

PARTNERSHIP FOR HEALTH DEVELOPMENT

(Background paper prepared by AMRO)

4th Global Meeting of Heads of WHO Country Offices with DG
and RDs

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Partnerships for Health Development

Definition

Partnerships for Health Development (PHD) are organizational models that bring together groups—including governments, international agencies, civil society, and a variety of private-sector representatives—into a formal, collaborative relationship dedicated to the pursuit of a shared health goal. Typically, partnerships support governments to develop and implement plans aimed to mobilizing resources to bridge the gaps for advancing the public health. During the past decade, such partnerships have grown to become the predominant organizational model for addressing the complex health problems of low- and middle-income countries. Today, partnerships provide everything from technical assistance and R&D to advocacy and financing.

Definition of a Partnership for Health:

- **Partnership:** the key criterion is a collaborative relationship among multiple organizations 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.

Typology to classify Partnerships:

- **Research and Development:** Partnerships involved in product discovery and development of new diagnostics, drugs and vaccines.
- **Technical assistance/service support:** Partnerships which support improved service access, may provide discounted or donated drugs, and give technical assistance.
- **Advocacy:** Partnerships which raise the profile of the disease and advocate for increased international and/or national response, and resource mobilization.
- **Financing:** Partnerships which provide funds for specific disease programs.

Regional/ thematic allocation of PHD funding:

Africa has the highest number of countries benefitting from PHDs, followed by Asia (East, Southeast and Central). Eastern and Central European countries have the lowest number of PHDs while the Americas region is somewhere in between. The vast majority of these PHDs focus on communicable diseases while 60% target the big three diseases - HIV/AIDS, TB and malaria - with HIV/AIDS attracting the most partnerships on health.

Examples of Partnerships for Health Development

Some positive examples of partnership actions are helpful to consider demonstrating increased resources, refined policy frameworks, stronger national planning capacity, improved transparency, and coordinated technical assistance:

- The **Global Fund to Fight AIDS, TB and Malaria (GFATM)**, **Global Alliance for Vaccines and Immunization (GAVI)**, and **UNITAID** have raised considerable sums for transfer to countries to support programming (over USD 4 billion per year). They have served to mobilize resources as well as to promote multi-partner engagement in government-led programming.
- **Health Metrics Network** has initiated work with GHPs and others to rely on partner countries' results-oriented reporting and monitoring frameworks.
- **Stop TB, Rollback Malaria, the Global Alliance for Improved Nutrition (GAIN)**, and a number of other disease specific partnerships have demonstrated positive experiences in raising awareness and advocacy for addressing specific diseases, coordinating technical assistance of participating partners, and coalescing multisectorial partner (i.e., civil society, NGOs, private sector) interest in achieving specific outcomes.
- The **Global Polio Eradication Initiative** presents useful lessons for formulating a large scale informal, multi-partner effort that does not have an independent governance structure, but

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does have clearly defined responsibilities for each partner united under WHO's framework and dedicated team (across all levels). Similar efforts have been launched with the Measles Partnership.

- The **Global Health Workforce Alliance, the Alliance for Health Policy and Systems Research, the Global Forum for Health Research, and the Council on Health Research for Development** have effectively marshaled a number of stakeholders to further specific health policy objectives and/or research efforts.
- Product oriented public-private partnerships (PPPs) have been instrumental in advancing innovation for new products, such as **Malaria Medicines Venture, Global TB Drug Alliance, Drugs for Neglected Diseases Initiative, Foundation for Innovative New Diagnostics, the International Partnership for Microbicides** and many others. These tend to be disease specific requiring an additional level of synergy across them.
- Some partnerships have created new avenues for non-traditional donors or innovative sources of financing (e.g. the solidarity levy or the international finance facility) to become engaged in health development
- Within the UN, the **Joint Programme on HIV/AIDS (UNAIDS)** illustrates many positive lessons in how different cosponsoring UN agencies collaborate to maximize their respective comparative advantages in tackling the HIV/AIDS pandemic. This involves understanding of division of labor among the agencies.

Examples of successful WHO engagement with partnerships include:

- WHO working closely with GAVI, GFATM, as well as with the Global Alliance for Health Workforce, Health Metrics Network, and other partnerships to spearhead renewed interest, support, and joint planning for health systems development.
- WHO norms and standards being used by PHDs such as HIV, TB, or malaria drug selection policy, use of WHO's prequalification program for selecting drugs, selection of vaccines, or health systems frameworks.
- WHO anticipates that requests for WHO assistance to help manage the complex policy dialogue surrounding partnerships, documenting best practice, as well as ensuring that its norms and guidelines are utilized will increase.

Challenges and Issues

In hand with visible benefits, the growth of PHDs has created several challenges, including the risks of duplication of effort, high transaction costs (to government and partners), varying accountability, variable country ownership, lack of alignment with country priorities and systems and slow progress on health outcomes. There is a recognized need for harmonization and alignment to ensure effectiveness and efficiency in resource mobilization, resource allocation, governance, technical assistance, monitoring and cross cutting approaches.

More specifically, the large number of independent Partnerships poses significant challenges to countries, a selection of which include:

- Countries struggling to absorb partnerships resources given disparate rules, procedures, and expectations of each partnership.
- The need for enhanced coordination of partners and countries involved in a given partnership to deliver and impact positively on health outcomes.
- Country coordination mechanisms and forums proliferating, each specific to a given Partnership.
- Performance-based funding approaches, although a positive development, leading to long term uncertainty of funding flows.
- Partnerships bypassing and undermining existing country plans and processes, often by insisting on new rules and/or leading to uncoordinated multiple processes.
- Distorting effects of uncoordinated funding flows and engagement by Partnerships at country level as they typically favour individual diseases or aspects of the health system

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- Proliferation of partnerships leading to lack of clarity of roles and responsibilities with multilateral and other implementing partners in general, as well as regarding partner responsibilities' towards supporting countries for partnerships initiatives and programs.
- Instability of partnerships funding leading to reluctance by countries to apply for funding given perceptions that it will result in increased government commitments. For some Partnerships, there is an equal risk of increased aid dependency and lack of sustainability.
- Inadequate information flow: Lack of communication and exchange of information (among agencies but also with countries) adds unnecessary complexity and confusion to work in this sector, including inadequate multilingual documentation. This serves to discourage countries and to require them to employ international consultants.
- Restricted concept of partnerships. Low and middle income countries defined as recipients are not participating fully as contributor of expertise, best practice and centers of excellence.

Partnerships also present several specific governance challenges. For example;

a. Accountability frameworks for Partnerships and countries. Questions have arisen as to whom are PHDs accountable. Whereas achieving health outcomes at country level is a shared goal, funding partnerships must weigh accountability to donors for funds. As a result, a fuller framework considering accountability to whom, by whom, and through what mechanisms would be useful.

b. Internal governance. Each partnership struggles with dynamics among its partners, between secretariat and board, precision of responsibilities of the secretariat vs. partner responsibilities, and with host institutions where applicable. Partnerships need to maximize the contribution of individual members rather than undermine them. Potential "mission creep" has the potential to increase tensions and transaction costs. These issues lead to a need to collect and share such experiences/practices across partnerships, including refined roles of partners in a partnership. In the case of WHO-hosted partnerships, consistency from Member State messages in their capacity as partnership Board members and as WHO Governing Body member is important.

c. Representation on multiple Boards. Many donors, multilateral agencies, developing countries, private sector, and NGO representatives now staff multiple Boards on which they sit. These present opportunities for and responsibilities of these partners to maintain an overarching set of policy frameworks linked to aid effectiveness and harmonization principles while at the same honoring the purpose of the stated partnership. Consequently, quantifying the burdens on agencies (WHO, UN, government, non-governmental organizations, civil society, etc) to staff these Boards is a priority need and is partially addressed in the Best Practice document noted in paragraph 15.

d. Interface of PHDs with multilateral organizations. As the number and type of PHDs have increased and evolved, so too has confusion over respective roles and responsibilities with existing multilateral organizations. Among the key characteristics of this dynamic are: a) the implications and limitations of financing partnerships with respect to WHO and other UN agency responsibilities, b) the role and interface with normative agencies, inclusive of their operational and representational responsibilities and work, c) increasing coordination of the work of partners, and d) ensuring sufficient funding for WHO and UN agency technical support to countries associated with PHD actions.

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Policy Issues / Questions

- Increasing alignment at country level
How can WHO increase global and regional health partnership alignment with national priorities in health? How can WHO best contribute to identify health priorities at country level that can benefit from multiple partnerships?

- WHO support to the countries
What do health outcomes need from WHO, particularly on capacity building and leadership role toward more effectively partnerships in health? How can global health partnerships be more efficiently linked with national health partnerships?

- WHO policy towards partnerships
What should be the criteria for WHO to engage or support a partnership? How can we evaluate the added value of a partnership from the country perspective?