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# DFID HEALTH RESOURCE CENTRE

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## ASSESSING THE IMPACT OF GLOBAL HEALTH PARTNERSHIPS

Synthesis of findings from the 2004 DFID Studies: *Global Health Partnerships: Assessing the Impact.*

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**GLOBAL HEALTH PARTNERSHIP ACRONYMS**

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 Filariasis
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
IAMI	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

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	<i>(insecticide treated net social marketing programme)</i>
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	<i>(international pharmaceutical company initiative to support AIDS orphans)</i>
TROPIVAL	<i>(French based R&amp;D partnership for neglected diseases)</i>
VDP	Viramune Donation Program
VF	Vaccine Fund
Vision 2020	<i>(global initiative to eliminate unnecessary blindness)</i>
VITA	Vitamin A Global Initiative
VVM	Vaccine Vial Monitors
WPRESS	WHO Programme to Eliminate Sleeping Sickness

**ABBREVIATIONS**

ACT	Artemisin combination therapy
ADIPs	Accelerated Development and Introduction Plans (for vaccines)
AMDS	AIDS Medicines and Diagnostics Service
ART	Antiretroviral therapy
ARV	Antiretroviral
BCG	Bacillus Camille Guerin (vaccine)
CCM	Country Coordinating Mechanism
DALYs	Disability Adjusted Life Years
DFID	UK Department for International Development
GDP	Gross domestic product
GFP	Global funds and partnerships
GHP	Global health partnership
GNI	Gross national income
GOI	Government of India
ICC	Inter-agency Coordinating Committee
IPPPH	Initiative on Public-Private Partnerships for Health
MAP	World Bank Multi-sectoral AIDS Programme
MDG	Millennium Development Goals
MMSS	Malaria Medicines Supply Service
MTEF	Medium term expenditure framework
NGO	Non-governmental organisation
NID	National Immunisation Day
PEPFAR	US President's Emergency Plan for HIV/AIDS Relief
PPP	Public-private partnership
R&D	Research and development
SSA	Sub Saharan Africa
STD	Sexually transmitted diseases
TB	Tuberculosis
TRIPS	Trade-Related Aspects of Intellectual Property
UN	United Nations
WHA	World Health Assembly
WHO	World Health Organization

## EXECUTIVE SUMMARY

DFID commissioned a substantial, evidence-based assessment of the impact of the Global Health Partnerships (GHPs) with which DFID engages at both global and country level, drawing out best practice principles to guide DFID's future engagement. This synthesis report summarises key findings from a series of component studies which in practice covered a wider range of GHPs.

GHPs are a moving target in a changing environment, and the evidence to assess them is sometimes limited. Nonetheless, some broad conclusions can be drawn.

First, despite some concerns, **individual GHPs are seen overall as having a positive impact in terms both of achieving their own objectives and of being welcomed by countries studied.** This is true even of GHPs where evaluation has found organisational or relationship shortcomings. The general theme of findings from most evaluations is one of GHP success, but with clear scope for yet further achievement if challenges are resolved.

Key areas of success have been raising the profile of the disease, mobilising commitment and funding, accelerating progress (though it is unclear whether some GHP targets will be delivered on time), and in some cases leading innovation. Most current and planned interventions funded by GHPs are potentially highly cost-effective. Neglected diseases are mostly being addressed by at least one GHP. GHP-led R&D for new tools to address neglected diseases is intensifying and focused on those diseases in greatest need. The R&D GHPs generally appear to be seen as a particularly fruitful way to foster research and development for new diagnostics, drugs and vaccines. Some GHPs - such as GAVI, the TB Global Drug Facility and the Green Light Committee for multidrug-resistant TB - have successfully secured commodity price reductions, and fostered both competition and research, though ARV price reductions may stem more from increased competition from generic manufacturers and global pressure than the Accelerating Access Initiative.

GHPs are bringing additional funding for communicable diseases and other global public goods. They have been successful in leveraging significant additional funds from Foundations, though not from other new sources. 97% of pledges for GFATM are from traditional donor countries. They appear to be relatively well targeted towards diseases which present the largest burden of ill health, towards countries in greatest need in terms of socio economic status and in relation to recent trends in development assistance for health and population. However, GHPs alone will be insufficient to provide countries with the financial means required to deliver a reasonable package of basic health services.

The limited literature on GHPs in difficult policy environments suggests that it is possible for GHPs to operate there and perhaps to deliver wider benefits beyond their specific programme. Country work in this study concluded that the situation presented by fragile states necessitates even more concerted effort on the part of multilaterals and bilaterals to provide direct support to the health system. It may make sense for financing and access/donation GHPs to adopt a slower, more hands on approach with fragile states, identifying strong national partners (either state or non-state) through whom they can work.

Second, there are at the same time some critical concerns and challenges. **The more taxing concerns relate to GHP operations at country level.**

Some GHPs operate above country level and are aimed at development and provision of important new public goods and technologies. Many are more aimed at acceleration of country progress towards the MDGs and other targets. These latter



GHPs are generally seen to fit well with national priorities and programmes, though there may be issues about the priority given to polio NIDs and HIV/AIDs. Evidence suggests that low resource countries are likely to need partnership or donor contribution of three elements to support a successful disease control programme: some contribution to providing the necessary drugs (through funding, donation or discounted price); funding for some operational costs, and technical assistance. Without all three, impact can be limited.

Some GHPs have also contributed to system strengthening. Nonetheless, while individual GHPs may be seen as effective and helpful, the wider concern is that they do not and cannot have a whole systems view of the health system they work in, and in general rely on. There is a serious risk that weak human resource and systems capacity at central and local levels may be overwhelmed by the proliferation of multiple GHPs (and other HIV/AIDS initiatives), each with its separate demands.

The major financing partnerships (GFATM and GAVI) will depend in large part for their effectiveness on technical assistance and capacity building provided by partners. However, to date resources to finance assistance have been limited, as has a structured approach to defining needs and building and co-ordinating demand and supply. Instead technical assistance has been ad hoc and driven by urgent and immediate needs at country level.

Part of the solution is for GHPs to internalise the lessons of other aid instruments. They need to take into account absorptive capacity and particularly broader HR and financing issues. Governance issues need to be addressed, as does the need for rigorous assessment of relevance and impact. Wherever possible, GHPs should pursue strategies for harmonisation and integration both with national systems and with each other (eg by providing funding through SWAPs or basket funding where available, by harmonising systems for budgeting, accounting, monitoring, procurement and audit, and by integrating programmes with similar modalities). More investment in operational research may be required to identify best implementation practices and opportunities for fruitful collaboration across disease programmes. Country studies found evidence that governance arrangements at country level for the GFATM and to some extent GAVI can be burdensome, divorced from normal national arrangements and fostering verticalisation of programmes.

More broadly, health system strengthening is a critical issue in its own right. Whatever the role of GHPs, there is clear need for donors and governments to invest more in health system strengthening if the health MDGs are to be achieved. Different ways to make a more explicit connection between health systems support and GHP funding and access programmes are being explored. These include donors 'top slicing' their contribution to the financing GHPs, so that a given percentage is withheld from the overall donation to GFATM or GAVI and invested instead in system strengthening activities, or putting extra funds directly into health system support, as with GTZ's BACKUP Initiative.

There may simultaneously be scope to rationalise some GHPs with low or unhelpful impact, but this would require a more systematic approach to monitoring and evaluation of GHPs. Several GHPs with time-limited elimination and eradication objectives will reach natural ends over the next few years. Similarly, consideration of proposals for new GHPs should take into account the consequences of GHP proliferation, as well as issues relating to the individual GHP's objectives.

Third, there is **a specific need for GHPs to tighten the focus on securing pro-poor and gender-related objectives**. GHP resources are more focused on low-income countries than recent donor commitments, and GHP allocations by disease are largely at least as pro-poor as past allocations. However, while most GHPs have equity objectives, they tend to lack explicit pro-poor or gender-sensitive operational approaches, or robust measures to provide evidence of benefit to the very poorest people. GHPs can play a role in advocating and stimulating appropriate policies and approaches, and special efforts need to be focused on the most impoverished, vulnerable and underserved populations, including women.

Fourth, **the availability of substantial amounts of new GHP funding – particularly through the GFATM – raises serious concerns about sustainability and perhaps also macroeconomic stability**. Although not particularly large in terms of the overall financing of health services, GHP resources are often highly significant at the country level. There is a risk that country spending patterns will be dictated by the GHPs, and the need to sustain the activities and services provided by them, rather than by national priorities. The issue of sustainability, the need for predictability and the ‘fit’ of GHP funds and donations with MTEFs and national macro-economic policies, needs more rigorous study and debate. But this is not likely to be solely a GHP problem. Similar considerations will arise in relation to the International Financing Facility, and the Millennium Project (draft) recommendations, if adopted, for substantial increases in donor financing for public investments in the poorest countries. This should be the subject of wider debate, including the IMF as an active participant.

Fifth, even given the complexity of partnership as a model, **the main concerns about GHP institutional issues at the global level are generally amenable to relatively straightforward solutions**. These include, for example, greater transparency, more appropriate partner representation on governing bodies, and more business-like approaches. For example, GHPs should develop and regularly review strategic, operational and business plans, delineating clearly defined roles and responsibilities for all major partners. To improve transparency, each GHP should make a minimum of defined key information on GHP processes, performance and decisions publicly available on its website.

Both GHP evaluations and business literature on the determinants of effective partnerships suggest that increasing the effectiveness of GHPs is likely to require greater formality and clarity. The full report provides a detailed framework for assessing the likely effectiveness of GHPs. Key determinants include the existence of SMART goals, structure and process; mechanisms for performance measurement and for generating the necessary participation; and implementation of strategies for capacity-building, technical assistance, resource mobilisation and actions to secure sustainability. Changes in the wider environment are also key drivers. Effective partnerships need the mechanisms to monitor changes and the flexibility to respond to them.

Most GHPs do not have specific governance mechanisms at country level; there are mixed views about the cost-benefit of the GFATM’s CCMs and GAVI’s ICCs. In post-conflict countries with weak government structures, country level coordination mechanisms should be streamlined to reduce transaction costs.

Finally, **views on the continuing role and implications of existing and additional GHPs appear to range from uncertain to polarised**. Given the positive impact of

individual GHPs and perceptions about lack of capacity in relevant UN agencies, GHPs are now seen by many as having a major role to play in scaling up the response to health needs, particularly in the short-term.

But this is not a universal view. Others express concerns about the increasing fragmentation of the global health landscape, poor coordination and duplication among GHPs, and the risk that the proliferation of multiple GHPs - alongside other initiatives, particularly on HIV/AIDS - may overwhelm countries' central capacity and weaker health systems. One alternative might be substantial strengthening of relevant multilateral bodies.

These issues are now becoming widely canvassed, and this seems an opportune moment for DFID to convene a meeting among key interested parties to share analyses and seek to achieve consensus. Such a meeting could take a broad view and explore: (1) the strengths and weaknesses of the global health architecture before GHPs, now and against future needs; (2) the future locus and accountability of GHPs specifically; and (3) possible alternative mechanisms.

The report provides detailed recommendations to DFID.

## 1 APPROACH TO THE STUDY

### 1.1 Terms of reference

The Development Effectiveness Group in DFID's Policy Division is engaged in taking forward work aiming 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 Development Effectiveness Group 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 to guide DFID's future engagement (see Annex 1 for terms of reference). For the purpose of the broader assessment of the impact of GHPs, DFID selected 19 core partnerships<sup>1</sup> for primary examination but individual reports on component studies refers to a range of GHPs relevant to the issue.

### 1.2 Approach to the study

The terms of reference prescribed that much of the work on the global impact of GHPs should be based on information already available, but in addition it draws on findings from three country studies, interviews with GHP personnel and WHO in Geneva, and a limited number of interviews with DFID country staff.

The country studies were undertaken in India, Sierra Leone and Uganda on the basis of rapid assessments. No country visit lasted longer than 13 days. These countries were selected to provide the widest possible coverage of the range of GHPs, plus variety in a number of country characteristics including geographical location, socio-economic status, type of health system and at least one 'difficult environment' country.

### 1.3 Detailed reports on component studies

This report is a synthesis of findings from component studies undertaken by study team members. Detailed reports are available on the DFID Health Resource Centre website ([www.dfidhealthrc.org](http://www.dfidhealthrc.org)) on the following topics:

GHP Study Paper 1: *Mapping GHPs* by Cindy Carlson

GHP Study Paper 2: *Economic and Financial Aspects of the GHPs* by Mark Pearson

GHP Study Paper 3: *GHP Impact on Commodity Pricing and Security* by Cheri Grace

GHP Study Paper 4: *GHPs and Neglected Diseases* by Karen Caines

GHP Study Paper 5: *Increasing GHP Impact by Improved Governance* by Kent Buse

GHP Study Paper 6: *The Determinants of Effectiveness: Partnerships that Deliver* by Nel Druce and Andrew Harmer

GHP Study Paper 7: *Country Case Study Report* by Cindy Carlson, incorporating a contribution on national coordination by Liz Tayler. The report includes:

- *India country study report* by Nel Druce and Rajeev Sadanandan
- *Sierra Leone country study report* by Cindy Carlson and Jennifer Sancho
- *Uganda country study report* by Rose-marie De Loor and Jennifer Sancho.

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<sup>1</sup> APOC, DNDI, GAEL, GAELF, GAVI, GFATM, GPEI, GWEP, IAVI, IPM, ITI, Microbicides Development Programme, MIM, MMV, MVI, RBM, SCI, Stop TB, and WPSS.

GHP Study Paper 8: *Mapping the Pathways on AIDS, TB and Malaria* by Chris Gingerich, was separately contracted and discussions on the potential use of the Product Development Pathway Tool (see Annex 3) in advocacy and analysis are still ongoing.

#### 1.4 Geographical mapping of GHPs

Geographical mapping<sup>2</sup> of GHPs shows that the strongest correlation for a high number of GHPs operating in a country is with the country's region. Africa consistently has the highest number of GHPs per country, followed by Asia (East, Southeast and Central). Eastern and Central European countries have the lowest number of GHPs. There appears to be a correlation between the number of GHPs operating in a country and its per capita GDP. In general, the lower the per capita GDP, the greater the number of GHPs, though this is inconsistent.

As would be hoped, there is a moderate correlation between the prevalence rate or case number of a disease and the presence of the relevant GHP. There is no apparent correlation between the number or type of GHPs operating in a country and the type of government (across a range from authoritarian to fully democratic); or the percentage of spending on the health sector coming from the public purse.

#### 1.5 Disease mapping of GHPs

The vast majority of GHPs focus on communicable diseases. 60% of identified GHPs target the big three diseases - HIV/AIDS, TB and malaria - with HIV/AIDS attracting the most GHPs by some margin. Nonetheless, almost all the 'most neglected' diseases are now supported by at least one GHP, many of which have been established in recent years. GHPs are perhaps particularly well-placed to address conditions, such as communicable diseases, which cross national borders.

Few GHPs address non-communicable diseases, or health systems per se. Collectively, GHPs may not be significantly active in areas with considerable Disability-Adjusted Life Years losses, such as maternal and reproductive health, depressive disorders, alcohol dependence, or road traffic accidents, as well as the rising incidence of cancers.

#### 1.6 A GHP typology

DFID proposed the following typology to classify GHPs:

*Research and Development:* GHPs involved in product discovery and development of new diagnostics, drugs and vaccines.

*Technical assistance/service support:* GHPs which support improved service access, may provide discounted or donated drugs, and give technical assistance.

*Advocacy:* GHPs which raise the profile of the disease and advocate for increased international and/or national response, and resource mobilisation.

*Financing:* GHPs which provide funds for specific disease programmes.

In Annex 2, Table 3 maps all GHPs for HIV/AIDS, TB and malaria by type.

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<sup>2</sup> See *GHP Study Paper 1: Mapping GHPs* by Cindy Carlson

## 2 GHP EFFECTIVENESS AND ITS DETERMINANTS

- *Evaluations of GHP effectiveness are still limited. They find individual GHPs have a positive impact, especially in mobilising commitment and funding and in accelerating progress, even when shortcomings are identified. Sustainability is a key concern.*
- *Effective partnerships require SMART goals, structure and process. A simple, compelling goal and clearly focused scope are prerequisites. Other determinants of effectiveness include mechanisms for performance measurement and for generating the necessary participation at national and international levels. Determinants of impact include implementation of capacity-building strategies, technical assistance, resources and actions to secure sustainability.*
- *GHPs target diseases which have most impact on the poor. While many have general equity aims, most lack explicit pro-poor or gender-sensitive operational approaches, or robust evidence of benefit to the very poorest people.*
- *Most 'neglected' diseases are being addressed by at least one GHP. GHP R&D for new tools is intensifying and focused on diseases in most need.*
- *Most GHPs for neglected diseases are providing technical support, drugs, and in a few cases funding. All three are needed. More operational funding is required.*

### 2.1 Key findings from evaluations

The evidence base on the effectiveness of GHPs is still limited, though growing. Many GHPs are relatively new. The real impact of the GFATM, for example, has yet to be felt. Globally some GHPs, and within countries some GHP-supported national programmes, are still building to full-scale, eg SCI began in 2003 and operates in seven countries, ITI works only in 11 countries, DNDi was set up in 2003.

Most studies which do exist – even multi-GHP studies – examine the effectiveness of individual GHPs. There is as yet little evidence about the collective impact of GHPs, though this is now emerging as a potential area of concern.

The broadest study to date, a 2002 McKinsey & Co study of 30 global health alliances<sup>3</sup>, concluded that “more than 80% of public health alliances appear to be working...in sharp contrast to the private sector’s ...success rate of 50%”. ‘Success’ was defined as accelerating, improving, or reducing the cost of, initiatives aimed at reducing disease burden, by comparison with what could be accomplished by bodies acting individually in a ‘solitary approach’.

However, the study also concluded that many global health alliances were not reaching their full potential. Factors included limited resources, difficulties in decision-making, or a slow start. These general findings of GHP success, but with scope for yet further achievement, are echoed in those GHP evaluations currently available.

In general, these evaluations assess the GHPs against the individual partnership’s objectives and targets. GHPs are mostly judged to have achieved success in key areas - particularly in mobilising commitment and funding, and catalysing action. Partnerships have accelerated the pace of progress (eg IAVI). Even so, it is not clear whether some will deliver targets on time (eg GPEI, the Stop TB Partnership, Roll Back Malaria, GAEL), and the current study’s limited country findings suggest that malaria GHPs may be less effective at country level. Some GHPs are leading

<sup>3</sup> McKinsey & Company (2002) *Developing successful Global Health Alliances*, for the Bill and Melinda Gates Foundation.

innovation. This is most apparent with the R&D partnerships – both in terms of process and product -, but is also true of others, eg GAVI's work on ADIPs; the TB Global Drug Facility and Green Light Committee which have respectively increased access to first and second-line TB drugs. More investment in operational research may be required to identify best implementation practices and opportunities for fruitful collaboration across disease programmes.

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. The expectation seems to have been that technical agencies in the UN and other sectors would provide support. However, to date, resources to finance assistance have been limited, as has a structured approach to defining needs and building and co-ordinating demand and supply. Instead technical assistance has been ad hoc and driven by urgent and immediate needs at country level.

GTZ is one of the few agencies that both recognised and responded to the need soon after the GFATM's launch, by developing a flexible and rapid response fund through its BACKUP Initiative, to meet demand for capacity related to accessing global finance at country level. It also provides financial and technical inputs towards efforts to develop strategies with WHO, UNAIDS and the ILO that reflect a longer term and more sustainable vision for capacity building, in collaboration with GTZ implementers and other partners at country level. In general, mechanisms for co-ordinating and financing such inputs need urgently to be developed and sustained at country level.

One somewhat unrecognised aspect of effective GHPs is their ability to catalyse a shift in the 'public sector' mindset for health care delivery. The Stop TB Partnership's emphasis on national public-private partnerships, together with its approach to inclusive governance (eg 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 evaluations (APOC, GAEL) note that smaller NGOs, especially indigenous ones, are limited in their participation at international and national levels.

Overall, evaluations see GHPs as having had a positive – usually a very positive – impact. This is true even of GHPs where the evaluation finds organisational or relationship shortcomings. Where cost-effectiveness has been assessed, it is high. Sustainability has been identified as a continuing concern.

## **2.2 The added value of partnerships**

Evaluations say less about 'added value'. Even high scoring GHPs, such as IAVI, had no mechanism for assessing added value. This is now being recognised as a lack. Some GHPs are trying to define their added value more precisely, and include:

- harnessing high-quality talent from disparate sources;
- enhanced capability of partners through coordination and consensus-building;
- information on resource flows, identifying funding gaps and priorities, resource mobilisation and funding additional support to countries for supplies and operational costs;
- innovation in processes and actions, and creating synergy between new developments and implementation; and
- consistent high-profile advocacy and broadspread communications.

While these are likely to be appropriate added value areas, there remains need for more specific indicators and mechanisms to monitor them.

Development of a clear strategy, building a consensus around it, and coordinating partner efforts are fundamental added value objectives for GHPs. It is worrying that in some cases there appear to be continuing tensions about technical strategies and operational priorities, in one case (GAEL) leading to partnership breakdown. At the same time, it is unreasonable to expect partnerships of this nature to operate without some strains, given the scale of the programme challenges, the complexity of the dynamics, and the differences in culture between constituent partners.

### 2.3 Determinants of partnership effectiveness<sup>4</sup>

This section discusses which factors appear to determine how effective partnerships are. It is based on literature reviews of evaluations for the major GHPs, and of partnership literature in the wider business and political science field.

A striking, though perhaps not unsurprising, finding is the commonality in the two literatures of good (and less good) practice that results in more (or less) effective partnerships. Despite considerable variations in partnership types and objectives, key messages from the business literature are relevant, often echoing the frequent recommendations in GHP evaluations for greater formality and clarity.

#### *Partnership inputs*

The inputs of an effective partnership are goals, structure and process. Goals should be specific, measurable, achievable, realistic and time-bound (SMART). The 2002 McKinsey & Co study identifies two prerequisites for partnership success: a simple and compelling goal, and a clearly defined and focused scope (disease, geography, population, activities). 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 resource mobilisation. Understanding purpose and role is emphasised as an important means of overcoming 'cultural' differences between partners from different sectors (eg public, private, NGO), a crucial need in GHPs.

The phrase 'trust but verify' encapsulates the critical 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 clear about their roles, and less trustful of each other. In several cases, they perceived one important partner as too dominant, (especially WHO by partners in RBM, GAEL and, to a more limited extent, APOC). GHPs perceived as particularly effective tend to be those where partners are positive about each other, about the partnership's ways of working and the secretariat's functioning (IAVI, GAVI).

Changes in the physical, economic, social/political and technological (PEST framework) aspects of the wider environment are major drivers affecting partnership effectiveness. Partnerships need the mechanisms to monitor, and the flexibility to respond to, changes. Several partnerships lack an operational research strategy, which weakens their ability to base activities on robust evidence.

#### *2.3.1 Partnership outputs*

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

- *partner alignment and mobilisation;*

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<sup>4</sup> See *GHP Study Paper 6: The Determinants of Effectiveness: Partnerships that Deliver* by Nel Druce and Andrew Harmer



- *raised profile and political commitment* through advocacy at international and national levels; joint governmental commitments (eg Amsterdam TB Declaration).
- *shared strategic vision and consensus on policy/technical objectives*,
- *mobilising, pooling and co-ordinating the allocation of resources* (financial, commodity and human)
- *co-ordination of efforts and capacity building* at national level.

The literature identifies two overall determinants of these outputs:

- mechanisms for measurement of performance against the strategic and operating plans described in the previous section. Shorter-term institutional and operational targets are required to assess and demonstrate effectiveness and efficiencies.
- mechanisms for generating the necessary participation. Means to involve development partners, government and others in-country actively were seen as critical success factors of APOC, OCP, GPEI, GAVI (and STOP TB in India).

The effectiveness of the access 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 co-ordinate appropriate human and financial resource allocations and to deliver appropriate technical inputs and/or finance or other resources, such as commodities.

The supply of free or reduced 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 (see also section 3).

#### *Partnership impact and outcomes*

Attributable impact is 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. Demonstrating the latter is particularly challenging.

Determinants include implementation of capacity-building strategies, technical assistance and resources. Planning and implementing for sustainability – defined 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.

Table 1 overleaf provides an integrated summary of the findings from both literatures. It links the determinants of effectiveness with results at different levels (inputs, outputs/outcomes, impact).

Table 1: Partnerships that deliver – determinants and results

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

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

## 2.4 Poverty and gender equity

GHPs have the potential to make a significant contribution to addressing equity issues. They could and should focus on:

- diseases with the greatest impact on the poor and marginalized;
- countries with greatest socio-economic need; and
- addressing the needs of poor people and women within individual countries.

Most GHPs claim to be pro-poor, and overall they do target diseases affecting the poor disproportionately. Analysis suggests that on the whole, GHP allocations by disease are at least as pro poor as past allocations - perhaps more pro poor for

malaria, slightly less so for HIV/AIDS. For diseases covered by GHPs, GHP resources are more focused on low-income countries than recent donor commitments. As an example, GAVI/Vaccine Fund support is restricted to countries below \$1,000 GNI per capita. However, individual GHPs tend mostly to lack specific indicators or measures for equity aims. At country level, they cannot show that the very poorest people are benefiting, and most lack specific objectives to work with country partners for delivering such impact.

These are vital issues, given the growing evidence of significant socio-economic differences within seemingly homogenous poor populations<sup>5</sup>. In evaluations, several partnerships were urged to consider donor commitments to poverty reduction in their strategic thinking (APOC, GAEL and others). 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). Similarly, Buse found that few GHPs had SMART objectives to address the needs of women, or monitoring systems to assess performance in this.

There is as yet very little evidence on impact. A recent evaluation of GAVI's performance-based Immunization Services Support (ISS) funding<sup>6</sup> found that "*case study countries generally did not undertake any special effort to target the "hard to reach," except to the extent that a significant portion of funding supported outreach efforts.*" But equally, the study found no distortion in favour of low-hanging fruit. "*Although the ISS reward has the potential to serve as a disincentive to investing funds to reach small disadvantaged populations, countries for the most part did not strategically plan either to ignore, or reach out to, the hard to reach.*"

The majority of GHPs can provide evidence of increased coverage attributable to their work, and this is sometimes taken as a proxy indicator. For example, GAVI has adopted a strategy of increasing immunization coverage, given research findings that the differential in access between the rich and the poor tends to decrease with increasing average immunization coverage. Importantly, GAVI has also set countries an equity-focused milestone to reach at least 80% immunization coverage in all districts by 2010 or sooner<sup>7</sup>. GAELF and GAIN links their activities to specific poverty-related goals.

A recent study of drug access partnerships<sup>8</sup> noted the widely-held conclusion at country and global levels that such partnerships have indeed assisted the poor to access necessary drugs. Data to support this remain limited and indirect, but the study found the conclusion reasonable given the nature of the diseases, generally high levels of programme coverage and the fact that the drugs are provided free and in unlimited amounts to recipients.

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<sup>5</sup> Gwatkin D R, *How well do health programmes reach the poor?* Lancet 2003; 361:540-1

<sup>6</sup> Evaluation of GAVI Immunization Services Support (ISS), Abt Associates, August 2004, [www.vaccinealliance.org/Support\\_to\\_Country/Monitoring\\_Evaluatio/ISS\\_study.php](http://www.vaccinealliance.org/Support_to_Country/Monitoring_Evaluatio/ISS_study.php)

<sup>7</sup> The full milestone is that by 2010 or sooner all countries will have routine immunization coverage at 90% nationally with at least 80% coverage in every district. The status as of April 2003 was that forty-five or 27% of developing countries (2) reported 90% national DTP3 coverage with >80% DTP3 coverage in all districts. An additional 17 countries reported >90% DTP3 national coverage, but had no district data; and eight or 11% of Vaccine Fund eligible countries reported 90% national DTP3 coverage with >80% DTP3 coverage in all districts. One additional Vaccine Fund eligible country reported >90% DTP3 national coverage, but had no district data.

<sup>8</sup> Caines K. and Lush L., *Impact of Public-Private Partnerships Addressing Access to Pharmaceuticals in Low and Middle Income Countries: A Synthesis Report from Studies in Botswana, Sri Lanka, Uganda and Zambia*, Initiative on Public-Private Partnerships for Health, Switzerland, 2004. ISBN 2-940286-21-3

A clear conclusion from this study's fieldwork is that at country level, GHPs are in practice only as pro-poor or gender-sensitive as the policy environment and health systems they operate within. Since systems are often far from pro-poor, it will be important to ensure that investment in GHPs is not at the expense of investments in system strengthening. Collection, analysis and use of disaggregated data are essential to inform the development of effective strategies. Routine data collection on socio-economic status is not recommended, but there is certainly a greater role for periodic household surveys, to generate baseline and outcome/impact data.

Special efforts need to be focused on the most impoverished, vulnerable and underserved populations, including women. GHPs can play a role in advocating and stimulating appropriate policies and approaches. Situational analysis should identify factors that inhibit service take-up, implementation strategies must address these bottlenecks, and monitoring and evaluation needs to collect indicators on access by different sub-populations, especially the most vulnerable. Geographical and population group targeting can be effective approaches for some diseases (particularly given the localised nature of neglected diseases) and some poor people. GHP support for new community-based and public-private service models aimed at increasing access to effective treatment (eg for TB), should explicitly address known poverty- and gender-related barriers to care.

### **2.5 Do GHPs address neglected diseases?<sup>9</sup>**

The group of diseases commonly described as 'neglected'<sup>10</sup> are a symptom of poverty and disadvantage and typically affect those least able to demand services. Health interventions – and research and development – have been regarded as inadequate to the need. After a period of neglect, most are now being addressed by at least one GHP, generally established in recent years and focused on a single disease.

Several of the diseases are the subjects of time-targeted World Health Assembly eradication or elimination resolutions. The clarity of the goal – and in some cases, the consciousness of insufficient progress being made towards it – may act as a stimulus to partnership formation. The GHPs' key test will be whether they can deliver on time the targets for eradication and elimination, several of which have proved elusive in the past. The financial dividend from achieving the targets will not be huge but success will relieve affected countries not only of the burden of disease, but also of the burden of dealing with several partnerships.

The extent and nature of GHP support for the individual diseases varies. For most neglected diseases, the GHP provides broad support for raising the profile of the disease and improving the delivery of interventions, usually backed by a drug donation agreement with one or more partner pharmaceutical companies. In some cases the drug donation provided the rationale for establishing the GHP. Country case studies suggest they have facilitated better drug availability very substantially. This is helpful in a context where the government of Uganda recently found that lack of drugs is now the biggest problem in health units.<sup>11</sup> The period of drug donation should align with the timescale for the GHP's objectives.

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<sup>9</sup> See *GHP Study Paper 4: GHPs and Neglected Diseases* by Karen Caines

<sup>10</sup> The following 15 'neglected' diseases were selected as the basis for analysis: Buruli Ulcer, Chagas' Disease (American Trypanosomiasis), Congenital Syphilis, Cysticercosis, Dengue and Dengue Haemorrhagic fever, Guinea worm, Human African Trypanosomiasis (Sleeping sickness), Leishmaniasis (kala azar), Leprosy, Lymphatic Filariasis, Maternal and Neonatal Tetanus, Onchocerciasis, Rabies, Schistosomiasis and Soil-transmitted helminthiasis and Trachoma.

<sup>11</sup> Uganda Poverty Status Report, 2003

In the poorer countries visited in recent studies, GHPs appear to be beginning to make a real difference in kick-starting or revitalising programmes for neglected diseases which have typically had a low political profile even at country level. By contrast, in India these GHPs are perceived as making only a limited contribution.

Only a few of these GHPs (eg APOC) provide direct access to operational funding in addition to facilitating drug supply. Failure by the GHP to provide or mobilise funding of this kind can seriously curtail programmes, as in the case of GAELF, or even jeopardise the value of past investments. Experience suggests that low resource countries are likely to need partnership or donor contribution of three elements to support a successful disease control programme:

- some contribution to providing the necessary drugs (through funding, donation or discounted price)
- funding for some operational costs, and
- technical assistance.

The main challenge to effectiveness noted in the literature is the need to plan for longer-term integration, where GHP programmes are run on a project basis.

Current consideration by WHO of a more integrated approach to tackling at least some of the neglected diseases should be encouraged. The emerging view is that some degree of integration across diseases would be both technically feasible and operationally beneficial. Developments of this kind will require much closer collaboration between individual GHPs for neglected diseases at global as well as country levels. This collaboration should cover advocacy for a group of diseases rather than an individual disease, as well as support for delivery of technical strategies.

A few diseases – Chagas disease, dengue and dengue haemorrhagic fever and leishmaniasis – appear to have GHP support only for the development of new tools, though WHO provides wider support. There are effective and affordable tools for prevention and treatment of many neglected diseases but some diseases have faced a serious unmet need for research and development. One critical problem has been the lack of sufficient market incentive. The indications are that R&D is now intensifying through the activities of newly-created GHPs. DNDi is targeting the three diseases generally accepted as being in greatest need of new drugs: Chagas disease, leishmaniasis and sleeping sickness. Other GHPs are working on a vaccine against dengue. These new GHPs will need continued support, though it is too soon to assess their impact. More research is needed into prevention and treatment of Buruli Ulcer.

In short, while a few gaps remain, GHPs do appear to be addressing a set of diseases principally affecting poor people which have previously been neglected.

### 3 GHP IMPACT ON COMMODITY PRICES AND SECURITY<sup>12</sup>

- *Some, but not all, GHPs have successfully secured commodity price reductions, and fostered both competition and research.*
- *The most effective GHPs achieve good prices without deterring manufacturers from providing a secure supply of existing products or investing in R&D for future products. They tailor their approach to product and market characteristics.*
- *In competitive markets, greater purchaser leverage can be achieved, for example, through pooling demand and bulk-purchasing.*
- *Where a competitive market does not exist, options to increase purchaser leverage include pooling demand and direct negotiation for exclusive purchasing contracts, subject to periodic retendering.*
- *Differential pricing may be the only alternative where the public market is a tiny fraction of the total market; competitive markets are preferable, where possible.*

#### 3.1 GHP impact on price and security of selected commodities

As noted in section 2, the supply of free or reduced cost and quality assured drugs and other commodities can be a key success factor for partnerships. This section considers whether and how GHPs, or structures within GHPs, have had an impact on commodity pricing and security of drugs and vaccines for selected diseases. Security in this context means the uninterrupted, sustainable supply of affordable commodities of accepted quality standards.

The variables of pricing and commodity security can be in conflict. Indeed, one of the greatest GHP challenges is to assure that static access to medicines, which may be enabled by single-firm contracting or reduced short-term prices, does not preclude dynamic access, made possible by manufacturers continuing to provide a secure supply of existing products, to invest in R&D for future products, as well as by the development and maintenance of competitive markets, facilitating price reductions.

#### 3.2 Tuberculosis

The TB Global Drug Facility (GDF) for first-line anti-TB drugs operates in a largely competitive market. It bundles global pooled procurement with pooled financing and a network of partners to provide technical assistance to support grants. An independent evaluation by McKinsey & Co. concluded that this combined approach of pooled financing and commodity purchase has been key for the GDF to meet some of its goals. The primary benefits of the GDF have been expansion of access to high quality TB drugs; facilitation of DOTS expansion; and system level benefits that have resulted in drug price reductions. The evaluation found that GDF prices were 40-50% lower than the prices on the MSH International Price Indicator Guide and 20 - 45% lower than previous tenders in Kenya.

The Green Light Committee for second-line TB drugs against multidrug resistant TB (MDR TB) tailors its approach to a differentiated market situation. Where drugs can be competitively sourced, a bulk purchasing approach is used. But many MDR TB drugs are single sourced or patented. For those, the GLC negotiates based on price and quality. The GLC's strategy has increased supply and decreased the price of quality-assured MDR TB drugs. The GLC has managed to achieve 85 - 99% reductions on US prices of the 14 products procured for GLC-endorsed projects. To

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<sup>12</sup> See GHP Study Paper 3: *GHP Impact on Commodity Pricing and Security* by Cheri Grace

maintain a competitive marketplace and ensure sustainable supply, the GLC awards a large percentage of its tender to the quality-assured company with the lowest-priced drug, and a proportional percentage to one or a few of the remaining quality manufacturers. The GLC also looks for opportunities to induce new suppliers into the market, thereby increasing competition.

### **3.3 Malaria**

The Malaria Medicines Supply Service (MMSS) has recently been formed in WHO to address the supply crisis for Artemisinin combination therapy (ACT). The MMSS is not yet operative, so its impact cannot be assessed, but the conditions of the ACT market are certainly favourable for a GHP of this kind. Global pooled procurement should help increase purchaser leverage that could reduce prices, ensure quality, and influence product norms. Meanwhile, demand creation activities, along with provision of finance, may lure new suppliers into a market with a large unmet demand. An MMSS approach is a welcome addition to the only GHP focused on ACTs at present - the WHO/Novartis agreement to provide Coartem (artemether-lumefantrine) through WHO at 'cost' price for ten years. This agreement certainly secures a concessionary price, but perhaps at the expense of the dynamic efficiency that could be obtained through market entry, particularly of lower cost developing country suppliers, leading to competition and lower prices.

### **3.4 Vaccines**

GAVI works closely with the limited number of vaccine suppliers, since many products are single-source or patented. To secure price concessions and supply, GAVI enhances the overall attractiveness of the vaccine market by stimulating demand in developing markets, strengthening vaccine delivery infrastructure, and guaranteeing future purchasing of the product, at least in the short term.

The combination products preferred by countries became commercially available specifically for GAVI and are still early in their lifecycle. Some price concessions for DTP-HepB and DTP-Hep+Hib vaccines have been achieved via firm contracting, involving making advance commitments to vaccine purchase and sharing risks with producers. Around 40% of the value of the total GAVI vaccine value is scheduled for firm contracting (as opposed to GDF- like bulk purchasing via competitive tender).

The prevailing monopoly situation for combination vaccines, with several buyers vying for limited supply, may be limiting the price concessions achieved; the main benefit of firm contracting in this environment is seen to be ensuring security of supply. Significant and sustained price reductions are not likely to be seen until competition has been established. In the latest procurement round, GAVI was noted to have been successful in stimulating the entry of new manufacturers in the production of HepB, Hib and Yellow Fever vaccines for low income countries, in particular DTP HepB.

In the traditional EPI vaccine market, the availability of BCG, DTP TT and measles vaccine has recently increased, but prices for several have also increased. The limited number of manufacturers for some products remains a concern, especially for measles. Demand exceeds supply, so broadening the supply base is necessary.



GAVI is currently exploring the potential to use the International Finance Facility, as a mechanism of creating greater predictability of funding flows.<sup>13</sup> This finance predictability could result in new suppliers being lured into the market and/or in the ability for GAVI to enter into longer-term and more secure advanced purchase contracting with suppliers. As noted, sharing risks with suppliers increases purchaser leverage and may result in greater commodity security or reduced prices during the contract period. However, in order to encourage dynamic access, the contract terms will need to be carefully defined and the market monitored to encourage new supplier entry during subsequent contracting rounds.

### 3.5 Antiretrovirals (ARVs)

The intention of the Accelerated Access Initiative (AAI) is to provide developing countries with access to ARV medicines at the lowest possible prices and to technical support for the implementation of national access programmes for ARV treatment. However, the ARVs offered through the six AAI participating companies remain more expensive than the prices offered by generic companies and the cost of ARV treatment still exceeds the annual GDP per capita of many LDCs. The AAI has claimed responsibility for ARV price reductions which have occurred during its lifetime, but increased competition from generic manufacturers and global pressure appear to have had a more significant impact.

Changes in the external environment – most notably, the impact from increases in ARV funding and from TRIPS - will have significant effects on the market structure for ARVs. With South Africa scaling up its ARV efforts, made partly possible through GFATM funding, suppliers from India, China and South Africa will soon become more important suppliers globally. This will make the marketplace more competitive generally, at least for the older ARVs. On the other hand, the market for newer ARVs is likely to become less competitive over time, since TRIPS implementation in major producing countries like India will make generic copying of patented products illegal. The result is likely to be bifurcation of the market for ARVs, with single-sourced newer products and competitively supplied older products.

The AIDS Medicines and Diagnostics Service (AMDS), established in December 2003, is a welcome addition to the GHPs aimed at securing reduced ARV prices and increased security. Its approach to suppliers is more appropriate to the bifurcated market structure, and it therefore has greater potential, as a GHP, to increase competition or help purchasers gain leverage for reduced prices or secured supply.

At present the structures focusing on commodity security and pricing (eg the GDF, GLC, MMSS and AMDS) operate separately by disease rather than within a single organisation. This is a sensible approach which can be justified on economic grounds, since there is little supplier overlap between diseases; engaging in either single-firm contracting or bulk purchase tendering is transaction-intensive; and the scope of work of many GHPs includes not only the aspect of dealing with suppliers and markets, but also of promoting better disease management and demand forecasting at country level. There are however important cross-disease lessons to be learnt about working with suppliers, creating optimal contracting structures and about promoting better disease management at country level.

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<sup>13</sup> IFF would allow increased funding security because governments could commit funding for up to 15 years, for example, beyond the terms of the current government. How GAVI would balance vaccination of existing children, versus subsequent generations, remains a question. The idea is that the commitments to be paid over 15 years would be front-loaded, theoretically bringing forth investments from industry that would induce competition and drive down prices that would benefit subsequent funding agencies (e.g. bilaterals, developing country health budgets).

### 3.6 Conclusions

#### *GHPs to tailor approach to product and market characteristics*

GHPs can best reduce commodity prices and increase security by adapting their approach according to product and market characteristics. DFID should support GHPs, or structures within GHPs, that can demonstrate that they have successfully set up their functions to achieve static *and* dynamic access to medicines.

#### *Competitive markets*

Where product competition already exists, effective GHPs bring about price reductions and enhanced security primarily through creating greater purchaser leverage. This can be achieved through pooling demand and bulk-purchasing, for example, or by offering professionally managed procurement services, disseminating pricing and quality information, and sharing country experiences and best practices.

#### *Single source or patented supplies*

Other GHPs are operating in an environment where the supply is single sourced and/or patented. Where a competitive market does not exist in the short-term, public purchasers have a variety of options aimed at increasing their leverage with suppliers, including pooling demand and direct negotiation for exclusive purchasing contracts. However, such agreements must be entered into with caution, and a view towards creating a competitive market longer-term. Periodic re-tendering is important, so that the sanction of losing the tender serves as at least partial incentive to offer good price and service, and so as to provide incentives to new firms to enter the market. Market surveillance is also necessary to gauge if, and when, other suppliers can be induced into the market.

#### *Differential pricing*

In situations where the public market is a tiny fraction of the overall global market, as with many ARVs and now with some newer vaccines, there will be little hope of creating any purchaser leverage, at least from a direct commercial perspective. In this case, differential pricing may be the only alternative. The leverage in this case relates perhaps to the more indirect benefits a company receives in the eyes of investors and activists or its own staff for engaging in such agreements. In certain market contexts, there is a risk in relying on differential pricing arrangements of possible heightened barriers to entry, which can decrease competition and therefore the potential for price reduction.

## 4 COUNTRY OPERATIONS, ALIGNMENT AND IMPACT ON HEALTH SYSTEMS<sup>14</sup>

- *GHPs are generally considered to fit well with national priorities and programmes, though there may be issues about the priority given to polio NIDs and HIV/AIDS. Some important conditions at country level lack support.*
- *GHPs should provide funding within a SWAP framework, where one exists.*
- *The issues of sustainability, predictability and the fit of GHP funds with MTEFs and national macro-economic policies need more rigorous study and debate.*
- *There is a serious risk that the proliferation of multiple GHPs (and other HIV/AIDS initiatives) may overwhelm central capacity and weaker health systems. GHPs should pursue more integrated and coordinated approaches, and donors should invest more in health system strengthening.*
- *Governance issues at country level need to be addressed, as does the need for rigorous assessment of relevance and impact.*

### 4.1 Fit with national priorities and programmes

Within the over-riding GHP typology by function, GHPs vary substantially by scale, cost, operational structure and impact on systems at country level.

#### *GFATM, GAVI, RBM, the Stop TB Partnership and the HIV/AIDS GHP constellation*

The commonality of this group of GHPs is the potentially powerful influence they can have at country level, whether as funding or access GHPs. In general, the country studies suggest GHPs are considered at present to fit with national strategies, since they mostly work through national programmes and address priority diseases. However, this must be seen in the context that health plans in most countries are not affordable (in Uganda, the basic minimum package is costed at US\$28 per capita, while spend is US\$9), and that health services are constrained by lack of human resources. In high aid-dependent countries, GHPs (and other donors) are likely to influence priorities – the very aim of the individual GHP but not always helpful in the individual country. In Sierra Leone, for example, there was concern about the imbalance between the priority being given to HIV/AIDS, and the absence of support for prevention and care of sexually transmitted diseases.

#### *GHPs for 'neglected' diseases*

The smaller-scale GHPs for mainly localised neglected diseases appear generally to be addressing national priorities, working through national systems (which may themselves operate in project mode), and welcomed by health services at national and district levels for bringing new resources, drugs and preventive measures.

#### *Global polio eradication initiative (GPEI)*

The GPEI is distinguished from other eradication initiatives by the sheer scale of its financial and infrastructure investment. Spending to date has been estimated at about US\$2.5 billion (1988-2003), with another US\$1.1 billion needed for eradication. Since most financial benefits from polio eradication are likely to be enjoyed by developed countries, it could be argued that non-ODA sources (eg OECD health budgets) rather than countries should contribute to filling the financing gap. The GPEI evaluation felt criticisms could not be ignored that GPEI has been too costly, diverted resources from routine services, and failed to give enough added value to health

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<sup>14</sup> See *GHP Study Paper 7: Country Case Study Report* by Cindy Carlson

services, despite benefits going beyond eradication. Staff in all three country studies indicated that National Immunisation Days (NIDs) for polio were a major drain on immunisation resources, and diverted attention and effort from struggling mainstream immunisation programmes.

## 4.2 National coordination and alignment

### *GHPs and SWAPs*

One read across from evidence on more conventional aid instruments is the growing recognition of the importance of harmonising donor efforts, given the damaging effect of uncoordinated donor activity, particularly where capacity is limited.

The country case study report<sup>15</sup> recommends that, where a SWAP or basket fund approach exists in the individual country's health sector, financing GHPs in particular should aim to provide funding within the SWAP framework, rather than parallel to it. They could provide support for ensuring monitoring and accounting systems provide the information needed. This would avoid the fragmentation seen in Uganda where a distinct Global Fund project unit reports direct to the GFATM Board, and GFTAM-supported programmes are dissociated from CCM oversight and National AIDS Committee programmes. However, the report notes that there is no evidence from the case studies on how best to take forward this recommendation, since fieldwork was limited to three countries, only one of which (Uganda) has a functioning SWAP.

### *GHPs and health sector budget ceilings*

GHP resources to countries tend to be 'off budget' and are often highly significant at the country level (see section 4). Financial capping (eg in Uganda and India) has led to moves to by-pass national systems. For example, in India the Gates Foundation is channelling HIV prevention funds equivalent to one-third of the government AIDS budget directly to NGOs in order to circumvent the fiscal limits imposed by the government budget. In Uganda, GHP funding has been designated 'project'. Funding from GAVI and GFATM (Rounds 1 and 2) were absorbed in the MTEF, as the financial ceiling was raised by the MOFPED. However, MOFPED has now made it clear that it will not raise the ceiling any further. Therefore if additional GHP projects are accepted, these have the prospect of depressing other budgets. Hence, some argue that GHP flows threaten to undermine fiscal discipline and government accountability. Others welcome increased resources coming in through GFATM and GAVI for putting pressure on governments to raise health budget ceilings.

The 'fit' of GHP funds and donations with countries' medium-term expenditure frameworks (MTEFs) and national macro-economic policies, together with the issues of sustainability and predictability of flows, need more rigorous study and debate. These should be taken forward as part of a wider debate about the relationship between the full range of development assistance and MTEFs, and should include the IMF as an active participant. The report of the Millennium Project, due in January 2005, could provide the context for such consideration. Its current draft report recommends increased financing - largely donor financing - for public investments in the poorest countries, and argues that the IMF's role should entail helping each country to establish a macroeconomic framework around the inflows of donor aid needed to achieve the MDGs rather than around the currently available flow of donor aid.

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<sup>15</sup> See *GHP Study Paper 7: Country Case Study Report* by Cindy Carlson

*National coordination*

One major benefit focused GHPs could bring is in aligning and coordinating efforts at country as well as at global level. However, for HIV/AIDS there is a critical unresolved problem about the fragmentation of initiatives, funding and conditionalities which goes beyond GHPs (including, for example, the US President's PEPFAR and the World Bank's MAP).

*Examples of good practice in improving coordination include:*

- *Alignment of key implementers in country for achievement of GHP objectives:* GHPs have emphasised inclusion of civil society groups, service consumers and in some cases the private sector. In India, NGO partners work hand in hand with government to implement the government's TB control and polio eradication programmes.
- *Key partners playing active roles:* In Sierra Leone, the strong, active roles played by UNICEF and WHO representatives were seen as instrumental in the effective functioning of both the CCM and ICC<sup>16</sup>, and widely welcomed by stakeholders. This may be particularly relevant to countries emerging from conflict or other forms of political instability, where leadership needs boosting from non-state actors.

**4.3 Impact on health systems**

Evidence suggests that different types of GHPs have varying relationships to health systems (see table 2).

*Table 2: GHP types and relationship with health system*

<b>Type of GHP</b>	<b>Fit with health system</b>	<b>Reliance on health system</b>
<i>Financing: GFATM and GAVI</i>	<i>Better fit with centralised system where main aid instrument is project support</i>	<i>High Reliance - Requires high level input for coordination committees, reporting and accountability</i>
<i>Access, donation: Stop TB, GPEI, GAEL, GAELF, GWEP etc.</i>	<i>Flexible fit with any health system, as donations etc. pass through and are accounted for within existing systems and mechanisms.</i>	<i>High reliance on health system to procure and ensure equitable distribution of commodities and services.</i>

Yet both financing and access/donation GHPs are highly reliant on having a well-functioning health system to deliver the GHP programme. For financing GHPs, programmes are generally run as project-aid through the appropriate National Disease Control Programme (e.g. HIV/AIDS, malaria, EPI etc.). Where these programmes have poor reach and/or ineffective systems, there is a direct impact on the effectiveness of how GHP funding is used. Access/donation GHPs impose less immediate burden on government programmes (for example, in that there are no coordination meeting requirements). This more hands-off approach means an even greater reliance on an effective National Disease Control Programme.

Overall current GHP contribution to health system strengthening appears to be little more than marginal, though there are some examples:

- providing technical assistance to national programmes, from the application phase onwards; and unfettered funding for system support (eg GAVI ISS funds).

<sup>16</sup> See also Section 6 on Governance for consideration of GFATM's Country Coordinating Mechanisms (CCMs) and GAVI's Inter-agency Coordinating Committees (ICCs).

- investing in training to help strengthen technical capacity (e.g. MIM training of African researchers) and financial systems (GAVI's financial sustainability workshops).
- developing new approaches, eg APOC's pioneering use of community directed treatment which holds promise of advantageous application in other disease control programmes.
- Stop TB and GFATM support to India's National TB programme, and especially to expanding the DOTS regime, has improved integration of NGO and private providers into the national programme and the health system more generally.
- Where GHPs do work through government systems, there is some evidence that this has helped governments take on greater ownership of programmes. GAVI's support in Sierra Leone has shifted ownership of the immunisation programme away from UNICEF to the MOHS, with UNICEF's blessing.

While individual GHPs may be seen as effective and helpful, the wider concern is that individual GHPs do not and cannot have a whole systems view of the health system they work in, and in general rely on. There is a serious risk that weak human resource and systems capacity at central and local levels can be overwhelmed by the growing proliferation of GHPs - and other HIV/AIDS initiatives - with separate demands.

The integral relationship between GHP programme implementation and health systems has led some to argue that the GHPs should include health system strengthening as part of the support they give to countries. The country studies suggest this needs nuancing, as the inclusion of yet more actors in strengthening health systems is likely to be counter-productive. These issues arise primarily for the financing GHPs (GAVI and GFATM), and less so for the small neglected disease GHPs who have no option but to work through existing systems.

Part of the solution is for GHPs to internalise the lessons of other aid instruments. They need to take into account absorptive capacity and particularly broader HR and financing issues. The negative impact of multiple GHPs could be mitigated, though not eliminated, by:

- pursuing strategies for better integration with district health services, in order to improve effectiveness in policy, financing and service delivery, and ensure impact and long term sustainability.
- decreasing transaction costs created by extra demands in proposal development, reporting and monitoring by harmonising more with government systems, and/or with each other.
- exploring opportunities for coordinated activities with other programmes/GHPs, eg Stop TB Partnership's promotion of collaborative activities to address TB and HIV/AIDS; WHO work on integrating approaches to some neglected diseases.
- cross-representation, or representation by others, in country bodies.

There may simultaneously be scope to rationalise some GHPs with low or unhelpful impact, but this would require a more systematic approach to monitoring and evaluation of GHPs. Several GHPs with time-limited elimination and eradication objectives will reach natural ends over the next few years. Similarly, consideration of proposals for new GHPs should take into account the consequences of GHP proliferation, as well as issues relating to the individual GHP's objectives.

Another part of the solution is for governments and donors to strive towards complementarity of different programmes to support health within countries. One interviewee noted that GHP support to priority programmes had allowed his

government to put more emphasis on health system strengthening, with a specific focus on human resource capacity development

Different ways to make a more explicit connection between health systems support and GHP funding and access programmes are being explored. One is for donors to 'top slice' their contribution to the financing GHPs, so that a given percentage is withheld from the overall donation to GFATM or GAVI and invested instead in system strengthening activities. USAID is proposing to 'top slice' their next round of funding to the Global Fund. Another is for donors to put extra funds directly into health system support, which is the approach GTZ has taken with the BACKUP Initiative. None of the countries included in the case study were recipients of GTZ BACKUP support.

Health system strengthening is a critical issue in its own right. Whatever the mechanism and whatever the role of GHPs, there seems to be clear need for donors to invest more in health system strengthening if the health MDGs are to be achieved.

#### **4.4 Post-conflict and difficult environment countries need special approaches**

An earlier study reviewed the limited literature on GHPs in difficult policy environments<sup>17</sup> and noted indications that it is possible for GHPs to operate in difficult policy environments and perhaps to deliver wider benefits beyond their specific programme (eg negotiating ceasefires for polio eradication initiatives, or the creation of a Southern Sudan Onchocerciasis Task Force despite breakdown of the health infrastructure).

But the approach needs to be carefully judged. The country case study report<sup>18</sup> concludes that the 'one size fits all' approach of most GHPs puts particular pressures on countries that are politically and socially fragile. The Sierra Leone case points to a number of concerns, including limited capacity for planning and prioritising, very limited absorptive capacity at all levels in the health system, and the potential for access and funding GHPs to exacerbate problems with corruption and accountability. The situation presented by fragile states necessitates even more concerted effort on the part of multilaterals and bilaterals to provide direct support to the health system. It may make sense for financing and access/donation GHPs to adopt a slower, more hands on approach with fragile states, identifying strong national partners (either state or non-state) through whom they can work.

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<sup>17</sup> Caines K. and Buse K., *Global Health Partnerships: A Selective Review of the Literature*, DFID Health Resource Centre, February 2004

<sup>18</sup> See *GHP Study Paper 7: Country Case Study Report* by Cindy Carlson

## 5 FINANCIAL AND ECONOMIC ASPECTS OF GHPS<sup>19</sup>

- *GHPs are bringing additional funding for communicable diseases and other global public goods, against a backdrop of strong growth in development assistance for health over the last three decades. The financing GHPs appear to improve the overall allocation of resources.*
- *They have been successful in leveraging significant additional funds from Foundations, but not from other new sources.*
- *Most current interventions funded by GHPs are potentially highly cost-effective, and new products being developed by GHPs are likely to be so too.*
- *GHPs alone will be insufficient to provide countries with the financial means required to deliver a reasonable package of basic health services.*
- *There is little clarity about GHP funding needs, or the timing of these needs.*
- *GHP resources are often highly significant at the country level, which raises serious concerns about sustainability and perhaps also macroeconomic stability.*

### 5.1 Additionality

One aim of Global Health Partnerships (GHPs) was to attract more, and more diversified, funding.

The evidence is that GHPs are bringing welcome additional resources to support country efforts to combat communicable diseases and for other global public goods. For malaria and TB, GFATM funding commitments far exceed recent levels of donor funding. Even if funding through other channels were to decline, or even stop, overall spending on these diseases should still increase. For HIV/AIDS, GFATM funding is less significant. However, donor spending through traditional sources – for both infectious disease control and STD control - appears to have been increasing rapidly since 1996 and there is no evidence of any slowdown at least up to 2002.

These trends need to be seen against a backdrop of strong growth in development assistance for health over the last three decades. Increases in real donor spending on health and population have been of the order of 3% per annum since 1975. There is little evidence of displacement (or fungibility) at country level – either by donors or by Governments. However, it is perhaps too soon for such changes to be reflected in strategic plans and expenditure frameworks yet and it may be worth revisiting this issue in two or three years time.

GHPs have been less successful in attracting a wide range of new funding sources, with the exception of Foundations - especially the Bill and Melinda Gates Foundation. Most funds continue to be provided by traditional donors. For example, 97% of pledges for GFATM are from donor countries although the Gates Foundation has played a key role for GAVI. In some cases, new players provide important seed money to establish GHPs (e.g. Gates for GAVI, MSF for DNDi and Until There's a Cure for IAVI) which have subsequently attracted additional resources from traditional donors. Thus, rather than donor funding leveraging new sources of funding, it can be argued that the opposite is taking place.

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<sup>19</sup> See GHP Study Paper 2: *Economic and Financial Aspects of the GHPs* by Mark Pearson



## 5.2 Cost-effectiveness and efficiency

Most interventions funded by GHPs are potentially highly cost effective. This applies also to the newer vaccines being promoted by GAVI which, although costly, are likely to be cost effective in many settings. Of the financing GHPs, GAVI is likely, on average, to offer the best value for money in terms of health improvements per pound spent. ART is an exception; although perhaps justified on social justice grounds, it cannot be justified on the basis of its cost effectiveness. GHPs also offer the potential to develop new products which, in time, will offer cost effective alternatives to current methods.

Reviews have been unable to make definitive judgements on the efficiency of GHPs but most suggest that administrative costs appear reasonable. In some cases, efficiency savings made through GHP operations can in part offset some partnership costs. Donors often have unrealistic expectations about how lean GHPs can be.

## 5.3 GHP funding needs

There is little clarity about GHP funding needs or over the timing of these needs. Approaches to financial management and strategic planning differ significantly between GHPs, making assessments of where, and when, to invest extra resources problematic. In addition, important issues such as sustainability are often viewed from the perspective of individual GHPs rather than from a broader perspective. It would be helpful to develop a series of resource scenarios mapping out possible future needs, taking into account the timing, cost and likely uptake of new products and measures to increase consistency in the way that GHPs present their financial plans.

In the run-up to 2015, pressure to achieve the MDGs may create short-term incentives at odds with long-term development objectives. For instance, there is a risk (though not yet evidence) that donors may temporarily be less willing to fund R&D GHPs whose products are unlikely to be widely adopted before 2015 but which have significant potential in the longer term. It will be important for DFID to take a balanced approach and, if necessary, be willing to cover neglected areas.

## 5.4 Adequacy

GHPs alone will be insufficient to provide countries with the financial means required to deliver a reasonable package of basic health services. Increasing public expenditure to a minimum of \$12 per head (far below the \$35 to \$40 that the Commission for Macroeconomics and Health thought necessary) in the 25 DFID PSA countries in Africa and Asia alone would require an estimated \$17bn per annum – some four or five times that proposed through the financing GHPs.

## 5.5 Macroeconomic stability

Paradoxically, at the same time, the very size of the financing GHPs poses major challenges in terms of:

- managing public finances to ensure that the increased aid flows can be absorbed without compromising macroeconomic stability; and
- financial sustainability in terms of sustaining the activities supported by the GHPs and the increased aid dependence implied.

In terms of macroeconomic stability, the evidence suggests that volatility in flows rather than the magnitude of support is the key factor. The demand based approach to proposals adopted by GFATM (by far the largest financial GHP), and the fact that it

guarantees funding only for two years, has its strengths but is not necessarily conducive to greater predictability in funding.

### 5.6 Sustainability and aid dependency

Although not particularly large in terms of overall funding for health in developing countries, the financing GHPs do play a major funding role in some countries, particularly low-income countries. Together with other health initiatives such as PEPFAR and MAP, these GHPs are likely to double the level of resources for health in around ten countries and significantly increase it in many others. There is little, if any, chance that many low-income countries will be able to meet ongoing costs themselves if GHPs funding for current activities ends as planned after a 5 year period and the GHPs embark on programmes to expand coverage.

In effect, there is a risk that country spending patterns will be dictated by the GHPs, and the need to sustain the activities and services provided by them, rather than by national priorities.

These pressures will vary by disease. According to GFATM, the funding needs for HIV/AIDS are likely to rise steadily for at least a decade, a pattern likely to be mirrored for TB. However, funding requirements for malaria, though subject to much uncertainty, may begin to decline after 2010. The cost savings from GHPs which aim to eliminate or eradicate diseases are likely to be minor – with the exception of polio – and do little to offset these increasing funding needs.

It is reassuring to see that GAVI specifically, and other donors more implicitly, no longer equate sustainability with self sufficiency and are considering alternative approaches such as spreading support over a longer period, bridge financing and considering alternative funding sources. Nonetheless, it is important that sustainability is considered *before* the introduction of new products rather than *after* as is the case at present.

### 5.7 Conclusions

Global Health Partnerships (GHPs) are bringing welcome additional resources to support country efforts to combat communicable diseases, and promote potentially cost-effective interventions. However, there are concerns about sustainability, and the earmarked nature of GHP funding undermines country level control of expenditure management processes (see the recommendation in section 4 for further debate about sustainability, predictability and the fit of GHP funds with MTEFs and national macro-economic policies). This is compounded by the additional conditions of some GHPs.

Together these factors raise a number of fundamental questions. Who should determine priorities - Governments or donors? The key question is perhaps less about whether the GHPs are distortionary but more about whether the distortions introduced improve the global allocation of resources, and more specifically whether such distortions are a price worth paying.

The evidence cannot resolve the more important second question but does suggest that the financing GHPs improve the overall allocation of resources. They appear to be relatively well targeted towards diseases which present the largest burden of ill health and to countries in greatest need in terms of socio economic status. Typically over 60% of financing GHPs' resources are channelled to Africa, where communicable diseases account for over 70% of the burden of disease and

infectious and parasitic diseases alone account for more than half. The share of GHP funding going to low income countries is extremely high – over 98% for GAVI and GPEI and almost 78% for GFATM. This compares to around 64% for OECD donors as a whole. Lower income countries tend to get higher per capita allocations than better off ones.

## 6 GOVERNANCE OF SELECTED GHPS<sup>20</sup>

- *Future GHP evaluations should address organisational and governance issues.*
- *GHPs should develop and review strategic, operational and business plans, delineating clearly defined roles and responsibilities for all major partners.*
- *Different GHP organisational types (eg 'independent' and 'hosted') have specific benefits and weaknesses. WHO-hosted GHPs would welcome further flexibilities.*
- *To improve transparency, each GHP should make a minimum of defined key information publicly available on its website.*
- *Certain groups – eg Southern governments, civil society and private-for-profit sector interests - continue to be under-represented in GHP governing bodies.*
- *There is no appropriate locus for GHP accountability to global health architecture.*

### 6.1 GHPs' need for strategic and operational plans

This section explores how 19 DFID-selected Global Health Partnerships (GHPs) are governed, in view of some concerns that have been expressed about GHP governance issues. Only five of them have been subject to an evaluation which explicitly considered governance. Future evaluations of GHPs should address organisational and governance issues. It is not surprising that these are areas of experiment and occasional tension, given the novel and complex structure of GHPs.

Some needs are clear. Shared goals and objectives, together with clearly defined roles and responsibilities, are pre-requisites of effective partnership. However, this principle is routinely violated in GHPs. Strategic, operational and business plans, with clearly defined roles and responsibilities of all major partners, should be developed and periodically reviewed as a criterion for DFID engaging with individual GHPs.

Getting partners to deliver on agreed commitments represents a challenge to many GHPs. This is partly explained by poor specification of responsibilities but more importantly by the horizontal and voluntary nature of partner relationships. Among possible mechanisms (such as Memoranda of Understanding between partners) to encourage greater accountability, consolidated work planning shows most promise. DFID should support these initiatives by advocating and participating in them, and by providing technical assistance to the processes and their evaluation.

### 6.2 'Hosted' and 'independent' GHPs

The target GHP sample contained two distinct organisational types, both at the more formal end of the spectrum: 'independent' (i.e., having their own legal identity) and 'hosted' (i.e., by another organisation). There is no clear correlation between scale of GHP and type. For example, of the large GHPs, the GFATM is independent whereas GAVI, the Global Partnership to Stop TB and Roll Back Malaria are all hosted in UN agencies. Product R&D GHPs are more likely to be independent or NGO-hosted. Access GHPs are more likely to be hosted, particularly by WHO, although there are prominent ones hosted by NGOs (e.g., Mectizan Donation Program) as well as independent ones (e.g., ITI).

Independent GHPs have considerable independence from parent organisations, decision-making bodies with substantial authority over the secretariat, and clear lines of accountability, but take longer to establish, can lack easy access to breadth of

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<sup>20</sup> See GHP Study Paper 5: *Increasing GHP Impact by Improved Governance* by Kent Buse

expertise, and are more costly to operate. Hosted GHPs can be set up quickly and can access a range of resources in the host, including technical expertise in WHO and UNICEF. However, evidence suggests that hosts may dominate – or be perceived to dominate, secretariats can be accountable to the host rather than the GHP, and there tends to be identity confusion between the host and the GHP secretariat. Some smaller GHPs lack governing bodies with significant authority.

There has been much debate over the pros and cons of WHO hosting arrangements. Some GHPs have benefited in important ways from this arrangement with WHO, while some have been plagued by problematic relationships. As a result, GAEL has been disbanded and the GAELF secretariat has migrated away from WHO. By contrast, the evaluation of the Stop TB Partnership concluded that the location of the Secretariat in WHO benefits both parties, despite administrative frustrations. Interestingly, GAVI seems to be freer of these administrative problems, despite being hosted in another UN body, UNICEF. WHO has sought to assist through formal bifurcation of accountability of the Executive Secretary to WHO and to the GHP board; limited participation of GHP partners in selecting the Executive Director; and clearer differentiation between WHO technical contributions to the GHP and the GHP's WHO-hosted secretariat. DFID should seek a process to improve WHO-wide efficiency (eg time taken for appointments) and identify further flexibilities for WHO-hosted GHPs, while respecting WHO's principles and accountability.

### 6.3 GHP governance at global level

#### *Partner representation on GHP governing bodies*

Certain groups continue to be under-represented in GHP governing bodies – particularly Southern governments, civil society and private-for-profit sector interests. DFID's criteria for engagement with GHPs should include an appropriate balance of partner representation in all GHP decision-making bodies. Where there are shortcomings, DFID should initiate discussions with the individual GHP about means to improve representation. There is an issue about the burden on senior officials from developing country governments who are often severely overcommitted, but they should nonetheless be given the opportunity to participate.

A complementary approach consists of increasing two-way communication between Board members and their constituents. It is recommended that DFID support nascent efforts to improve constituency functioning with technical assistance<sup>21</sup>.

Screening potential partners for good corporate practices is both a tool to exercise due diligence and a potentially powerful mechanism to leverage the influence of development cooperation organisations to change the behaviour of firms in ways that support development aims. DFID should consider advocating wider use among GHPs of screening of potential corporate GHP partners.

#### *GHP accountability to partners and the public*

To hold GHPs to account, partners and the public must have timely access to relevant information about decision-making processes and substantive information on matters under consideration. Trust and transparency are keystones of effective partnership working, but the level of transparency varies considerably across GHPs. Each GHP should make publicly available through its website:

- strategic and annual plans and budgets, and annual performance reports:
- meeting agendas, background papers and subsequent decisions of the Board

<sup>21</sup> For details of approaches to improved constituency management and communication, see Section 7: Constituency Management of GHP Study Paper 5: *Increasing GHP Impact by Improved Governance* by Kent Buse.

- and any other executive body;
- governance arrangements including mandates, membership and processes for appointments and decision-making;
- detailed information on how constituencies are managed.

#### *GHP accountability to the international health architecture*

The proliferation of GHPs over the last 5-10 years has raised concerns in some quarters about the lack of accountability of GHPs beyond their partners, funders or host. There is no magic bullet solution because of the perceived lack of appropriate institutions to provide a locus for a wider accountability. Instead, a number of ad hoc mechanisms, mainly voluntary in nature, are being developed to improve the coordination of priority setting and action among GHPs and with relevant global programmes (see Study Paper 5<sup>22</sup> for greater detail).

This report recommends in section 7 the desirability of wider analysis and discussion of the role and implications of GHPs within the global health architecture. Any such development should also consider GHP accountability issues at their broadest.

#### **6.4 GHP governance at country level**

Most GHPs have no specific governance mechanisms at country level. They tend to work through national programmes.

However, two require specific country coordination bodies: the GFATM has Country Coordinating Mechanisms (CCMs) and GAVI Inter-agency Coordinating Committees (ICCs). The country case studies reported mixed views. On the positive side, these country level bodies were felt to have promoted participation by a wider group of stakeholders concerned with GFATM diseases and immunisation respectively. Effectiveness is increased where the same coordination mechanism is used for all aspects of the particular condition or disease, and not just for specific GHP funding of the programme. But the burden of participation appeared to be a major downside.

The studies found little or no relationship between the GFATM, CCMs and the related access/donation GHPs, indicating either poor national level coordination within those disease control programmes or too many external demands on government, leading it to respond in an ad hoc manner. GAVI, ICCs and access/donation programmes related to immunisation appear to be more joined up. For example, the ICCs also provide strategic oversight of National Immunisation Days as part of the polio eradication programme. One common denominator in making the links in immunisation seems to be UNICEF's ongoing strong support to country EPI offices.

In a post-conflict country such as Sierra Leone, the weakness of government structures means that country level coordination mechanisms need to be streamlined to reduce transaction costs. One option would be for GHPs to work through integrated Ministry of Health-led coordinating structures. This would also ensure that all health priorities are visible.

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<sup>22</sup> GHP Study Paper 5: *Increasing GHP Impact by Improved Governance* by Kent Buse

## 7 CONCLUSIONS AND RECOMMENDATIONS FOR DFID

### 7.1 Conclusions from the evidence

GHPs are a moving target in a changing environment, and the evidence to assess their impact is sometimes limited. Nonetheless, some broad conclusions can be drawn.

First, despite some concerns, they are seen overall as having a positive impact. Evaluated access GHPs are judged to have accelerated progress, and access to commodities. The R&D GHPs appear to be seen as a particularly fruitful way to foster research and development for new diagnostics, drugs and vaccines for this range of diseases.

Second, the more taxing concerns relate to operations at country level. Individual GHPs may be evaluated as effective, but the proliferation of multiple GHPs (alongside other HIV/AIDS initiatives) runs the serious risk of overwhelming central capacity and weaker health systems. GHPs must take into account absorptive capacity and, particularly, broader HR and financing issues. Governance issues need to be addressed, as does the need for rigorous assessment of relevance and impact. Wherever possible, GHPs should pursue strategies for harmonisation and integration both with national systems and with each other (eg by providing funding through SWAp or basket funding where available, and by harmonising systems for budgeting, accounting, monitoring, procurement and audit).

More broadly, health system strengthening is a critical issue in its own right. Whatever the role of GHPs, there is clear need for donors and governments to invest more in health system strengthening if the health MDGs are to be achieved. Different ways to make a more explicit connection between health systems support and GHP funding and access programmes are being explored. These include donors 'top slicing' their contribution to the financing GHPs, so that a given percentage is withheld from the overall donation to GFATM or GAVI and invested instead in system strengthening activities, or putting extra funds directly into health system support, as with GTZ's BACKUP Initiative.

There may also be scope for some rationalisation of existing GHPs, and more stringent scrutiny of proposals for new GHPs to assess the consequences of GHP proliferation.

Third, there is a specific need for GHPs to tighten their focus on securing pro-poor and gender-related objectives. They can and should play a role in advocating and stimulating appropriate policies and approaches, and special efforts need to be focused on the most impoverished, vulnerable and underserved populations, including women.

Fourth, the availability of substantial amounts of new GHP funding – particularly through the GFATM – raises key issues about sustainability, predictability and macroeconomic stability. But this is not likely to be solely a GHP phenomenon. Similar considerations will arise in relation to the International Financing Facility, and the (draft) recommendations, if adopted, of the Millennium Project for substantial increases in donor financing for public investments in the poorest countries. This should be the subject of wider debate.

Fifth, even given the complexity of partnership as a model, the main concerns about GHP institutional issues at global level are generally amenable to relatively straightforward solutions. These include, for example, greater transparency, more appropriate partner representation on governing bodies, and more business-like approaches (including more specific measures to assess achievements against poverty and gender-related objectives). Most GHPs do not have specific governance

mechanisms at country level; there are mixed views about the cost-benefit of the GFATM's CCMs and GAVI's ICCs. In post-conflict countries with weak government structures, country level coordination mechanisms should be streamlined to reduce transaction costs.

## 7.2 Need to foster international consensus on the future of GHPs

In commissioning this series of studies, DFID emphasised the importance of founding conclusions on evidence but recognised the likely limitations. Both arise in relation to the central questions to be addressed in the next few years about the continuing role and implications of multiple GHPs.

Views on these issues appear to range from uncertain to polarised. On the one hand, there is clear (if as yet limited) evidence of the achievements of some individual GHPs and of the benefits of collaboration among public, private and civil society sectors, particularly in shared decision-making and coordination. The 2002 McKinsey study<sup>23</sup> of successful global health alliances went beyond noting GHPs' high success rate compared with what bodies could accomplish acting individually. It argued that 'in most cases a solitary approach was not feasible, given the objectives.' For some, the impetus for GHPs was strengthened by perceived weaknesses in the capacity and competence of the relevant UN agencies, and lack of confidence in the prospect for major reform over the short- to medium-term. GHPs are now seen by many (for example, the Millennium Project) as having a major role to play in scaling up the response to health needs, particularly in the short-term.

But this is not a universal view. Others express concerns about the increasing fragmentation of the global health landscape, poor coordination and duplication among GHPs, and the risk noted in this study's fieldwork that the proliferation of multiple GHPs - alongside other initiatives, particularly on HIV/AIDS - may overwhelm countries' central capacity and weaker health systems. For example, a current draft paper<sup>24</sup> from the secretariat of the International Task Force on Global Public Goods argues that "*donors should increase the quantity and quality of their capacity building support [for health systems and] be especially cautious in the implementation of global health programs, which too often erode rather than enhance national capacity.*" For its purposes, it envisages strengthening WHO with greater funds and clout, in line with broader suggestions of transitioning from GHPs to strengthened UN agencies.

These arguments are now becoming widely canvassed, including at the recent High Level Forum, and this seems an opportune moment for DFID to convene a meeting among interested parties to share analyses and seek to achieve consensus. Such a meeting could take a broad view and explore: (1) the strengths and weaknesses of the global health architecture before GHPs, now and against future needs; (2) the future locus and accountability of GHPs specifically; and (3) possible alternative mechanisms.

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<sup>23</sup> McKinsey & Company (2002) *Developing successful Global Health Alliances*, for the Bill and Melinda Gates Foundation.

<sup>24</sup> International Task Force on Global Public Goods, Secretariat Working paper (November 2004), *Meeting Global Challenges: International Cooperation in the national interest. Towards an Action plan for increasing the provision and impact of global public goods*



### 7.3 Detailed recommendations to DFID

This section sets out a number of detailed recommendations to DFID.

#### 7.3.1 *GHP effectiveness and its determinants*

- The developing nature of the GHP approach provides an additional rationale for periodic monitoring and evaluation, not only of individual GHPs but crucially of their collective impact, especially at country level.
- The determinants of success set out in Table 1 provide a framework for assessing which GHPs DFID should engage with (depending on whether they wish to back likely success or influence likely poorer performers).
- In line with its own policy stance on poverty and gender, one criterion for DFID engagement with a GHP should be an active and explicit approach to mainstreaming pro-poor and gender considerations. This should include clear equity objectives, and specific measures to demonstrate that women and the very poorest people are benefiting.
- DFID consideration of support for GHPs for neglected diseases should seek assurances about mobilisation of resources for the full range of needs, including technical support, drugs, and funding. Donors collectively should be prepared to contribute more to the operational costs of national control programmes.
- DFID should encourage the consideration being led by WHO of a more integrated approach to tackling at least some of the neglected diseases.
- New GHPs working on new tools – drugs, diagnostics and vaccines - for neglected diseases will need continued donor support. More research is needed into prevention and treatment of Buruli Ulcer.

#### 7.3.2 *Commodity prices and security:*

- DFID should support GHPs that have successfully set up their functions to achieve good prices without deterring manufacturers from providing a secure supply of existing products or investing in R&D for future products.
- To make the best gains in security and pricing, GHPs' and donors' primary focus should be directed towards encouraging competitive markets wherever possible. Where a competitive market can exist, support for sources of transparent pricing and quality information and for competitive procurement are essential.
- DFID should advocate differential pricing only if such arrangements do not impede the development of competitive markets longer term.
- Donors could seek more proactively to lower barriers to entry for developing country suppliers, since their lower cost-structure makes them more sustainable partners for publicly funded programmes concerned with cost. Support for the WHO pre-qualification project for HIV/AIDS, TB and malaria medicines is one important means of lowering barriers to entry.
- DFID funds for drug purchase should be allocated through larger partner agencies to increase purchaser leverage with suppliers, and include long-term commitments in order to lure producers, increase competition, lower prices, increase security of supply and increase incentives for R&D. In certain contexts, especially post-conflict, direct financing of the private sector or NGOs may be required in the short to medium term.

### 7.3.3 Country operations, alignment and impact on health systems

- Donors such as DFID who support both GHPs and direct national and sector budget aid, should lobby funding GHPs (GFATM and GAVI) to provide funding within SWAp or basket fund frameworks, where these exist.
- The issues of sustainability, predictability and the fit of GHP funds with MTEFs and national macro-economic policies need more rigorous study and debate. DFID should press for these to be considered as part of a wider debate about the relationship between the full range of development assistance and MTEFs, and should include the IMF as an active participant.
- DFID should encourage relevant GHPs to work with country partners to harmonise multiple HIV/AIDS GHP programmes (where they exist in country) as well as seeking to influence directly all those concerned in the initiatives.
- Bi-lateral and multi-lateral donors should invest more in health system strengthening to complement approaches and resources brought in by GHPs. DFID may wish to trial approaches such as top-slicing contributions to financing GHP for system-strengthening activities.
- Donors should examine critically any proposals for new GHPs and the scope for rationalisation of existing GHPs, based on systematic monitoring and evaluation.

### 7.3.4 Economic and financial aspects of GHPs

There are no hard and fast conclusions about whether it is better to channel resources through GHPs or country programmes. This would only be possible on the basis of detailed impact evaluations of all the key GHPs and country programmes. However, the review did identify a number of criteria which might be used to guide DFID's decision making process.

- In terms of resource allocation, DFID will need to consider whether the global allocation of GHP resources is good enough to warrant further investment in GHPs or, if gaps are identified, whether DFID should channel more resources bilaterally. Key issues will include the balance *between* diseases (eg HIV/AIDS and STDs), the balance *within* diseases (e.g. between prevention and cure) and also whether non-GHP conditions important for achieving the MDGs (e.g. reproductive health) and broader systems strengthening are being adequately covered.
- An important question for DFID is whether to focus its efforts on GHP expansion, or to assist countries consolidate earlier GHP efforts through budget or sector support where appropriate. Issues for consideration include the overall performance of the individual GHP, the programmes it promotes, and the fallout from not supporting it. There is a risk that DFID may become locked into a cycle of support for GHPs either directly or by helping meet their recurrent implications.
- Similar questions will also apply to the use of the International Financing Facility (IFF). Though the mechanism is due to be piloted as a means of promoting market development of new vaccines, it could presumably also be used to meet the recurrent implications of the GHPs.
- Financing needs are likely to change over time. DFID should consider, for example, how to respond to the polio dividend once eradication is achieved. This will include money freed up from the aid programme but also Governments' health budgets. This might take place as part of a broader financial planning exercise to assess the future needs of all of the financing GHPs – recent efforts at

- the individual GHP level to model requirements (eg by GAVI) could help support this process.
- If DFID is interested in assessing the cost effectiveness of GHPs and their additionality, it will be important to get better data on expenditure by type of intervention by investing more in supporting health accounts exercises or disease specific expenditure reviews.

### 7.3.5 Governance

- Strategic, operational and business plans, with clearly defined roles and responsibilities of all major partners, should be developed and periodically reviewed as a criterion for DFID engaging with particular GHPs. DFID should advocate for, and participate in, promising initiatives in consolidated work planning among GHP partners, and provide technical assistance to the processes and their evaluation.
- DFID should use its influence to ensure that future evaluations of GHPs address organisational and governance issues.
- Given evidence of administrative difficulties, DFID should support a process to improve WHO-wide efficiency (eg time taken for staff appointments and promotions) and identify further flexibilities for WHO-hosted GHPs, while respecting WHO's principles and accountability.
- DFID's criteria for engagement with GHPs should include:
  - transparency, including public access to all key GHP information, and
  - an appropriate balance of partner representation in all GHP decision-making bodies. DFID should also support efforts to improve communication between Board members and their constituents, for example through technical assistance.
- DFID should support current ad hoc mechanisms to improve the coordination of priority setting and action among GHPs and with relevant global programmes, but should also initiate a dialogue among concerned actors on the issue of the accountability of GHPs to the global health architecture.

## ANNEX 1: TERMS OF REFERENCE

### Summary

1. The Development Effectiveness Group in DFID's Policy Division is engaged in three significant workstreams, taking forward the work outlined in the paper produced for the 2003 Tidewater conference. These aim 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.

2. A significant proportion of the GFPs with which DFID engages are concerned with health issues. The Global Health Partnership (GHP) Team within the Development Effectiveness Group therefore wishes to commission three pieces of work to contribute to these workstreams:

- 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.
- A health-focused contribution to a short policy note on GFPs, drawing on the above, for dissemination to our external partners.
- A health-focused contribution to a practical toolkit, also drawing on the above, to guide DFID advisers in-country on how best to engage with GFPs to maximise their effectiveness.

3. In addition to feeding into the broader work of the Development Effectiveness group, the work to be commissioned will have the additional objective of assisting DFID to clarify good practice in governance and operational aspects of partnerships in order to refine engagement strategies with new partnerships or continuing strategies with ones with which we are already engaged. Although consultants will not be expected to revise DFID's current draft engagement criteria as part of this work, consultants will be expected to give some feedback on debrief (October). Much of the work on the global impact of GHPs should draw on information that is already available; evidence of impact at country level will need to be gathered from selected DFID country offices. Work on the main report and supporting studies should be completed by the end of November 2004.

### Detail

#### *The Component Studies*

4. The new pieces of work required for this study will include:

- i. An analysis of the extent to which GHPs address the needs of the poor and are gender-focused in practice (not just in aspiration), and the ways in which they operationalise a gender or poverty focus. Who actually accesses the benefits provided?
- ii. For the relevant health partnerships, an economic analysis of support for Global Health Partnerships focusing on:

- a. Relationships between Inputs, Outputs and Outcomes (Assessment of impact; Assessment of Allocative Efficiency; Assessment of Technical and Administrative Efficiency; Assessment of Equity; Spending).
- b. Financing Impact
- c. Financing Needs
- iii. A synthesis of existing material on the extent to which GHPs have succeeded in reducing commodity prices.
- iv. An assessment of whether Global Health Partnerships have addressed diseases which have been neglected by other forms of development assistance.
- v. An assessment of the differing structures for the governance of Global Health Partnerships and the extent to which they are accountable to international governance structures.
- vi. Case studies demonstrating evidence of the impact (positive and negative) of GHPs at country level. These should include best practice examples of GHP programmes working well with country programmes. The countries to be chosen and the methodology for gaining this information will be agreed in consultation with DFID. This section will be organised by the different types of partnership (as set out in the Tidewater paper) and will look at the links between partnerships of different types.
- vii. An examination of GHPs against determinants of effectiveness and good governance. Based on best possible evidence, provide an analysis of positive and negative behaviours that impact on the above.
- viii. Consideration of solutions for improving the national coordination of activities associated with GHPs and with the management of country operations; and for better alignment with country plans and programmes.

### *The Main Report*

5. Following a feedback workshop on 30 September 2004, DFID advised that the main report should be structured on these lines:

- Effectiveness: outcomes and second layer effects (process)
- Financing of and from global initiatives – inputs and outputs (cost effectiveness), economic impacts
- Country operations, alignment and effects at country level
- Health systems
- Commodity security and prices
- Governance, linkage to international health governance
- Determinants of effectiveness
- Recommendations for DFID.

### *The Policy Note*

6. The Team requires a short piece (no more than about a dozen pages) which summarises the key points from the main report, focusing on both the evidence on the impact of GHPs and the proposed best practice principles. This will subsequently be synthesised by a separate consultancy into a broader Policy Note, covering all types of GFPs, for dissemination to DFID's external partners. It will therefore be

necessary to work closely with this consultancy, to ensure that an appropriate input is provided.

#### *The Toolkit*

7. This should briefly set out the case for country programmes to work with GHPs and then provide some very practical guidelines – with examples and case studies - on how best to engage, in order to maximise the effectiveness of GHPs. It should be designed in consultation with one or two in-country DFID advisers, to ensure that it meets their needs. The output of this work will subsequently be synthesised by a separate consultancy into a set of guidelines for engagement with all types of GFPs. It will therefore be necessary to work closely with this consultancy, to ensure that an appropriate input is provided.

#### *Timescales*

8. A summary report of key findings so far should also be produced at the end of September 2004. The first draft of the main report and reports on the component studies should be submitted to DFID by the end of October 2004; DFID will provide comments by 19 November; and the final reports should be provided by end November 2004. DFID will advise on the approach to the policy note and the toolkit by the end of November 2004. The GHP team will give feedback (no later than September 2004) regarding the desired format for these contributions which will allow it to feed into the broader work of the Development Effectiveness Group.

#### *Reporting*

9. The main liaison point for this work will be Billy Stewart in the Global Health Partnerships Team, who will liaise with a steering group drawing in other key DFID staff. Hilary Sunman will provide specific advice on economics/financing sections.

## ANNEX 2: DEFINITION AND IDENTIFICATION OF GHPS

### Definition of a Global Health Partnership (GHP)

This study adopted the definition of a GHP set out by Buse in earlier work<sup>25</sup> for DFID in this series. This defined the concept of Global Health Partnership in a broad manner:

*Partnership:* the key criterion is a collaborative relationship among multiple organisations in which risks and benefits are shared in pursuit of a shared goal. The focus is on more formal collaborative ventures and not exclusively on public-private partnerships, although these constitute the majority. Some important global health initiatives that are not partnerships per se, such as the World Bank's MAP, are not included.

*Health:* The goal of the partnerships has to concern the redress of health problems of significance for the poor in low- and middle-income countries.

*'Global'* is interpreted to capture initiatives that extend across or transcend national boundaries. In this paper for example, APOC – the African Programme for Onchocerciasis Control – is included as a GHP addressing a neglected disease, though technically it operates only within Africa rather than globally. It forms the main operating component of the Global Partnership to Eliminate River Blindness.

The World Bank's definition of global programs are those partnerships and related initiatives whose benefits cut across more than one region of the world, and in which the partners reach explicit agreements on objectives; agree to establish a new (formal or informal) organization; generate new products or services; and contribute dedicated resources to the program<sup>26</sup>. This is a tighter definition but can generally be applied to the GHPs covered in the study, other than the wider geographical requirement.

### Typology of GHPs

DFID proposed the following typology to classify GHPs:

*Research and Development:* GHPs involved in product discovery and development of new diagnostics, drugs and vaccines.

*Technical assistance/service support:* GHPs which support improved service access, may provide discounted or donated drugs, and give technical assistance.

*Advocacy:* GHPs which raise the profile of the disease and advocate for increased international and/or national response, and resource mobilisation.

*Financing:* GHPs which provide funds for specific disease programmes.

Table 3 below maps GHPs involved in HIV/AIDS, Malaria and TB by type.

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<sup>25</sup> Buse K., 2004. *Global Health Partnerships: Mapping a shifting terrain*. London: DFID Health Resource Centre.

<sup>26</sup> Operations Evaluation Department, World Bank. *The World Bank's Approach to Global Programs: An Independent Evaluation*. The World Bank, August 1, 2002.

Table 3: Classification of GHPs involved in HIV/AIDS, Malaria and TB

<b>GHP</b>	<b>Research and development</b>	<b>International and national advocacy</b>	<b>Financing</b>	<b>Technical support, service delivery, donations and discounted products</b>
HIV/AIDS	CICCR CONRAD GMP IAVI IPM HTVN MDP (2)	GBC GCM GCWA GMAI GRI	GFATM	AAI ACHAP CF DPP HACI HATC IPAAA MTCTPlus SF Step Forward VDP
Malaria	Artesunate DNDi EMVI JPMW MIM MMV MVI LAPDAP TROPICAL	Roll Back Malaria	GFATM	AMP Coartem NetMark Plus
TB	Aeras FIND GATBDD TROPICAL	Global Partnership to Stop TB	GFATM	EL-MDRTPB GLC GDF



### **ANNEX 3: THE PRODUCT DEVELOPMENT PATHWAY – A ROAD MAP FOR RESEARCH**

#### ***GHP Study Paper 8: Mapping the Pathways on AIDS, TB and Malaria by Chris Gingerich***

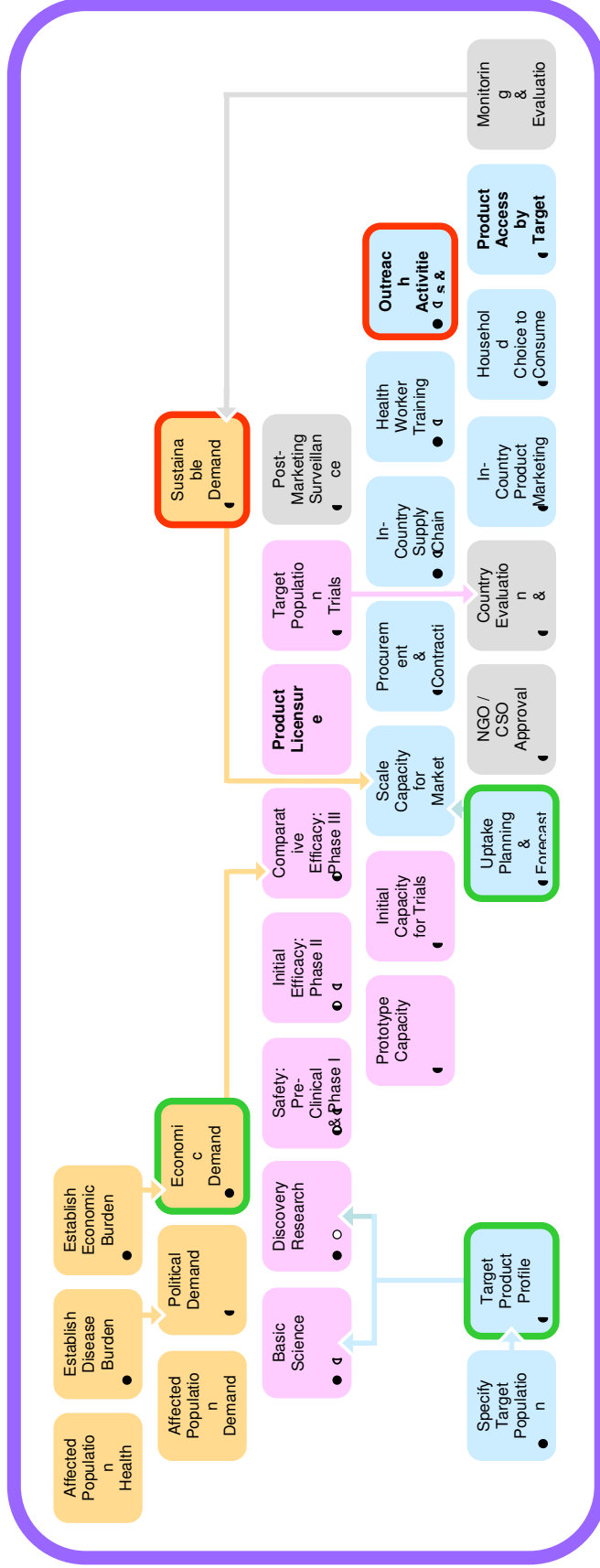
New, cheap and simple to use health products are needed if poor countries are to combat HIV, TB, Malaria and other diseases. DFID and other donors are making substantial investments in health research, but research to develop new health products is an expensive and complex process. It involves many different players, multiple sources of funding and a range of investment strategies. This makes it difficult for DFID to identify how it can use relatively small resources to best effect.

During the early stages of the wider GHP study commissioned by DFID in 2004, a need was identified to produce a visual representation of the processes that must occur to move a health product from original concept to tangible products being used in a developing country setting. The requirement was a user-friendly tool to aid both advocacy and analysis. The Product Development Pathway tool has been developed by Chris Gingerich, using HIV, TB and Malaria as the disease examples. Each diagram identifies the different processes required to generate new products, and the barriers and linkages between the various processes. It also identifies “who is doing what” at each stage of the research process. Examples are given below.

Discussions on the potential use of the Product Development Pathway Tool in advocacy and analysis are still ongoing, with interest from partners including The Gates Foundation; MRC; Wellcome and Rockefeller. The discussions will have possible implications for DFID’s research funding strategy and evaluation of Public Private Partnerships. Issues being debated include:

1. Does the pathway differ between drugs and vaccines, and between diseases?
2. How can the tool be used to address health systems and pro-poor issues? Do issues of poverty need to be more strongly embedded within the tool, or is it more a question of how the tool is used and interpreted?
3. How can the tool be used for advocacy?
4. Where are the gaps/shortfalls/overkill – in terms of research spend/activity, particularly in the field of vaccine research?
5. How can the tool be used to evaluate investments in product development, such as, for example, investments in malaria drug research?

# TB



### Process Groups

- - Product Demand
- - Product Development
- - Product Supply, Marketing & Access
- - Product Monitoring, Evaluation & Approval

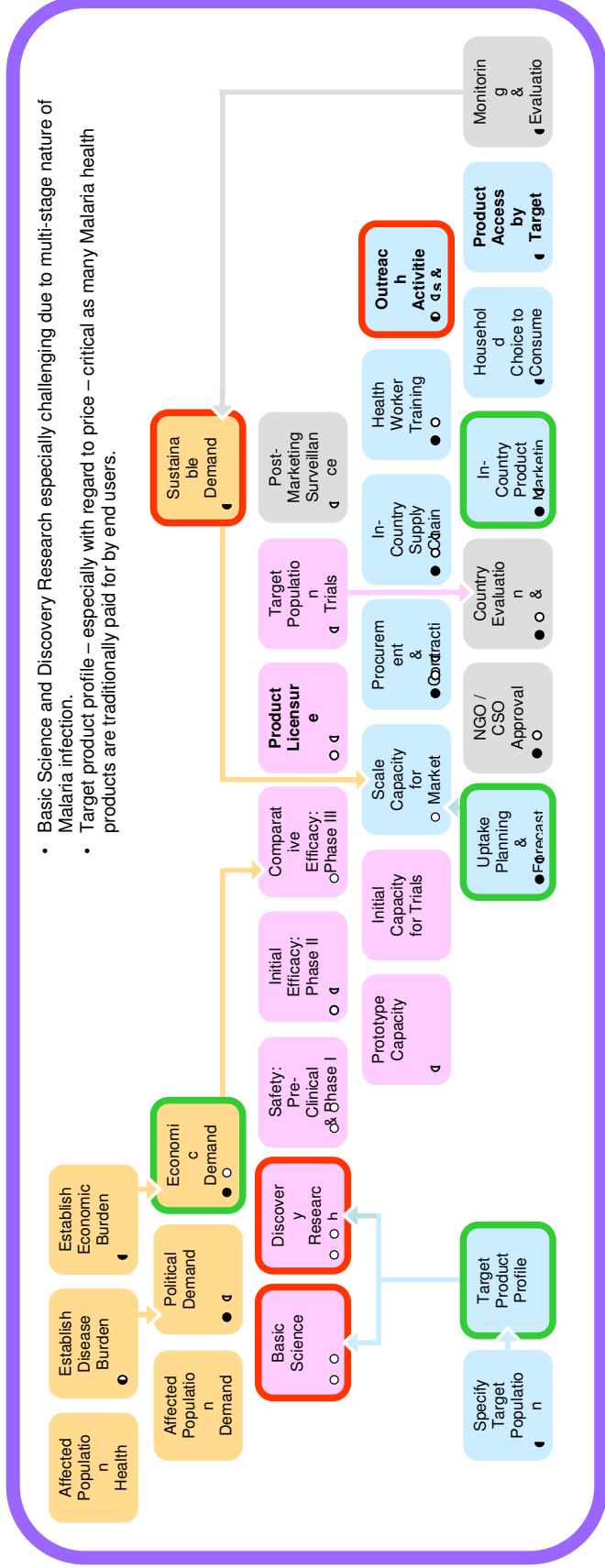
### Barriers & Linkages

- - Potential Barrier / Difficult Process
- - Important Process (Often Overlooked)
- ↑ - Key Dependency

### GHP / PPP Mapping

- = 2
- = 2
- = 1 GHP & 1
- = 1
- = 1

# Malaria



- Basic Science and Discovery Research especially challenging due to multi-stage nature of Malaria infection.
- Target product profile – especially with regard to price – critical as many Malaria health products are traditionally paid for by end users.

## Process Groups

- - Product Demand
- - Product Development
- - Product Supply, Marketing & Access
- - Product Monitoring, Evaluation & Approval

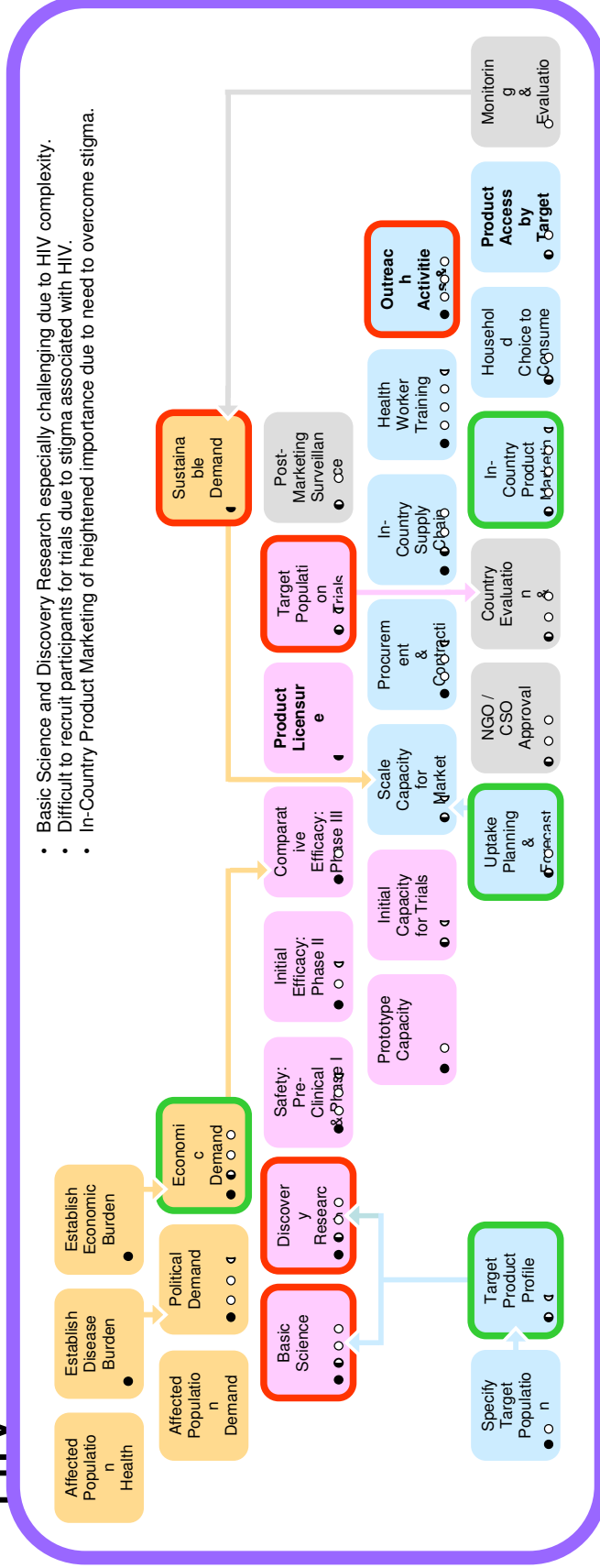
## Barriers & Linkages

- - Potential Barrier / Difficult Process
- - Important Process (Often Overlooked)
- ↑ - Key Dependency

## GHP / PPP Mapping

- = 2
- = 2
- = 1 GHP & 1
- = 1
- = 1

# HIV



- Basic Science and Discovery Research especially challenging due to HIV complexity.
- Difficult to recruit participants for trials due to stigma associated with HIV.
- In-Country Product Marketing of heightened importance due to need to overcome stigma.

## Process Groups

- Product Demand
- Product Development
- Product Supply, Marketing & Access
- Product Monitoring, Evaluation & Approval

## Barriers & Linkages

- Potential Barrier / Difficult Process
- Important Process (Often Overlooked)
- Key Dependency

## GHP / PPP Mapping

- = 2
- = 2
- ◐ = 1 GHP & 1
- ◑ = 1
- ◒ = 1