researcher</td>
<td>(two interviews)</td>
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<tr>
<td>Director II</td>
<td>(two interviews)</td>
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<tr>
<td>Coordination</td>
<td>(two interviews)</td>
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*These employees changed jobs across our sample CSPs.
### Appendix: The Role of a CSP’s Product Focus in Collective Action

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<th>Initially Detached Product Focus</th>
<th>Anchored</th>
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<tr>
<td><strong>Catalysts promoting their partnership idea</strong></td>
<td><strong>Drug-P</strong></td>
</tr>
<tr>
<td>Business-sector vs. humanitarian actors promoting a product-based solution</td>
<td>• “We are dedicated to (...) sharing advances in health (...) for example for vaccine-preventable diseases.” Press release, main funder</td>
</tr>
<tr>
<td>Vacc-P described as “emblematic of the so-called [funder X] approach to global health, focused on targeted technical solutions with clear, measurable outcomes.” Health article 2014</td>
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<tr>
<td>• “[The association] claims that its previous initiative was a catalyst for [Eradi-P].” Press 1997</td>
<td>• “[Drug-P] was financed regionally by (Organization X), (…)” D1</td>
</tr>
<tr>
<td>• “A number of nutrition interventions have been shown to significantly improve child health and survival. (...) These tools must be scaled up.” Funder website</td>
<td>• “Since the beginning, it was clear that we have a different DNA because of our founder.” (D4)</td>
</tr>
<tr>
<td>Leveraging financial resources for their solution vision</td>
<td>• “[Donor Y] made it clear that [they] would contribute funds only to a streamlined organization that could act quickly.” Health book 2012</td>
</tr>
<tr>
<td>• “For him [a Vacc-P donor], there are no unsolvable problems; it is just a question of financial resources.” Press 2006</td>
<td><strong>Absence or existence of suitable products</strong></td>
</tr>
<tr>
<td>• “[The association] had raised $248 million in a campaign to combat [the disease]. Contributions came from individuals, firms, foundations, and government grants.” Press 1997</td>
<td>• “We now have the knowledge that can protect the muscles, brains, and blood.” Website</td>
</tr>
<tr>
<td>• “…not established until Western donors (...) provided significant funds…” Agriculture article 2010</td>
<td>• “First line drugs are unfortunately failing because of spreading resistance.” Report 2000</td>
</tr>
<tr>
<td>• “Foundation [X] which provided more than 60% of the funds, had its own employees to work with [Med-P].” Health book 2012</td>
<td>• “…left without adequate treatment options when the only available drugs are archaic, ineffective, or toxic.” Think tank 2001</td>
</tr>
<tr>
<td><strong>Building on extant knowledge or products</strong></td>
<td><strong>CSP with a product focus</strong></td>
</tr>
<tr>
<td>• “Yet there are well-proven medical interventions to combat these infections.” Annual report 2002-3</td>
<td><strong>Specialization: Product development or delivery</strong></td>
</tr>
<tr>
<td>• “prioritize strengthening the delivery system of existing vaccines.” Press 2002</td>
<td>• “purchase and support the diffusion of drugs, vaccines, and other commodities,” article 2000</td>
</tr>
<tr>
<td>• “There was a vaccine, [and] there was the strong motivation.” E1</td>
<td>• “Our sourcing department tries to influence the prices of the drugs through pooling demand.” P2</td>
</tr>
<tr>
<td>• “We now have the knowledge that can protect the muscles, brains, and blood.” Website</td>
<td>• “Address market failures that have led to stagnating global immunization rates.” Annual report 2001</td>
</tr>
<tr>
<td>• “First line drugs are unfortunately failing because of spreading resistance.” Report 2000</td>
<td>• Focus on “diffusion and uptake of prevention interventions,” article 2009</td>
</tr>
<tr>
<td><strong>Focus on “easy,” fast, and cost-effective solutions</strong></td>
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<td>• “There is nothing worse than having a great product (...) and not being able to scale that up.” P5</td>
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<tr>
<td>• “3 million people, most of them children, die each year from diseases that we can prevent with simple, inexpensive vaccines.” Annual report 2001</td>
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<td>• “Despite the availability of an effective, cheap, oral vaccine for more than 25 years, over 350 000 children were still being permanently paralyzed by the virus each year.” Health article 2007</td>
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<td>• “We have technologies that can bring […] at an extremely low cost into a” Annual report 2000</td>
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<tr>
<td>• “First line drugs constitute some of humanity’s most remarkably cost-effective medicines.” Annual report 2000</td>
<td>• “First line drugs constitute some of humanity’s most remarkably cost-effective medicines.” Annual report 2000</td>
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<tr>
<td>• “(1) develop new drugs (…); (2) use and strengthen capacities in disease-endemic countries; (3) (…) advocate for increased public responsibility,” annual report 2006</td>
<td>• “address the lack of effective, affordable, or easy to use drug treatments.” Article 2003</td>
</tr>
<tr>
<td>• “We are testing things, such as open innovation or having things done mainly on a free basis.” D4</td>
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| Social adaptation | • “We need to acknowledge that not all patient requirements are the same. (…). We need to adapt to where they’re living, who they’re living with, what they’re doing. We need to have differentiated approaches to care.” P5 | • “Certain groups are getting vaccinated much more frequently than others and we look at how those inequalities can be addressed and how coverage can be improved.” V1. • “Mobile teams bring (…) immunizations to outlying communities.” Annual report 2002 | • “Creating an enabling environment for the parents” E6. • “…mapped and brought health interventions to chronically (…) under-served communities.” Health article 2012 | • “Advocacy and communications: talking to women’s groups (…), a series of public announcements for broadcast by 60 radio stations.” Examples of report 2002 | • “Children don’t like bitter medicines, pregnant women cannot take certain medicines, so we are looking for sweet tasting medicines and safe ones for women.” M5 | • “address patient needs in a cost-effective way,” report 2013 |
| Product focus shaping the partner configuration | • “We have close connections with governments, both ministry of health and ministry of finance, with civil society, and with affected communities.” P10. • “Private sector engagement is mainly via our Innovation Center.” P4. | • “[Vacc-P] is an alliance including multi-laterals, donors, foundations, developing countries, industry, NGOs, and academia. (…)” Press. • “The private companies are the manufacturers of vaccines purchased.” V5. | • Centered on “two multi-lateral organizations and polio-affected countries to implement eradication efforts.” Report 2005 | • “In the nutrition context, the system is made of mostly the private sector. They are a primary stakeholder in the food system. So it is important to engage with them.” F10. | • Companies “bring expertise and facilities in drug discovery and development; (…) academic research institutions bring facilities (…) and field expertise.” Website. | • “Primarily located in low-income countries, partners include national disease control programs, health ministries, universities, civil society, pharmaceutical companies, health experts, and donors.” Health article 2019 |
| Product focus shaping the collaborative culture and structure | • “You need your model to be effective when you are dealing with such scale. (…) We have very strict measures for planning, budgeting, accounting, and auditing.” P2. • “The set operational structure could be seen as complex but it also involves multiple sectors.” P4. | • Besides its core model, [Vacc-P] is not overly innovative. Our comparative advantage is in the reduction of vaccine prices and procuring of mass quantities of vaccines.” V1. • “Every part of the process depends upon the interaction of all the actors involved.” V6. | • “Actually, have we now become too institutionalized. Are we slowing ourselves down?” E1. • “Comments included: ‘[Erad]–P has a very complicated administrative structure both globally and within countries’.” External evaluation 2016 | • “We’re always interested in being innovative, and making sure that we’re one step ahead.” F9. • “You need to not be afraid to build the structures you need.” F1. | • “It is one of the most creative places I’ve ever worked at.” M2. • “We have less structures and heavy processes than the UN; We have the same spirit as a private company.” M1. | • “[Drug-P] started out as an experiment which required innovation [and] risk taking.” Annual report 2012; • “[Drug-P] has an innovative, flexible, and efficient approach.” Health article 2011 |
| Self-contained vs anchored CSP design | • “urgency (…) to be operational (…) suggests that the complexities have been underestimated” article, 2010, p. 154; • “designed to be efficient, independent…” article 2007, p. 307 | • initially narrow and internationally managed program, health article 2011 • “business-like framework for action” report, 2002, p. 8. | • global coalition initially focused on “a single technological solution” to be promoted, health article, 2005, p. 381 see also evaluation, 2016, p. 20 | • “attention to business plans and seeks to achieve a high degree of efficiency” report 2004 | • “guarantee organizational independence” article 2015, p. 319. • “like a virtual pharmaceutical company,” D6. See “Field related design adaptations” which Drug-P incorporated early on. | |

Note: For Drug-P’s additional focus on strengthening local field capacity and global field integration see “CSP field anchoring.”
<table>
<thead>
<tr>
<th>Push-P</th>
<th>Vacc-P</th>
<th>Eradi-P</th>
<th>Forti-P</th>
<th>Med-P</th>
<th>Drug-P</th>
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<tr>
<td><strong>Disrupting local field actors and systems</strong></td>
<td><strong>Initially Detached Product Focus</strong></td>
<td><strong>Initially Anchored</strong></td>
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<tr>
<td><strong>• Local resource absorption and negative ripple effects</strong></td>
<td>• Criticism about “too high transaction costs associated with receiving support.” External evaluation 2006</td>
<td>• “In India, experts admit that [the disease] is not a priority number one in public health.” Health article 2005</td>
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<td></td>
<td>• “Inmunization is only one of a backbreaking press of challenges (…) and by no means the most urgent. (…) Field workers have been unenthusiastic supporters of that goal.” Health article 2004</td>
<td>• “[Forti-P’s] approach (…) criticized for relying on technical solutions which do not tackle the structural causes of hunger and malnutrition, e.g. poverty.” Nutrition article 2010</td>
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<td></td>
<td>• “(…) too much attention to specific disease programs, which are relatively easy to measure and assess in terms of outcomes, may attract resources, but detract from support for the systems which deliver services.” Health article 2000</td>
<td>• “[Med P] should consider increasing developing country membership in its board” (i.e. to better acknowledge local voices). External evaluation 2007</td>
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<td></td>
<td>• “The costs of vaccines are only a fraction of the vaccine programs’ cost (…) [which] includes staff salaries, transport, facilities, and training. But the partnership was often reluctant to support recurrent expenditure for health systems.” Health article 2000</td>
<td>• “A large number of difficult policy and institutional issues, both at the global and the national levels, have to be addressed before delivery can be effective.” External evaluation 2007</td>
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<tr>
<td><strong>• Fragmentation of field solutions</strong></td>
<td>• “Too many independent initiatives leading to “a supermarket approach: some vehicles here, some refrigerators there, but [without] strong health systems strategies behind.” Health article 2014</td>
<td>• “duplication, fragmentation, (…) conflict of interest, and rivalries are rife and make the international nutrition system ineffective and, worse still, potentially counterproductive.” Health article 2008</td>
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<td></td>
<td>• “We argue there is an opportunity for improved coordination between the three institutions at the country level in supporting health-related activities.” Health article 2012</td>
<td>• “Critics also claim that [Forti-P] provides quick fixes (…) [rather than] working with sustainable, community-based programs.” Nutrition article 2010</td>
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<td></td>
<td>• “In the West, control of [disease X] was achieved with a combination of sanitary reforms and immunization. [Eradi-P’s] promotion of vaccination as a single, unconnected technological solution was unsound.” Health article 2005</td>
<td>• “The remarkable proliferation of product development partnerships has resulted in duplication of mandates and activities.” Health article 2011</td>
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<td></td>
<td>• “[Eradi-P’s] strategy will require (…) to coordinate with a broader set of immunization stakeholders, including [Vacc-P], (…) But [Eradi-P’s] successes have often come by working outside systems.” Press 2018</td>
<td>• “Regular consultations, particularly with partnership [X] need to ensure that drugs developed meet priority medical needs.” Annual report 2000</td>
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### Adaptation: Toward an Anchored Product Focus

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<tr>
<td>Push-P</td>
<td>CSP field anchoring</td>
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<tr>
<td>Vacc-P</td>
<td>• Product-centric strengthening of field capacity</td>
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<tr>
<td>Eradi-P</td>
<td>• Enhancing global field integration</td>
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<tr>
<td>Forti-P</td>
<td>• Design adaptation</td>
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<tr>
<td>Med-P</td>
<td>• Adding of capacity-building workteams</td>
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<tr>
<td>Drug-P</td>
<td>• Enhancing coordination mechanisms</td>
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#### CSP field anchoring

- **• Product-centric strengthening of field capacity**
  - “The first executive director said ‘raise it, spend it, prove it’ – that’s what we do. Our last executive director said ‘We and our partners are building durable health delivery systems for chronic pandemics.’ That is a mindset shift.” P9
  - “In 2005, [Vacc-P] made the decision to expand its investment envelope to include initiatives in health system strengthening.” Evaluation 2009
  - “In 2006 we started to reinforce health systems and in 2015, we decided to link it more to immunization.” V8
  - “There is a lot work that we now do around the disease to strengthen the routine immunization systems in countries where they were practically non-existent.” E1
  - “…to rapidly align with broader efforts to strengthen immunization systems.” Strategy document 2013
  - “We now want to bring more suppliers on board.” Website
  - “[Forti-P] is working on a “nutritious foods financing facility to support small and medium enterprises in Africa to scale up their production and delivery of healthy foods.” Press 2018
  - “…reformulated its founding mission (…). This shift in mission has led to initiate a work program on improving the access and systems of drugs.” External evaluation 2007
  - “Drug development and access, including capacity strengthening are our pillars.” D5
  - “Supporting existing capacity in countries where the diseases are endemic, [and] helping to strengthen additional capacity.” Report 2006

#### Enhancing global field integration

- “There is now increased coordination with other organizations.” P7
- Collaboration with several initiatives (incl. Vacc-P) on health systems strengthening as of 2011
- Upcoming sharing of a building with Vacc-P, annual report 2018
- “Clear commitment to better co-ordinate activities and align support behind national health strategies, as is evident in initiatives such an international health partnership and a systems funding platform.” Health article on Vacc-P 2017
- “We now have some interest from other health initiatives to use our social data platform.” E6
- “[Vacc-P] has worked with [Eradi-P] to tailor its processes and support the global eradication efforts.” Press release 2014
- “[Organization X] and [Forti-P] have agreed to join forces to increase the availability and affordability of nutritious food for all in developing countries.” Website
- “[Forti-P] has joined forces with [Organization Y] to encourage employers…” Website
- “Regular consultations with [CSP X]” report 2000
- “Member of the global health technology coalition,” report 2010
- “[Initiative X] aims to help coordinate, support, and influence global efforts to combat […] major diseases of the poor and disadvantaged. It is a permanent observer of our Board of Directors.” Report 2007

#### Design adaptation

- “…recently created two new technical positions (…) and has implemented an active work program in relation to health systems strengthening.” Progress report 2009
- “A health system strengthening task team [was] added in 2005 to provide technical input and oversight at the global level and is charged with coordinating communication between partners and global and regional levels.” Evaluation 2009
- “To support these activities, the target is that by the end of 2014, at least 50% of funded field personnel’s time will be devoted to specific, measurable activities to help national authorities strengthen immunization systems and services.” Strategy doc 2013
- “Adding of about five new programs that focus on developing market capacities, in particular with a focus on smallholder, medium-sized companies, and nutrition governance.”
- “We started with a focus just on drug development and research, but we had to expand into a transitional department and now we have the more systems-oriented department.” M4
- “Strengthening endemic country capacity to advance new treatments” through partner selection, platforms, and local support from the onset. Website

- “Moving into the [same location] gives opportunities for further programmatic collaboration.” Progress report 2018
- “Teams across [CSPs] will regularly share information and expertise.” Report 2018
- “Informal collaborative spaces will encourage interactions and meetings and facilitate the exchange of expertise across different partnerships” Press 2017
- “Joint steering committee” report 2018
- “Just recently, last year, [Vacc-P] has been invited to join our aside board. For many years, we have been reluctant to engage them more because we felt that might add complexity.” E2
- “Membership in coordinating coalitions”
- “Membership in coordinating coalitions”
- “Regional research platforms to maximize worldwide collaborations.” Website
- “Membership in coordinating coalitions”
Endnotes

1 Given that many of these articles contain the CSPs’ names in their title and in order to keep our promises of case anonymity, we refer to them more generally, for example, as “health articles.”

2 For more information about each CSP’s formation process please consult the online supplement.