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Background paper:
Key evidence from major studies of selected Global Health Partnerships

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Title: **Key evidence from major studies of selected Global Health Partnerships**
A background paper for a meeting of the High-Level Forum on the Health MDGs' Working Group on Global Health Initiatives and Partnerships, 25-26 April 2005

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EXECUTIVE SUMMARY

Key evidence from major studies of selected Global Health Partnerships

This background paper notes key evidence from recent major studies of selected Global Health Partnerships, focusing mainly on four GHPs: the Global Fund to Fight AIDS, TB and Malaria (GFATM), GAVI, the Global Partnership to Stop TB and Roll Back Malaria (RBM).

Overview

Most studies agree that GHPs are providing large-scale new financing as well as mobilizing new global expertise and knowledge for problem-solving from a variety of fields. They have increased global and national awareness of health issues at the highest political levels.

However, views on the continuing role and implications of existing and additional GHPs appear to range from uncertain to polarised - both for and against. GHPs are seen by many as having a major role to play in scaling up the response to health needs, given findings of the positive impact of most individual GHPs and perceptions about lack of capacity and responsiveness in relevant UN agencies. 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.

Performance of GHPs

Global health initiatives and partnerships have been attractive to some stakeholders in that they appear to offer opportunities to:

- channel resources into politically high profile areas
- raise the profile of neglected issues and, in some cases, lead policy
- attract new partners (eg the private sector) into the global fight against specific diseases
- leverage additional funds and diversify the donor base
- provide a means of supporting global public goods
- secure substantial economies of scale (eg in drug procurement)
- support a more coordinated international and national response by pooling resources to enhance aid effectiveness.

Evaluations suggest that key areas of success have been raising the profile of the diseases, mobilising commitment and increased funding, accelerating progress (though it remains unclear whether some GHP targets will be delivered on time, including those for the Stop TB Partnership and Roll Back Malaria) and in some cases leading innovation. Development of a clear strategy, building a consensus around it, and coordinating partner efforts are fundamental added value objectives for GHPs. There is some concern that a focus on disease treatment may be diverting attention from prevention, particularly for HIV/AIDS.

Most GHPs claim to be pro-poor, though they tend to lack specific indicators for equity aims. GHP allocations by disease are at least as pro poor as past allocations, and the share of GHP funding going to low income countries is extremely high – almost 78% for GFATM and over 98% for the Global Polio Eradication Initiative (GPEI) and GAVI/Vaccine Fund. This compares with around 64% for OECD donors as a whole.

Current studies suggest that there is stronger evidence of positive outcomes (or the potential for achieving them) from the Stop TB Partnership, GAVI and the GFATM than from Roll Back Malaria. **The Stop TB Partnership** is seen as one of the most successful global health partnerships, offering important lessons for global TB control, for application to other communicable diseases, and for effectively linking advocacy to financing mechanisms. **RBM** has helped mobilise support and funding, particularly from the Global Fund, but has so far had very little impact on malaria outcomes in malaria-endemic countries. **GAVI**'s programmes have boosted immunization efforts, reduced child morbidity and mortality, improved implementation capacity, and incorporated new vaccines and technologies. The **GFATM** has substantially increased the availability of resources, though it is too early to assess outcomes. It is now a much larger player than the World Bank in financing control of all three diseases.

Governance

Studies identify several common GHP governance problems at global level: ensuring effective representation of key stakeholders on governing boards, defining clear roles and responsibilities for all partners; and having systems to ensure accountability, transparency and performance monitoring. Problems in country governance have been most visible with the GFATM Country Coordination Mechanisms (CCMs), including: ineffective representation of some constituencies, doubts about their legitimacy, poor participation in meetings, and a general perception of competition, especially between civil society and government.

Country operations, alignment and impact on health systems

Alongside the many important positive contributions made by GHPs, they have created or exacerbated a series of problems at country level including: partnership overlap and duplication; high transaction costs to government and donors from having to deal with multiple parallel initiatives; variable degrees of country ownership; and lack of harmonisation across GHPs and of alignment with country systems, undermining the latter. They do not and cannot take a health sector wide overview, and run the risk of undermining the sustainability of national development plans, distorting national priorities, diverting scarce human resources and/or establishing uncoordinated service delivery structures.

Studies note a serious risk that weak national human resource and systems capacity at central and local levels may be overwhelmed by the multiplicity of GHPs and other HIV/AIDS initiatives operating independently at country level, each with its separate demands. Problems are particularly severe in small, low-income countries that depend heavily on aid. However, the December 2004 meeting of the High-Level Forum on the Health MDGs noted progress in improving practice regarding GHP alignment with national systems, including a recent GFATM agreement to channel funds through the national budget. The GFATM in particular needs to reduce the burden of its processes, consistent with proper accountability.

Without increased support to help build health system capacity in almost all developing countries, the resources mobilised by global partnerships are unlikely to achieve their full potential. GHPs generally have neglected critical components such as prevention, system capacity building (reflected most dramatically in shortages of professional health workers), surveillance, research, monitoring and evaluation, and the role of non-health sectors. Current studies provide scant data about the impact of GHPs on human resources. Given the pressure on GHPs to show rapid results and the potential of some civil society organisations to deliver them, migration of staff out of the public sector is felt likely to occur.

Financial and economic aspects of GHPs

GHPs have mobilised large-scale new 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. Assessing additionality is technically problematic, and the picture remains unclear. However, GHPs have not achieved their aim of attracting new funding sources with the exception of Foundations, especially the Gates Foundation. Most funds continue to be provided by traditional donors – who provide 97% of pledges for GFATM.

Most interventions funded by GHPs – except ARVs - 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. However, sustainability is a recurrent concern in studies. GHPs have had a prominent role in introducing high value goods - eg antiretrovirals - into under-resourced health systems, benefiting recipients but potentially committing future increases in aid for many years to come. Low-income countries are unlikely to be able to meet ongoing costs themselves.

Reviews have been unable to make definitive judgements on the efficiency of GHPs. Most suggest that GHPs' own administrative costs appear reasonable, though such lean administrations could be unsustainable over time, given increasing workloads. However, account must also be taken of the costs, and opportunity costs, in developing countries.

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ABBREVIATIONS

ACT	Artemisin combination therapy
ADIP	Accelerated Development and Introduction Plans (for vaccines)
APOC	African Programme for Onchocerciasis Control
ART	Antiretroviral therapy
ARV	Antiretroviral
CCM	Country coordinating mechanism
DFID	UK Department for International Development
DQA	Data Quality Audit
EC	European Commission
GAO	US General Accounting Office
GAVI	Global Alliance for Vaccines and Immunization
GDF	(TB) Global Drug Facility
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHP	Global Health Partnership
GNI	Gross National Income
GPEI	Global Polio Eradication Initiative
HLF	High-level Forum
IFF	International Financing Facility
ISAC	Intensified Support and Action Countries (Stop TB Partnership)
ISS	Immunization Services Support (GAVI)
LFA	(GFATM's) Local Fund Agent
LSHTM	London School for Hygiene and Tropical Medicine
MAP	World Bank Multi-country AIDS Programme
MDG	Millennium Development Goal
NGO	Non-governmental organisation
PEPFAR	US President's Emergency Plan for HIV/AIDS Relief
PMTCT	Prevention of mother to child transmission
PPP	Public-private partnership
PR	Principal recipient
R&D	Research and development
RBM	Roll Back Malaria
SWAp	Sector-wide Approach
TB	Tuberculosis
UN	United Nations
VCT	Voluntary testing and counselling
WHO	World Health Organization

1: INTRODUCTION

1.1 Scope of paper

As background for the first meeting on 25-66 April of the HLF Working Group on Global Health Initiatives and Partnerships, the HLF Secretariat commissioned this DFID-supported summary of key evidence from major studies of selected Global Health Partnerships (GHPs).

In line with decisions on the scope of the Working Group meeting, the paper focuses mainly on four GHPs: the Global Fund to Fight AIDS, TB and Malaria (GFATM), GAVI, the Global Partnership to Stop TB and Roll Back Malaria (RBM). R&D/product development GHPs have been specifically excluded, except insofar as they form part of wider GHPs such as the Stop TB Partnership. This paper reviews in particular evidence on:

- the performance of GHPs (section 2)
- country operations, alignment and impact on health systems (section 3)
- financial and economic aspects of GHPs (section 4)
- the four specific GHPs: GFATM (Annex 1), GAVI (Annex 2), the Stop TB Partnership (Annex 3) and RBM (Annex 4).

1.2 Global Health Partnerships (GHPs)

There has been a recent, rapid proliferation of GHPs, with establishment of new partnerships peaking around 2001(Brugha R., 2005). Global Health Partnership (GHP) is a generally understood term, though there is no single definition or typology (see Annex 5). Estimates suggest from 75 to 100 GHPs, depending on definition. Most are relatively small or very specialised. They are a heteregeneous group, and any effort to compare them with the same yardstick has considerable limitations. For example, the Stop TB Partnership and RBM are technical/advocacy GHPs, the GFATM purely financing, and GAVI covers all three functions.

While GHPs are highly diverse in nature, size and scope, the vast majority relate to 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 (Caines et al, 2004). Nonetheless, almost all the 'most neglected' diseases are now supported by at least one GHP, though there remain concerns about funding for research and development. Few GHPs address non-communicable diseases, or health systems per se. 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 (Pearson M., 2004).

1.3 Major studies of GHPs

The body of evidence on GHPs is growing, but studies can date quickly because of Partnerships' rapid evolution. To capture the latest findings, this synthesis takes into account draft findings from forthcoming reports on GHPs from the International Task Force on Global Public Goods, Development Cooperation Ireland and the EC. Since many GHPs are relatively new, most studies tend to be qualitative rather than quantitative, and were undertaken too early fully to assess achieved benefits. For example, the GFATM began operations only in January 2002 and its real impact has yet to be felt. The primary focus of many studies to date has been on process issues - particularly concerns and frustrations about GFATM processes.

The GFATM has been extensively studied from its establishment. While GAVI – like the GFATM - has not had a full programme evaluation, it has been subject to a number of specific studies initiated by its own management, donors and interested bodies. Both the Stop TB Partnership and Roll Back Malaria have undergone formal external evaluations. Table 1 lists selected major studies of these four GHPs and of GHPs generally.

Most published studies – even multi-GHP studies – examine the effectiveness of individual GHPs. Only the most recent are beginning to provide evidence about the collective impact of GHPs at country level, which is now emerging as an issue of concern.

Table 1: Selected major GHP studies

Focus of study	Date GHP operational	Selected major GHP studies
General GHP studies	-	DRAFT**:** Lele U., Ridker R., Upadhyay J., Skolnik R., *Health System Capacities in Developing Countries and Global Health Initiatives: Background paper for the International Task Force on Global Public Goods* (draft 18 April 2005).
		DRAFT: Brugha R., *Engagement and Support to Global Health Partnerships: A Review for Development Cooperation Ireland* (draft 10 April 2005).
		DRAFT: Delcour L., Vellutini C., *Added Value of Global Funds and Global partnerships to Development Cooperation.* For the EC (draft Feb 2005)
		DRAFT: Montes C., *Review of Global programmes: country level evidence, and Policy Findings,* Dev-Strategies Ltd UK for DFID (draft Feb 2005).
		Lele U., Gerrard C., et al., (2004) *Addressing Challenges of Globalization: The World Bank's Approach to Global Programs*, Operations Evaluation Department, World Bank.
		Lele U. et al., (2004) *Global Health Programs, Millennium Development Goals, and the World Bank's Role,* Operations Evaluation Department, World Bank.
		Caines K. et al., (2004) *Assessing the impact of Global Health Partnerships*. DFID Health Resource Centre. Plus eight supporting studies.
		Buse K., (2003) *Global Health Partnerships: mapping a shifting terrain,* for DFID.
		McKinsey & Company (2002) *Developing successful Global Health Alliances,* for the Bill and Melinda Gates Foundation.
GAVI	1999	Chee G., Fields R., Hsi N. and Schott W., (2004) *Evaluation of GAVI Immunization Services (ISS),* Abt Associates for GAVI.
		Starling M., Brugha R., Walt G., (2002) *New Products into Old Systems: The initial impact of the Global Alliance for Vaccines and Immunization (GAVI) at country level,* London, Save the Children.
		Caines K., N'jie H., (2002) *External Review of the Functions and Interactions of the GAVI Working Group, Secretariat and Board*, IHSD for GAVI.
GFATM	2002	Radelet S., Caines K. (2005): *The Global Fund to Fight AIDS, TB, and Malaria: Performance and Vision,* for DFID.
		Radelet S. (2004), *The Global Fund to Fight AIDS, TB, and Malaria: Progress, Potential, and Challenges for the Future,* Center for Global Development.
		Brugha R., Donoghue M., Starling M., Ndubani P., Ssengooba F., Fernandes B., Walt G., *The Global Fund: managing great expectations. Lancet* 364: 95-100, 2004. Also individual reports for the 4 countries (January 2005) and a cross-country comparative analysis of the Tracking Study (draft Dec 2004).
		Brugha R., Walt G., Starling M., Donoghue M., (2003) *Tracking the Global Fund in Four Countries: an interim report - Mozambique, Tanzania, Uganda, Zambia,* London School of Hygiene and Tropical Medicine (LSHTM).
		Kruse S. and Claussen J., (2004) *Review of the Roles, Functions and Performance of Local Fund Agents*.
		Miscellaneous authors of 20 individual studies, (2004) *Country Coordinating Mechanism: A Case Study (20 countries),* for GFATM.
		US General Accounting Office (2003) *GFATM has Advanced in Key Areas but Difficult Challenges Remain,*GAO-03-601
		Grace, C (2003) *Global Fund Country Case Studies Report*. DFID Health Systems Resource Centre.
		Bennett S. and Fairbank A., (2003) *The System Wide Effects of The Global Fund: A Conceptual Framework,* Partners for Health Reform Plus - ABT Associates.
		UNAIDS, (2002) *UNAIDS Support for Countries Accessing the Global Fund. HIV/AIDS Proposals: Lessons from Round One.*
Stop TB Partnership	2001*	Caines K., et al. (2003) *Independent External Evaluation of the Global Stop TB Partnership,* IHSD for the Stop TB Partnership.
		McKinsey & Company (2003), *Evaluation of the Global TB Drug Facility, Final Report.* Stop TB Partnership / WHO.
RBM	1998	Feachem R., Medlin C., Daniels D., Dunlop D., Mshinda H., Petko J., et al. (2002). *Achieving impact: roll back malaria in the next phase.* Final report of the external evaluation of Roll Back Malaria. August 2002. Plus supporting studies.

*Note: The formal Stop TB Partnership bodies (e.g., the Partners' Forum and the Coordinating Board) were established only in 2001 but were preceded by strong, less formalised, partnership activity.

2: PERFORMANCE OF GHPs

2.1 Overview

The context is that rapid and far-reaching changes have taken place in the global health sector, with many positive results. Four important trends identified are:

- the placement of global health on a 'war footing';
- the growing share of development aid being directed to health;
- the increased programming of health aid through new global health programmes outside the key traditional international organisations such as the World Bank and WHO; and
- the focus of global health efforts on a few communicable diseases. Yet health systems of developing countries must concurrently address a whole range of nationally and locally important health challenges, in situations of extreme resource scarcity (Lele U. et al, April 2005).

Most major studies share the conclusion that 'most [new global programs] are providing large-scale new financing and mobilizing new global expertise and knowledge for problem-solving from a variety of fields, and through advocacy they have increased global and national awareness of health issues at the highest political levels (Lele U. et al, April 2005).

However, views on the continuing role and implications of existing and additional GHPs appear to range from uncertain to polarised - both for and against. 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, given findings of the positive impact of most individual GHPs and perceptions about lack of capacity and responsiveness in relevant UN agencies (Caines K. et al, 2004).

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[1] - may overwhelm countries' central capacity and weaker health systems (Caines K. et al, 2004).

One study notes that aid agencies are ambivalent towards the increasing popularity of global programmes, but concludes that their increasing importance will continue, given their political attractiveness (Montes C., 2005). GHPs are an attractive field of investment for donors with growing development budgets and a comparatively limited number of technical staff, because they have potential to absorb and account for the use of large amounts of development funds (Brugha R., 2005).

2.2 Key findings on GHP performance

This section explores some key aspects of GHP performance, principally overall performance, innovation, poverty and gender equity, governance and selected process issues. Issues relating to country operations, harmonisation and alignment, and impact on health systems are considered in more detail in section 3. The financial and economic aspects of GHPs are considered in section 4.

Annexes 1-4 provide a brief summary of recent key findings on the four individual GHPs selected as the focus for consideration by the High Level Forum Working Group on Global Health Initiatives and Partnerships: GFATM, GAVI, the Stop TB Partnership and RBM.

2.2.1 Overall performance

A now somewhat dated 2002 McKinsey & Co study of 30 global health alliances (McKinsey & Co., 2002) 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

[1] Eg the US President's Emergency Plan for HIV/AIDS Relief (PEPFAR) and the World Bank's Multi-sectoral AIDS Programme (MAP).

reaching their full potential. Factors included limited resources, difficulties in decision-making, or a slow start[2].

These general findings of GHP success, but with scope for yet further achievement, are echoed in full GHP evaluations currently available. 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.

Global health initiatives and partnerships have been attractive to some stakeholders in that they appear to offer opportunities to:

- channel resources into politically high profile areas;
- raise the profile of neglected issues and, in some cases, lead policy;
- attract new partners (eg the private sector) into the global fight against specific diseases;
- leverage additional funds and diversify the donor base;
- provide a means of supporting global public goods;
- secure substantial economies of scale (eg in drug procurement); and
- support a more coordinated international and national response by pooling resources to enhance aid effectiveness.

There is a perception that many GHPs have arisen, in part at least, as a response to the failure of previous support mechanisms and inadequate supra-national architecture. One view is that they offer a swifter route to health gains.

Evaluations suggest that key areas of success have been raising the profile of the disease, mobilising commitment and increased funding, accelerating progress (though it remains unclear whether some GHP targets will be delivered on time, including those for the Stop TB Partnership and Roll Back Malaria) and in some cases leading innovation. Development of a clear strategy, building a consensus around it, and coordinating partner efforts are fundamental added value objectives for GHPs (Caines K. et al, 2004). There is some concern that a focus on disease treatment may be diverting attention from prevention (Lele U. et al, 2005), particularly in relation to HIV/AIDS.

Most full programme evaluations of GHPs (including those of the Stop TB Partnership and RBM) took place too early in the life of the GHP to present outcome and impact data. Current studies suggest that there is stronger evidence of positive process outcomes (or the potential for achieving them) from the Stop TB Partnership, GAVI and the GFATM than from Roll Back Malaria (Lele U. et al, 2005). Sustainability is a recurring concern (see section 4 on financial and economic aspects of GHPs). Funding is needed on a consistent, long-term, predictable basis with a graduated increase commensurate with systematically expanded domestic capacity to sustain the drug and vaccine delivery approaches promoted by the GHPs.

More details are given in annexes 1-4 but key points on achievements include the following:

- **The Stop TB Partnership** is seen as one of the most successful global health partnerships, offering important lessons for global TB control, for application to other communicable diseases, and for effectively linking advocacy to financing mechanisms. The greatest success against communicable diseases in recent years has been achieved in the control of TB, through effective implementation of the DOTS strategy (Lele U.et al, 2005). DOTS coverage has been extended to areas with 69% of the world's TB-affected populations in 182 countries. The TB Global Drug Facility has reduced the cost of first-line drugs, and provided drugs for 4.4 million people in more than 65 countries. TB as an opportunistic infection of HIV (especially in Africa) and multi-drug resistance (especially in Eastern Europe) remain huge challenges, particularly given the need for much more effective collaboration between TB and HIV/AIDS programmes.
- There has been less success in controlling malaria, particularly in Africa. **RBM** has increased global awareness and political support, and it has helped to mobilise greater funding in support of malaria prevention, treatment and control, particularly from the

[2] Slow starts are not confined to GHPs. The US Millennium Challenge Account is, like GFATM, a recent start-up focusing on country-led programmes, with entirely new procedures and operations. Despite an initial targeting of only 17 countries (compared with GFATM's 127), it had yet to disburse a single dollar by February 2005, three years after the President announced the programme. Radelet S. and Caines K., *The Global Fund to Fight AIDS, TB, and Malaria: Performance and Vision,* 2005.

Global Fund. But RBM has so far had very little impact on malaria outcomes in malaria-endemic countries) (Lele U. et al, 2005). The DFID study (Sierra Leone, Uganda and India) found that RBM had the lowest profile of all the partnerships (Carlson C., 2004).

- **GAVI**'s programmes are judged to have boosted immunization efforts, reduced child morbidity and mortality, improved project preparation and implementation capacity, and incorporated the use of new vaccines and technologies while increasing vaccine coverage. Since establishment in 1999, GAVI/Vaccine Fund have committed more than $1 billion to 69 developing countries and cumulatively immunised 30 million children. The Vaccine Fund is also financing the development of vaccines for rotavirus and pneumococcus. The key challenge will be to sustain increased immunization coverage using new vaccines when GAVI/Vaccine Fund support ends.
- The **GFATM** has substantially increased the availability of resources. It is the world's largest donor for TB and malaria, and a much larger player than the World Bank in financing control of all three diseases. By end 2004, it had attracted pledges of $5.9 billion and contributions of $3.3 billion; approved 310 grants in 127 countries, committing $3.1 billion for the first two years; signed $2.1 billion (67%) in formal agreements, and disbursed $878 million (equivalent to 28% of commitments and 42% of signed agreements) (Radelet and Caines, 2005). One study called GFATM's disbursement record 'an impressive performance by any account' (Lele U.et al, 2005). Cumulative results for the grant portfolio as of the end of 2004 include: 130,000 people on ARV treatment for AIDS; more than 1 million people reached with voluntary HIV testing; 385,000 people treated under the DOTS TB strategy; 300,000 people had received third-generation malaria drugs; 1.35 million families had received insecticide-treated bed nets; 350,000 people trained to fight HIV, TB, and malaria (Radelet and Caines, 2005).

The dynamism both of the background environment and of some individual GHPs means that these findings date quickly. For example, the advent of the GFATM has had implications for the grant-making role of the Stop TB Partnership's Global Drug Facility.

2.2.2 Innovation

GHPs have introduced new technology for addressing communicable diseases on a scale not known before, and a concurrent shift towards the deployment of vaccines and drugs. They have invoked the 40-year old debate about the merits of mass campaigns versus general health services programs, although a consensus has now emerged that each approach has its own merits and weaknesses and the two need to be seen as mutually complementary (Lele U. et al, 2005). GHPs have had a prominent role in introducing high value goods - eg antiretrovirals (ARVs) - into under-resourced health systems, bringing benefits to recipients but potentially committing future increases in ODA for many years to come. Nonetheless, most current and planned interventions funded by GHPs - ARVs excluded - are potentially highly cost-effective. More investment in operational research may be required to identify best implementation practices and opportunities for fruitful collaboration across disease programmes (Caines K. et al, 2004).

Innovation is understandably most apparent with the R&D partnerships – both in terms of process and product. GHPs/Product Development Public-Private Partnerships that mobilise private sector expertise are likely to be an efficient mechanism for developing much-needed new tools (diagnostics, drugs, vaccines, microbicides) to address neglected diseases (Brugha R., 2005). GHP-led R&D is intensifying and focused on those diseases in greatest need. Some GHPs - such as GAVI and the Stop TB Partnership/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. ARV price reductions may stem more from increased competition from generic manufacturers and global pressure.

GHPs are also innovative on broader fronts, eg GAVI's work on ADIPs, performance-based grants for immunisation services support, financial sustainability planning, and data quality audits. One study of 10 global programmes across different sectors found that GAVI appeared to be the most innovative, perhaps because of its strong private sector participation (Montes C., 2005).

2.2.3 Poverty and gender equity

GHPs can make a significant contribution to addressing equity issues by focusing 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. One analysis (Pearson M., 2004) 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. The share of GHP funding going to low income countries is extremely high – almost 78% for GFATM and over 98% for the Global Polio Eradication Initiative (GPEI) and GAVI/Vaccine Fund, which restricts its support to countries below $1,000 GNI per capita. This compares with around 64% for OECD donors as a whole. By contrast, a draft EC report of six sample Global Funds and Partnerships including three in health – GAVI, GFATM and the Global Polio Eradication Initiative – concludes that GFPs generally have not contributed towards improving aid allocation (Delcour L., 2005).

A background paper for the International Task Force on Global Public Goods notes that GFATM allocations give priority to countries most affected or at risk over those with strong capacity for implementation. However, it argues that, because both the GFATM and the World Bank have concentrated their resources simultaneously in Africa (the region with the weakest institutional capacity), they have compounded the problems of absorptive capacity, resource transfers and the pace of implementation (Lele U. et al, 2005).

The DFID GHP study (Caines K. et al, 2004) found that 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 to achieve this or to address the needs of women. Country studies suggest that 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. The Stop TB Partnership has established a TB and Poverty Secretariat to promote models of good practice for TB service delivery to poor people.

An evaluation of GAVI's performance-based Immunization Services Support (ISS) funding (Abt Associates, 2004) found that "c*ase study countries generally did not undertake any special effort to target the "hard to reach,"* but equally 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.

A study of drug access partnerships (Caines K. and Lush L., 2004) 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.

2.2.4 Governance

Studies identify several common GHP governance problems at global level: ensuring effective representation of key stakeholders on governing boards, defining clear roles and responsibilities for all partners; and having systems in place to ensure accountability, transparency and performance monitoring. One beneficial difference between GHPs and

more traditional UN agencies is that there is some (if fairly circumscribed) involvement of civil society, philanthropic Trusts and the private sector in their governance structures. Getting partners to deliver on agreed commitments represents a challenge to many GHPs, and supports the wider need for strategic and operational plans delineating clear roles and responsibilities for all major partners[3].

Problems in country governance have been most visible with the GFATM Country Coordination Mechanisms (CCMs), including: ineffective representation of some constituencies, doubts about their legitimacy, poor participation in meetings, and a general perception of competition, especially between civil society and government[4]. CCMs have been involved in proposal preparation, though in some cases nominally. But an immediate concern is that CCMs are not seen as well-placed or equipped to carry out their role in overseeing implementation[5].

2.2.5 Other GHP process issues

The most important process issues relate to GHPs' country operations and their impact on national capacity and health systems. These are considered in section 3 below. This section notes three other sets of process issues.

First, GHPs have introduced new ways of doing business at country level:

- expecting countries to apply for aid and making them accountable for its use;
- broadening levels of participation in the application and delivery process[6].
- making aid performance-related (GFATM, GAVI);
- monitoring and evaluating performance and progress.

These have required new roles and relationships between traditional players at country level.

Second, the Stop TB Partnership has shown the benefit of developing a shared global plan, detailing partners' responsibilities. This provides realistic short-, medium-, and long-term objectives ranging from research and development to field implementation on a country-by-country basis. It has been backed by a cost-effective technical (DOTS-based) strategy for diagnosis and treatment, with detailed technical guidelines for implementation.

Third, not only have some GHP procedures been burdensome but in relation the GFATM, there have also been delays in grant processing and disbursement – both from the GFATM to Principal Recipients, and from Principal Recipients to sub-recipients.

For more details of process issues, see Annexes 1-4 on individual GHPs.

[3] Several including: Brugha R., 2005; Buse K., 2004; Caines K. and Buse K., 2004; Caines K. et al., 2004.
[4] Brugha R., 2005. Also Brugha R.et al 2004. Also individual reports for the 4 countries (January 2005) and a cross-country comparative analysis of the Tracking Study (draft Dec 2004).
[5] Many studies including 20 country case studies initiated by the GFATM itself; (Grace C., 2003); the various reports from the LSHTM tracking study cited above; UNAIDS, 2002; and other studies.
[6] Lele et al. note that opening up large-scale access to international funds for non-state agents is seen as a strong GFATM feature in principle but in practice GFATM's record on that score is not strong[6];

3: COUNTRY OPERATIONS, ALIGNMENT AND IMPACT ON HEALTH SYSTEMS

3.1 Overview

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. The goals of these latter GHPs are generally seen as highly relevant, fitting well with national priorities and programmes, though there may be issues about the priority given to polio National Immunisation Days and HIV/AIDS.

However, there is striking consensus among the recent multi-GHP studies[7] that, alongside the many important positive contributions made by GHPs, they have created or exacerbated a series of problems including: partnership overlap and duplication, high transaction costs to government and donors from having to deal with multiple parallel initiatives; variable degrees of country ownership; and lack of harmonisation across GHPs and of alignment with country systems, undermining the latter.

While individual GHPs may be seen as effective and helpful, the wider concern is that they do not and cannot take a health sector wide overview, and run the risk of undermining the sustainability of national development plans, distorting national priorities, diverting scarce human resources and/or establishing uncoordinated service delivery structures. Global health programs need to shift away from a tendency for crisis management to a greater focus on longer-term strategic planning and implementation. The crisis mentality, stimulated in part by effective advocacy programs, has led to a justifiable shift in resources towards treatment of communicable diseases. But it is argued that it has also resulted in inefficient use of resources and neglect of critical components such as prevention, system capacity building (reflected most dramatically in shortages of professional health workers), surveillance, research, monitoring and evaluation, and the role of non-health sectors (Lele U. et al, 2005).

The crisis mentality has also resulted in a proliferation of uncoordinated agencies and programmes that increase transaction costs and further reduce the effectiveness of foreign assistance. These problems are particularly severe in small, low-income countries that depend heavily on aid (Lele U. et al, 2005). Studies note a serious risk that weak national human resource and systems capacity at central and local levels may be overwhelmed by the multiplicity of GHPs (and other HIV/AIDS initiatives) operating independently at country level, each with its separate demands (Caines K. et al, 2004). In particular, GFATM procedures are adding to recipient burdens and fragmentation, and there have been major challenges in integrating GFATM finances with existing mechanisms such as SWAps (sector-wide approaches) (Radelet and Caines, 2005). There is need for greater donor coherence in relation to GHPs, aimed at securing consistency of policies both in GHP Boards and in discussion of harmonisation.

The sections below report key findings from studies in more detail.

3.2 Country ownership

The GFATM Tracking Study[8] found conflicting views. In some countries, systems-focused GHPs (GFATM in Zambia and GAVI in Ghana) were considered to be more country owned than existing forms of donor assistance, since applications for support had to come from countries and were generally government led. GHPs were welcomed for offering an alternative source of assistance to bilateral and multilateral donor agencies. In other countries, (Tanzania, for example), governments perceived aspects of the Global Fund, such as the mandatory CCM model, as an imposition.

3.3 Transaction costs

There is unanimity in recent country-based studies that the current myriad disease-specific GHPs, together with the activities of traditional international organizations (which are a mix of

[7] For example, Brugha R., 2005; Caines K. et al., 2004; Delcour L., Vellutini C, 2005; Lele U., et al 2005).
[8] See Brugha R et al, 2004; plus Brugha R et al, 2003; draft discussion paper 18 December 2004, and individual case studies in the four countries.

disease specific and system wide interventions), carry high transaction costs for developing countries. Making efficient use of the additional funds GHPs offer requires skills that are in extremely short supply (Lele U. et al, 2005).

The major financing partnerships (GFATM and GAVI) 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 partners would provide support. However, resources to finance assistance have been limited, at least initially, 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 immediate needs at country level. GTZ is one of the few agencies that 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 (Caines K., et al, 2004).

GHP requirements - for preparing proposals, reporting progress, procuring supplies, or in terms of institutional arrangements - differ dramatically from programme to programme. Each often calls for the establishment of new structures and procedures that rarely build on existing government or donor processes. Sometimes special units are established (Lele U.et al, 2005). A particular feature of some GHPs has been their pressure on countries to respond urgently to very tight time-frame (Brugha R., 2005; Radelet and Caines, 2005).

The literature suggests that these problems relate particularly to the GFATM (see also Annex 1 for more detailed findings on the GFATM). This has been compounded by the fact that GFATM guidance has changed frequently, occasionally been applied retrospectively (e.g., to approved Round 1 applications) and sometimes come late (e.g., on the role and responsibilities of CCMs). Countries have felt both uncertain and that the goalposts were moved. But, in part at least, changes in guidance have reflected GFATM's willingness to modify its systems (Radelet and Caines, 2005). Nevertheless, high country transaction costs in preparing proposals and accessing GFATM funds is beginning to impair implementation of other donor-funded programmes (Lele U. et al, 2005).

However, GFATM is showing greater willingness to tailor requirements to countries. In Zambia, the GFATM reporting cycle has been adjusted to fit country monitoring periods, and GFATM is moving towards joining the SWAp. But much more needs to be done to reduce the general burden of GFATM bureaucratic processes, consistent with proper accountability. GFATM has outlined possible proposals for a new business model; pilots are to take place in Zambia and Swaziland (Radelet and Caines, 2005).

The bulk of the commentary in studies relates to a limited number of sizeable global health partnerships and initiatives: GFATM, GAVI, RBM, the Stop TB Partnership, the constellation of HIV/AIDS programmes, and the Global Polio Eradication Initiative (GPEI). The GPEI evaluation, for example, felt that GPEI has been too costly, diverted resources from routine services, and failed to give enough added value to health services despite benefits going beyond eradication (WHO, 2002; Daniels D. et al, 2001).

By contrast, the problems described above are seen as less of an issue with the smaller-scale GHPs for mainly localised 'neglected diseases' (eg Schistosomiasis Control Initiative, African Program for Onchocerciasis Control, Global Alliance for the Elimination of Lymphatic Filariasis etc). These GHPs 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 (Caines K. and Lush L., 2004). With the encouragement of the Gates Foundation, detailed practical work is currently underway to secure greater integration of GHP programmes for schistosomiasis, lymphatic filariasis, trachoma, onchocerciasis, intestinal helminths, and the micronutrient initiative, in countries where they are co-operational.

3.4 Harmonisation and alignment

Much of the global debate in 2003-5 around GHPs and development assistance more broadly has been about the need for harmonisation and alignment of aid instruments at the country

level, to reduce the burden on countries from multiple, parallel financing, planning, management and reporting systems.

At the country level, the synergy among the various GHPs, and between them and the activities of the traditional international organizations, remains weak even when there is scope for complementarity, and the various sources of assistance are not well coordinated. For example, duplication in planning and resourcing HIV/AIDS control undermines the Three Ones concept: one overarching national HIV/AIDS framework, one national coordinating body, and one monitoring and evaluation system. However, Brugha argues that, rather than being a feature of the GFATM *per se*, this reflects a longstanding failure to operationalise HIV/AIDS control through national AIDS councils (Brugha R., 2005).

Lele et al. (2005) suggest that, while some individual programmes have been quite successful in achieving their objectives and even in building disease specific capacity (as in the case of TB), synergy among the programmes could be improved by:

- Exploiting economies of scale and scope in dealing simultaneously with more than one disease
- Improving coherence between the activities of GHPs and those of key international institutions, such as the World Bank and World Health Organization (WHO).
- Developing complementary policies, strategies, and investments - in such areas as research and development, country capacity, prevention and treatment, drug procurement and distribution, and pricing and subsidies - to enhance the effectiveness of the disease-specific global programmes.

They recommend that WHO, strengthened with higher core funding, is best placed to take the lead in securing greater coherence and coordination at both the strategic and the country operational level, especially among the three core organisations: WHO, the World Bank, and GFATM. They see a natural division of labour, with WHO setting standards and providing technical assistance, the World Bank providing assistance for system-wide policy planning and capacity building, and GFATM providing large-scale funding. The World Bank should become more proactive in building country-level health system capacities and coordinating the activities of bilateral donors in this field. GFATM should scale up its support for country-wide disease-specific strategies supported by other donors, without weakening its laudable approach of directing funding in response to performance (Lele U.et al, 2005).

Brugha notes that by late 2004, some of the major GHPs were recognising the need for harmonisation to be driven from the top down – a point reiterated at the December 2004 High-Level Forum on the Health MDGs in Abuja and at the March 2005 meeting in London on the Three Ones. Harmonisation should not be left to countries to try to achieve bottom-up, in the face of uncoordinated global initiatives (Brugha R., 2005).

At the same time, given the sheer number of all GHPs, there may be scope to rationalise some 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[9]. 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 (Caines K. et al, 2004).

The December 2004 meeting of the High-Level Forum on the Health MDGs noted progress in improving practice regarding GHP alignment with national systems.

This includes a recent GFATM agreement to channel funds through the budget. Mozambique is the first country where GFATM is participating in a SWAp. In the process, the GFATM Secretariat has been pragmatic and willing to take some risks, albeit not always quickly[10].

[9] For example, target dates for eradication of guinea worm (GWEP) and elimination of leprosy (GAEL) and maternal and tetanus (MTNE) are 2005; APOC plans to phase out by 2010 following elimination of onchocerciasis in Africa. Caines K., *GHP Study Paper 4: GHPs and Neglected Diseases,* DFID Health Resource Centre, 2004.

[10] For example, the GFATM waived assessment requirements as preconditions for disbursing to the Mozambique SWAp, given partners' close oversight of SWAp mechanisms, and made the first major disbursements (in December 2004) despite an adverse

The Clinton Foundation has also agreed that their funds would be channelled through the SWAP in selected countries, but other global heath initiatives such as PEPFAR and MAP are precluded from doing so.

Brugha argues that the focus now, in the face of a complex donor architecture, is on a common financing framework as an integral element of a common national framework, given the diverse range of potential and actual implementing agencies, public and private, rather than on a single financing instrument (UNAIDS, 2004). While some donors might see this as a 'rowing back' on SWAps, it can also be seen as an effort to get the different financing instruments to adopt the principles of a SWAp (Brugha R., 2005).

Studies note the weak strategic link between the country level assistance of bilateral donors and their contributions to GHPs (Lele U. et al, 2005; Brugha R., 2005). Some country-based donor agency staff feel there is a lack of congruence between the stated commitment of their agencies to supporting SWAps and donor support to the GFATM.

3.5 Health system issues

Lele et al. find that the predominantly single disease focus of GHPs has fuelled the 40-year old debate about the merits of mass campaigns versus general health services programmes, although a consensus now seems to have emerged that each approach has its own merits and weaknesses and the two need to be seen as mutually complementary.

Some of the potential positive impacts of disease-specific programming include: increased political awareness of specific diseases; augmented financial resources to combat the diseases; aid coordination around the disease-specific approach; development of disease-specific strategies; mobilization of cutting-edge technical knowledge from diverse sources; efforts to address issues of disease-specific global drug supply, distribution, and pricing; promoting global networking among professionals; development of technical guidelines and performance indicators; improved surveillance; support for epidemiological and operational research; disease-specific planning and implementation, monitoring and evaluation, education, and training of professionals; and the development of incentive systems.

Negative impacts include competition among different disease-specific programs for the same resources; a lack of effort to develop single-purpose staff into multipurpose health workers; a failure to build up the capacity of developing country health systems to the point where they can sustain the achievements of the disease-specific campaigns; fragmentation of multipurpose health services; distorted allocation of scarce human and financial resources and distorted incentive systems; and lack of evidence on the cost effectiveness of different disease-specific approaches.

To make the most of the opportunities provided by the GHPs, almost all developing countries require help in building the capacities of their health systems. Lele et al find that, while successful disease specific GHPs help build capacity for control or eradication of those diseases, they do not always take into account some of the generic, system level issues that need support. Such items include human capital development, overall drug and vaccine procurement and distribution systems, or the development of the laboratory capacity that can serve more than one disease. Carlson (2004) concludes that past GHP contribution to health system strengthening appears to have been little more than marginal, though there are some examples, eg GAVI's unfettered ISS funding for system support; some investment in training, for example GAVI's financial sustainability workshops; Stop TB and GFATM's support to expanding DOTS in India's national TB programme which has improved integration of NGO and private providers into the national programme and the health system generally.

Brugha cites a 2001 report by Kevany which argued that "PPPs generally choose to address the financial aspects of technical constraints ... (whereas) the failure to provide complete cover with basic health care in poor countries is the result of a wide range of political, managerial, financial and technical constraints that vary from country to country. … As long

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recommendation from the LFA. Radelet S. and Caines K., *The Global Fund to Fight AIDS, TB, and Malaria: Performance and Vision,* 2005

as (these) more complex constraints on the organisation and delivery of care remain un-addressed, the absorptive capacity of health systems and services is likely to remain limited, and thus frustrate the positive intervention of the PPPs" (Kevany J., 2001).

The December 2004 meeting of the High-Level Forum on the Health MDGs similarly notes that, without increased investment in human resources, financing, oversight, and other key health system functions, the resources mobilised by global partnerships are unlikely to achieve their full potential.

By providing competition, the new programmes have challenged the capacities of the World Bank, WHO, and UNICEF to deliver financial aid and technical assistance, and spurred these organisations to improve their own responses and procedures (Lele U. et al, 2005). Lele at el suggest that the World Health Organization offers the most potential to provide technical assistance to the health systems on a global scale. However, while demands on WHO of this nature have increased particularly since the establishment of GFATM, its regular budget has been flat. WHO has increased its reliance on temporary extra-budgetary resources from donors to fund activities on an ad hoc basis, but it cannot meet the growing demands. The World Bank has rapidly increased its financial assistance for communicable diseases, particularly HIV/AIDS and TB, but its assistance for the development of overall health sector capacity has grown only slowly. Overall, a larger share of support for health in developing countries has been provided in support of communicable disease control—in part in response to the growing need, but also because of the strong external advocacy in support of specific diseases.

Country work for the DFID study of GHPs (Carlson C, 2004) 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. The Global Fund Replenishment first meeting held in Stockholm in March 2005 has asked for a report on the effects of performance-based funding on weak systems and fragile states at their next meeting in June 2005.

3.6 Human resources

The studies provide scant data about the impact of GHPs on human resources. The argument turns in part on the historical experience that vertical initiatives (whether global or national) tend to cream off the limited human resources available, often using financial incentives and better conditions of service.

Brugha (2005) notes that, by 2003, it was clear to recipient governments and country NGOs that GHPs and other global initiatives channelling new funds to non-government implementers – NGOs and faith-based bodies – would have a major impact on human resource availability. NGOs who were to be recipients of GFATM funds reported that they were being expected to adhere to certain good practice principles, such as not 'poaching' public sector staff. However, Brugha judges that, given the pressure on global initiatives to show rapid results and the potential of some civil society organisations (especially faith-based organisations) to deliver them, migration of staff out of the public sector is likely to occur. A perverse effect of the channelling of funds to NGOs, at times treating them preferentially vis-a-vis the public sector, is the reported setting up of 'briefcase NGOs', with limited capacity and accountability, established primarily because funds are available.

He concludes that under-investment in human resources, i.e. providing countries with the tools but not allowing the public sector to employ the health workers to deliver them, will obstruct attempts to scale up disease control. Capping the flow of external assistance through the public but not the private sector is unlikely to be acceptable to global financing policy makers in the long-run, as the macroeconomic effects will be similar. More broadly, the contradiction in the advice from global policy makers to country ministries of finance and ministries of health, points to an inconsistency in the financial and social policy prescriptions coming from wealthy 'northern' countries.

Lele et al. (2005) agree that shortages of well-trained doctors, nurses, and health administrators are the principal bottleneck to more rapid progress in fighting communicable diseases, and recommend establishing programs across disease-specific programmes aimed at overcoming shortages of skilled and motivated professionals for the health system as a whole. Donors need to be willing to ramp up investments in health education and research institutes and to assist governments in funding adequate salaries for public health workers.

4: FINANCIAL AND ECONOMIC ASPECTS OF GHPs

This section draws heavily on a report by Mark Pearson (2004) which provides the most extensive recent examination of the financial and economic aspects of GHPs. All references are from that report unless otherwise shown.

4.1 Additionality

A principal aim of GHPs is to attract more, and more diversified, funding.

Pearson concludes that GHPs are beginning to deliver significant 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[11]. 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. Lele et al (draft 2005) agree that GHPs have mobilised large-scale new financing.

Assessing additionality is technically problematic, and the picture remains unclear. Brugha notes early evidence from his London School of Hygiene Tracking Study of the GFATM in four countries that the new global funds were enabling governments to substitute these for government funding (Brugha et al, 2004). Pearson finds little evidence of displacement (or fungibility) at country level – either by donors or by Governments, but suggests that the issue should be revisited since 2004 was perhaps too soon for such changes to be reflected in strategic plans and expenditure frameworks. The draft EC report on Global Funds and Partnerships (GFPs) in all sectors found no conclusive evidence of any global additionality, nor of global crowding out of additionality (Delcour L., 2005). It notes the GFATM's emphasis that some of their major donors have provided contributions from non-aid budget sources, eg Italy uses the health section of its national budget rather than its aid section to finance about 90% of its contribution to GFATM. At the same time, the EC report finds a significant degree of country additionality for GFP beneficiary countries.

In general, GHPs have not achieved their aim of 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 in funding GAVI/Vaccine Fund.

There is little clarity about GHP funding needs or 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.

4.2 Stability and sustainability

Despite the new resources, GHPs alone will be insufficient to provide countries with the financial means required to deliver a reasonable package of basic health services. Paradoxically, at the same time, Pearson argues that the very size of the financing GHP funds poses major challenges in terms of:

- the fit of GHP funds with MTEFs and national macro-economic policies, and 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.

He suggests that volatility in flows rather than the magnitude of support is the key factor In terms of macroeconomic stability. Brugha (2005) notes that poor predictability of levels and timing of external aid flows has a detrimental effect on planning and resource allocation in recipient countries, and that disbursement delays have been a feature of the GFATM (and MAP).

[11] Increases in real donor spending on health and population have been of the order of 3% per annum since 1975 (Pearson, 2004).

Although the financing GHPs are relatively minor in terms of overall public funding for health, they do significantly add to existing resource flows in a number of countries. Other health initiatives such as PEPFAR and MAP will intensify sustainability and dependence concerns. Possible inputs from the GFATM, GAVI, GPEI, PEPFAR and MAP alone could double overall health spending (already highly dependent on aid) in 10 countries, quadruple it in Ethiopia, and increase it by a half in a further 25 countries. Pearson concludes that there is little, if any, chance that many low-income countries will be able to meet ongoing costs themselves if GHPs' funding ends as planned after a 5-year period and the GHPs embark on programmes to expand coverage.

These pressures will vary by disease. According to the 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 the polio eradication initiative – and do little to offset these increasing funding needs. GFATM has prepared papers on funding needs for its 2005 replenishment process, but still needs to ensure coherence between methodologies for calculating needs and consistency in shared issues, e.g. health systems requirements.

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. Pearson argues that 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.

4.3 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. The extent to which this potential is translated into reality will depend on a number of factors, including health system capacity and disease prevalence. 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 (eg procurement savings provided by the Global Drug Facility in the case of the Stop TB Partnership, (Caines K. et al, 2003)). One principle shared by many GFPs is a light-touch view of administration, though several studies[12] suggest that such lean administrations could be unsustainable over time, given increasing workloads. GFATM's small secretariat creates heavy staff burdens and difficulties in communication and follow-through; the limited cadre of country portfolio managers has been of particular concern (Radelet and Caines, 2005) and is now being increased. While the GFATM's own operating costs may be low, high transaction costs are incurred by developing countries and international partners in preparing proposals and accessing GFATM finance (Lele U. et al, 2005).

[12] For example, Delcour L., 2005; Pearson M., 2004; Caines K., N'jie H., 2002 .

ANNEX 1

FINDINGS ON SELECTED GHPs: GFATM

The Global Fund to Fight AIDS, TB and Malaria is the subject of significantly more commentary than any other GHP. This annex provides a brief summary of recent key findings. The title of a 2003 US GAO study (2003) encapsulates their overall message: "*GFATM has advanced in key areas but difficult challenges remain*".

1. GFATM progress

The GFATM made substantial progress in its first three years. Key findings include:

- a recognition of the potential of the GFATM as a radical new financial instrument to contribute to an exceptional response to tackling HIV/AIDS, TB and malaria.
- swift establishment of governance and other supporting structures, including the Board, the Secretariat, and the creation of CCMs in recipient countries (US GAO, 2003).
- early success in raising substantial funding. Most relevant studies find difficulty in judging how much is truly additional to amounts already programmed. One study concluded that a large part is clearly new money (Radelet S., 2004). It is the world's largest donor for TB and malaria (Radelet and Caines, 2005), and a much larger player than the World Bank in financing control of all three diseases (Lele U. et al, 2005).
- very rapid growth. In its first 2 years, the GFATM approved funding for over 220 programmes in 122 countries (Radelet S., 2004). Some timescales may have been too fast, eg countries were given only 6 weeks to submit their first round proposals (UNAIDS, 2002; Grace C., 2003).
- the introduction of new ways of doing business at country level: making aid performance-related; expecting countries to apply for aid and making them accountable for its use; broadening levels of participation in the application and delivery process; and monitoring and evaluating performance and progress. These have required new roles and relationships between traditional players at country level. Opening up large-scale access to international funds for non-state agents is seen as a strong GFATM feature in principle but in practice GFATM's record on that score is not strong (Lele U. et al, 2005).
- the GFATM's openness and willingness to learn and respond flexibly to country concerns (Radelet and Caines, 2005; Brugha R.et al, 2003).
- in one tracking study, governments and NGOs were most positive about the Global Fund, citing the new funding and the autonomy of a country-led process. Country representatives of bilateral donors supporting SWAps were sceptical about reverticalising health systems and forcing a diseases-specific approach (Brugha R.et al, 2004). There was some suggestion that bilateral donors have felt marginalized[13]. However, another early study suggested that aspects of GFATM operations were designed to ensure a good fit between the disease-specific focus and the broader health care system (Bennett S. and Fairbank A., 2003).

2. GFATM Performance to date (end 2004) (Radelet and Caines, 2005)

Generating financial resources, grant processing and disbursements

- GFATM attracted pledges of $5.9 billion and contributions of $3.3 billion (33% from the U.S and 14% from the E.C.).
- GFATM approved 310 grants in 127 countries, committing $3.1 billion for the first two years.
- It signed $2.1 billion (67%) in formal agreements, and disbursed $878 million (equivalent to 28% of commitments and 42% of signed agreements). One study called GFATM's disbursement record 'an impressive performance by any account' (Lele U. et al, 2005). By comparison, the World Bank's Multi-Country HIV/AIDS Program for Africa (MAP) -

[13] Brugha R et al, 2003. Plus draft discussion paper 18 December 2004, and individual case studies in the four countries.

initiated in 2000 - in its first 4.5 years has committed about $1.1 billion to 34 countries in sub-Saharan Africa and disbursed $376 million (34%).

- Nonetheless, grant processing time and disbursement speed have been major concerns.
    - The time from Board approval to grant signing dropped from 370 to 271 days between rounds 1 and 2, but grew to 300 days in round 3.
    - the average time from grant signing to first disbursement fell from 68 to 43 days between rounds 1 and 3. Non-government Principal Recipients (PRs) moved faster than others, averaging about one month faster than government PRs.
- Once disbursements started, broadly speaking they were on track: on average 50% was disbursed during the first 52% of the life of the grant. Disbursements were notably faster for non-government PRs. On average non-government PRs were about 3.5 months ahead of government PRs.
- Many countries report significant delays in disbursements from PRs to sub-recipients. The GFATM does not track these data. Some PRs take a long time to negotiate agreements with sub-recipients. Some governments do not have appropriate procedures and are reluctant to disburse to NGOs.

Grant performance and substantive results

- Cumulative results for the grant portfolio as of the end of 2004 include:
    - 130,000 people on ARV treatment for AIDS
    - more than 1 million people reached with voluntary HIV testing
    - 385,000 people treated under the DOTS TB strategy
    - 300,000 people received third-generation malaria drugs
    - 1.35 million families received insecticide-treated bed nets
    - 350,000 people trained to fight HIV, TB, and malaria.
- Of the first 27 grants to reach the 2 year grant renewal stage, 70% made adequate progress (9 grants) or better (10 grants); 22% (6 grants) were rated inadequate but with potential; 8% (2 grants) were rated unacceptable. Several countries exceeded expectations. For example, Rwanda's HIV/AIDS program administered VCT services to 110,400 people (115% of target), treated 7,284 people for sexually transmitted infections (130% of target), and put 4,115 patients on ARV treatment (232% of target).
- Performance was strongest for non-government Principal Recipients and more mixed for grants with government or UNDP Principal Recipients.
- Performance was particularly strong on TB grants, the distribution of bed nets, and some service delivery (PMTCT testing, VCTs, and orphans). ARV treatment was behind schedule for these first 27 grants, due mainly to procurement issues in Senegal and Uganda (similar issues have affected malaria drugs and bed nets), but according to the Secretariat, ARV performance for the overall portfolio exceeded targets.

3. Concerns and challenges

The many studies, mostly qualitative reporting country-level views, explore a range of concerns and challenges. The most important include:

- the financial sustainability of the GFATM, and the specific consequences for ARV and ACT treatment programmes of interrupted support.[14] Although resources generated to date are substantial, the challenge to fund grant renewals and new proposal rounds is greater. Global requirements for the three diseases are expanding dramatically: WHO estimates they will reach $14 billion in 2007.
- the Fund's Comprehensive Funding policy which limits the Secretariat to signing grants only if 100% of the funds are in hand. This very conservative approach is driven by GFATM's uncertain funding base and the desire to provide certainty to grantees, but it results in the Fund continuously holding cash balances of about $2 billion (Radelet and Caines, 2005). The Fund is reviewing this policy.
- delays in grant processing and disbursement, particularly compared with original expectations (see above)[15]. One factor was the need to establish untested systems for disbursing funds. The pace has accelerated, but there is ample room for improvement.
- lack of harmonisation and alignment with national processes and other donors, even where strong systems already exist. GFATM's structure, mandate, and focus on three diseases help focus its objectives and attract funds, but create difficulties in integrating with existing systems with different objectives, especially given its small secretariat and large number of client countries (Radelet and Caines, 2005). There has been widespread concern about the establishment of parallel processes[16]. One general study noted that, in most countries, either the Fund has very few (if any) partners to coordinate with, or existing reporting and monitoring systems are weak (Radelet S., 2004). The LSHTM tracking study of four SWAp countries found that government and donor representatives emphasised the importance of the GFATM supporting coordinated national strategies, but noted growing flexibility on the part of the Fund (Brugha R. et al, 2004).
- burdensome procedures, and a strong sense of the goalposts having been changed over time with some retrospective requirements. Studies suggest that the GFATM should minimise the burden of its reporting requirements in particular. For example, annual or biannual assessments of performance should replace quarterly reports as a basis for decisions on disbursement. Excessive reporting will be beyond the capacity of countries with weak systems which have greatest need of additional funds (Brugha R.et al, 2004). High country transaction costs in preparing proposals and accessing GFATM funds is now beginning to impair implementation of other donor-funded programme (Lele U. et al, 2005).
- inadequate attention to country context and health systems issues in the technical evaluation by the GFATM Technical Review Panel. Concerns also related to lack of transparency, and a perception that better packaged proposals win approval (Lele U. et al, 2005). An early study also recommended that increased focus should be given to issues of equity in the evaluation process (Grace C., 2003).
- some aspects of GFATM-specific architecture, especially the evolution over time of CCMs and LFAs, with some continuing confusion. These are crucial bodies given the GFATM's decision not to have local staff. One study (Kruse S., 2004) suggested that a national or regional GFATM representative – perhaps hosted by a multilateral agency – would not be likely to exceed the cost of the current LFA system.
- CCMs, which have been studied extensively. They are working well in some countries but not in many others (Radelet S.,2004). Rapid rolling-out of new structures without adequate and timely guidelines on CCM roles and operations led to confusion among some CCM members (Brugha R. et al, 2004). Studies note concerns about legitimacy, especially in comparison to national AIDS councils; size, representation and appropriate skills for the task; ineffective representation of line ministries other than health, undermining intersectoral coordination; government dominance; the uneasy fit of CCMs with national AIDS councils. CCMs have been involved in proposal preparation, though in

[14] GFATM Board papers; Radelet S., 2004
[15] Several studies, for example Brugha R et al, 2004.
[16] In many reports, including: UNAIDS, 2002; Grace C., 2003, and the Brugha et al GFATM tracking studies, 2003

some cases nominally. But an immediate concern is that CCMs are not seen as well-placed or equipped to carry out their role in overseeing implementation[17]. NB Brugha notes a longstanding failure, unrelated to the GFATM, to operationalise HIV/AIDS control through national AIDS councils, undermining the 'Three Ones' concept.

- LFAs. The cost of LFAs amounted to 31% of Global Fund operating costs in 2003 and an estimated 42% in 2004, where overall GFATM operational expenditure is judged to be low compared with total funds committed. The continuing growth in GFATM activity will increase future reliance on LFAs in project appraisal and monitoring. There are concerns about LFAs' weakness in some technical expertise (eg in procurement and health monitoring and evaluation). So far most performance has been assessed on relatively simple indicators, but LFAs will need to assess more complex programme indicators as implementation gets fully underway (Kruse S., 2004).
- a critical lack of an institutional mechanism to link assessments with technical advice and remedial action. "Most LFAs do not share reports with CCMs and PRs, and the Global Fund were not found to release the assessments. In practice, they were not available to technical partners" who could support countries (Kruse S., 2004). GFATM's reliance on partners to play complementary roles has created unforeseen pressure on those agencies to devote resources and adjust their own systems (Radelet and Caines, 2005).
- wider complaints of weak communications between most sets of players involved[18].
- how best to design and operate a robust performance-based system that judges performance fairly and provides appropriate incentives. Substantial progress has been made in establishing a transparent performance measurement framework (eg GFATM, WHO, UNAIDS, UNICEF, the World Bank, and several US agencies have jointly developed a "Monitoring and Evaluation Toolkit" with common indicators for the three GFATM diseases) but there is ample room for further improvement. GFATM needs to develop systems that are flexible enough for a range of country systems while maintaining comparability across countries. Similarly, partners must be willing to adjust their systems to accommodate GFATM's mandates. It is also not clear how the Board will react when countries achieve sub-par performance. This is an immediate issue given the review of Phase 1 performance on the first 100+ grants in 2005.
- One study concluded there are major tensions between GFATM's mandates to focus on the three diseases, measure performance, and show additionality while at the same time integrating and harmonizing with existing systems with different objectives. Balancing these tensions will require flexibility and commitment by both GFATM and SWAp partners. Radelet estimates these problems are currently important for relatively few countries: fewer than 20 of GFATM's 127 countries have SWAps, and the others require different approaches. At a broader level, GFATM needs to have the depth and flexibility to use different approaches in different countries, while still being able to compare results across countries (Radelet and Caines, 2005).
- the increasing complexity of the HIV/AIDS aid environment at country level (especially in relation to MAP and PEPFAR). This has created problems of coordination and capacity shortfalls (Brugha R. et al, 2004).

[17] Many studies including 20 country case studies initiated by the GFATM itself; Grace C., 2003; the various reports from the LSHTM tracking study cited above; UNAIDS, 2002; and other studies.
[18] For example, in Grace C., 2003

ANNEX 2

FINDINGS ON SELECTED GHPs: GAVI

This section draws heavily on a draft report for the International Task Force on Global Public Goods (Lele U., et al, 2005). All references are from that report unless shown. GAVI is assessed as having galvanised developing countries and several key international partners by stimulating a market for new vaccines and by bringing in additional resources, a performance orientation, and an immunisation delivery system that performs. GAVI's programmes have boosted immunization efforts, reduced child morbidity and mortality, improved project preparation and implementation capacity, and incorporated the use of new vaccines and technologies while increasing vaccine coverage. The key challenge will be to sustain increased immunization coverage using new vaccines when GAVI/Vaccine Fund support ends.

1. Key findings and conclusions include the following:

- GAVI provides support to immunisation programmes through the Vaccine Fund in the form of in-kind support for the introduction of new vaccines, in-kind and cash contributions for injection safety, and cash contributions for immunisation services support (ISS). A 2005 review of ten global programmes rates GAVI strongly in terms of outputs, outcomes, transparency, performance management, pro-poor political impact, local capacity building and effective non-government participation (Montes C., 2005).
- Since establishment in 1999, GAVI/Vaccine Fund have committed more than $1 billion to 69 developing countries and cumulatively immunised 30 million children. The Vaccine Fund is also financing the development of vaccines for rotavirus and pneumococcus.
- Routine immunisation is primarily supported through ISS funding. In order to be eligible for ISS grants, countries must have a per capita gross national income of less than $1,000 (which includes 75 of the world's poorest countries) and DTP3 coverage rates below 80 percent. An evaluation by Abt Associates (2004) found that, on a country by country basis, ISS funds appear to be related to modest improvements in performance.
- GAVI has contributed to introducing new and improved vaccines. As an example, it has sought to increase and accelerate the introduction of hepatitis B vaccine into EPI, to provide this vaccine to all infants in defined areas. It has also contributed to efforts to stimulate the market for new multivalent vaccines.
- To secure vaccine supply and price concessions, GAVI has enhanced 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. It has worked closely with the limited number of vaccine manufacturers, since many products are single-source or patented (Grace C., 2004).
- Awareness of injection safety has been fostered through use of auto-disposable syringes.
- GAVI links disbursements to performance, verifying immunisation reports through an externally-audited Data Quality Audit (DQA). First year ISS funding is investment funding. The final four years is reward funding contingent on both increasing the number of children immunised with DTP3 and achieving a DQA verification factor of 80%. However, immunisation data quality was a major problem in most of ISS evaluation case studies (Abt Associates 2004).
- The ISS evaluation found several positive changes related to financing of immunization programmes. Total funding for immunization had increased, total government funding for immunization had increased, and ISS funds had not replaced other funding in most countries. However, large gaps are expected once Vaccine Fund support ends (Abt Associates, 2004).
- Even with a considerable reduction in prices, the budgetary costs of the new multivalent vaccines are too high for most developing countries without continued predictable external assistance, or sacrificing other goals in the health sector.
- GAVI has informed countries that it is phasing out in 2006. Its partners have launched a global campaign through the International Financing Facility (IFF) to mobilize funding specifically for a program on immunization known as IFFIm.

ANNEX 3

FINDINGS ON SELECTED GHPs: THE STOP TB PARTNERSHIP

The 2003 external evaluation of the Global Partnership to Stop TB (Caines K. et al, 2003) found that it had established itself in a very short time as a widely respected global health partnership. A 2005 draft study report (Lele U., et al, 2005) also defines the Stop TB Partnership as one of the most successful global health partnerships, offering important lessons for global TB control, for application to other communicable diseases, and for effectively linking advocacy to financing mechanisms.

1. Progress and performance

- The Partnership scored some major achievements in its first three years. It built a broad network of partners; established a partnership architecture which commanded broad support; heightened political commitment and marshalled widespread commitment to a detailed Global Plan to Stop TB; made significant progress against TB, even in difficult environments; highlighted work on new diagnostics, drugs and vaccines which was critical but working to longer timescales; and swiftly operationalised widely appreciated new initiatives such as the the Green Light Committee for second-line TB drugs and a complex Global Drug Facility (GDF) covering grant-making, procurement and partner mobilisation for technical assistance for first-line drugs (Caines K. et al, 2003).
- The DOTS-based technical strategy it promotes is being implemented in 180 countries. DOTS coverage has been extended to areas with 69% of the TB-affected populations.
- The GDF has now provided first-line drugs for more than 1.9 million people in 49 countries. A 2003 external evaluation of the GDF by McKinsey and Company (2003) found that the cost of drugs was reduced by 30 percent to less than $10 per course of treatment.
- The perception of partners at the time of the full Partnership evaluation was that the Stop TB Partnership had added value to what they were already doing.

Lele et al. argue that this 'success story' has large potential for scaling up and for transferring learning to other programmes. Keys to Partnership success were:

- giving high priority to developing a shared global plan.
- developing concrete cost-effective DOTS-based approaches for diagnosis and treatment with detailed technical guidelines for implementation
- actively helping countries such as India and China to mobilize funding on attractive terms from the World Bank, UK's DFID, and other donors in support of the strategy.
- developing concrete realistic short-, medium-, and long-term objectives ranging from research and development to field implementation on a country-by-country basis.
- making available advice in the form of easily implementable and monitorable guidelines for treatment, together with free access to drugs and high quality technical assistance.
- establishing the Global Drug Facility [and Green Light Committee], and working closely with countries to take advantage of World Bank loans and credits and GFATM funds.

2. Concerns and challenges[19]

- Controlling TB has become more complex due to TB as an opportunistic infection of HIV/AIDS; multi-drug-resistant strains of TB; and sizeable gaps in funding for DOTS implementation, the GDF, and work on new diagnostics, drugs and vaccines.
- Implementation of collaborative TB/HIV activities at the country level is slow in relation to the accelerated pace of the epidemic.
- Containing new outbreaks and eradicating TB are multisectoral challenges. The Partnership has thus far focused more on treatment than on removal of root causes, many of which relate to poverty, nutrition, ignorance, and stigma.

[19] Among others, Lele U. et al 2005.

ANNEX 4

FINDINGS ON SELECTED GHPs: ROLL BACK MALARIA (RBM)

Monitoring and evaluation data are weak on the outcomes and impacts of the Roll Back Malaria Partnership. Even so, there is considerable consensus among recent studies[20] about RBM's approach and performance. RBM has increased global awareness and political support, and has helped mobilise greater funding in support of malaria prevention/treatment/ control, particularly from the Global Fund. But it has been less successful than the Stop TB Partnership in engendering concrete strategies at the country level and has had very little impact on malaria outcomes in malaria-endemic countries. In general, progress against malaria has been slow, particularly in Africa.

1. Key findings and conclusions include the following:

- The 2002 external evaluation of RBM (Feachem et al, 2002) contrasted initial ambitious programme goals of reducing the malaria burden by 50% by 2010 with the absence of clear, monitorable, realistic objectives; lack of clarity in the responsibilities of the individual partners; slow progress in achieving country-level buy in, insufficient political mobilization, inconsistent quality of technical advice and the lack of country by country operational strategies to achieve the goals. It found partner responses wanting and stressed the importance for RBM of developing concrete focused operational plans by working with them.
- A 2004 World Bank review (Lele U.et al, 2004) finds that RBM has been restructured substantially on the basis of the evaluation recommendations. RBM now has a clearer strategy, a focus on selected countries and a stronger governance structure, with clearer roles, responsibilities and accountabilities between the board, secretariat, working groups, regions, and with more focused participation of "beneficiary countries" in its governance. The roles of WHO and those of the partnership are being clarified, and a Malaria Medicines and Supplies Service (MMSS) is being established. RBM is encouraging the development of new malaria drugs, diagnostics, and vaccines, in conjunction with others. It is working more than before at the country level and trying to learn more about and disseminate best practice. It is exploring with the Global Fund and others how ACT can be purchased in sufficient quantities and at reasonable prices.
- Nevertheless, the review concludes that weaknesses remain. At country level, there is more agreement on what strategy to follow on malaria than how to apply the instruments RBM promotes in practice on the ground. Assessing where malaria is being effectively controlled, why and what its transferable lessons for other countries are warrants more and better interdisciplinary, multisectoral, on-the-ground empirical research than seems currently supported to promote effective actionable control and eradication strategies.
- RBM spent much of its early years advocating more attention to malaria worldwide. The various country case studies share common findings that RBM appears to have had limited impact at country level. The DFID study (Sierra Leone, Uganda and India) found that RBM had the lowest profile of all the partnerships (Carlson C., 2004).
- Brazil, Eritrea, and India are among the few countries that have successfully controlled malaria. Lessons from these countries may hold relevance for the design of RBM's operational approaches. Lele et al advise the factors underlying success in these countries have also applied in the case of the TB control programmes and accord with what is needed for HIV/AIDS strategies to succeed on the ground (Lele U.et al, 2005).
- The current need is to focus on country capacity building. GFATM experience suggests that the World Bank and WHO can play an active role in institutional and technical capacity building (Lele U. et al, 2005).

[20] These include a 2002 external evaluation of RBM, a 2004 World Bank Operations Evaluation Department Global Review, a recently issued World Bank Malaria Strategy paper, a 2004 DFID Review of Global Health Partnerships and the 2005 draft paper for the International task Force on Global Public Goods.

ANNEX 5

DEFINITIONS

Definition of a Global Health Partnership

Brugha (2005) notes that the rapid emergence of a plethora of new global partnerships focusing on disease control has been associated with a sometimes confusing array of terms for these new entities: Global Health Partnerships (GHPs), Global Public Private Partnerships (GPPPs), Public Private Partnerships for Health (PPPH), Product Development Public Private Partnerships (PD PPPs) and Global Health Initiatives (GHIs).

Brugha follows the approach of the DFID studies which use the term Global Health Partnership and define the concept in a broad manner (Buse K., 2004).

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 (eg this definition includes APOC – the African Programme for Onchocerciasis Control – as a GHP addressing a neglected disease, though technically it operates only within Africa rather than globally).

The World Bank, and Lele et al in their study for the International Task Force on Global Public Goods, use the term 'global programs' which are defined as 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 (World Bank, 2002).

Typologies of Global Health Partnerships

A number of typologies have been suggested for classifying the different GHPs.

For example, Widdus & White (2004) categorise Public Private Partnerships for Health (PPPHs) as (1) product development, (2) improving access to health products, (3) global coordinating mechanisms including funding vehicles, (4) strengthening of health services, (5) public education and advocacy, (6) regulation quality assurance & standards.

The simplified typology adopted by Brugha (2005) categorises GHPs as 'product development,' 'product access' and 'systems focused'. Global Fund and GAVI as seen as 'systems focused' partnerships, as it is at the health systems level that they interface with activities at the recipient country level.

DFID, and Caines et al., propose four categories of GHPs:

i) Research and Development: includes GHPs that are involved in product discovery and development of new therapies (vaccines, treatments etc.);
ii) Technical assistance/service support: includes GHPs that provide drug donations, support improved service access and give technical assistance;
iii) Advocacy (national and international levels): includes GHPs who advocate for increased international and national response to specific diseases, who fund-raise for specific control programmes etc.
iv) Financing: includes GHPs who provide funds for specific programmes (not as donations) (Caines K. et al,2003).

Whichever the typology, some GHPs may span a number of categories. For example, GAVI aims to stimulate vaccine development, increase access to vaccines and strengthen health vaccine delivery systems.

Definition of a Global Public Good

Lele et al. (2005) define *public goods* as being distinguished from private goods by non-rivalry and non-excludability. Non-rivalry means that many people can consume, use, or enjoy a public good at the same time: one person's consumption does not reduce the benefits that others can derive from consuming the same good at the same time. Non-excludability means that it is difficult to exclude from consumption those who do not pay for, or otherwise contribute to, the cost of supplying the good.

Global public goods are distinguished from national and local public goods by their reach. Their public characteristics of non-rivalry and non-excludability spill across national boundaries. People in more than one country can benefit from the provision of a global public good, whether or not they contributed to the cost of supplying the good. For national and local public goods, however, only those who live in a given country or in a given locality can benefit from the provision of these goods.

They note that in the health sector, there is considerable ambiguity on what constitutes a public good, and even more ambiguity about what constitutes a global public good, since the definition also depends on the level of development, technological options, and social choices. The fight against communicable diseases, for example, requires important investments in global public goods, beyond the means or incentives of any single government and beyond the sum total of national-level programs in activities such as global surveillance, information and knowledge that international institutions such as WHO perform, but that are developed at the national level and aggregated (WHO 2001). Similarly, scientific knowledge, which enables the production of medicines and vaccines, is a global public good. So are the international trade rules that determine prices at which drugs and vaccines are available to developing countries.

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