DFID HEALTH RESOURCE CENTRE

GHP Study Paper 6:

THE DETERMINANTS OF EFFECTIVENESS: PARTNERSHIPS THAT DELIVER
REVIEW OF THE GHP AND 'BUSINESS' LITERATURE

This paper forms part of the 2004 DFID Study: ***Global Health Partnerships: Assessing the Impact.***

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The DFID Health Resource Centre (HRC) provides technical assistance and information to the British Government's Department for International Development (DFID) and its partners in support of pro-poor health policies, financing and services. The HRC is based at IHSD's UK offices and managed by an international consortium of five organisations: Ifakara Health Research and Development Centre, Tanzania (IHRDC); Institute for Health Sector Development, UK (IHSD Limited); ICDDR,B - Centre for Health and Population Research, Bangladesh; Sharan, India; Swiss Centre for International Health (SCIH) of the Swiss Tropical Institute, Switzerland.

Title: The Determinants Of Effectiveness: Partnerships That Deliver Review of the GHP and 'Business' Literature

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Table of Contents

ACRONYM LIST

AAI	Accelerating Access Initiative to HIV Care
ACHAP	African Comprehensive HIV/AIDS Partnerships
AHPSR	Alliance for Health Policy and Systems Research
AMD	Alliance for Microbicide Development
AMP	African Malaria Partnership (GSK)
APOC	African Program for Onchocerciasis Control
CF	Concept Foundation
CICCR	Consortium for Industrial Collaboration in Contraceptive Research
CVP	Children's Vaccine Program at PATH
DPP	Diflucan Partnership Program
DNDi	Drugs for Neglected Diseases Initiative
DVP	Dengue Vaccine Project
EL-MDRTBP	Eli Lilly Multi-Drug Resistance Tuberculosis Partnership
EMVI	European Malaria Vaccine Initiative
FIND	Foundation for Innovative New Diagnostics
GAEL	Global Alliance to Eliminate Leprosy
GAELF	Global Alliance for the Elimination of Lymphatic Filiariasis
GAIN	Global Alliance for Improved Nutrition
GAVI	Global Alliance for Vaccines and Immunization
GBC	Global Business Coalition on HIV/AIDS
GCM	Global Campaign for Microbicides
GCWA	Global Coalition on Women and AIDS
GET 2020	WHO Alliance for the Global Elimination of Trachoma
GFATM	Global Fund to Fight AIDS, TB and Malaria
GFUNC	Gates Foundation/U. of North Carolina Partnership for the Development of New Drugs
GMAI	Global Media AIDS Initiative
GMP	Global Microbicide Project
GOARN	Global Outbreak Alert and Response Network
GPEI	Global Polio Eradication Initiative
GPHW	Global Public-Private Partnership for Hand Washing with Soap
GRI	Global Reporting Initiative
GWEP	Guinea Worm Eradication Program
HACI	Hope for African Children Initiative
HATC	HIV/AIDS Treatment Consortium (Clinton Foundation AIDS Initiative)
HHVI	Human Hookworm Vaccine Initiative
HIN	Health InterNetwork
HTVN	HIV Vaccine Trials Network
IAVI	International AIDS Vaccine Initiative
IDRI	Infectious Disease Research Institute
IOWH	Infectious Disease Research Institute
IPAAA	International Partnership Against AIDS in Africa
IPM	International Partnership for Microbicides
ITI	International Trachoma Initiative
JPMW	Japanese Pharmaceutical, Ministry of Health, WHO Malaria Drug Partnership

LAPDAP	*Name of anti-malarial treatment developed in public-private partnership*
LFI	Lassa Fever Initiative
MDP 1	Mectizan Donation Program
MDP 2	Microbicides Development Programme
MI	Micronutrient Initiative
MIM	Multilateral Initiative on Malaria
MMV	Medicines for Malaria Venture
MNT	Campaign to Eliminate Maternal and Neo-natal Tetanus
MTCT-Plus	Maternal to Child Transmission
MVI	Malaria Vaccine Initiative
MVP	Meningitis Vaccine Programme
NetMark Plus	*(insecticide treated net social marketing programme)*
PARTNERS	Partnership Against Resistant Tuberculosis: A Network for Equity and Resource Strengthening
PDVI	Paediatric Dengue Vaccine Initiative
PneumoADIP	Pneumococcal Accelerated Development and Introduction Plan
RBM	Roll Back Malaria
SCI	Schistosomiasis Control Initiative
SF	Secure the Future Initiative
SIGN	Safe Injection Global Network
Step Forward	*(international pharmaceutical company initiative to support AIDS orphans)*
TROPIVAL	*(French based R&D partnership for neglected diseases)*
VDP	Viramune Donation Program
VF	Vaccine Fund
Vision 2020	*(global initiative to eliminate unnecessary blindness)*
VITA	Vitamin A Global Initiative
VVM	Vaccine Vial Monitors
WPESS	WHO Programme to Eliminate Sleeping Sickness

SECTION 1: BACKGROUND AND SUMMARY OF FINDINGS

1.1 Background and methodology

DFID's development effectiveness team is undertaking a series of studies to:

- assess the impact of aid channelled through Global Funds and Partnerships (GFPs) in comparison with other aid instruments;
- determine a set of criteria for donor engagement with GFPs; and
- identify strategies to increase the effectiveness of the GFPs with which DFID is engaged.

A significant proportion of the GFPs with which DFID engages are concerned with health issues. The Global Health Partnership (GHP) Team within the Aid Effectiveness Group has therefore commissioned a substantial, evidence-based assessment of the impact of the GHPs with which DFID engages at both global and country level, drawing out best practice principles which will guide DFID's future engagement.

As part of this, DFID is interested in understanding what makes for good practice in governance and operations, and what determines 'partnership effectiveness'. In the terms of the OECD DAC Evaluation Framework, what factors determine the extent to which the partnership objectives are achieved?[1] What makes some partnerships work better and deliver more added value than others? What does the evidence tell us about the results of different types of inputs (types of partners involved, resources, structure) and process (partnership ways of working at national and international level)? What are the links between these inputs, with outputs and outcome level achievements (eg political profile and commitment, finance mobilisation, country buy-in, co-ordination and integration), and with impact (eg coverage, health outcomes and health system strengthening) at country level?

In response to the TORs, two literature reviews were commissioned, aiming to: a) synthesise the evidence for the determinants of effective partnership from the existing evaluation literature for the major GHPs; and b) from the wider business and political science field.

Both reviews took a similar approach. In order to help conceptualise 'effectiveness', the *determinants* and the *results* of partnership are distinguished at different levels (cf logframe methodology). Following the literature reviews, findings were compiled into summary matrices to link the determinants of effectiveness with results at different levels (inputs, process, outputs, outcomes/impact). The findings also suggest a series of hypothetical causal links between determinants and results at different levels.

This summary section covers both reviews, for which detailed findings are provided in sections 3 and 4, following section 2 on approach and general observations. Table 1 provides an integrated summary of the findings from both literatures. Annexes 1 and 2 summarise the key features of an effective partnership, as seen by the

[1] The five DAC dimensions are: Relevance: To what extent are objectives valid? Are activities and outputs of the programme consistent with the overall goal? Effectiveness To what extent were the objectives achieved? Efficiency Were activities cost efficient? Where objectives achieved in time? Was activities implemented in the most efficient way compared to alternatives? Impact What has happened as a result of the support? What real difference has it made for the beneficiaries? How many people have benefited of the support? Sustainability To what extent will the benefit continue after the activity has ceased to exist? What are the major factors that influenced the achievement or non-achievement of the sustainability of the support?

business and political science communities, and include an analysis of the 17 water and sanitation partnerships featured on the International Chamber of Commerce database.

It should be noted that neither literature is extensive – of over 50 GHPs, no more than 10 have been formally evaluated. GHPs were established in the late 1990s, and it is early days to review impact. As Caines points out, most evaluations focus on organisational and process issues, as opposed to assessing results in terms of impact (Caines 2004). Buse's paper complements and reinforces review findings on GHPs and governance structures and ways of working (Buse 2004).

1.2 Overall findings and conclusions

A striking, though perhaps not unsurprising, finding is the repetition in the two literatures of good (and less good) practice that results in more (or less) effective partnerships[2]. This is in spite of the huge variety of partnership types and objectives. Most business alliances tend to be formal joint ventures, involving few partners, as opposed to the looser partnerships with a greater number of players adopted by social sector partnerships. Despite this, key messages from the business literature are relevant, often echoing the frequent recommendations for greater formality and clarity in the GHP evaluations.

Partnership inputs

The inputs of an effective partnership can be categorised as: goals, structure and process. The *goals* of an effective partnership can be summarised using the familiar acronym SMART: Specific, Measurable, Achievable, Realistic and Time-Bound. The McKinsey study identifies two fundamental prerequisites for partnership success: a simple and compelling goal, together with a clearly defined and focused scope (disease, geography, population, activities) (McKinsey 2002). There appears to be a strong link between unclear goals, and low understanding among partners and stakeholders about their roles, which results in weak advocacy and poor results in resource mobilisation.

The business literature identifies five elements of *structure* that must be in place before the partnership can be effective: forms, partners, knowledge, people and resources. In common with Buse, it flags a 'fit for purpose' institutional structure as being particularly critical, and emphasises the importance of adequate financial and well-tailored human resources in delivering partnership objectives.

The '7Cs of partnership working' are consistently emphasised (DETR 1999). The 7Cs are: clarity of leadership, understanding, purpose, role, commitment, management, and measurement. The most common reasons for a partnership failing (according to a survey of CEOs) are poor or unclear leadership and cultural differences (Kotelnikov 2004). *Understanding, purpose* and *role* are emphasised as an important means of overcoming 'cultural' differences between partners from different sectors (public versus private).

Crucial to the *process* of an effective partnership is agreement by all partners of its governance structure – who has responsibility for what. A key factor for effective partnership working is a strong and shared vision for the partnership itself, one in

[2] For ease of illustration, examples of partnership practice are referred to simply by their acronym (the relevant evaluation report reference can be found in the bibliography). Evidence from these reports informs the analysis, but the comments should not be assumed to apply to specific partnerships now – it has been noted that many have made changes in their governance, management and operations as a result of evaluations and reviews (see Buse on governance).

which partners feel equal in terms of commitment and how they are valued, and clear about their roles and accountabilities. The RBM Partnership was viewed as too loose at national and international levels to enable clear definition of roles, expectations and commitments. Hence accountability and inputs, especially at national level were weak, contributing to low profile and resources allocated to malaria (in 2002).

Trust is emphasised as a key element of an effective partnership (WEF, 2001; Parkhe, 1998; Adams and Goldsmith, 1999; AMG, 2003). The phrase 'trust but verify' is reiterated in various studies to indicate the importance of both trust and transparency between partners. Partnerships evaluated as less effective in generating consensus and delivering results also tended to have partners who were less trustful and more critical of each other, and less clear about their roles.

A striking finding across several reviews is that, where one important partner's role is perceived as over-controlling, dominant, exclusive, non-consultative (especially WHO by partners in RBM, GAEL, and APOC to more limited extent), these partnerships were also perceived as less effective in terms of their outputs. Partnerships that are perceived as particularly effective also tend to be ones where partners are positive about each other, about the partnership's ways of working and the secretariat's functioning (IAVI, GAVI).

The wider *environment* is a major driver affecting partnership effectiveness. Partnerships need to be sufficiently flexible to accommodate changes in the physical, economic, social/political and technological (PEST framework) aspects of the environment. However, the literature also highlights the need to manage the tension between generating policy and technical consensus while moving the agenda forward. Partnerships need to monitor and respond to changes, by undertaking regular strategic review and redefining objectives. However, several partnerships lack an operational research strategy, which weaken their ability to respond to, and to base their activities on, a robust evidence base.

Shifts in development policy priorities are a major challenge for many GHPs – RBM, IAVI, MIM, APOC, GFATM are all noted as lacking a specific strategy for how they are contributing to poverty reduction and 'pro-poor health system strengthening' (RBM). Almost every commentary suggests that disease specific partnerships must consider the opportunities provided by health sector development strategies, and the new aid instruments such as PRSPs and SWAPs. In particular, strategies were recommended for better integration on the ground, in order to improve effectiveness in policy, financing and service delivery, and ensure impact and long term sustainability. (RBM, APOC, OCP, GFATM).

Partnership outputs and outcomes

The majority of GHPs deliver outputs, linked to outcomes – with measurable results - in five main areas:

- *partner alignment and mobilisation*; committed and informed senior champions among wider stakeholders; alliances with other partnerships, expert networks and institutions; affected communities and civil society and the private sector contributing to wider forum; and regional or other groupings where appropriate. Advocacy and communication generally tended to be much weaker at national level, resulting in lower effectiveness across the range of activities.
- *raised profile and political commitment* through advocacy at international and national levels; joint governmental commitments (eg Abuja Declaration, high burden TB countries Amsterdam Declaration),

- *shared strategic vision* and *consensus on policy/technical objectives*, including institutionalising technical strategies (treatment and quality standards), key monitoring indicators. The majority of partnerships were deemed to add value in enhancing efforts to establish norms and standardisation in treatment protocols.
- *mobilising, pooling and co-ordinating the allocation of resources* (financial, commodity and human) The supply of free/low cost and quality assured drugs and other commodities was a key success driver for several partnerships, and a major contributor to country buy-in to the GHP.
- *co-ordination of efforts and capacity building* at national level (eg allocation of specific partner responsibilities, funds, TA; delivery of national strategic plan and coherence or integration with national programme and wider health sector plan)

The literature also highlights two overarching determinants – mechanisms for a) performance measurement or *metrics* and b) for generating the necessary *participation at national and international levels.*

Metrics refers to measures put in place to track, monitor and thus gauge the progress of partnerships, which requires clear target setting. A SMART strategic plan is needed (setting out international and country plans), supported by all the partners. Transparent monitoring of delivery on their commitments enables accountability for progress made (or not).

Shorter-term institutional and operational targets are required, to assess and demonstrate effectiveness and efficiencies (eg in speed and transparency of the assessment and grant making processes, in disbursement of grants, in administration costs as a proportion of overall budget, in types of grants awarded, to whom etc). GFATM and GAVI are seen to be putting considerable effort into developing the systems required to deliver this. GAVI was also advised to develop intermediate or process indicators, as well as at input and output level, in order to understand better system aspects of increased coverage.

Participation refers to a range of participatory processes and outputs generated by the partnership. There is a complex relationship between supply and demand for GHPs. Involvement of national governments at regional and international level is critical. Several evaluations emphasise the importance of participation in a 'demand-based' partnership – highlighting the role of country governments – and the need for partnership advocacy to develop this. Partnerships lacking formal methods to involve endemic country governments in governance structures tended to be less successful at generating country ownership. Partnerships with mechanisms to actively involve development partners, government and others in-country were seen as critical success factors of APOC, OCP, GPEI, GAVI (and STOP TB in India).

One somewhat unrecognised aspect of effective GHPs is their ability to catalyse a shift in the 'public sector' mindset for health care delivery. STOP TB's emphasis on national PPPs, together with its approach to inclusive governance (eg its Partners Forum) has led to the involvement of civil society and the private sector in delivering TB treatment in India. NGOs are essential partners in community based treatment interventions and wider community mobilisation in several GHPs. But several reports (APOC, GAEL) noted that smaller NGOs, especially indigenous ones, were limited in their participation at international and national levels.

Effectiveness of the partnerships that focus on access to commodities/services at national level has much to do with the partnership's ability to mobilise political and official support, and to develop ownership, at national and local levels. Effectiveness also depends on partnership mechanisms to co-ordinate appropriate human and financial resource allocations and to deliver appropriate technical inputs and/or finance or other resources, such as commodities.

Evaluations identified the following areas as particularly important: awareness and commitment beyond the programme team, including high level officials, coupled with priority setting and resource allocation in sector and district budgets; country arrangements for co-ordination of financing and for identifying and funding TA (through local capacity building); national strategic plans and a systematic approach to sustainability planning (human and financial resources, M&E and procurement system harmonisation etc).

The partnerships that focus on disease elimination tend to provide a very focused cluster of inputs at country level: drugs (or earmarked finance for drugs), operational costs and technical assistance. For these partnerships, the impending WHA deadline (or awareness of impending failure) is a key partnership driver. The need to manage and ensure good governance arrangements for the substantial drug donations is another driver (APOC, GAEL, GAELF, ITI). For these, many of the country programmes, and technical support arrangements, were already in place before the GHP was launched. The main challenge to effectiveness highlighted in the literature is the need to plan for longer-term integration.

Findings suggest that major financing partnerships (GFATM and GAVI) will depend in large part for their effectiveness on technical assistance and capacity building provided by partners. Mechanisms for co-ordinating and financing such inputs need to be developed and sustained at country level (see DFID GHP country case studies, GAVI). For GAVI, the most significant factor for country success was stronger Inter-agency Co-ordinating Committees, especially those who had developed a locally appropriate strategic plan. This was associated with more rational allocation of GAVI finance and the ability to 'transform a plan into reality'.

However, very few evaluations comment on the possible effects of such single issue efforts on the wider system, or on the risks of multiple co-ordination structures to government and agency efficiency. These are highlighted in DFID's country studies as significant in countries with weaker capacity. They are also discussed in the recent GFATM tracking studies. GFATM reports also suggest that issue specific CCMs could provide co-ordination of a wider group of initiatives than the GF alone. It is also important that any GHP conditionalities, required for reasonable governance and accountability purposes also benefit the national partner, such as linking a reporting requirement to the wider strengthening of the monitoring system.

Provision of finance or in-kind grants clearly generates political commitment to the partnership's issue – but also raises questions of sustainability (noted in reviews of GDF, GAVI, and GFATM country tracking studies). There remain unresolved tensions in donor harmonisation moves to sector and budget support, which potentially conflict with disease focused GHPs, particularly if substantial finance is involved, such as the GFATM. Emerging arrangements for managing GFATM funds through a SWAp offer a way forward.

Outcomes/Impact

Attributable impact is undoubtedly difficult to determine at this point for most GHPs. Possible indicators of impact are: 1) coverage and take-up of a service; 2) effects on other parts of the (health) system; 3) adoption of norms and standards advocated by the partnership; and 4) improvements in the life-conditions of people for whom the partnership was established.

The latter issue is particularly challenging. While most GHPs can provide evidence on increased coverage that is attributable to their work, none can show that the very poorest are benefiting, and the vast majority lack specific objectives to work with country partners for delivering such impact.

The business literature review identifies seven broad determinants of outcomes/impact for social sector alliances: the implementation of *pro-poor objectives;* the implementation of *capacity-building strategies*; an *accountable and transparent* partnership; a *solid infrastructure* and established institution-building mechanisms; *norm-setting* agendas in place; *standard-setting* protocols in place, and *support for international* conventions/agreements.

Planning and implementing for sustainability – defined by one evaluation as having the political decisions, policy, resources and administrative inputs in place to continue a programme over time – is felt to be a critical determinant of all three aspects of impact. Indicators vary, depending on the partnership goals, but many are felt to be addressing this issue inadequately or late especially with national partners.

Adoption of norms and standards are an important outcome of GHPs. However, evaluations generally find that advocacy and communication are weaker at national level, resulting in lower effectiveness in several key areas. For example, RBM's lack of success in raising profile of malaria, MOHs low awareness of APOC, IAVI's lack of a communications strategy for constituency awareness in developing country partners (although it had achieved wins in raising profile in India with politicians). While RBM and OCP had made some progress in eliminating taxes and tariffs, and including new drugs in national drugs lists, it was not clear how strategic the process was, and more planned advocacy was advised.

Evaluations say less about the determinants of efficiency, cost effectiveness, and 'added value'. Even high scoring GHPs, such as IAVI, had no mechanism for assessing added value. But in spite of this, almost all the evaluations deemed that the partnerships had added value overall, in that their results would not have been achieved as fast or efficiently without the partnerships.

Most are felt to be catalysts, as opposed to absolute innovators (IAVI, GAEL, STOP TB). Some were also felt to have achieved major synergies, by bringing together different but highly complementary components in an innovative way. For example, GDF was judged to have demonstrated 'proof of concept' in its bundling of grant making, partner mobilisation for TA and promoting of a common technical strategy (DOTS).

Table 1: Partnerships that deliver – determinants and results

Levels of effectiveness	Determinants (process indicators)	Results (criteria/benchmarks for effectiveness)
Inputs	Clear rationale & evidence base; appropriate choice of partners; consultation involves appropriate and influential stakeholders.	Agreed simple and compelling goal; clearly defined and focused scope, priorities and vision for success.
Goal and scope	Periodic reviews of objectives. Regular review and realistic assessment of strategies and tools.	Scope, objectives and strategies tailored to current need. Inclusion of pro-poor and gender equity principles.
Structure/ organisation	Clear and transparent governance, legal and institutional arrangements; understanding of risk and risk management. Suitable incentives for involving range of partner types. Clear definition of roles and functions, and sufficient resources allocated. No more than 1 or 2 primary governance structures with smaller number of members, involving constituencies and relevant skill base. Strategic board with clear decision making rights for 10-20 most important decisions. Constituency management and methods to involve stakeholders. Accountable, strong leader (skills, networks) Delegated executive and strong project management (focused team to structure, launch and manage the GHP). Mechanisms for involving national partners, delivering technical assistance and other inputs at country level	Structure fit for purpose (NB 5 McKinsey models for GHPs) Procedures established for governance, management and administration cope effectively with GHP issues. Inclusive structures perceived to be working by all partners, including developing countries. Senior champions in partner organisations, actively engaged and delegating appropriately to secretariat. Inclusivity and representation of constituencies, including countries, NGOs, people affected Effective use of resources (eg % administrative costs).
Process/ ways of working	'Trust but verify' – managing open debate and transparency; understand and respect cultural differences; the 7 Cs of partnership working; trust building Mechanisms for managing debate and achieving consensus on policy and strategic issues Framework agreement or MOU that includes partner conflict resolution. SMART business plan setting out objectives, strategies and roles for partners (international and national levels). Agreed partner roles and commitments (people, money, technology), including national level. Communication plan and mechanisms. Detailed operating, reporting and financial/fundraising plans and progress reports publicly available.	Partners understand roles and processes; make, and deliver on, commitments (financial, technical assistance etc). Reported spirit of partnership (transparent, collegial). Communication of partnership position and individual commitments within partner organisations (taken forward among partners at country level) Active linkages at international through to national levels, co-ordinated activities taken forward with other GHPs as appropriate Active country ownership at national level. Operational and monitoring process effective at all levels.
Environment	Flexible approach and mechanism in place to detect and respond to changing environment (eg regular reviews undertaken).	Flexible partnership that is monitoring and responding to environment changes. Partners aware of changes and take action. Scenario planning – entrepreneurial thinking. Strategic alliances and joint working undertaken where needed.

Levels of effectiveness	Determinants (process/monitoring indicators)	Results (performance benchmarks)
Outputs 2 key dimensions: - progress measured (and feedback acted on) -'participation' and linkages/integration developed at international and country level.	Performance metrics and milestones agreed by partners, in place and in use – to identify, track and measure success; review progress; and modify plans as necessary (in advocacy, financing, partner involvement, country ownership, stakeholder mobilisation etc). Agreed and resourced strategies delivered for advocacy, financing, delivery of technical assistance etc. Strategies for partner mobilisation, and country stakeholder involvement. National level mechanisms for delivering programme objectives eg co-ordinating mechanism, TA, national strategy/plan National level mechanisms for delivering GHP eg Country co-ordinating mechanism, technical staff, national programme team.	Partner activities in line with agreed policies and strategies. GHP on track to achieve milestones, or corrective action being taken. Consensus on policy and technical strategies (standard treatments, core indicators etc). Profile of issue raised. Political commitment enhanced at international/national levels. Additional partners mobilised and activities co-ordinated. Additional funds and other resources mobilised and co-ordinated (without duplication). Alignment with, and buy-in. of country stakeholders. Appropriate country level structures established and operating effectively for co-ordination and delivery of programmes (technical assistance, finances etc). Operational plan delivered in priority areas/countries by all partners.
Outcomes/impact	Integration of pro-poor objectives and metrics (Strategy and operational plan delivered for integrating pro-poor objectives into plans and operations: geographical and population based targets) Implementation of capacity building strategies/technical assistance/resources. Strategy for health system strengthening activities developed with country partners and integrated into country plans. Access plan for product development (taking user profiles and market into account). Accountable and transparent partnership. Norm setting agendas and standard protocols. Method for demonstrating added value, efficiency etc.	Measurable impact on poverty, gender, and health outcomes. Health system not distorted and ideally strengthened (training, drug delivery systems capacity built, etc) Judicious and beneficial use of necessary conditionalities. Low transaction costs and support to systems harmonisation for reporting, procurement etc. Norms and standards adopted by target audiences eg national governments, international agencies International agreement/convention goals delivered. Product developed to meet needs of target users. Demonstration of added value and efficiency gains (eg, catalytic role in accelerating progress).

SECTION 2*:* APPROACH AND GENERAL OBSERVATIONS ABOUT THE LITERATURES

2.1 Methodology

In response to the TORs, two literature reviews were commissioned, aiming to: a) synthesise the evidence for the determinants of effective partnership from the existing evaluation literature for the major GHPs; and b) the wider business and political science field.

DFID's interest lies in understanding what makes good practice in governance and operations, and in what determines partnership effectiveness. In order to help conceptualise 'effectiveness', the *determinants* and the *results* of partnership are distinguished at different levels of effectiveness. Both reviews took a similar approach:

- an initial assessment of existing review and synthesis studies of both the results and determinants of global health partnerships and wider business partnerships
- synthesis of findings into a logframe type matrix (Figure 1) to link cause (determinants) with effects (results) at different levels of effectiveness, and to suggest a series of hypothetical links between determinants and results at the different levels

Figure 1: Determinants and results at key levels of effectiveness

Levels of effectiveness	Determinants (monitoring indicators)	Results (performance benchmarks)
Inputs Goal and scope Structure/organisation Process/ways of working		
Outputs (eg advocacy for political support and policy consensus; co-ordination and resource mobilisation; national programmatic activities, capacity and ownership building)		
Outcomes/Impact Product development/access Improvements in beneficiaries' health and lives; capacity building; standards/norms Value added and cost effectiveness		
Context/environment *PEST analysis (physical, economic, social/political and technological factors)*		

2.2 Observations on the literature

Section 3 (GHP literature) is based on over 30 reports of evaluations of specific GHPs or overviews, such as McKinsey's 2002 review. About 10 GHPs have had some kind of formal evaluation in the last four years.

A major and persisting gap to date are reviews that look at a number of GHPs and their combined effects on the ground – concerning issues of synergy and duplication, government overload, imbalances in priority setting, systems effects etc. Forthcoming GFATM and World Bank reviews, in addition to DFID's own study, should provide invaluable data on these issues.

As noted by Caines, GHP evaluations to date tend to focus on the effectiveness of partnership working, as measured against the partnership's strategic focus and achievement of their objectives in technical support, partner mobilisation, fundraising, policy advocacy, and communication (Caines 2004). It is too early to assess how effective the partnerships are at achieving impact. Identification and measuring of added value and efficiency or resource effectiveness is also challenging for evaluation teams. Several make the point that a counterfactual is absent – it is not possible to know what would have happened without the partnership, although some hypothesise this in an attempt to define added value.

It is certainly not possible to rank the GHPs in terms of their effectiveness at impact level, partly because it is early days for many of them, and their structures, goals and objectives and methods of working vary so much. However, insofar as attribution can be assumed, it is possible to determine what contributes to making some partnerships better at delivering components of their mission than others with similar missions. Some evaluations (eg RBM 2002) specifically (and helpfully) compare different governance and operational structures, with a view to recommending a more effective structure to deliver the partnership's goal.

Section 4 draws on studies published in business and political science journals, work published by international and regional organisations, and international forums such as the World Economic Forum (WEF), providing insights on a broad spectrum of interactions, including: public-private partnerships (PPPs), strategic alliances and social action coalitions. Give the lack of comparability between business and social good partnerships, the review draws on the International Chamber of Commerce's database of partnerships, taking the listed 17 water and sanitation partnerships to illustrate the determinants of effective partnership outcomes.

An important gap in the business literature on partnerships is a lack of follow-up studies that track the success or failures of particular partnerships. The health sector has established something of a niche market for well-publicised, headline-grabbing GHPs. These have attracted considerable academic interest. Consequently, it is at least possible, though by no means easy, to make assessments of GHP pogress, effectiveness, strengths and weaknesses. Such analysis is not reflected in other sectors where partnerships have been established. There is very little long-term analysis of particular partnerships outside of the health sector. This makes assessment of the *impact* of the non-health sector partnerships very difficult, though not impossible. Such an assessment would require a much more in-depth research project.

SECTION 3: DETAILED FINDINGS: GHP LITERATURE

3.1 Factors in the wider environment: opportunities and threats to effectiveness

The literature illustrates the importance of wider environment factors in challenging partnerships with threats, risks and opportunities. The strategic importance of various environmental factors is summarised using the PEST framework below. Given the importance of external environmental factors as drivers of effectiveness, a partnership's ability to respond flexibly while maintaining partner engagement is a critical determinant of success.

P - physical factors eg changes in environment, new epidemic outbreaks, persistent endemic zones etc, globalisation of some diseases, regional basis of others, malaria and TB resistance patterns requiring changes in therapy. Also providing opportunities for partnerships such as RBM and APOC to prioritise highly endemic border regions, and achieve quicker wins.

E - economic factors. Several reports (eg IAVI, GFATM) point out the limitations of donor funding patterns – for example, funding beyond 5 years is rarely possible; multilaterals may not have windows for product development; donor fashions/fatigue and their need for rapid demonstration of results. National ceilings on health budgets can perpetuate trends for off-budget project-type financing and complex reporting and management arrangements (see Uganda case study). On the other hand, prospects of additional finance can leverage raising of such ceilings (Uganda, India), although such cash injections in single sectors may have longer term implications for overall fiscal stability.

S - social and political factors. Conflict is mentioned as a major constraint in the achievement of GAEL, OCP and APOC elimination goals, and in RBM activities, although PEI was felt to have successfully negotiated opportunities for NIDs even in conflict-affected areas.

World Health Assembly goals have stimulated the establishment of many GHPs, and achieving targets set by the global community is a major driver. Generating national and international political support for GHP priorities also helps develop an enabling policy environment, successful implementation on the ground, and resource mobilisation. Shifts in development priorities are a major challenge, especially in the shift to poverty reduction targets. New programmes and new partners are emerging in a rapidly changing landscape, and require alliance strategies.

The wider policy developments in health system strengthening and decentralisation are also considered critical. There is clearly a strong (and often rational) tendency for GHPs to perpetuate the vertical approach to disease control already used in many countries. Almost every commentary suggests that disease specific partnerships must consider the opportunities provided both by health sector development, and new aid instruments such as PRSPs and SWAps, and develop strategies for better integration on the ground, in order to ensure long term sustainability. (RBM, APOC, OCP, GFATM).

T- technological factors. Innovative developments in treatment and prevention of priority diseases present challenges and opportunities to APOC, GAVI, RBM, GAEL, GFATM, STOPTB. Such developments require partnerships to be flexible and innovative while maintaining consensus among all stakeholders, and delivering the

challenging function of establishing norms and standards in a rapidly changing environment.

3.2 Inputs

3.2.1 Vision, goal and scope

The McKinsey study identifies two fundamental prerequisites for partnership success: a simple and compelling goal, together with a clearly defined and focused scope (disease, geography, population, activities).

Several RBM 2002 findings illustrate this: on the positive side, the partnership has developed a persuasive and evidence based rationale for its four strategies to combat malaria, and achieved substantial international consensus for them. On the negative side, failure to develop a rationale and consensus on priority countries was a factor that prevented focus on achieving results in a few countries, thereby limiting ability to demonstrate the effectiveness of both the partnership and its strategies (and importantly, also limiting RBM's advocacy case for strategy and fundraising).

Equally important was that RBM had too many, often contradictory and ambitious goals, agreed at various international and African fora – the partnership was strongly recommended to rationalise, make realistic and simplify them. Intermediate targets and indicators are needed, that are both reasonable as well as maintaining momentum. Some partnerships concerned with neglected diseases had confusing goals, especially with respect to complex messages concerning eradication versus elimination, and lack of a measurable plan to reach ultimate goals.

There also appears to be a strong link between unclear goals (MIM, GPEI), and low understanding among partners and stakeholders about their roles, coupled with weak advocacy and poor results in resource mobilisation. Reports also highlight the importance of clarity on the business case (or the value proposition) especially when there are a large number of other partnerships and organisations working in the same field (GAVI, IAVI, STOP TB). However, it is clear that many partnerships do not do this. Even IAVI, which received high marks in both its 2003 evaluation and McKinsey's study, was seen to be developing too many roles – it was recommended to focus down, and work under others' leadership in some areas. STOP TB's GDF was strongly recommended to continue its focus on a set of core countries and core services. GAELF was advised to focus down on key countries, but at the same time to widen its efforts to integrate LF programmes into national and district planning processes.

STOP TB and GDF evaluations emphasise the importance of a demand-based partnership – highlighting the role of high burden country governments in generating consensus on the role of the GDF, and the critical importance of STOP TB partnership advocacy for financing this. It is also clear that a strong technical and economic rationale for the partnership's key goals, and broad consensus and support among core partners, are important factors for effectiveness in terms of partnership working, outputs and impact.

There needs to be a justification for tackling the problem through a high level partnership, as opposed to other strategies, and a clear articulation of alliance benefits and costs. Most GHPs included such a justification in developing the partnership at its start, together with a wide-ranging consultation with senior policy makers and technical experts. This was critical for creating initial support and

consensus for the partnership's approach. However, most partnerships do not appear to have a well defined and ongoing analysis of their costs and benefits – having such would undoubtedly support their advocacy case for political and financial support.

Partnerships need to balance their specific focus with awareness and need to take on board the wider policy context. For example, GAEL and GAELF have been criticised by some of its partners for prioritising drug treatment over providing care and support. IAVI was accused of competing for resources for a preventive vaccine versus treatment needs, which it has resolved by improving involvement of people with AIDS, and clarity on treatment provision for trial participants.

To be effective, partnerships need to keep their 'business case' up to date, and invest appropriately in an operational research strategy to deliver this. Several partnerships lacked capacity and planning for an operational research capacity, and were failing to develop and expand the evidence base on a continuing basis (eg GAELF, APOC). Notably, the vast majority of GHPs reviewed lacked such strategy to understand and improve their impact in relation to poverty and gender issues. Some even lacked sufficient evidence to justify and monitor the impact of a key approach, eg APOC and its advocacy for community directed treatment.

3.2.2 Structure/organisation

Strong organisational determinants of effective governance, strategic management and implementation suggested by McKinsey and other reports are:

- One or two governance structures with 10 to 20 members maximum (gender, constituency and skill balance), with clear decision making rights over 10-20 most important decisions. National and regional participation is essential.
- A consultative forum involving wider partners and stakeholders, supported by a constituency management strategy
- Substantial delegation to an executive secretariat accountable to the partnership, rather than any single partner or the host organisation (eg WHO)
- Strong executive leader with skills, credibility and contacts, and capacity to delegate both strategic and technical functions to the project team
- A job-secure and skilled team to structure, launch and manage operations, with skills in project management, advocacy, communications, policy and operations, fundraising, proposal assessment, grant making and M&E. The team to include secondees and nominees from the partners themselves. Administration costs limited to about 10% in most cases.
- A limited number of small, independent technical committees or working groups to support expert consultation, furthering consensus, managing debate.
- National level implementers (programmes and grantees), partner co-ordinating fora and TA mechanisms (also see under Outputs, national operations)

Involving partners and stakeholders

GAVI and Stop TB have a governing board (comprised of very senior partner representatives) together with a small working group or other structure that oversees day-to-day operations (middle management partner staff). IAVI's broad board representing policy, industry, science, and activist groups was felt very effective, although lacking in women's representation. APOC was advised to reduce its governance and management structures and related meetings, as these contributed

to an unmanageable workload for its executive, and to develop a simpler, less top heavy and rigid governance structure. GAELF's shift from loose to tighter governance in early 2004 was contributing to clearer roles and responsibilities, but there were concerns that the structure lacked endemic country representation.

WHO and Unicef respectively have a governance stake in about two-thirds and one-third of GHPs (WEMOS 2003). WHO at international, regional and national levels is a key partner, especially those GHPs for which technical inputs are a priority and whose secretariats are hosted by WHO (RBM, STOP TB, GAEL). However, issues with WHO's ways of working and style were also seen as limiting effective partnership, outputs and ultimately impact. Negative perceptions cited in reports that limited effective outputs were: technical arrogance, poor dialogue, and lack of consultative consensus (GAEL); accountability of day to day operational and technical officers to WHO rather than the Secretariat (RBM, STOP TB); lack of effective regional communication and delegation (RBM-AFRO); communication not dialogue (APOC); weaknesses at country level (eg bottlenecks in disbursing funds at country level for APOC).

Key solutions proposed were to: delink the technical advisory functions from other functions such as overall strategy, finance mobilisation, advocacy and communication (GAEL, RBM). This would also enable partnership secretariats to deal with the issues of political sensitivities, such as prioritising focus countries, and enable WHO to focus on providing technical assistance, once consensus on technical approaches has been achieved among the partners. (See Buse's governance paper for further discussion).

National involvement at regional and international level is critical. Buse's research on governing structures reveals that certain groups are systematically under-represented, particularly Southern governments and civil society organisations. The Global Alliance to Improve Nutrition (GAIN) is an exception in this respect. GAIN gives poor countries a 40 percent stake, while the rest including private industry, private foundations, NGOs, bi-and multi-lateral agencies such as the UN and scientific agencies have 10 percent each.

India's commitment to STOP TB was in part attributed to its Board membership and the Partners Forum meeting in India. Strong commitment and fostering of collective responsibility of governments at regional level were among OCP's success determinants. However, formalising this as a regional forum was recommended to take forward the programme, as well as a regional governmental commitment to eradication. The need for regional governance groupings was also suggested in GFATM studies.

Thought needs to be given to the risks as well as the gains of involving private sector representation in governance structures, an issue concerning some GAVI public sector partners. Where private partners are involved, transparency and a 'level playing field' are essential to prevent conflict of interests arising. Partnerships involved in competitive commodity procurement need to be especially aware of the need for open communication across industry, in order to avoid prejudicing supply.

Effective partnerships on the ground were seen as critical to the success of GAEL, APOC, OCP, GPEI (and STOP TB in India). Some GHPs depend heavily on NGO partnership at national and international levels, especially where community based delivery is critical. But several reports (APOC, GAEL) noted that smaller NGOs,

especially indigenous ones were limited in their participation at international and national levels. This was felt to critically limit effectiveness, as NGOs are essential partners in community based treatment interventions and wider community mobilisation and political support for programmes. Removal of financial barriers to partnership, and enabling serve in as well as buy in arrangements would support better involvement of civil society and affected communities.

GFATM is perceived as one of the most inclusive partnerships at international level, in terms of offering governance roles to constituencies including affected communities, NGOs and the private sector. At national level the GFATM Tracking studies found that CCMs tended to be dominated by government representatives, with NGOs lacking due to lack of capacity and resources. It is too early to say how CCMs will ultimately contribute to effectiveness, although in India, the CCM is felt to be contributing to effective working between government and civil society, especially in AIDS.

A wider forum, meeting once or twice a year, is considered essential for enabling continued consultation and consensus generation. For example GAEL was recommended to develop a partners forum, to be run by its non-governmental partners. STOP TB's Partners Forum has certainly helped to build constituency buy-in and commitment to take DOTS forward at country level.

Accountability

Clarity among partners about roles and responsibilities is critical to effectiveness. Although RBM was set up as a highly flexible partnership, it was criticised for its loose structure and use of a vague group of core partners, which resulted in a disabling lack of definition of partner roles and accountabilities, and weakened activities. Hence inputs, especially at national level were weak, and the profile and resources allocated to malaria typically low in 2002.

For PEI, lack of clarity among partners led to tensions in delivering technical versus procurement functions, for example, and partner involvement 'waxing and waning' in delivery of partnership activities. MOUs setting out clear responsibilities were recommended.

While the role of WHO as a lead management partner for the GDF was welcomed for the first two years, the evaluation found that lack of clarity about roles of WHO, the STOP TB Board and the GDF Working Committee was weakening accountability, strategic oversight and decision making. It recommended a much stronger governance function for the STOP TB Board as delegated to its Working Committee, which should include WHO.

Stop TB, RBMs and GAEL's executive structures were found to be poorly accountable to the partnership, and administratively responsive to WHO, which led to unclear partnership governance and roles. Although formally accountable to UNICEF, GAVI's strong leadership and motivated partners has led to substantial independence. APOC's able leadership was important for an effective HQ, but increased delegation of both strategy and management was required. As WHO's PEI report in 2001 says, 'partnerships do not manage themselves', and specific skills in 'partner management' are required.

A limited number of small, independent technical committees or working groups are needed to support expert consultation, in furthering consensus and managing debate

(IAVI, RBM, PEI). Such committees should include WHO representation, other partners and experts from relevant fields, including national level. They provide an invaluable forum for developing consensus on key technical challenges, and technical strategies for delivery by WHO and other technical agencies at country level. However technical committees should not manage projects (APOC). Potential for conflict of interest with involvement of private sector should be avoided, particularly if the group is concerned with commodity supply and procurement, or financing research (PEI, GAVI, IAVI).

Links with other partnerships and initiatives were recommended in several evaluations as necessary for enhanced effectiveness (RBM with IMCI and EPI, APOC with GAELF, national and international levels. However, it is clear that the partnership's mandate must enable links with other partnerships, at international and national levels.

Governance issues are dealt with in more detail in Buse's paper, commissioned as part of the wider DFID GHP study.

3.2.3 Process/ways of working

Partnership working is closely linked to structure and organisation. Results of effective partnership working can be assessed using the following indicators:

- partner understanding of the structure, and their roles and accountabilities
- a reported sense of partnership 'spirit' (equality, fairness, transparent relationships), and openness in communications
- willingness of senior officials in partners to champion the partnership, and to ensure communication of partnership position and commitments to be taken forward at country level
- partners' commitment of financial and technical resources, and delivery as agreed, according to an overall plan, at national and international levels.

Planning and monitoring performance

A SMART strategic plan is essential (setting out international and country plans), supported by all the partners, and setting out their commitments enables accountability for progress made (or not). STOP TB's effectiveness at mobilising support in some high burden countries is attributed to such plans. A 2001 WHO EB report on PEI, and RBM's evaluation, recommend more use of targets and indicators to help measure progress along the way.

At the executive and administrative level, the GHP secretariat needs to develop institutional and operational targets and indicators with which to assess and demonstrate its effectiveness and efficiencies (in speed and transparency of the assessment and grant making processes, in disbursement of grants, in admin costs as a proportion of overall budget, in types of grants awarded, to whom etc). GFATM and GAVI are seen to be putting considerable effort into developing the systems required to deliver this.

Factors affecting participation

A key factor for effective partnership working is a strong and shared vision for the partnership itself, one in which partners feel equal in terms of commitment and how they are valued, and clear about their roles and accountabilities. Partnerships that are evaluated as less effective in generating consensus and delivering results also

tended to have partners who were less trustful and more critical of each other, and less clear about their roles (GAEL, MIM).

A striking finding across several reviews is that, where one important partner's role is perceived as over-controlling, dominant, exclusive, non-consultative (especially WHO by partners in RBM, GAEL, and APOC to more limited extent), these were also perceived as less effective partnerships in terms of their outputs. Partnerships that are perceived as particularly effective also tend to be ones where partners are positive about each other, about the partnership's ways of working and the secretariat functions (IAVI, GAVI).

Transparency between partners, and between the secretariat and partners is perceived as critical. Regular and critical review, and strategic discussions are working especially well in IAVI and GAVI, and contributing greatly to partner trust. Regular communication and clear reporting mechanisms are needed. GFATM's and GAVI's information on proposals and funding rounds is generally felt to be strong, contributing to effective partner working and stakeholder involvement. Lack of sufficient transparency affected some of IAVI's collaborations, and the secretariat was sometimes perceived to be too 'American', and aggressive – a fine balance is needed between leadership and consultative roles.

Flexibility, and the ability to adapt rapidly and to introduce innovation through building consensus appear to be two of the major determinants of effective partnership working. And, very broadly, the access partnerships providing technical support are deemed to be insufficiently flexible. There are clear tensions and tradeoffs between generating and maintaining consensus, while moving forward as agendas change.

Adaptability problems were most emphasised for GAEL and RBM. This could be linked to the fact that these partnerships are tackling problems for which there are traditional solutions and large scientific and technical constituencies, but where technological opportunities have developed very rapidly since the late 1990s. In GFATM interviews, government officials observed that most new initiatives start off being prescriptive, but become more flexible, and willing to adapt to local contexts. Greater effectiveness might be achieved with greater flexibility at national level, which would also build ownership.

OCP was praised for responding flexibly and rapidly to new technological strategies (notably community based ivermectin treatment). This was attributed to flexibility in delivering strategy and operations, driven by the evidence base and sound operational research, with a strong and responsive country focus, and a capacity building and devolution strategy in place early on.

3.3 Outputs

Key (and eminently measurable) outputs, common to all GHPs, are in five main areas:

- *raised profile and political commitment* at international and national levels; joint governmental commitments (eg Abuja Declaration, high burden TB countries Amsterdam Declaration).
- *partner alignment and mobilisation* for tackling the issue among all stakeholders; committed and informed senior champions among wider stakeholders; alliances with other partnerships, expert networks and institutions; affected communities and civil society and the private sector

contributing to wider forum; and regional or other groupings where appropriate
- *shared strategic vision* and *consensus on policy and technical requirements*, including norms and standardisation of technical strategies (treatment and quality standards), key monitoring indicators;
- *mobilising and pooling resources* (financial, commodity and human)
- *co-ordination* of efforts at international and national level (eg allocation of partner responsibility, funds, TA; delivery of national strategic plan and coherence or integration with national programme and wider health sector plan)
- *improvements in enabling environment* (eg removing taxes and tariffs on products, stimulating supply and demand, introducing mechanisms for quality improvements and price reductions etc)

Given the nature of these outputs, many can also be defined as outcome level results as well, in terms of what the partnerships are achieving.

3.3.1 Stakeholder alignment and policy/technical consensus

Most of the GHPs were felt to have delivered at least some of these outputs, especially at the international level – particularly in aligning key partners and raising the profile of their issue. As discussed above, the generation of consensus on policy and technical issues is challenging to many partnerships. However, the majority of partnerships were deemed to add value in enhancing the efforts to establish norms and standardisation in treatment protocols, and in supply of quality assured drugs and other commodities, needed to control diseases and prevent resistance.

Strong policy advocacy and communication strategies are needed to achieve this range of outputs. IAVI's communications (eg using an e mail bulletin, blueprints for access and research priorities) were seen as a major contributor to its policy advocacy outputs – which included international consensus on vaccine research priorities, on issues to consider to ensure access to any new vaccine.

Advocacy, in terms of marketing brand and building credibility, clearly contributes to effectiveness in resource mobilisation and country level operations. The GDF's fundraising crisis in 2003 was attributed to weak brand marketing, as well as poor financial planning. The need for communication about GDF's improvement of its (formerly problematic) procurement processes featured in GDF's evaluation. Likewise, stronger communication was needed to build stakeholder support and new partners in providing TA at country level, as well as for catalysing implementation of DOTS. 'High impact-low investment' policy advocacy activities (events, innovative partner projects in PPPs at national level) were recommended to expand support for the brand. Several partnerships were also advised to improve strategies for lesson learning and dissemination of country experience, in order to develop an evidence base for good practice (GAVI, IAVI, APOC).

Lack of a clear advocacy and communications strategy was seen as a serious impediment to MIM's effectiveness in fundraising, which was also limited by lack of clear goals and partner roles. Internal communications and understanding of MIM among its sub components was also weak and affected impact.

Advocacy and communication generally tended to be much weaker at national level, resulting in lower effectiveness across the range of activities – eg RBM's lack of

success in raising profile of malaria, low awareness in health ministries of APOC, IAVI's lack of a communications strategy for constituency awareness in developing country partners (although it had achieved wins in raising profile in India with politicians).

GAVI was advised to strengthen its communications of policy and procedures to both country partners, and to WHO and UNICEF. While RBM and OCP had made some progress in eliminating taxes and tariffs, it was not clear how strategic the process was, and more planned advocacy was advised. For APOC, there was poor communication to country programmes of treatment guidelines, reducing impact of programme delivery. Ivermectin was not yet in all national drug lists in focus countries.

3.3.2 Finance and resource mobilisation

Key outputs include additional funds raised at international and national levels, ideally from non-traditional as well as public sector and foundation partners. Determinants include a well-designed strategy, a persuasive business case, and a strong team.

According to literature reviewed, access and research GHPs have raised additional funds, but mainly from traditional sources (Pearson, DFID GHP study). They have not succeeded in raising new finance from the private for profit sector, asides from the significant in kind contributions of drugs for leprosy, oncho. etc. For product development PPPs, a similar finding is borne up by the recent IPPPH studies of product development partnerships, where the vast majority of PPPs, including IAVI, are funded through Foundations (Gates) and public sector finance.

IAVI's innovative use of research partnerships and 'integrated network collaborations' (functioning as a virtual vaccine company) was felt to be more effective in terms of resource mobilisation than more traditional grant giving arrangements. IAVI is reported to be responsible for quadrupling research resources in six years.

Other issues related to grant making functions are discussed below

Value for money commodities (uninterrupted supply, assured quality, price reductions)
The key output, at the international level, is the secure and sustainable supply of free or competitively priced commodities, procured through donation arrangements or pooled tenders. Several technically focused partnerships include various types of support to, and influence on, commodity procurement, supply and delivery (GPEI, STOP TB/GDF, APOC, GAEL). Substantial financing for commodity procurement is provided through STOP TB's GDF in kind drug grants and the GFATM's finances (nearly 50% of proposal value).

For sustainability, it is important to develop the market without distorting it. Both the two main vaccine procurers, GAVI and PEI, faced early problems with demand forecasting, and major supply side problems. In particular supply has not been managed to keep up with increased demand stimulated by the GHPs. Transparent dealings with the industry and strengthening of UNICEF's functions in demand pooling and forecasting have now greatly improved supply side predictability. GAVI's Vaccine Procurement Project, is thought to have greatly improved vaccine supply project management, bringing in new suppliers although prices of newer vaccines have not dropped as hoped. It is also critical that GHP objectives to signal commodity

demand to the global market (and hence to reduce prices overall) are not pursued at the expense of country priorities and sustainability. Several evaluations comment on the risks of providing short-term finance for new products (especially vaccines).

There have been results in drug price reduction and improved quality through pooled procurement, increased demand, and a prequalified suppliers list. While it is equally possible that a public sector procurer could have achieved such results, GDF's evaluators insist that the partnership's unique combination of functions (in kind grants, partner mobilisation for TA and procurement) will deliver more in challenging environments than a simple public sector model. There was also no evidence of possible negatives eg a negative impact on national or regional procurement, and monopsony tendencies linked to a dominant purchaser.

(see Grace's paper on commodities, DFID GHP study)

3.3.3 Operations at national level

Effectiveness of partnerships at national level has much to do with the partnership's ability to mobilise political and official support, and to develop ownership, at national and local levels. Effectiveness also depends on partnership mechanisms to facilitate appropriate human and financial resource allocations and to deliver appropriate technical inputs and/or finance or other resources, such as commodities.

Most partnerships involved in providing technical and financial inputs are judged to have delivered reasonably well, in terms of delivering progress on elimination targets, for example. To do this, they have so far selected mostly vertical delivery models, in line with what remains the dominant model for disease control in many countries.

However, in line with the current emphasis on a health system development approach to delivering health care more sustainably, effectively and efficiently, most evaluations and reviews suggest that all programme operations need to develop stronger integration strategies, to improve effectiveness in policy, financing and service delivery. But, as emphasised in Caines' review, the evidence base for linking integration with increased impact is limited. In many contexts, integration cannot take place if the existing system is very weak. Context and process are all important. That said, most evaluations make clear that even where integration is not possible now, planning for it in the medium to longer term with country stakeholders should begin as early as possible.

All the GHP evaluations to date cite at least three of the following determinants that contribute to effective outputs at the country level, with a view to generating longer term impact and sustainability.

Awareness and political commitment

Most partnerships had achieved high level knowledge about the partnership strategies in the national (typically vertical) disease progamme (APOC, RBM, STOP TB), but more was needed in other ministries and programmes, and among wider political stakeholders. RBM team reported that low levels of acknowledgement of malaria as a problem were directly reflected in low levels of resource allocation. Often there is higher awareness at district level, where the programmes are active, than at the national level. However, this is still rarely reflected in adequate resource allocation in district budgets.

Stronger links between programmes at national level are felt to improve effectiveness by reducing duplication, increasing synergies in reporting systems eg PEI NIDS and EPI routine systems, RBM with EPI and IMCI, APOC and GAELF community delivery strategies.

Planning for sustainability
Most partnerships need to develop a systematic approach and plan with stakeholders for sustainability at country level, plus empowering national structures to take on the programme (APOC, OCP, GAEL, PEI, STOP TB and GDF). There still appears to be a project mindset. Several evaluations (APOC, GAEL) employ the 'project' language (presumably) used by the programme staff. Structures for sustainability include a role for regional structures such as WHO's Multi Disease Surveillance Centre for monitoring neglected diseases.

Priority setting
Programmes can have major impact in building recognition of the disease as a local and/or national issue, while attempting to avoid distorting resource allocation. At the minimum, the programme needs to be included in national and district level priority setting and planning processes, and any resources provided reflected in the budget, taking into account decentralisation processes (which offer major opportunities where specific disease burden is highly localised). However, evaluators also observe that unless the issue is prioritised and included in sector strategy (where it exists), there is a risk of marginalisation. For example, malaria still has a low priority despite strengthened national programmes through RBM. While some diseases benefited from GHP focus, by raising their profile in national policy, a disease-specific focus is also felt to undermine the health sector development approach, especially if new parallel arrangements are put in place. This is potentially a major risk to GFATM's ability to counter distortion or weakening of the current system. The recent decision to put funds through the SWAp in some countries is likely to have positive benefit.

HR issues
A national plan, involving partners, is needed for capacity building of staff. Staffing, training and incentive structures must take into account the longer term needs to integrate any special programme staff into district health teams. OCP's contribution to polyvalent staff development was felt to have contributed to the success of its legacy.

Systems harmonisation
At national level, GFATM tracking studies noted 'initiative fatigue' – as a small number of government officials are engaged in parallel negotiations with several partnerships and new initiatives such as PEPFAR, and burdened with increased management and reporting roles. It is clear that harmonisation of finance reporting through the sector MTEF or other means, as well as a unified strategic planning and M&E framework is critical (as per the 'three ones' advocated for HIV/AIDS).

Supply of drugs and commodities provided by the partnerships needs to be integrated into delivery systems. Even if not possible when the programme starts, a medium term plan is required, that establishes how the programme will support or mobilise TA to help the drug supply unit to deliver this, possibly with other programmes (APOC, GAEL, STOP TB/GDF). Strengthening security may be needed to prevent leakage.

Financing and resources provided by programmes need to be included in planning and budgetary cycles, ideally at sector level, and in MTEFs and basic package allocations. While RBM had prioritised developing country strategy papers with country malaria programmes, the team noted that these did not reflect national budgetary frameworks or planning, and were highly unrealistic, hence reducing feasibility for adoption by the MOH. APOC typically had low level allocations in the district budget, which reflected lack of commitment beyond the programme. GDF insists on a budget line for TB drugs, even when provided in kind, and was further recommended to develop a phase out financial sustainability plan. GDF was recommended to supply less than 100% of finance/drugs required, and to require some matching finance from government, to increase over time. GAVI is also engaged in such an approach with its partner countries.

Programmes engage in advocacy to raise profile of disease in the resource envelope through a sector approach, but earmarking is also suggested to ensure sufficient allocations (RBM). WHO Africa malaria report notes that by 2003 in 8 countries, malaria financing is now specified in the SWAp.

In kind and financial grants - Where partners have a direct financing role, financial management systems including budgeting guidelines need to be transparent, speedy and simple to ensure grants are accessed for effective delivery of supplies and interventions (APOC). The GFATM will need to pay particular attention to this, as disbursement is already perceived as slow and complex, and linkages to performance are as yet very unclear (GFATM tracking case studies) Complex application processes and lack of/changes in guidelines were also felt to reduce effectiveness. The flexibility of GAVI's Immunization Strengthening Services funds was seen as a major strength for national immunisation programmes.

Observers have noted an emerging tension in resource allocation processes between different interest groups – this could lead to unhealthy competition between programmes benefiting from GHPs unless an over-arching priority setting process is in place.

Co-ordination structures and mechanisms

Mechanisms for co-ordinating and financing such inputs need to be developed and sustained at country level (noted in DFID GHP country case studies). These structures support effectiveness of partnership working, governance and programme delivery at country level, involving a mix of national and international partners (CCMs/GFATM, ICCs/GAVI, NOTFs/APOC). RBM was recommended to develop more arrangements for partnership working at country level, and PEI to strengthen the role of national inter-agency committees, ideally looking across the immunisation subsector.

A recent evaluation of GAVI's Immunization Strengthening Services found the most significant factor for country success were strong Inter-agency Co-ordinating Committees, who had developed a locally appropriate immunisation strategic plan. This was associated with more rational allocation of GAVI finance and the ability to 'transform a plan into reality'. GFATM CCMs are also credited with raising issue profiles, bringing in more constituencies to the table, and accelerating the development of a national strategy, that includes affected communities, the private sector, civil society and other stakeholders.

Few of the evaluations comment on the risks of multiple co-ordination structures to government and agency efficiency, but these are highlighted DFID's country studies and discussed most in the recent GFATM tracking studies. GFATM reports also suggest that issue specific CCMs could provide co-ordination of a wider group of initiatives than GFATM processes alone.

Access to high quality technical know how
Partnerships are recommended by their reviewers to move away from the 'mission mentality'. Capacity building for country expertise was recommended for IAVI, GAVI and RBM, ideally involving local as well international staff. GPEI and STOP TB's success in India was linked to WHO's support for high quality local expertise. Linked to this is the need for capacity building strategy and mechanisms for a national operational programme team (APOCs national task forces, RBM's recommended country champions). However, it is also important that the team reports to its national programme, not the partnership HQ (as APOC's task forces did). Where programme support is projectised, a plan for decentralising and handover is needed. TA needs to support programme implementation, in particular facilitate use of agreed protocols and drugs, plus standardise monitoring and data collection.

Involvement of NGOs and for profits
Innovative partnerships with NGOs in national PPPs were given credit for coverage especially in countries where public system was weak (APOC, GAEL). Given the urgent need to scaling up coverage of priority diseases, evaluations also recommended that national strategies should include mechanisms for involving for profit providers, as well as non-profits, and more contractual relationships with both NGOs and private sector (RBM, Stop TB). The GFATM is also keen to scale up non public sector provision, but it is too early to determine whether such PPPs will improve coverage, and what government oversight will be required.

Surveillance and M&E.
As with other system functions, it is important to integrate surveillance and M&E functions into national system (PEI, APOC, RBM etc). APOC's independent M&E strategy was considered to have contributed to its high coverage rates, but more accurate reporting required to enable defaulters follow-up.

There is tension between partnership responsibility to generate internationally comparable data on a few core and consensus indicators with support for national capacity building. Also issues re perverse incentives linked to performance based funding, and need to verify performance for the release of funds, raising challenges for incountry oversight and accountability issues.(GAVI, GFATM, GDF, PEI)

Research partnerships at country level - There is less information available on activities of research partnerships at country level. IAVI's track record is generally good, achieving effective profile and mobilisation of political leadership in India, and developing strong in-country partnerships that addressed the 'access chain' (eg considering factors driving product availability, acceptability (user perspectives) and affordability. A key recommendation for increased effectiveness was stronger national technical teams (as for the access partnerships) and more adaptation to country contexts. The team also felt that increased involvement of affected groups was needed.

3.4 Outcomes and impact

Evaluations identify several core indicators of impact: programme coverage, and health outcomes (mortality and morbidity). Both are determined to a great extent by the extent to which the outputs described above are achieved, especially advocacy for political commitment and sustainable operations at country level.

Planning and implementing for sustainability – defined by one evaluation as having the political decisions, policy, resources and administrative inputs in place to continue a programme over time – is felt to be a critical determinant of impact. Indicators vary, depending on the partnership goals. For example, the OCP evaluation found that focus OCP countries were willing to maintain OCP activities after end of programme, and the community in most programme areas was able to implement without OCP staff. APOC's lack of a strategy for sustainable integration at country level was perceived as a critical concern for long term impact. It deemed that integration into the district system is a prerequisite for sustainability.

Several partnerships were urged to consider donor commitments to poverty reduction in their strategic thinking (APOC, GAEL and others). Countries partnering with GAVI's ISS are making no special effort to target the hard to reach (but neither do they appear to be motivated by the potentially perverse incentive of performance based funding to target the more accessible. For GDF, while no direct link is made by the partnership between increased access and the drugs grant, it is suggested by the evaluators that the focus on poorer countries, and the additionality of funding, means that impact on the poorest is a potential result. This 'trickle down' assumption is common to many, although its effectiveness should be questioned.

However, there is striking lack of objectives and strategy to ensure high benefit incidence for very low-income groups. Equally, M&E systems and operational research are also lacking to generate data on the profile of population covered and the socio-economic impact of the partnership programme operations, at country level. One report mentioned the risks to access by the poorest of introducing a cost recovery strategy in the Cameroon for oncho. treatment. As noted above, many partnerships were recommended to include such an operational research strategy.

None of the research partnerships tackled these areas either. IAVI actively considers vaccine strategies suitable for contexts where HIV has the highest impact, but was recommended to build up a work plan for stronger involvement of poor and vulnerable communities at country level (given the necessary focus for a preventive vaccine). It is clear that its India country strategy is beginning to do so.

Evaluations say less about the determinants of efficiency, cost effectiveness, and 'added value'. Even high scoring programmes such as IAVI had no mechanism for assessing added value. But in spite of this, almost all the evaluations, despite criticisms, deemed that the partnerships had added value overall, in that their results would not have been achieved as fast or efficiently without the partnerships.

Most are felt to be catalysts, as opposed to absolute innovators (IAVI, GAEL, STOP TB). Some were also felt to have achieved major synergies, by bringing together different but highly complementary components in an innovative way. For example, GDF was judged to have demonstrated 'proof of concept' in its bundling of grant making, partner mobilisation for TA and promoting of a common technical strategy (DOTS). It was felt that, unbundled, these strategies would not have been individually so effective.

SECTION 4: DETAILED FINDINGS: 'BUSINESS' LITERATURE

The review draws on studies published in business and political science journals, and by international and regional organisations, such as the World Economic Forum (WEF). The term 'partnership' is used as an inclusive, 'catch-all' term. Consequently, the literature draws on insights from a broad spectrum of interactions, including: public-private partnerships (PPP), strategic alliances and social action coalitions.

Annex 1 summarises the key features of an effective partnership, as seen by the business and political science communities. Most business alliances tend to be formal joint ventures, involving few partners, as opposed to the looser partnerships with a greater number of players adopted by social sector partnerships. Despite this, key messages from the business literature are found to be relevant for GHP effectiveness.

To examine social sector partnership impact in more detail, the review draws on 17 water and sanitation partnerships described in the International Chamber of Commerce's comprehensive database of partnerships to support comments made about the determinants and results of effective partnership outcomes (Annex 2).

4.1 Inputs

The review identified three inputs: goals; structure; processes. The wider environment is a critical driver of inputs. For each of these inputs, first the determinants are summarised and then the results of an effective partnership.

Goals and scope

There is common agreement that the determinants of an effective partnership include a strong rationale and evidence base for the partnership, an inclusive consultation process, and a realistic assessment of the tools and funding required (WEF, 2003; DETR, 1999; USAID, 1999). One study suggested the acronym SMART – Specific, Measurable, Achievable, Realistic and Time-Bound as a summary of the key goals of an effective partnership (MERC, 2004).

Partnerships that exhibit these determinants are shown to produce the following results. First, the partnership has a simple and compelling goal, and a clearly defined, and focused, scope and priorities (Wildridge et al, 2003; WEF, 2003; CCPP, 2004; Elmuti and Kathawala, 2001; AMG, 2003). Second, the partnership will therefore have the knowledge to provide a medium to long-term strategic plan, and thus be in a position to conduct a feasibility analysis (USAID, 1999). Third, the partners have a clear understanding of what 'effectiveness' means, and what benchmarks must be achieved for a partnership to be effective (Dowling et al, 2004; Anslinger and Jenk, 2003).

Structure and organisation

The literature on the structural determinants of an effective partnership is divided into five broad categories: forms, partners, knowledge, people and resources. The first category includes formal structural determinants such as institutional and legal structures.

Partnerships with appropriate institutional structures are able to provide potential future partners with attractive incentives to join (Dowling, 2004; EC, 2000). Clear

legal structures are important because partnerships operate in a complex legal environment and careful legal due diligence is "an absolute requirement" (EC, 2000). In addition, effective partnerships have dispute resolution procedures firmly in place (EC, 2000), and arbitration mechanisms (WEF, 2003).

Establishing a clear legal and administrative structure helps the partnership to negotiate contractual agreements (WEF, 2003). A partnership with a clear institutional structure means that the partners are clear about their roles and responsibilities (CCPP, 2004). In addition, clear assumptions of risk are undertaken by partners (USAID, 1999). This in turn generates additional positive outcomes. One partnership found that where partners bore financial risk, and were clear about the consequences of bearing financial risk, an incentive was established to control costs (USAID,1999).

The second category of structural determinants focuses on the partners. In their overview of strategic alliances, Elmuti and Kathawala argue that, "partnership selection is perhaps the most important step" (Elmuti and Kathawala, 2001); whilst another study maintains that, "the foundation of a successful strategic alliance is laid during the internal formation process" (Lorange et al, 1999). Selecting appropriate partners results in a solid foundation; a prerequisite for an effective partnership.

The third category emphasises knowledge structures. Here, determinants of an effective partnership include an appreciation by the partners of the 'partnership' debate. The EC devotes four chapters of their 'Guidelines for Successful PPP' to alternative PPP structures (EC, 2000), whilst the WEF note that certain issue-areas lend themselves to PPP arrangements better than others (WEF, 2003). In addition, a clear determinant of effective partnership is a shared understanding by all partners of how the partnership has been conceived and planned, and how it will be implemented. As noted above, a partnership with a clear institutional structure encourages partners to assume risk. However, in order to do so requires partners to have an appreciation of the concept of risk and risk-management, and its impact on the partnership project. Solid knowledge structures results in the selection of an *appropriate* partnership for the specific project in hand, but also a *flexible* partnership that can evolve to accommodate changing environments (EC, 2000; Adams and Goldsmith, 1999; Anslinger and Jenk, 2003)

The fourth determinant is people. An effective partnership must have committed senior management, a strong middle management team, and an adequately skilled general staff. One study noted that for effective parterships "everyone must be sold" on the idea (Elmuti and Kathawala, 2001). Dowling et al cite various studies that show how successful partnerships depend on the level of engagement and commitment of the partners (Dowling et al, 2004). Two studies also noted the importance of restricting the 10-20 most important decisions to a small number of senior partner- representatives (Dowling et al, 2004; Wildridge, 2004). A partnership that gives due attention to its staff and management structure will have senior "champions" in place that can take the partnership forward actively and enthusiastically (CCPP, 2004). The performance of senior staff can be measured by periodic assessments of quality of partnership's executive authority over the strategic direction of the P, and the management of activities designed to achieve that broad direction (Dowling et al, 2004). The final determinant focuses on the resources available to the partnership. An effective partnership must have sufficient funds, staff, materials and time (DETR, 1999).

Process and ways of working
A crucial determinant of an effective partnership is a clear process. This begins with partners agreeing on a shared governance structure that defines their roles and responsibilities (WEF, 2003; CCPP, 2004; Anslinger and Jenk, 2003; Elmuti and Kathawala, 2001). The process sets the ground rules of the partnership (WEF, 2003; CCPP, 2004). It provides transparency, and helps to overcome fears that partners are pursuing 'hidden agendas' (Duysters et al, 1999). In addition, a clear process allows partners to anticipate likely conflicts (Anslinger and Jenk, 2003).

The business literature places great emphasis on the concept of 'trust' as a determinant of effective partnership (WEF, 2001; Parkhe, 1998; Adams and Goldsmith, 1999; AMG, 2003). Effective partnerships have managers who are able to manipulate trust-building factors. Parkhe (1998) distinguishes between process-based trust production (where consistent behaviour generates trust), characteristic-based trust production (partners are more trusting when they share similar societal and corporate cultures), and institutional-based trust production (where trust is generated through formal mechanisms such as 'locking-in' to the partnership or by establishing contractual safeguards and legal stipulations). A number of studies cite a Russian proverb – "trust, but verify" – to draw attention to the importance of 'calibrating' trust: too much trust from one partner may lead to exploitation from another; too little trust by all partners, and the partnership is weakened (Parkhe, 1998; WEF, 2003; AMG, 2003).

Communication is a key determinant of trust. Elmuti and Kathawala argue that: "Without effective communication between partners, the alliance will inevitably dissolve as a result of doubt and mistrust…" (Elmuti and Kathwala, 2001:214-215). Communication within the partnership, then, is an essential determinant of trust, but communication with all the stakeholders in the partnership is crucial too. The WEF describes this latter process as "community buy-in" (WEF, 2003). A principal means of securing 'community buy-in' is by conducting a stakeholder analysis. Additional determinants of an effective process include investment in staff training, and long-term planning for the evolution of the partnership. The result of these determinants is a trusting staff with transferable skills and an ability to capacity-build (WEF, 2003).

Environment influences
The final factor relates to environmental conditions external to the partnership such as a favourable financial climate, a positive history of collaborative relations, and a political and social climate conducive to partnership-working (Dowling et al, 2003). The literature indicates that an effective partnership provides strategies that accommodate changes in these environmental conditions (WEF, 2003; Dowling, 2004; CCPP, 2004). A partnership with flexible senior executives who adopt a flexible approach to problem-solving in recognition of changeable environment, results in a flexible partnership that can respond to a changing environment. In order to achieve this degree of flexibility, Dowling et al suggests periodic reviews of partnership practice, and the establishment of favourable conditions for 'entrepreneurial thinking' (Dowling et al, 1999).

4.2 Outputs
This review identifies two broad output categories: metrics and participation. The first category includes the establishment of clear metrics to track, measure, monitor and provide feedback on the progress and thus gauge the effectiveness of the partnership (CCPP, 2004; Anslinger and Jenk, 2003; Elmuti and Kathawala, 2001). The second category incorporates a whole range of participatory action. These

actions include: employee participation, community participation, cross-sectoral collaboration, policy development, and mobilisation of local resources.

Anslinger and Jenk provide a clear indication of the importance of metrics as a determinant of a successful partnership: "The biggest reason many alliances do not succeed is a simple one: most organisations do not employ performance measurement concepts" (Anslinger and Jenk, 2003:7). For a partnership to be able to track and measure its effectiveness, it must first be clear about its strategic objectives and establish how those objectives will be measured. This requires the partners to ask a clear set of questions. Anslinger and Jenk suggest the following: "What is the alliance value proposition? Is it articulated clearly, concisely and compellingly? How will alliance partners know if it is reaching its objective? What elements of value-creation are most important to alliance partners and stakeholders? What outcomes are expected in terms of financial and market impact, organisation capability, innovative capacity and competitive advantage?" (ibid). In addition to providing metrics, *feedback* is also a key determinant of an effective partnership. Alliance Management International, Ltd (a consultancy firm that specialises in advising clients on how to form and manage strategic alliances) uses a survey form to gauge the effectiveness of the work it does for its clients (AMI, 1999).

One clear result of establishing effective metrics for measuring the progress of a partnership is that it establishes accountability in both public and private sectors by showing that limited resources are being used effectively (CCPP, 2004). Another result is that the partnership arrangements are able to adequately reflect underlying power relations. In addition, effective communication and inclusive participation is established (CCPP, 2004; WEF, 2004).

The second output category is participation. One determinant of an effective partnership identified in the business literature is the active linking and integration of the partnership to national or local programs. This determinant produces a number of positive results: employee participation; community participation; cross-sectoral collaboration; diverse activities initiated; policy change; policy development, and mobilisation of local resources (Dowling et al, 2004).

4.3 Outcomes/impact

The review identified two distinct types of impact: (1) changes in the provision of a service, and (2) improvements in the life-conditions of people for whom the partnership is established. Examples of the former include: improvements in the accessibility of services to users; more equitable distribution of services; and improvements in the efficiency, effectiveness or quality of the service. Examples of the latter include improvements in the experiences of staff as well as improvements in the well-being of those affected by the partnership (Dowling et al, 2004: 314).

Attributable impact is difficult to assess. In order to determine the range of outcomes provided by effective partnership, this review draws on the experiences of 17 water and sanitation partnerships (ICC, 2004). The review identified seven determinants of effective outcomes of partnership, which contribute to enhanced impact: the integration of *pro-poor objectives;* the implementation of *capacity-building strategies*; an *accountable* and transparent partnership; a *solid infrastructure* and established institution-building mechanisms; *norm-setting* agendas in place; *standard-setting* protocols in place, and *support for international conventions*/agreements.

The results of these determinants of effective partnership outcomes include: increased access to water and sanitation services for the poor; developed "human capital" through job-creation; increased learning and shared 'best practice'; empowered, less dependent, 'energised', local communities; improved impact of government activity; expanded services; more effective national response structure; altered perceptions at local level (eg, environmental awareness); the sustainable performance of partnerships, and enhanced national and regional cooperation between public and private sectors.

Integration of pro-poor objectives – access to services

Of the 17 sample partnerships, seven make explicit reference to having established and delivered a strategy and operational plan for integrating pro-poor objectives (measured in terms of geographical and population-based targets). Partnership (a) connected more than 200,000 low-income inhabitants to the water network over a two year period; partnership (b) focused on "poverty mitigation" through 'Tri-Sector Partnering', that put "communities at the centre of development"; partnership (g) successfully launched a "blue connection" programme designed to facilitate access to drinking water for very low income individuals; partnerships (h and n) achieved sustainable servicing of poor communities through PPP; partnership (p and q) sought to alleviate poverty by creating a more healthy, productive labour force.

Capacity-building

Five of the partnerships established a strategy for building the capacity of specific target groups. These strategies included engagement with/support for local level projects, and the transfer of project management skills to local communities. Partnership (a, b, c, h and q) focused on the development of 'human capital' and community empowerment through job-creation. They were able to achieve this through training strategies for transaction advisors, regulators, municipal managers, private companies and donors; and they conducted research and analysis on issues relating to water and partnership.

Accountability and transparency

Five of the partnerships were able to achieve and increase accountability and transparency. Partnership (a) was able to enhance an already existing forum for international debate that balanced the participation of public, private, civil society and donor sectors; partnership (b) actively engaged communities in the implementation stage of the partnership, and this enhanced the transfer of skills and energised local communities; partnership (g) set up three 'pilot structures' with the specific function of providing transparency to the partnership: a societal board, an advancement committee, and a feasibility team; partnership (h and q) also established pilot structures that functioned transparently, and set targets to increase representation of local workforces. In te case of partnership (q), the target is to increase representation of Yemen national employees from 65% to 80% by 2009.

Infrastructure and institution-building

Three partnership were integrated into national service infrastructure, with significant evidence of institution-building. Partnership (c) assisted the local authority ti implement and improve its waste-management system and integrate the programme into its service infrastructure; partnership (e) recognises the importance of providing institutional support structures such as information systems, technology centres, and R&D institutions; partnership (g) has initiated pilot structures that will support existing national and local institutions.

Norm-setting

An important determinant of effective outcomes is the ability of the partnership to change perceptions. Six of the partnerships identified this as an important part of their operations. Partnership (c) encouraged communities with a shortage of waste collection services to see waste collection as an income generator; partnership (i) educated communities on the necessity and benefits of recycling in order to reduce the volumes of waste that would otherwise be sent to landfill sites; partnership (k) pursued a global commitment to the core value of "every place a better place because we are there" through innovative sustainability efforts; partnership (l,o) established value-driven innovation to sustainable development, such as establishing internationally recognised eco-labels (f)

Standard-setting

More partnerships demonstrated a commitment to setting standards than any other outcome determinant. In total, eight partnerships explicitly addressed this concern. Partnership (d) describes itself as "a fully functioning, international standards-setting body, and the partnership's guidelines have become *the* standard framework for sustainability reporting; partnership (f) established and develops the MSC standard; partnership (j) has established a series of codes, guidance notes and checklists to assist companies to implement the commitment to Responsible Care, and thus achieved continuous health and environmental improvements; partnerships (k,l and m) also focus on standard-setting, with partnership (l) launching the world's first sustainability stock index family (the Dow Jones Sustainability Index – DJSI – in 1999) described as "a global benchmark for sustainability-related financial products".

Ratification of international agreements and agendas

Four partnerships supported international agendas and agreements. Partnership (e) encouraged regional and national ratification and implementation of the International Convention on Oil Pollution Preparedness, Response and Cooperation, and the conventions relating to oil spill compensation; partnership (j) supports the Bahia Declaration, which builds on Ch 19 of Agenda 21; and partnership (l and m) also support Chapters of Agenda 21.

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ANNEX 1: EFFECTIVE PARTNERSHIPS:

	Determinants	Results
Inputs		
Goal and scope	Strong rationale and evidence base for P; consultation process involves appropriate and influential stakeholders (8,15); Realistic assessment of tools and strategies available, and resource gaps (7)	Agreed simple and compelling goal; clearly defined and focused scope and priorities (6,8,9,14,15,16); clear definition of 'success' (3,12); Mid to long-term strategic plan; feasibility analysis conducted (7)
Structure/organisation	Suitable and effective incentive and institutional arrangements, and legal structures (3,4,5,7); dispute resolution procedures in place (5). Appropriate partners chosen through internal formation process (14) Appreciation of the P 'debate' – pros and cons, range of possible P structures etc (5,8,12); understanding of P conception, planning, and implementation; appreciation of risk management and its impact on P project (4); Clear decision making rights for 10-20 most important decisions (3,6); committed senior management team, "everyone must be 'sold'" (14); strong management team (14) Sufficient resources: funds, staff, materials and time (15)	Clear assumption of risk by partners (7); contractual agreement negotiated that includes arbitration mechanisms (1) Solid foundation for P Appropriate P structure matched to individual project characteristics (4,11,12); Senior "champions" in partner organisations, actively and enthusiastically engaged (3,9); Periodic assessments of quality of partnership's executive authority over the strategic direction of the P, and the management of activities designed to achieve that broad direction (3)

Process/ways of working	Agreement on shared governance structure that define partner roles and responsibilities (8,9,12,14); set the ground rules (8,9); transparency/ no 'hidden agendas' (10); anticipate likely conflicts (12) The 7Cs – Clarity of:leadership,understanding, purpose, role, commitment, management, measurement (15)	P arrangements adequately reflect underlying power relations; effective communication and inclusive participation (8,9);
	"Trust, but verify" (1, 2,11,16);	Process-based, characteristic-based, and institutional-based mechanisms for trust-building established (2,11)
	Respect cultural differences (1)	
	Communication within partnership AND all stakeholders (1,9,14)	Stakeholder analysis carried out with consumers. "Community buy-in" understood and addressed (1)
	Invest in training of staff (1)	Staff have transferable skills and ability to capacity-build (1)
	Plan for evolution of P (12)	
Environment:		
managing change	Flexible senior executives; Flexible approach to problem-solving in recognition of changeable environment (1,9)	Flexible P that can respond to changing environment. Periodic reviews of P practice timetabled; favourable conditions for 'entrepreneurial thinking' (1,9)
economic	Favourable financial climate;	
history	Positive history of collaborative relations	
politics	A political and social climate conducive to partnership working (3);	A political and social climate conducive to partnership working (3)

	Determinants	Results
Outputs		
	Establish clear metrics to track and measure success (12). Quality monitoring (5); regular measures of progress (9) Performance feedback (14) Part of national programme	Successful feedback monitoring sytem established Effective assessment of progress (9) Employee participation; community participation; cross-sectoral collaboration; diverse activities initiated; policy change; policy development; mobilisation of local resources (3);

Annex 2: Outcomes/impact determinants and results for sample partnerships in water and sanitation
(from International Chamber of Commerce database)

a. BPD Water and Sanitation Cluster
b. Business Partners for Development
c. Clean and Green
d. Global Reporting Initiative
e. IMO/IPIECA Global Initiative in Africa
f. Marine Stewardship Council: the MSC Standard for Sustainable Fisheries
g. Partnership for the Development of Urban Services in Casablanca
h. Partnership for the Development of Water and Sanitation Services
i. Recycle Millions of Lives
j. Responsible Care in the Chemical Industry
k. Sustainable Communities
l. Sustainable Development and Asset Management
m. The Western Indian Ocean Regional Oil Spill Contingency Planning Project
n. Treatment of Arsenic Contaminated Drinking Water
o. WBCSD Access to Water
p. West Africa Water Initiative
q. Yemen Technology Transfer and Community Assistance

	Determinants	Results	Sample Partnerships
Outcomes/ Impact			
	Strategy and operational plan delivered for integrating pro-poor objectives into plans and operations (geographical and population based targets)	Increased access to water and sanitation services for poor;	*a;b;g;h;n;p;q*
	Strategy for building capacity of specific target groups (to engage in/support local level projects; transfer of project management skills to local communities	Developed "human capital": Jobs created; Increased learning and shared 'best practice'; Empowered, less dependent, 'energised', local communities.	a;b;c;h;q
	Increased accountability and transparency of partnership	Improved impact of gov activity; Expanded services; more effective national response structure	
	Partnership integrated into service infrastructure; evidence of institution-		a;b;g

	building	Altered perceptions at local level eg, environmental awareness	c;d;e;g
	Partnership addresses social development; norm-setting	Sustainable performance of partnership	c;i;k;l;o;
	Metrics implemented, standardisation of reporting and standard-setting, progress measured, frameworks in place	Enhanced national and regional cooperation between public and private sectors	d;f;h;i;j;k;l;m
	Explicit support /encouragement for ratification of International conventions etc (eg, Agenda 21)		e;j;l;m