
DFID
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GHP Study Paper 5:

**GLOBAL HEALTH PARTNERSHIPS
INCREASING THEIR IMPACT BY IMPROVED GOVERNANCE**

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

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ACRONYMS

CM	Constituency Management
CSR	Corporate Social Responsibility
DFID	Department for International Development
DNDi	Drugs for Neglected Diseases initiative
ESAC	Expert Scientific Advisory Committee
GAEL	Global Alliance to Eliminate Leprosy
GAELF	Global Alliance for the Elimination of Lymphatic Filariasis
GAIN	Global Alliance for Improved Nutrition
GATBDD	Global Alliance for TB Drug Development
GAVI	Global Alliance for Vaccines and Immunization
GDF	Global TB Drug Facility
GHP	Global Health Partnership
GPEI	Global Polio Eradication Initiative
GWEP	Global Guinea Worm Eradication Program
IAVI	International AIDS Vaccine Initiative
ITI	International Trachoma Initiative
IUATLD	International Union Against Tuberculosis and Lung Disease (UNION)
KNCV	KNCV Tuberculosis Foundation
LMIC	Low- and Middle-Income Countries
MDG	Millennium Development Goals
MDP	Malaria Donation Program
MEC	Mectizan Expert Committee
MI	Micronutrient Initiative
MIM	Multilateral Initiative on Malaria
MIP	Meeting of Interested Parties
MMV	Medicines for Malaria Venture
MOU	Memorandum of Understanding
MVI	Malaria Vaccine Initiative
PPP	Public Private Partnership
R&D	Research and Development
RPRG	Regional Programme Review Groups
SAB	Strategic Advisory Board
SAC	Strategic Advisory Council
SCI	Schistosomiasis Control Initiative
STBCB	Stop TB Coordinating Board
Stop TB	The Global Partnership to Stop TB
TA	Technical Assistance
TAG	Technical Advisory Group
TEC	Trachoma Expert Committee
TOR	Terms of Reference
TP	Technical Panel
TRC	Technical Review Committee (of GDF)
UNICEF	United Nations Children's' Programme
VF	Vaccine Fund
WC	Working Committee (of STOP TB Partnership)
WHA	World Health Assembly
WHO	World Health Organization
WPSS	WHO Programme to Eliminate Sleeping Sickness

ABBREVIATIONS

APOC	African Programme for Onchocerciasis Control
BPD	Building Partnerships for Development
CCM	Country coordinating mechanism
CCPP	Child Care Partnership Project
CEO	Chief Executive Officer
DAC	Development Assistance Committee (OECD)
DETR	Dept of the Environment, Transport and the Regions
DFID	Department for International Development
DJSI	Jones Sustainability Index
DOTS	Directly Observed Therapy, Short Course
EPI	Expanded Programme of Immunization
GAEL	Global Alliance to Eliminate Leprosy
GAELF	Global Alliance to Eliminate Lymphatic Filariasis
GAIN	Global Alliance to Improve Nutrition
GAVI	Global Alliance for Vaccines and Immunisation
GDF	Global TB Drug Facility
GFATM	Global fund to fight AIDS, Tuberculosis and Malaria
GFP	Global Funds and Partnerships
GHP	The Global Health Partnership
GPEI	Global Polio Eradication Initiative
IAMI	International AIDS Vaccine Initiative
ICC	Inter-agency Coordinating Committee
IDA	International development association
IMCI	Integrated Management of Childhood Illness
IMO/Pieca	International Maritime Organisation / International Petroleum Industry Environmental Conservation Association
ITI	International Trachoma Initiative
M&E	Monitoring and evaluation
MIM	Multilateral Initiative on Malaria
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSC	Maritime Stewardship Council.
MTEF	Medium Term Expenditure Framework
NGO	Non-Governmental Organisation
NID	National immunisation day
OCP	Onchocerciasis Control Programme
PEI	Polio Eradication Initiative
PEPFAR	President's Emergency Program for Aids Relief
PEST	In text already
PPP	public-private partnerships
PRSP	(Interim) Poverty Reduction Strategy Paper
RBM	Roll Back Malaria
SMART	Specific, Measurable, Achievable, Realistic and Time-Bound
SWAP	Sector Wide Approaches
TA	Technical Assistance
TDR	Tropical Disease Research
TOR	Terms of Reference
WEF	World Economic Forum
WHA	World Health Assembly
WHOEB	WHO Executive Board

EXECUTIVE SUMMARY AND RECOMMENDATIONS

Governance concerns how an organisation steers itself. This report explores the manner in which 19 DFID-selected Global Health Partnerships (GHPs) are governed – in relation to a number of good governance criteria – and the manner in which GHPs are accountable to the international health architecture. It is based on a mixture of secondary source material on these, and other, GHPs as well as interviews and primary sources.

The target GHPs are a heterogeneous group and only five of them have been subject to an evaluation which explicitly considered governance. Consequently it is **recommended** that future evaluations of other GHPs address organisational and governance issues – particularly those GHPs which operate as legally independent entities (see below).

Although it is axiomatic that shared goals and objectives and clearly defined roles and responsibilities are pre-requisites of effective partnership, this principle is routinely violated in GHPs. It is **recommended** that strategic, operational and business plans, with clearly defined roles and responsibilities of all major partners, are developed (or there are plans to develop them) and periodically reviewed as a criterion for DFID engaging with particular GHPs.

One review of GHPs identified five distinct organisational arrangements – arguing that the appropriate model would depend on the purpose of the alliance among other factors. The target GHP sample contained just two of these types, both of which are at the more formal end of the spectrum. For purposes of this report, these are referred to ‘hosted’ (i.e., by another organisation, be it a multilateral such as UNICEF or a non-governmental organisation such as PATH) and ‘independent’ (i.e., have their own legal identity) GHPs. It may be the case that some of the smaller target GHPs may have been better served by looser arrangements without elaborate secretariats.

There are significant differences between these two types of organisational models with benefits and disadvantages to each. Independent GHPs have considerable independence from parent organisations, decision-making bodies with substantial authority over the secretariat, and clear lines of accountability, but take longer to establish and are more costly to operate. Hosted GHPs are more heterogeneous – depending on the host and the size of the partnership. While they can be set up quickly and have access to a range of resources in the host (in WHO this includes access to technical expertise), some of the smaller GHPs fail to have governing bodies with significant authority, secretariats are often more accountable to the host than to other partners, hosts often dominate, and there tends to be identity confusion between the host and the GHP secretariat.

There has been much debate over the relative pros and cons of WHO hosting arrangements. And although many GHPs have benefited in important ways from this arrangement with WHO, many have been plagued by highly problematic relationships. As a result, GAEL has been disbanded and the GAELF secretariat has migrated away from WHO. By contrast, the evaluation of the Stop TB Partnership concluded that the location of the Secretariat in WHO benefits both parties, despite the administrative frustrations. WHO has recently begun to grant some GHPs exemptions from specific rules so as to address recurring problems. Reforms include formal bifurcation of accountability of the Executive to WHO and to the GHP board; engagement of GHP partners in selecting the Executive Director; and clearer differentiation between WHO technical contributions to the GHP and the WHO-hosted secretariat of the GHP. It is **recommended** that DFID support a process to identify additional rules and regulations which could be modified to provide greater flexibility for WHO-hosted partnerships – while respecting the principles and accountability of the Organisation.

Accountability is concerned with the extent to which, and manner through which, those with

authority can be held responsible for their decisions and actions. In relation to GHPs, accountability can be considered in relation to that of Executive to the partners; of the partners to the partnership; of the GHP to stakeholders and constituencies; and of the GHP to the global health architecture. The accountability of the Executive to partners is unproblematic in independent GHPs, but has posed considerable challenges in some hosted ones. Getting partners to deliver on commitments represents a challenge to many GHPs. This is partially explained by poor specification of roles and responsibilities but more importantly as a result of the horizontal and voluntary nature of these relationships. A number of mechanisms to encourage this form of accountability are outlined in this report, with consolidated work planning showing most promise. It is **recommended** that DFID support these initiatives by advocating and participating in them, and by providing technical assistance (TA) to the processes and their evaluation (including comparative analysis and lesson learning). If proven successful, DFID may consider adopting coordinated approaches to consolidated partner work planning and review as a criterion for its engagement with GHPs.

Certain groups continue to be under-represented in GHPs – particularly Southern governments, civil society and private-for-profit sector interests. It is **recommended** that DFID's engagement strategy consider the accessibility of all affected groups to participation and representation in board decision-making. Where shortcomings are evident in relation to the non- or under-representation of key stakeholders, DFID should initiate discussions to adopt one of the strategies outlined in the report to enhance representation. A complementary approach consists of improving the processes through which constituencies are managed, so as to increase the two-way communication between Board members and their constituents. It is **recommended** that DFID support nascent efforts to improve constituency functioning in the form of TA and lesson-learning through comparative analysis.

Timely access to relevant information, about decision-making processes and substantive information on the matter under consideration, is essential to hold an organisation to account. Information is similarly required to enable participants and stakeholders to make meaningful contributions to deliberations. Open and effective communications are particularly critical to create trust in dispersed organisational forms, such as partnership, and trust is critical to partnership functioning. The level of transparency varies considerably across GHPs but is uniformly poor in relation to a number of criteria. The following information should be freely available through the Internet: (1) strategic and annual plans and budgets; and (2) Board meeting agendas, background papers and subsequent decisions; (3) governance arrangements including mandates, membership and processes of decision-making bodies; (4) detailed information on how constituencies are managed; and (5) annual performance reports against objectives. It is **recommended** that DFID include transparency among its criteria for engaging with GHPs.

Screening potential partners for good corporate practices is both a tool to exercise due diligence and a potentially powerful mechanism to leverage the influence of development cooperation organisations to change the behaviour of firms in ways that support development aims. Few GHPs have adopted the practice of corporate screening. It is **recommended** that DFID consider advocating wider use of corporate screening among GHPs to realise its development objectives.

In light of the governance challenges faced by GHPs, it is **recommended** that DFID should encourage and support efforts, such as establishing GHP Board standing committees, aimed at reviewing and engineering appropriate governance structures in GHPs.

Formal vertical accountability of GHPs does not exist beyond their governing bodies and hosts, in part because of resistance to the idea and in part due to the apparent lack of appropriate institutions to provide a locus for such accountability. Instead, a number of ad hoc

mechanisms, mainly horizontal and voluntary in nature, are being developed to improve coordinated priority setting and action among GHPs and with relevant global programmes. It is **recommended** that DFID support these initiatives but also initiate a dialogue among concerned actors on the issue of the accountability of GHPs to the global health architecture.

1 INTRODUCTION, BACKGROUND & AIMS

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

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

A significant proportion of the GFPs with which DFID engages are concerned with health issues. The Global Health Partnership (GHP) Team within the Aid Effectiveness Group has therefore commissioned a substantial, evidence-based assessment of the impact of the GHPs with which DFID engages at both global and country level, drawing out best practice principles which will guide DFID's future engagement. For a report on the wider study see Caines (2004). For the purpose of this exercise, and in common with the wider study, a broad definition of a GHP was adopted which encompass collaborative relationships among multiple organisations in which risk and benefits are shared in pursuit of a shared goal, wherein the goal concerns redress of health problems of significance for the poor in low- and middle-income countries, and which extend across or transcend national boundaries (Buse 2004a). The review was confined, at the request of DFID, to a group of 19 GHPs on the basis of significant DFID involvement in these initiatives (see Annex One).

As a component of the wider review process, DFID is interested to learn about how GHPs are governed, lessons in relation to good and bad governance practices, and what measures can be undertaken to improve the governance of the initiatives in which DFID is engaged. DFID was particularly interested in:

- The differing structures for the governance of GHPs;
- The extent to which GHP exhibit open and transparent governance; and
- The extent to which GHPs are accountable to international health governance structures;

While the first two topics are relatively straight forward, the third raises major questions concerning the appropriate global architecture for cooperation on health. This review focuses on a narrower task based on culling evidence from the existing literature, evaluations and expert opinion on the following governance issues (which are further specified in a Terms of Reference – Annex Two):

- 1 Clarity on aims, goals, objectives and roles and responsibilities;
- 2 Organisational arrangements – particularly legal status and governing bodies;
- 3 Representation and participation in governing bodies, with specific reference to:
 - o Developing country governments;
 - o Civil society;
 - o Commercial sector; and
 - o Mechanisms for constituency development, facilitating participation and representation of developing countries and civil society organisations
- 4 Accountability, with specific reference to:
 - o Secretariats to Boards and hosting organisations;
 - o Partners to partnership
 - o Partnership to the relevant international health architecture (e.g., World Health Assembly (WHA) and relevant global programmes) and stakeholders;
- 5 Transparency: using the proxy indicator of Internet availability of relevant information;
- 6 GHP oversight: using proxy indicators of policy and practice of screening companies for corporate social responsibility, as well as independent and external auditing.

2 METHODS AND OBSERVATIONS ON THE LITERATURE

The report is based on a limited number of interviews with key opinion leaders (the latter selected on basis of expedience and availability) (Annex three), email communication with staff in a number of target GHP secretariats (purposefully selected), a review of the literature, a synthesis of GHP evaluations and progress reports – some of which were external (Annex four), and a review of the Internet sites of the target partnerships (to assess transparency).

A number of GHP evaluation reports touch upon governance within the partnership but only five of the target GHPs have been subject to assessments/reviews which deal specifically or substantially with organisational arrangements. These are:

- International AIDS Vaccine Initiative (IAVI) (Skolnik et al, 2003a);
- Global Alliance for Vaccines and Immunization (GAVI) (Caines et al 2002);
- The Global Partnership to Stop TB (Stop TB) (Caines et al, 2003);
- Roll Back Malaria (RBM) (Feachem et al, 2002);
- Global Alliance to Eliminate Leprosy (GAEL) (Skolnik et al 2003b);
- In addition, an in-depth evaluation of the Global Drug Facility (GDF), a sub-component of Stop TB, has been undertaken (McKinsey 2003).

The paucity of evaluations may arguably be the result of the fact that a number of these GHPs have been established within the past five years -- but that is not universally the case. Consequently, there are grounds to **recommend** that more of the GHPs be reviewed in light of their governing arrangements (perhaps around 2-3 years after they have been established) and in particular those partnerships which exist as legally independent entities, for example, the International Trachoma Initiative (ITI) or Medicines for Malaria Venture (MMV), and those hosted by Non-Governmental Organisations (NGOs), for example, the Global Guinea Worm Eradication Programme (GWEP) or Malaria Vaccine Initiative (MVI), which have not been subject to evaluation.

In relation to comparative analyses of GHP governance and organisational arrangements, this review found three reports particularly informative – but again lacking in detail in important respects: (1) a review carried out by McKinsey & Co based on interviews with 50 public health leaders coupled with a review of 30 global health alliances (McKinsey 2002); and (2) an in-depth empirical analysis of a sample of 18 global public-private (health) partnerships (PPPs) (Buse 2003; 2004b). Both studies suffered from methodological weaknesses and further research in this area is warranted, particularly given the fact that there is now greater experience with these organisational forms compared to when the aforementioned studies were undertaken.

In relation to the issue how GHPs sit and fit into the global landscape on health cooperation, there are generalised accounts and concerns raised in particular about partnership proliferation, inadequate coordination, the relationships between WHO and partnerships, and between WHO and the commercial sector (Richter 2004; Buse and Walt, 2000a & 2000b; Buse and Walt 2002; Buse and Waxman 2001). Nonetheless, this review was not able to find any serious and systematic attempt to set out the issues, and possible options, with respect to improving the relationship among GHPs, and to put in place mechanisms to enhance the accountability of GHPs to the wider international health architecture. The paucity of research and informed discussion represents a hole that needs to be filled. This review addressed a sub-set of the issue in relation to coordination among relevant GHPs and global health/disease initiatives and programmes. It makes some recommendations in terms of supporting nascent efforts to enhance this form of accountability and initiate a dialogue with like-minded development partners on moving forward with blue skies brainstorming and problem solving.

Two caveats are worth making. First, while the above evaluations and studies have provided some useful information in relation to lessons on emerging good practice, it must be stressed that they represent rather thin evidence. More proper in-depth research, not consultancy, is required. Second, many of the observations and findings from the above-mentioned evaluations and studies are time specific. GHP governing arrangements have likely changed in the intervening period, often as a result of evaluation reports, and, consequently, the findings may no longer be valid with respect to any particular GHP. The findings are rehearsed in this report to illustrate challenges faced in these social experiments – particularly when specific issues come repeatedly to the fore.

3 CLARITY ON GOALS, OBJECTIVES AND RESPONSIBILITY: TOO OFTEN LACKING

Governance concerns how an organisation (or society) steers itself – where it is going and how it will get there. Governance embraces the informal and formal rules, norms, principles and decision-making procedures which bring order and structure cooperation. Most analysts, supported by findings from evaluations, would support the proposition that clear and explicit agreement on aims, goals and objectives are fundamental to partnership success. Lack of which may lead to a variety of outcomes which undermine partnership effort, including tension among partners, poor partner alignment and commitment and, ultimately, lack of partnership performance. Similar clarity is required in relation to specifying roles and responsibilities, ways of working and making decisions, as well as clear lines of accountability. Similarly, lack of clarity leads to tension, undermines commitment and trust, and ultimately to GHP performance failure.

Evaluations of GHPs repeatedly uncover evidence of insufficient clarity of aims, goals, objectives and responsibilities. The evidence reveals that differences over goals, priorities and approaches, or understanding on roles and responsibilities among parties to partnerships have arisen. For example, over whether or not GAVI should primarily focus on a limited number of new vaccines, or improving immunisation more generally. Or in the case of GAEL, whether the goal should be elimination or eradication. More specifically:

- Review of the Multilateral Initiative on Malaria (MIM) found that the lack of a single overarching set of goals and strategic plan represented a stumbling block (Bockarie et al., 2002) and suggested that Initiative members review their definition of partnership, establish guidelines for the responsibilities of partners and for partner accountability;
- WHO report on the Global Polio Eradication Initiative (GPEI) made observations on unclear roles and lack of consensus on technical strategies (placing emphasis on technical vs. procurement functions). This led to tension and to waxing and waning partner commitment and partnership activity. A memorandum of understanding (MOU) was recommended to rectify the situation;
- Mercer study of GAVI procurement found a lack of lead accountability, overlapping and unclear roles, and inconsistencies between partners about priorities (2002);
- GDF evaluation found: "lack of clarity about roles of WHO, Stop TB Coordinating Board (STBCB) and GDF Working Committee have not been clearly specified and there is lack of clarity on which party is responsible for GDF's successes or its mistakes." The evaluation concluded such ambiguity was weakening accountability, strategic oversight and decision making and that "WHO and STBCB must clarify their respective roles and establish clear accountability for decision-making, oversight and legal liability." (McKinsey 2003)
- GAEL evaluation found: roles and responsibilities of the different participants in the Alliance were never sufficiently clarified; expectations of various participants were not clarified and differed among partners; differences of understanding of how decisions would be made in the Alliance; and poor conflict management within the Alliance (Skolnik et al, 2003). Although a global strategy was agreed, partners took different views on the goal (eradication vs. elimination) and subsequently adopted different positions on priorities and interventions;
- RBM evaluation found that: 'Core partners are not defined and their roles and responsibilities are not clear... it allows partners to avoid responsibility and to put the blame on others...' (Feachem et al, 2002);
- Buse (2003) review of 18 PPPs revealed considerable variation in terms of the specificity and time-boundedness of objectives, with for example, half of the product access GHPs articulating explicit and quantified epidemiological targets (particularly the eradication GHPs) but the remainder failing to do so;

- A mapping exercise of 74 GHPs found that very few of them articulate objectives in a specific and measurable manner (Buse 2004a).

If it is seemingly axiomatic that shared goals and objectives and clearly defined roles and responsibilities are pre-requisites of effective partnership, why has this principle been routinely violated? It could be that:

- In their haste to get off the ground, founding partners didn't bother with the detail on the assumption that there was implicit agreement. But the devil is in the detail, and at some stage the detail has to be addressed and, as demonstrated above, differences usually surface;
- Founding partners were aware of differences over goals, emphasis, or strategy at the outset, but were either: (1) compelled to enter into partnerships for other reasons (presumably with the hope that differences could be overcome, or that they didn't matter); or (2) assumed it would be possible to reconcile differences once relationships were more firmly established. It is likely that the latter is the most widespread explanation for the lack of ex ante specification of goals: wily politicians and managers emphasise relationship building, building bridges between different cultures (see Frost et al, 2002 on boundary spanning) and the finding of common ground so as to get partnerships off the ground.

Whatever the explanation, the evaluation literature makes a strong case for investing in exhaustive discussions to arrive at agreement ex ante to obviate later costs and frustrations. While there may be the need for some ambiguity during the early stages of partnership formation, due to cultural and other differences among partners, what is important is that a process is put in place and agreed that compels partners to devote time and energy to articulating common goals, time bound objectives, roles and responsibilities. There is similarly the need to revisit these issues after some years in light of changing context (e.g., new technologies, interventions, changing burden of disease, new players etc).

Recommendation Strategic, operational and business plans, with clearly defined roles and responsibilities of all major partners, are integral to effective partnership, consequently, DFID should seek to ensure that these are developed (or there are plans to develop them) and periodically reviewed as a criteria for engaging with particular GHPs.

4 ORGANIZATIONAL ARRANGEMENTS

This section concerns organisational arrangements. It begins by presenting and critiquing a typology of GHPs proposed by McKinsey (2002) and argues that the major question for GHPs is really a choice between simple organisational coordination, hosted arrangements, or the establishment of new, independent organisations to facilitate coordinated action. The pros and cons of each model are presented, with particular attention paid to opportunities and challenges related to WHO-hosting arrangements and recent reforms to address those challenges.

The McKinsey study argued that organisational arrangements need to conform to the 'fit to purpose' rule (2002). The authors differentiated between five different organisational models for global health alliances (see Figure 1). These ranged from extremely loose and informal structures on the one end of the continuum to more formal and tight knit models at the other:

- 1 **Simple affiliation.** Without formal structure or staff, the simple affiliation is the loosest form of collaboration. It depends on informal steering or technical groups and informal communication to make decisions. It is attractive in that it is low cost and promotes fast, personalised decision making. It is best suited to informal collaboration – mainly sharing of information. It is less appropriate when a large number of partners and deeper collaboration are required. There were no simple affiliations among the target GHPs.
- 2 **Lead partner.** In this model, one partner assumes the lead, but not dominant, role and will take responsibility for developing the strategic and technical agenda but will work with other partners to make operational decisions. This is thought to work well when there are a small number of partners (i.e., 4-6) and when one partner is recognised as a natural leader (e.g., has expertise and alliance leadership is part of its mandate). This model is reported to have worked well in the case of the Harvard PARTNERS initiative (www.taskforce.org/tbhome.html).
- 3 **General contractor.** One partner is the clear leader, decision-maker, controller of funds and runs the secretariat. In that it places most responsibility in the hands of one partner, it can be effective in situations where quick decision-making and risk-taking are involved. Other partners have to be willing to follow, or work as 'subcontractors'.
- 4 **Secretariat** (termed 'hosted' in this report). A core group of partners work, more or less as equals, to establish a small secretariat to support key alliance functions. This is a desirable arrangement when partners seek deep combination gains, where a large number of partners are involved, and when separation from parent institutions is possible and desirable. Can be more expensive than previous models to establish and maintain. GAVI and Global Polio Eradication Initiative (GPEI) serve as examples.
- 5 **Joint venture company** (termed 'independent' in this report). Partners create a separate legal entity, with its own staff and resources, and allow it to operate more or less independently. Works best when a deep combination of resources are involved, and speed and risk taking are required. Allows great independence from partners and offers increased focus. Joint venture companies require more effort and resources to establish. IAVI and MMV are examples.

The McKinsey analysis usefully concludes that the appropriateness of an organisational structure depends upon a number of factors relating to:

- Number of partners;
- Perceptions among potential partners of a natural lead organisation and tolerance of single partner pre-eminence;
- Purpose of the alliance (e.g., information sharing, improving alignment, vs. deep asset mixing). Numerous studies indicate that where the function is more of developing policy as opposed to implementing it, a loose structure may work. But implementation demands active and accountable project management teams – be they centralised in one partner or

- coordinated among them;
- Speed of decision-making required;
- Speed and costs of establishing the alliance; and
- Partners' willingness to pay for coordination services, etc.

In other words, as the saying doesn't quite go, different courses are required for different horses.

The McKinsey typology offers useful criteria for thinking about the pros and cons of the suitability of set organisational arrangements for a given collaborative activity, but it may not provide the most useful lens for examining the 19 target GHPs for four reasons.

First, it is arguably the case that none of the target GHPs take the form of Simple Alliance, Lead Partner or General Contractor – instead they are either Secretariat or Joint Venture Company types (perhaps due to the number of partners involved or the need for deeper and tighter collaboration) (see Annex 1). It is, however, interesting to note that staff in one secretariat-type partnership, which ultimately unravelled (GAEL), indicated that it may have worked better as a Simple Affiliation as it was the shared decision-making process which proved problematic. In their words 'the global strategy was successful despite the partnership.' These staff were of the opinion that given the limited number of partners, a coordination forum would have served the needs of the various partners. A Simple Affiliation would have allowed various organisations to better align their work in support of a global plan. Activities crucial to support the implementation of the plan could have been undertaken independently by the different organisations, underpinned, where required by bilateral memoranda of understanding (MOUs). In this case, MOUs already existed between the WHO and Novartis (as drug provider) and between WHO and the Sasakawa Foundation. It is, however, not clear that this approach would have been able to resolve problems of lack of alignment among partner priorities and partner accountability to the Global Plan (see below). Moreover, from other perspectives, problems arose due to the role that WHO assumed, in providing the Secretariat and assuming a lead and, according to some, dominant position -- not necessarily because a Secretariat model was adopted per se (Skolnik 2003b). Nonetheless, it would appear that less formal arrangements may be appropriate in given circumstances, particularly where partners are content to have one partner lead and service collaborative activities. Consequently, Simple Affiliation, Lead Partner and Contractor models warrant further experimentation and, where they have been established (such as the Coartem partnership), they warrant review.

Second, the McKinsey framework doesn't provide sufficient differentiation between types of Secretariat models. A more nuanced approach to the secretariat model is required as there are significant differences between those GHPs which are hosted by: WHO (e.g., RBM, Stop TB, GAEL etc.); UNICEF (e.g., GAVI), NGOs (e.g., Malarone Donation Program (MDP) or indeed commercial organisations (none in this sample. See Annex 1 which situates the target GHPs according to this categorisation). Buse (2004b) found significant differences in relation to a range of governance related variables on the basis of whether or not GHPs were hosted in multilaterals, in NGOs or functioned as legally independent initiatives (i.e., joint venture companies). Some of these findings are presented below. Moreover, it is important to recognise differences even among hosted GHPs (i.e., Secretariat model) in relation to the scale of the secretariats and programmes they administer. A number of Secretariats are large and have a corporate identity which is distinct from their hosts (e.g., GAVI, Stop TB, RBM) whereas the Secretariats in other WHO-hosted GHPs are much smaller, consisting of two or three WHO technical staff (e.g., WHO Programme to Eliminate Sleeping Sickness (WPSS) and GAEL). These small Secretariats have a much less distinct GHP corporate identity, in that they are much more closely aligned with WHO. Indeed, although WPSS had intended to launch itself as an Alliance in 2002; it never did so formally and, as its title suggests, it remains what some have called 'a WHO programme with friends.' This is not altogether a fair assessment as the Programme exhibits a number of the key characteristics of a collaborative

venture. In particular, there are formal agreements with various pharmaceutical companies for donated products, regular meetings with an increasing number of players (up to 60 at its last meeting) and shared decision-taking. Yet, similar to a number of other small hosted partnerships, it has a small technical group which provides some support for the alliance, but is predominantly responsible for providing technical support for a small tropical disease programme and for managing a drug donation programme.

This represents a practical and sensible reality. The big partnerships can afford to fund an independent, if hosted, secretariat (e.g., GAVI, Stop TB etc). But for the smaller ones, it may make perfect sense for one partner to provide the secretariat using its staff, and WHO is an obvious – though not inevitable - candidate since it has both the technical and administrative expertise. These differences do not imply any necessary deficiencies in governance, but rather support the McKinsey dictum, different courses for different horses. In short, differences among hosting institutions and differences in the scale and function of hosted GHPs mean that the Secretariat category is far too ambiguous a term in relation to GHPs (more on this below).

Third, the McKinsey model fails to describe a model which is in the process of emerging among GHPs with the convergence between the secretariats of the Vaccine Fund (VF) and GAVI. There will be one management, a consolidated or coordinated work plan, and one staff but two Boards. A separate Board is being maintained by the VF primarily due to benefits of tax free status in the US.

Fourth, although the McKinsey typology provides some useful analytic categories in relation to governance features, it ignores an equal number (e.g., the level of seniority of the Board, communication structures with constituencies, scale of operations, etc.).

4.1 Legal status of GHPs: independent vs. hosted arrangements¹

In that the sample GHPs are either of the hosted (i.e., secretariat) or independent (i.e., joint venture company) type (Table 1), it is important to understand the implications of these two organisational forms. As indicated above, it is similarly important to differentiate between the hosted GHPs according to type of host. Prior to turning to governance issues, it is worth indicating that the distinct organisational forms have some bearing on the functional focus of the GHPs. In particular:

- Product R&D is less likely to take place in WHO-hosted partnerships and more likely in the independent and NGO hosted GHPs;
- Access GHPs are more likely to be hosted, particularly by WHO, although there are prominent ones hosted by NGOs (e.g., Mectizan Donation Program) as well as independent ones (e.g., ITI and GFATM);
- WHO hosts the global coordination GHPs (i.e., Stop TB and RBM).

Table 1: Organisational type of sample GHPs

Independent	Hosted			
	WHO	UNICEF	World Bank	NGO
DNDi	GAEL	GAVI	APOC	GWEP

¹ The distinction between independent and hosted partnerships has become somewhat blurred as some of the independent partnerships (i.e., joint ventures with their own legal identity) have concluded service agreements with UN organizations which provide the GHPs with a range of administrative services. For example, GFATM with WHO and GAIN with UNDP. Although these are sometime referred to hosting arrangements, there is a fundamental difference in that these independent initiatives have their own legal identities and independence from the UN agencies which simply deliver specific services in return for fixed costs.

GFATM	GAELF			MDP
IAVI	GPEI			MIM
IPM	RBM			MVI
ITI	Stop TB			SCI
MMV	WPSS			

Studies point to pros and cons of each model. While independent GHPs (i.e., joint ventures) may take longer to set up and be more costly to operate, they will have more independence from parent organisations. Conversely, while hosted GHPs (i.e., secretariat) may be quicker to start up, as the infrastructure (administrative, legal, human resources, financial, etc) is in place, and are likely to have ready access to technical support, it runs the risk that the hosting partner will assume the role of *primus inter pares* and will dominate over other partners.

Some hosted GHPs have overcome this problem by rotating the Secretariat. For example, the MIM secretariat revolves between member organisations. This is seen as democratic, widens and builds ownership, assists in sharing the burden, and brings new energy and new thinking. Yet the review of MIM suggested that rotation should not be any more frequent than four years as it takes time to 'learn the ropes,' and that the present Secretariat should work to prepare interested African entities to build necessary capacity to shift the Secretariat there in the future (Bockarie 2002).

From a legal perspective, hosted GHPs do not possess a juridical personality, which in practical terms means that the Partnership does not have the capacity to contract, to acquire and dispose of property or to initiate legal proceedings -- these are functions that the host must assume. Some of the GHPs which lack legal status may also face particular problems. For example, MIM is a loose knit group of related organisations coordinated by a Secretariat. While a review found positive attributes, it also pointed to challenges with respect to securing funds from some organisations due to its lack of legal status (Bockarie et al 2002). In other hosted partnerships there have been reports of competition between the host organisation and the Partnership for funds (i.e., the host has blocked donations to the Partnership so as to obtain them for the organisation's use).

Buse (2003) found that there were striking differences in relation to the governing bodies between hosted and independent partnerships (See table 2) -- although there have been important changes in a number hosted GHPs since the review was conducted, some of which are discussed in subsequent sections.

Independent partnerships

Buse (2003) found that each of the independent PPPs had similar governing arrangements which are relatively straightforward and easy to describe. Each had established a Board (of Directors) with overall fiduciary responsibility for the partnership. Typically, these Boards develop policies and principles for the partnership, review and guide the corporate strategy, appoint, monitor and advise key executives, and assure financial integrity by reviewing finance and budgets and undertaking fund raising. They meet two or three times per year and are composed of between 7 and 15 members. On each of the Boards, with the exception of ITI, there is representation of the commercial, public and not-for profit sectors (although GATBDD stresses that membership on its Board is based on specific areas of expertise rather than sector or geographical representation, per se). In the IAVI Board, the commercial sector has greatest representation, which stands in contrast to the MMV Board. The public sector is not represented on the ITI Board. Decision-making in Board meetings is typically by consensus. The activities of each of the independent partnerships is executed by a secretariat and advised by a technical expert group. Senior management of the secretariats is accountable to its respective Board via the chairperson. In relation to responsibilities and functions, these boards resemble those found in the corporate sector.

GHPs hosted in multilaterals and NGOs

Buse (2003) noted that the 'governing bodies' of many partnerships hosted in non-governmental and multilateral organizations are complex and often not well communicated.

- In some cases, governing bodies are said not to exist (e.g., GAEL, WPRESS). There is some debate on the desirability of governing bodies, with some WHO staff insisting on the one hand that the costs are too high, and on the other, that they fear that decision-making will be dominated by other partners. In the afore mentioned GHPs, certainly the secretariats are extremely small and stretched for resources, and any additional workload arising from serving governing bodies has a observable and immediate opportunity cost on the technical programme. Nonetheless, these GHPs do convene their partners on a regular basis (hence no major additional expense unless greater representation were required) and, as argued above, agreed rules on decision-making procedures would likely improve relationships among these partners, not undermine them. Based on existing experience, it would be reasonable to **recommend** that all GHPs establish some explicit and agreed rules of engagement for their collaborative efforts, irrespective of the scale of venture;
- In some cases, there are no independent oversight bodies, with significant authority, fiduciary and strategic responsibilities. Indeed in many of these initiatives the 'governing bodies' have highly curtailed authority (i.e., are advisory²) while fiduciary and oversight responsibility rest with the host. This is arguably the case with the Technical Advisory Group of GAEL, and the Biennial Meeting of GAELF,. This is not always the case. The SCI, for example, has a ten member Advisory Board which approves the budget, receives reports on progress and oversees the performance of the SCI and its partners towards SCI goals and objectives;
- Many hosted GHPs fail to provide a venue for ensuring the voice of both public and private sectors in their governing bodies (i.e., either the public or private sector is not represented or serves in a liaison capacity);
- There tends to be significant identity confusion in the eyes of many stakeholders between the Partnership secretariat and the host organization;
- Despite the above findings, GAVI demonstrates that relatively straightforward governing structures are possible in a hosted arrangement, even in a multilateral one. GAVI has developed structures which exhibit many characteristics of the legally independent partnerships. The Alliance has a sixteen member Board with high-level representation of public, not for-profit and private sectors (although the balance is tipped to the former). The Board is responsible for approving budgets and overseeing the strategy, terms of reference, and objectives of both the Alliance and its secretariat. This mandate provides the Board with considerable authority over the initiative. Despite the fact that UNICEF hosts the Alliance, senior staff are accountable to the GAVI Board. Similarly, although most UNICEF rules and regulations govern the staff and activities of the Alliance, exceptions are made on recruitment and publication of materials.

Table 2: A comparison of independent and hosted GHPs

Independent	Hosted
<ul style="list-style-type: none"> • All have Boards • Boards have significant fiduciary and strategic authority • Initiatives have significant independence from partners • Executive reports to Board • Subject to independent audits 	<ul style="list-style-type: none"> • Great heterogeneity in governing arrangements • Some lack governing bodies (e.g., GAEL) • Many governing bodies lack authority (i.e., TAGs) • Identity confusion (between host and

² Many hosted PPPs indicate that their Technical Advisory Groups serve as governing bodies. Yet these groups have no fiduciary responsibility and circumscribed decision-taking authority.

<ul style="list-style-type: none"> • Tax free status in US 	<ul style="list-style-type: none"> partnership) • Executive reports to host • Host retains oversight and fiduciary responsibility • Host may dominate • GAVI 'exceptionalism'
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Table 3: Advantages of hosted arrangements

Generic	UN Generic	WHO Specific
<ul style="list-style-type: none"> • Rapid start up • Access to admin, legal, human resources, financial systems • Cost-savings 	<ul style="list-style-type: none"> • Tax free salaries and diplomatic privileges for staff • Facilitates communication and financial transfers to countries 	<ul style="list-style-type: none"> • Access to critical mass of experts, technical networks, global programmes • Access to MOH • LMIC representation on governing bodies • Legitimacy (in some eyes)

4.2 Issues arising from WHO hosting

Despite the drawbacks which hosted governing arrangements may exhibit, there also considerable benefits which are summarised in Table 3. Some of these benefits are generic to any hosting arrangement (e.g., rapid start up and lower costs), while some are specific to UN hosting, particularly privileges for staff and established mechanisms for financial transfers to recipient countries, while others are specific to WHO. The latter are particularly important in light of the health-focus of the GHP sample and include access to global disease specific programmes, access to a critical mass of technical expertise across a range of health issues within the Organisation, access to the significant technical networks maintained by WHO, as well as often unique and close relationships between WHO and ministries of health in endemic countries.

To reiterate, beyond the generic benefits of a hosted partnership, a WHO hosting arrangement confers a number of benefits which can provide GHPs with a comparative advantage:

- Access and proximity to major pool of expertise at WHO and through WHO networks;
- Enhanced recognition and legitimacy in some quarters;
- Access and support at country level;
- Higher likelihood that developing country governments will be considered 'partners' and/or represented on the governing body of the GHP (than if GHP is independent or hosted by an NGO).

Yet, there are also considerable challenges to WHO hosting arrangements which have been aired in various evaluations and interviews. These include:

- WHO rules and regulations apply to Secretariat staff:
 - At times these rules may impede progress and even the quality of the secretariat's work. These include, for example, restrictions imposed on hiring and employment practices which entail, for example, prohibitions on appointment of certain over-represented nationalities on the so-called 'C-list' (e.g., British, Canadian etc.), high reliance on the use of short term contracts (e.g., 11 months), which require mandatory contract breaks, and can not exceed four successive contracts, rules governing internal meetings, rules governing requirement for approval for

- expenditure and travel, protocols governing correspondence with outside organisations (for example, secretariat staff may not write directly on behalf of Partnership to Ministerial level as Assistant Director General signature is required);
- At times these rules may undermine the accountability of the Secretariat to the Partners (which may reduce partner commitment). For example, because the executive secretary reports to a relevant WHO Director as opposed to reporting to the Partnership board;
 - High turn over of the most senior staff. For example, the evaluation of RBM reported that there had been four directors in three years with delays and uncertainties between appointments which was said to have affected performance (Feachem et al., 2002);
 - Often little representation of the commercial sector on governing bodies
 - Misperception that commercial sector organisations may not sit on governing bodies of WHO hosted partnerships. This is not the case as the examples of Stop TB and RBM indicate. Company candidacy will be considered, but (at least in theory – see below for exceptions) company/industry association must meet WHO criteria for corporate social responsibility (currently applied through process managed by Government and Private Sector Relations Department);
 - Style of working which has been perceived, at times, as dominant, arrogant, lacking in collegiality and slow in making decisions. Such critiques are, however, not uniquely made of WHO. For example, the external evaluation of IAVI found that its Executive had been perceived as ‘too American’, ‘too aggressive’, or ‘too insensitive’ by some of its stakeholders (Skolnik et al., 2003). The evaluators commented that the Initiative would have to become more ‘international in style’ (which is a particular strength of WHO).

In part because of some of the drawbacks listed above, GAEL broke up during the course of 2004 and the secretariat of GAELF appeared to be migrating de facto from WHO to a US-based NGO. It may also be the case that similar challenges are manifest in other hosted arrangements but have not been publicly aired due the lack of evaluations of GHPs hosted in organisations, other than WHO.

Experience suggests, however, that these drawbacks are not manifest in all partnerships hosted by WHO. For example, the GDF review found that WHO was remarkably and unexpectedly 'hands off' in relation to its governance, and the evaluators did not recommend significant changes to organisational arrangements (McKinsey 2003). Nevertheless, the report did suggest that “an administrated arrangement that offers more flexible staffing and legal support, greater transparency, and a partnership-oriented attitude is now necessary.” And moreover that legal, contracting and audit processes should be aligned with needs of broader partnership, and not WHO alone. In this regard, it is worth reiterating that the evaluation of the Stop TB Partnership concluded that WHO was charging a reasonable fee for the services that it was providing in relation to the GDF, and making a substantial net contribution to the Partnership (Caines et al, 2003). These evaluators also commented on WHO's light touch in relation to its involvement in the governance of Stop TB, and found that technical relationships were strong, without compromising the Partnership's independence. Overall, they concluded that the location of the Stop TB Partnership Secretariat in WHO benefits both parties, despite the administrative frustrations .

Some of the debate, however, is not about putative pros and cons but about ideological biases (for or against multilateralism), as well as protecting, expanding and/or undermining bureaucratic empires and turf.

4.3 WHO reforms

In response to the above-mentioned problems associated with hosted, and in particular WHO-hosted partnerships, it is evident that WHO is making strenuous efforts to deal with many of the problems which have in the past plagued many of the partnerships it hosts (it is not clear the extent to which similar reforms are taking place in GHPs hosted by NGOs). The extent and speed of reforms are perhaps most striking in the case of RBM following a critical evaluation (Feachem et al, 2002) and are summarised in Text Box 1.

Among the most important reforms are the following:

- In a number of partnerships, clear distinctions have been made between WHO technical teams working on WHO global technical programmes (which retain a variety of mechanisms to provide technical inputs to the Partnership) and Partnership secretariats;
- Formal mechanisms have been established and harmonised across the Organization which enable the Partnership Executive to report for administrative matters to WHO Departmental Directors (i.e., for following the administrative policies and procedures of the host agency when relevant in the implementation of the Secretariat work plan) and for functional matters to Partnership Board (i.e., achieving objectives through implementation of approved strategies and work plans and for appropriate use of resources provided by the partnership) (see RBM 2004b);
- Procedures are being experimented with which allow Partners' involvement in the selection and appointment of Executive Staff (e.g., Stop TB and RBM). This compromise was not easy to achieve. In relation to the search for the present Executive Secretary, the original vacancy notice proposed that he/she would be accountable, and report functionally, to the RBM Partnership Board and ultimately to the RBM Partners' Forum but administratively to the Director of WHO's RBM Department. Caines et al (2003) report that this notice was subsequently found not to be in conformity with WHO staff regulations, and should have read that the Executive Secretary should operate 'under the guidance of the RBM Board and report to the WHO Director, RBM, on both technical and administrative matters.' Apparently, WHO subsequently retracted from this position and a form of dual accountability has been established.

Illustrative Case Study: Governance reforms in RBM

An external evaluation of RBM conducted in 2002 found widespread dissatisfaction and frustration concerning the RBM Partnership among all partners (Feachem et al, 2002). The evaluation identified inappropriate governance mechanisms as the source of the discontent. The findings of the evaluation are described in considerable detail below, as they provide important lessons in relation to GHP governance.

Founding partners took the deliberate decision to make the Partnership loose and informal so as to encourage wider participation. The Partnership was seen as an organic entity which would change its membership in response to circumstances and encourage maximum participation from a maximum number of actors. While this was seen as fuelling early success (notably the landmark Abuja Declaration which signalled high level international support for malaria control, and RBM as a vehicle for achieving global malaria goals), all core partners felt that loose were arrangements no longer appropriate.

The evaluators stated that 'it is not clear who the partners are or what partnership means... Core partners are not defined and their roles and responsibilities are not clear... it allows partners to avoid responsibility and to put the blame on others...' The result of the loose Partnership has been that Partners yield responsibility to WHO (as host) and then blame the organisation when things go wrong. The Partnership is more akin to a 'WHO Programme with friends' rather than a partnership of equals, all of whom are committed to specific roles and responsibilities. The structure was thought to encourage a go-it-alone approach: WHO often

failed to consult other partners, failed to respond to partners' requests, and failed to appreciate the value of fully involving other partners.

Organizationally, one of the problems was that no clear distinction was made between the technical functions and contributions of WHO to the Partnership and the Secretariat functions of the Partnership assumed by WHO. The functions were co-mingled and Secretariat staff reported to the same Director (as opposed to the Partnership).

A second major problem was, as the evaluator asserted, that 'RBM has no governance structure.' Although a periodic Partners' Meeting provided opportunities for input, it was deemed an inadequate substitute for a formal governance structure where issues can be collectively resolved and clear direction provided to the Secretariat and other partners. The evaluation called for the establishment of a governing body, a ten member Board, to advise and oversee the activities of the Secretariat and to make decisions on behalf of the RBM Partnership. It recognised that to achieve acceptable representation, a larger board may be required and, hence, recommended a sub-group (e.g., Executive Committee) be established which could be more involved in the day to day activities of the secretariat.

The biennial Partners' Meetings were deemed of value in terms of raising issues and proposing solutions, yet membership rights were ill defined and consequently, partners left the table with no clarity concerning what precisely was agreed and what steps would be taken by the Secretariat to ensure implementation.

In the original design of RBM, it was envisaged that two types of Technical Support Networks (Resource Networks) would be created: those providing direct support to country control operations (e.g., malaria control in complex emergencies) and those that addressed specific technical issues (e.g., monitoring of resistance). Most partners saw these as performing poorly. The evaluation suggested that these be re-constituted around the themes of the RBM strategy, so that they could create and support technical consensus and deal with complex strategic issues. Functionally, they would report to the Secretariat (this is different than Stop TB wherein WGs report to Board and wherein interaction with Board is seen as critical). It was stressed that these Networks would require a strong chair -- one who was independent of WHO.

The evaluation found that partners were dissatisfied with the performance of other partners – for failing to live up to expectations or deliver on commitments. Some partners questioned the value-added of RBM, expressing doubt as to whether returns on their investments would not have been better had they acted independently.

The RBM secretariat was found to report to the RBM Manager, who in turn reported to the Executive Director of the WHO Cluster; and consequently not to the Partnership. The Secretariat was staffed mainly by WHO members along side a small number of staff seconded from partner organisations. Consequently, it was found to be more responsive to the WHO management than to the Partnership. The Secretariat was not viewed by the evaluators as effective at coordinating activities within WHO, and even less so in stimulating and coordinating activities among the partners as a group. Partners complained that they did not feel that the Secretariat kept them informed or involved at crucial stages in policy formulation and decision-making. Nor had it been proactive in bringing in new partners or in identifying and resolving major discontent among partners. The evaluators suggested clearly distinguishing between the Secretariat, which should represent all partners, and the organisational structure of WHO's malaria control activities. It was argued that it was essential that the Secretariat be made accountable to the RBM Board (at least de facto). Moreover, the review suggested that the team should include secondments from partners to demonstrate their commitment to the partnership.

RBM's founding partners consisted of four multilaterals. The external evaluation found that bilaterals' involvement was viewed more favourably than that of the founding partners (UNDP, for example, was described as a completely silent partner).

It was observed that a good flow of information within and among partners would be required if the RBM Partnership wished to function more effectively.

Most revealingly, the RBM evaluation persuasively argued that although there was support for the concept of a global partnership for malaria, successful country level progress would require appropriate governance structures and management at the global level.

RBM stakeholders acted swiftly and decisively to resurrect the failing partnership. A steering committee was established on an interim basis and discussions held to develop a more robust governance structure. As a result, by March 2003 a board was in place and met for the first time. The board is composed of 18 voting (and two non voting) members (i.e., much larger than proposed by the evaluation) representing the following constituencies: endemic countries, multilateral development partners, OECD countries, research and academia, the private sector, non government organisations, foundations and the GFATM (although the private sector argues for the need for two seats to represent the two distinct constituencies (manufacturers of antimalarial products on the one hand and workplace and community based business on the other). Instead of creating an Executive Committee (recommended by the evaluation in the event that a large Board was established), it was agreed that the Board would meet more frequently. The Board meets twice a year physically with monthly teleconferences in between -- in which the majority of the Board participate. A number of important reforms were undertaken to improve the governance of the partnership, in line with the recommendations made by the external evaluation, during a transition period from April 2003 to March 2004 (RBM 2004a). These included:

- Bye laws were drafted;
- An RBM operating framework was drafted (RBM 2004b) together with board operating procedures. This was important for a number of reasons, among them resolving the confusion over roles and responsibilities and accountability;
- The RBM secretariat, which continued to be housed by WHO, was separated from WHO's technical malaria team -- although confusingly to both those inside and outside of WHO, the WHO Department retained the name of RBM Department;
- An executive director was recruited through a process which involved both routine WHO procedures and a Partnership panel (and was ultimately appointed by the Partnership Board) and made functionally accountable to the Partnership Board while remaining administratively responsible to the WHO Director. A secretariat work plan was developed and agreed by the Board;
- Two constituency consultations for Board representatives from endemic countries in Africa were organised by the Secretariat and two for NGOs facilitated;
- A number of mechanisms were put in place to improve the timeliness and quality of support to countries by the Global Partnership;
- Six Working Groups were reconstituted, TORs adopted, chairs and co-chairs elected and strategic plans developed;
- A Partnership website was launched and information critical to improved transparency made widely available, including minutes and decisions of Board meetings, Secretariat and Partnership work plans (see table x on transparency)
- A partnership performance assessment system was established.

Experience with the RBM Partnership suggest that where commitment to the partnerships' goals are high and widespread among a number of partners, there is scope for significant reform of the governance and institutional arrangements of a partnership -- even those hosted by WHO. There are good indications that this reform will yield significant returns to

partner investment...although it is similarly clear that good governance is only meaningful if the partnership is adequately resourced. There are indications that this may not be the case for RBM

While these reforms clearly signal a move in the right direction, there are signs that certain rules and procedures continue to frustrate Secretariats, partners and undermine Partnership effectiveness and efficiency. The complaints cited include hiring procedures, financial signing authority, and travel regulations. This appears to be particularly the case in GHPs with larger secretariats and where attempts are being made to create distinctions between the secretariat and WHO.

Consequently, some argue that review of experience with recent reforms (e.g., bifurcation of accountabilities) and the identification of procedures, which may warrant modification (for example fast-tracking appointments) on the basis of exceptions in light of the special needs of Partnerships, should be considered. One approach worth considering would be to establish a process to identify and understand constraints to WHO hosted partnership secretariats, identify where exceptions to rules may improve flexibility of GHPs, lobby/advocate for exceptions, and review progress on the impacts of these reforms (both on GHP and on WHO). If reforms are demonstrated to improve efficiency of GHPs, without posing undue risks to WHO, they should become standard practice in relation to WHO hosted GHPs.

It is worth drawing attention to a number of caveats in relation to the proposed strategy:

- First, development partners should continue to press WHO for organisation-wide reforms to improve efficiency for all WHO programmes (for example in relation to the time it takes to make appointments) not just for GHPs;
- Second, there are precedents for discussion of procedural exemptions for GHPs. For example, the Stop TB Partnership has engaged in detailed discussions with key players including WHO legal, human resources, administrative and finance departments on procedural matters. On the positive side, these discussions led to a series of reforms (described above) and there may not remain a great deal of 'wiggle' room in relation to organisational changes (at least in relation to Stop TB and RBM);
- Third, it is important to consider that there are good reasons why a number of 'irksome' procedures and rules exist. For example, where the host, as a legal entity, has fiduciary responsibility, it will need robust systems in place to ensure financial integrity and prudence. Moreover, it would not be justifiable to suggest that GHPs should be exempt from good human resource practices (for example, the need to properly advertise posts and endeavour to create a better balance of representation of Member States within the Secretariat – including the GHP secretariats). Hence, the challenge is to identify those rules and practices for which there may be some flexibility while also recognising WHO needs and requirements. Discussions involving the Secretariats, relevant WHO departments, and Partners will be required in the search for creative, yet realistic, solutions to the constraints. In some cases solutions may simply not be possible. Some procedures will have to remain in place and these will need to be factored into the cost of WHO hosting;
- Fourth, in any hosting arrangement, despite attempts to create systems of dual accountability, it is very likely that secretariat staff will remain more attuned and responsive to signals sent from the host (their employer, performance appraiser and possible career ladder) than from the partnership board. Again, this is one of the costs of a hosted model;
- Fifth, the WHO team dealing with GHPs (Government and Private Sector Relations) has shrunk considerably under the present WHO leadership and it is not clear the corporate direction nor impetus that will be accorded to pursuing reforms and exceptions for GHPs; and
- Sixth, there is a perception that some parts of the Organisation are intransigent and

inflexible when it comes to considering the needs of GHPs. On the other hand, staff within WHO question why GHP-based WHO staff should be treated differently and better than 'regular' programmes and staff, and why GHPs should be accorded special procedures which are not available across the Organisation. Some staff complain that the Organisation runs the risk of simply becoming 'a warehouse' for GHPs wherein GHPs benefit from the services provided by the Organisation without considering organisational requirements and obligations of an inter-governmental organisation. Discussions will have to be handled sensitively.

Recommendation: DFID should support reforms in WHO, above all those which will improve organisational efficiency in general (e.g., by reducing the length of time taken to make staff appointment) and provide greater flexibility for hosted partnerships. In particular, DFID should build commitment among other partners to establish a process to identify, support, advocate, lobby for reforms and exceptions to WHO rules and regulations which impact negatively on hosted GHPs. A case by case approach, relying on well informed opinion and fact, is required to identify exceptions where these are in the interest of partnership functioning and do not expose the Organization to undue risk. Where exceptions prove beneficial without putting WHO at risk, DFID should press for widespread application of these exceptions, in the interest of improved partnership functioning.

4.4 Boards

Some general findings and conclusions are emerging from various evaluations in relation to decision making bodies in GHPs:

- Composition, skills, seniority, representation and other characteristics need to be appropriate to the Board's mandate.
- Size of Board. McKinsey study on GHPs (2002) recommends keeping decision-making body small. Only a few of the GHPs have managed to keep them under ten persons (e.g., ITI, MVI which are both independent) as a premium has been placed on wide ownership of the initiatives. To be effective, a number of Boards have adopted a sub-committee approach (see below).
- Strategic engagement. The importance of Boards focussing on strategic guidance, as opposed to operational control of secretariat, is highlighted in many evaluations with the corollary of greater delegation to sub-groups of the Board or to the Executive. The GAVI Board appears to contravene this rule, as it is very involved in operational matters, and it has not empowered its Executive Secretary to sign cheques or appoint staff (although this is related to its hosting arrangements), and this level of involvement is probably unsustainable.
- Board composition. There is a need to balance geographic, gender, sectoral and functional/skill representation as well as to change its skill mix over time in keeping with an evolving context and mandate. For example, as IAVI shifts its attention to vaccine production and country preparedness, members with appropriate experience need to be recruited to its Board. Mechanisms for dense communication with constituencies have to be developed so as to improve the diversity represented on most boards and to improve the disconnect that it said to exist between many Boards, and their constituencies (see below);
- Seniority of board members. The seniority of Board members carries important implications for the functioning of the Partnership. Some Boards have very high, political level representation (e.g., Stop TB, GAVI, GFATM, and IAVI). These make it possible for representatives to commit their agencies to decisions adopted at the Board, and make high level advocacy and fundraising more likely. Moreover, it is thought that they are able to transcend competition and rivalry characteristic of more technically oriented senior staff in partner organisations. In contrast, the RBM Board is presently comprised mainly of

senior level technical representatives, notwithstanding two seats have Minister and Deputy Minister level representation. The Executive Secretary wants to have more political level representation on the Board so as to increase its effectiveness. This effort is difficult in that the OECD constituency will not send a high level delegate and hence persuading other constituencies to do so is difficult. Constituting Boards with high level representation (e.g., head of agency) has an obvious drawback: convening the Board on an ad hoc basis, sometimes even for a video-conference, can be next to impossible. With the proliferation of GHPs, some constituencies will find it challenging to meet their commitments to participate in Board meetings (particularly the Foundations and smaller bilateral organisations). It is **recommended** that DFID consider the advantages that would accrue from saving its political fire power for participation in four or five important GHPs which best meet its criteria for GHP engagement;

Decision road map. The McKinsey report (2002) recommended that Alliances develop a decision-making roadmap to facilitate effective decision making at a high or strategic level. This would prioritise the ten to fifteen most important decisions (per year) (e.g., approval of annual plan and budget, programme expansion) and identify who would be involved (director, senior management team, Board, technical committee, partner organisation) and what their role(s) would be (e.g., review, decide, vote). While some of the partnerships have adopted the practice of agreeing on the most important decisions (e.g., GAIN), and many of the Boards are more clearly specifying roles and responsibilities, it is not clear how widespread a systematic approach to decision-making road mapping is. This would appear to be a desirable Board level activity. It should be noted that in some GHPs (e.g., GAVI and the Stop TB Partnership) the decisions of the Board are not considered as binding upon the partner organisations, and cannot override the authority of the governing boards of each individual member organisation.

- More thought often needs to be given to Board member succession planning and procedures. A number of the GHPs have well developed systems in place (e.g., GFATM) and other GHPs could learn from their experience;
- Board members need to be well informed. IAVI evaluators were impressed with the very well prepared briefing books for the regular meetings of the Board (Skolnik 2003a). This might be considered best practice;
- Board development and team building processes are seen as important by some informants. Some Boards have gone through team building processes (e.g., GAIN). Such team building may enhance trust (see Druce report for more detail);
- Rotation of the Board chair is seen as important in sharing power among partners and encouraging wider partner buy-in, and is a practice which ought to be encouraged.

4.5 Executive committees

To reduce the workload of the Board and to provide direction to the Executive between Board meetings, a number of the GHPs have established Executive Committees or other sub-board groupings.

- GAVI has established an Executive Committee which meets once per year physically, and by teleconference when necessary - but in practice it is hard to convene the group due to the seniority of its membership (this is made more difficult by the fact that members can not delegate to alternates). While it has authority to make recommendations to the full Board (except on decisions relating to country support), the Executive Committee contains half of the Board membership, and importantly, the major partners and thus its recommendations carry significant weight. It has been active and provides strong direction to staff which can keep momentum on various initiatives between meetings of the full Board. Its functioning after one year is currently being reviewed by McKinsey.
- GAIN has established an Executive Committee which has authority to make decisions on behalf of the Board.
- Stop TB has established a 7 member Executive Committee. It makes recommendations

for endorsement by the Board – which Board members have a week to comment upon them.

- GAELF has recently established an Executive Group.

Even those Executive Committees which lack the authority to make decisions on behalf of the Board are found to be effective in keeping up momentum between meetings and recommendations tend to be endorsed by the Board. Nonetheless, effective communication is vital if other Board members and constituencies are not to feel excluded and become suspicious.

5 ACCOUNTABILITY

Accountability is concerned with the extent to which, and manner through which, those with authority can be held responsible for their decisions and actions. In relation to GHPs, accountability can be considered in four dimensions:

- Accountability of Executive (i.e., management) to the partners;
- Accountability of the partners to the partnership;
- Accountability of the partnership to stakeholders and constituencies;
- Accountability of the partnership to the global health architecture.

The first two of these issues are addressed in the following section, the third is addressed in relation to representation and participation, and the fourth in the final section of this report.

5.1 Accountability of the Executive to the partners

Legally independent partnerships do not generally raise questions or challenges concerning the accountability of the Executive to GHP partner organisations. Accountability of this kind is straightforward and achieved through formal, clear and direct lines through the Chair of the Board.

Accountability is more complex in the hosted partnerships. As noted above, there is some tension between the accountability of the executive to his/her employing organisation (i.e., host) and accountability to the other partners (through the Board). Typically, for reasons that are on the one hand legal (e.g., WHO staff may not take instructions from other organisations), and on the other hand concerned with aspects of institutional culture and career considerations, executive staff are more inclined to exercise their accountability to their hierarchical superiors in the organisation than to other organisations in the partnership. This can be problematic if demands made on the secretariat differ between the host and other partners which, as experience has shown, can lead to tensions among the partner organisations and between the host organisation and the secretariat. Depending on the personalities of the executive and his/her boss and the relationship between them, tensions can either be managed and differences reconciled or generate conflict in the relationship. Recognising these difficulties, WHO has instituted two important reforms which attempt to resolve, in part, this problem of hosted partnerships. As discussed above, there have been attempts both to bifurcate accountability (administrative to WHO and programmatic/functional to the partnership board) and to include the perspectives of partners in candidate selection. DFID is encouraged, as recommended above, to support, monitor and review such reforms in WHO.

Due to the lack of evaluations of NGO hosted partnerships, it is not clear the extent to which the accountability of executive staff to partners is problematic and whether or not novel mechanisms have been developed to improve accountability to partners while maintaining formal chains of command in host organisations. This represents an important area for enquiry from which WHO may be able to draw lessons.

Recommendation: Whatever the location of the secretariat, there should be a clear delineation of how the Secretariat is to account to the partnership governing body, and transparency in the exercise of that accountability. As a minimum, this should include a written report on key issues (both retrospective and prospective) from the head of the secretariat to each meeting of the GHP governing body, with an opportunity for members to pose questions. It is important that the report take a written format for the benefit of members who cannot attend and so that it encourages more accurate statements.

5.2 Keeping partners accountable

Getting partners to deliver on commitments represents a major challenge to many partnerships – particularly those which have lean secretariats and rely on partners to undertake most of the operational work. Such accountability may be less of a challenge in the R&D partnerships where a great deal of activity is sub-contracted by the Partnership to biotech companies, research institutes, etc. IAVI, for example, concludes MOUs for each of its vaccine development partnerships for which contractors are accountable to IAVI in a formal and straightforward manner. Nonetheless, a number of evaluations highlight the lack of this form of accountability as a problem which undermines trusts and reduces GHP effectiveness. For example, the evaluation of RBM found that partners were dissatisfied with the performance of other partners – for failing to live up to expectations or deliver on commitments (Feachem et al, 2002). This is not a problem that is unique to RBM. Nevertheless, the perception and practice of partner fulfilment of roles and responsibilities is a critical determinant of the viability of the partnership (see Druce report).

Three factors account for why partners may not fulfil their commitments and obligations. First, as mentioned above, there is a surprising lack of clarity in many GHPs on roles, responsibilities and accountability mechanisms. In this context of unspoken expectations, it is not surprising that expectations are sometimes not met. Second, bearing in mind that relationships among partners in a GHP are horizontal and voluntary, accountability of partners to the partnership will not be on a hierarchical basis. Consequently, it may be difficult, if not impossible, to compel a partner to deliver. Third, the voluntary nature of the relationship may imply that a partner's corporate agenda is likely to take precedence when there are competing priorities and even direct competition with the GHP (for funding for example).

Despite these challenges, there are a number of mechanisms (beyond improved role specification), both formal and informal, which can encourage partner accountability to the partnership.

- **Strategic alignment.** Getting partners to coalesce around a shared global strategy may lead to strategic alignment of partner actions in pursuit of the shared goal as a first step in getting partners to understand their interdependence (see Druce report on interdependence as a determinant of effective partnership);
- **Coordinated and consolidated work planning.** The idea is to map out not only a secretariat work plan, but an operational plan for each relevant work stream which includes the goals, objectives, activities, resources and roles and responsibilities of each of the most relevant organisations/partners/constituencies within a consolidated medium term plan. The process would not only include coordinated planning but also a commitment to joint reporting and review of the progress of each partner in meeting individual commitments in respect of the consolidate plan. Such a process provides a mechanism for holding all partners to account. GAVI is in the process of developing such a 'value-added' work plan. Although it does not include all the activities or all the partners (but does include the implementing partners) which it is hoped that it will provide a tool for improved coordination and accountability. Stop TB has had a Global Plan based on workplans for its six Working Groups since the outset, and is currently preparing its next forward Plan to 2015. Experience suggests that it is not easy to achieve consolidated plans and that several iterations are required (GAVI's first one was too ambitious; RBM attempt to develop a partners' appraisal was jettisoned). Developing coordinated and consolidated planning processes may provide the most important tool to increase accountability of partners to the partnership. Yet to realise these benefits, more attention has to be paid to improving planning process. Most of the evaluations stress the need for a more business-like approach in relation to planning and progress reporting. For example, by ensuring that performance indicators for all key activities are well defined and by indicating the actions that it has taken to meet key aims, the extent to which specific

performance indicators have been met, and how and when performance gaps will be filled;

- **Partnering practices.** Good partnering practice at the Board and secretariat levels enhances the prospects of buy-in, commitment and partner performance (see Druce/Harmer report);
- **Informal relationships.** Good informal personal relationships (between the executive and the various partners) at the Board and management levels can assist in cajoling partners to fulfil commitments, although these cannot get a reluctant partner to deliver particularly where secretariat staff have no direct relationship with senior decision-makers in partner organisations;
- **Development of MOUs among the partners.** This has taken place within a number of the GHPs, particularly in relation to formalising relationships within the product access partnerships (e.g., between donating companies and WHO in case of GAEL, GAELF, WPESS) and between host organisations and some GHP boards (e.g., UNICEF and GAVI, WHO and Stop TB). Many of the legally independent GHPs do not rely on these formal agreements (although some such as GFATM do). Buse (2003) reports that staff in independent PPPs were sceptical of their value and concerned that they brought unnecessary complication and bureaucracy to these relationships;
- **Sanctions.** In light of the voluntary nature of these relationships, formal sanctions do not appear to be particularly well suited. The process of joint review of consolidated work programmes may provide some mechanism to 'shame' partners for non-fulfilment of obligations. More formal mechanisms exist. For example, the Drugs for Neglected Diseases initiative (DNDi) provides a process for dismissal of Board members as a result of non-fulfilment of obligations (by consensus of other board members). While such a measure may be useful for other purposes (e.g., protecting the integrity of the initiative) it is unlikely to encourage or compel member organisations to be more accountable to their partners.

A number of GHPs are experimenting with different approaches to developing joint or coordinated planning tools which may serve a number of purposes, including enhancing the ability of partners to hold one another to account for the performance of the partnership. Consolidated work planning may not guarantee that partners will deliver but might improve the chances that they do so.

Recommendation: DFID should encourage and support initiatives aimed at improving partner accountability by providing technical assistance to the processes and their evaluation (including comparative analysis and lesson learning) and by becoming fully engaged in these processes. If these approaches prove successful, DFID may consider adopting coordinated approaches to consolidated work planning and review as a criterion for its engagement with GHPs.

6 BOARD PARTICIPATION AND REPRESENTATION

6.1 Skewed composition?

The TORs expressed interest in representation and participation of various groups in GHPs. Earlier work found that an analysis of ‘partners’ in PPPs was not straightforward as the term was used in a variety of different ways – often without definition, and as stated above, often in the absence of specification of rights, roles and responsibilities of partner organisations (Buse 2003). Nonetheless, PPP self-reporting of their partners revealed that:

- The number of partners ranged from just two to over 200 organisations in the 18 PPPs sampled;
- Institutions based in the global north were the most frequently cited partners;
- Southern/endemic country governments were most likely to be named as partners in UN-hosted PPPs and in access PPPs and less likely to be named as partners in PPPs hosted by NGO or in independent ones;
- Commercial sector partners were predominantly northern-based and almost exclusively research and development pharmaceutical companies

Although the analysis suggests possible structural imbalances in PPPs and GHPs (e.g., too dominated by the north, failure to embrace wider private sector community, etc), the lack of specificity with respect to the way the term partner is employed means that it is not possible to use the data to draw conclusions in relation to representation and participation in GHPs.

In relation to governance, it is more meaningful to analyse who participates and is represented in the decision-making bodies of the GHPs. The same study found:

- Half of the sample did not have a governing body which included both public and commercial sector participation (the private sector tends to be better represented in the independent partnerships);
- There was limited participation of individuals working for organisations based in LMICs on the governing bodies. Some had no participation of such individuals and not one had at least half of its membership drawn from this group. The participation of Southern individuals was lowest on the Boards of independent and R&D PPPs;
- Private sector participation was almost exclusively the preserve of Northern R&D pharmaceutical companies;
- Many technical advisory groups exhibit similarly skewed membership.

Evaluations of GHPs have, similarly, drawn attention to skewed or inappropriate composition of governing bodies – drawing particular attention to the relative lack of participation and representation of governments and civil society organizations from the South. The GAVI review, for example, questioned whether or not there was sufficient representation of developing country governments on the Board (2 in contrast to 3 from OECD region) – as well as on the Working Group (i.e., one). In response to the findings, GAVI increased the number of developing country representatives by one and reduced the OECD delegation by one on its Board. IAVI was encouraged to recruit more women to its Board (Skolnik et al. 2003a). The MIM review suggested that at least 50% of the MIM/TDR task force should be African to improve the diversity of participation and influence (Bockarie et al 2002). It further stressed ‘the need for both buy-in and serve-in components so that poorer partners without funds will not be marginalised and so that cash-only contributors, otherwise not involved in MIM on function, will not be able to overwhelm the Initiative’s democratic pool.’ The Stop TB evaluation was concerned that there was inadequate representation of TB patients.

Attempts have been made to improve participation of specific groups which are under-represented on governing bodies, for example on IAVI and MMV. Some groups are exemplary in this regard. For example, DNDi provides an example of an independent GHP,

whose primary aim is product development, which has structured the composition of its Board to ensure representation of the south. In particular, of its seven chartered members, one seat is reserved for a patient and four for nominees from organizations (public and civil society) based in the south. Yet it lacks a seat for the commercial sector. The GFATM's large board is able to ensure a balanced participation of all sectors.

Despite these improvements in the composition of some Boards, challenges remain in the target sample. For example, among the independent GHPs, in relation to participation of individuals working for organisations based in LMICs, the ITI has none in an eleven person board, IPM has three out of a ten person board, MMV has three out of nine, and IAVI has three in a thirteen person board. Some of the NGO-hosted GHPs do not do much better, for example, SCI only has one on a ten member board. In relation to functional characteristics, the product discovery and development GHPs have fewer board members from the global south – both in the target GHPs as well as more generally (e.g., GATBDD currently has none on a 11 member board). Of course, the development partnerships are also often the independent ones.

While it can be argued that the appropriate composition on a Board will depend on the function and mandate of the particular GHP, it is almost self-evident that participation (or at least representation) is critical to ownership, buy-in, commitment (i.e., ultimately to effectiveness) of the initiative.³ As the McKinsey study concludes, successful alliances depend on involving large numbers of people in meaningful ways (2002).

6.2 Who should participate?

Although there may be agreement on the need to involve a great many people in GHPs, the question arises as to who they should be, and how this should be done in relation to decision-making at the Board level. Direct participation of all stakeholders in governing bodies is obviously impractical and it has been suggested that Boards remain relatively small. Writing about R&D GHPs, Kettler and Twose (2002) have taken the position that “token political representation on a PPP Board or Council” is not required. They fear that such representation will diminish the capacity of the governing bodies to make decisions on ‘efficiency grounds’ as these will be made on political grounds. They also argue that because GHPs should “first and foremost be made accountable to funders and stakeholders directly involved in the specific R&D problem”, Board composition should be biased to these groups as well (as indeed most are). It goes without saying that the representation of any constituency, commercial or public, on a governing body should not be token – as this will not result in effective representation nor participation. More fundamental is the question of which groups have a legitimate say in the affairs of the GHP. Stakeholder approaches stress the need to involve all those affected by particular decisions in decision-making (for both instrumental and ethical reasons). It is this view which informs those evaluations that stress the need to increase the participation (and thereby representation) of certain groups which appear to be systematically under-represented – specifically, governments from south or endemic countries, NGOs from south (particularly those representing patient groups), small industry.

6.3 Improving participation and representation of under-represented groups

It would appear that there are two related ways to increase the diversity of views and perspectives and improve representation of under-represented groups in decision making in GHPs: improve access to participation in decision-making bodies and improve representation of diverse groups through improved constituency management. These two approaches are not mutually exclusive but rather complementary.

³ Notwithstanding the need to have appropriate technical/functional skills on the board, and of course the need to pay attention to gender balance, here the issue concerns interest representation.

If groups are to be represented in decision-making bodies of GHPs, they require access to a board seat. There are a variety of approaches to increasing access to seats on the governing body:

- Create additional board seats for each group which lacks adequate representation. Increasing the number of seats is likely to reduce the effectiveness of many boards (although there is as of yet no empirical evidence to support this in the case of GHPs), as most Boards are already large (by McKinsey standards). Consequently, it is unlikely that this option would be feasible or desirable in most cases;
- Decrease numbers of seats for 'over'-represented constituencies and allocate these to under-represented groups. There may be some scope in some of the Boards to pursue this option. GAVI, as mentioned above, reduced the number of seats for OECD governments and thereby made space for one under-represented constituency. There may be scope for this in other GHPs;
- Merge seats for existing constituencies. Ask certain over-represented groups to share a seat in order to make room for another group to take a seat;
- Allocate non-voting, observer seats for under-represented group or make provisions for larger non-voting delegations. GFATM has adopted both strategies; it allows delegations of up to ten members. This strategy can improve representation of constituencies but due to non-voting nature of seats sets limits on participation and control;
- Establish (non-voting) focal point for each seat who can attend Board meetings. Although this has been done primarily to improve constituency functioning (see following section), for example on the GFATM, it can also serve to increase access for groups to Board meetings. This strategy can improve representation of constituencies but due to non-voting nature sets limits on participation and control;
- Where possible aggregate similarly minded interest groups in relation to board seat allocation. For example, through use of apex organizations. A number of GHPs, for example, use the World Economic Forum (WEF) to recruit and organize commercial sector representation on the Board – others have used International Federation of Pharmaceutical Manufacturers Associations. For example, the Stop TB Partnership has just appointed a Board member from Heineken after a process led by the WEF involving 8 interested organisations.

6.4 The costs of participation

Common to many of the strategies is the need to explicitly fund the Board participation of some groups which are materially constrained. A number of GHPs provide such support (e.g., GFATM and GAVI) while others do not.

Whilst there may be agreement on the need to improve the representation of many groups on the governing bodies of GHPs, there are legitimate questions concerning the transaction costs for senior officials from developing country governments who are often severely overcommitted. While it may be difficult for officials to balance the trade-off between representation and capacity, we argue that, in principle, they should be given the opportunity to decide on their priorities as opposed to facing a foreclosed option (i.e., no possibility for representation). Moreover, there are recommendations in this report which aim to decrease the burden on individual country representatives through, for example, improved constituency management (see next section), while other reports in the series make recommendations to ease the burden on officials imposed through GHPs. For example, ensuring that GHPs use existing and common reporting mechanisms and participate in thematic coordination arrangements.

Recommendation: DFID's engagement strategy should consider the accessibility of all

affected groups to participation and representation in board decision-making. Where shortcomings are evident in relation to the non- or under-representation of key stakeholders, DFID should initiate discussions to adopt one of the strategies outlined in the report to enhance representation.

7 CONSTITUENCY MANAGEMENT

As suggested above, some Board members may represent only their organisation (or indeed act in a personal capacity) whereas others may act in a personal and/or organisational capacity but also serve a larger constituency through a representational function. A number of Boards have explicitly established seats for key constituencies to ensure that the views of the constituency are represented in decision-making (e.g., GAVI, GFATM, GAIN etc.). The McKinsey study found that successful alliances involve a large number of people in dense webs of communication (2002), pointing to the benefits of diversity. Allocating seats to constituencies, as opposed to individuals or organisations, can enable the diversity of views to be factored into decision making, yet relies on well functioning constituencies.

7.1 Constituency management challenges

A number of the evaluations note the challenges to such systems of representation. It should be recognized that representation will never be as effective as participation. As highlighted in the India country study component report, election of the Indian government to the Board of Stop TB notably energized the country's involvement in the initiative despite the fact that it had previously been 'represented' through another country. Yet the challenges are more generic and often have to do with how communication is handled. For example, IAVI evaluation found that linkages with women's groups and key constituencies in developing countries, including people living with HIV/AIDS, were inadequate. The evaluators thought it would be valuable to find more systematic ways of bringing in and communicating with these constituencies (Skolnik et al. 2003a). The RBM review noted a continuing disconnect between some Board members and the constituency that they are meant to represent (Feachem et al., 2002). And although the GAVI secretariat provided human and material support to enable one of its members to interact with his constituency, she complained that it was nearly impossible as it comprised 36 Ministers of Health (Caines et al 2002).

Some constituencies are more easy to 'manage' than others.

- GAVI, for example, has allocated a seat to the vaccine industry. In practice, there are only five major vaccine producers which makes for a relatively small and homogenous group. As noted above, the IFPMA and WEF appear to provide effective and useful umbrella organisations through which to communicate with certain kinds of business – but are probably less useful as representatives of small business in the south, generics etc.;
- Bilaterals represent another relatively small group of relatively homogenous organisations – and some even adopt the designation of like-minded for purposes of constituency formulation. Nonetheless, bilaterals can take conflicting positions. There are reports that experience with bilateral constituency management has been variable – in some cases providing effective coordination and not doing so in other GHPs. Bilateral board representatives have been criticized for not mobilising sufficient political will and resources and for failing to deliver unified positions to Board debates.
- In contrast, civil society and NGOs are more tricky as the sector is so heterogeneous and because it is often not clear the extent to which any group has legitimacy to speak for others or is accountable to them. For example, to what extent are northern NGOs, some of which are largely contract firms for bilateral organisations and Foundations, appropriate representatives of grass roots or patient groups in the south – a task that a number of them appear to have accepted? And given the lack of organisation among NGOs in some fields, it has been very difficult to find NGOs that do more than represent their individual interests in GHP boards. It would appear that experience and practice has been quite variable in terms of how GHPs have dealt with this issue, but not yet properly documented;
- Foundations. Many of the GHP have allocated a seat for Foundations, in recognition of the role that they have played in incubation and funding, but also because of other

resources that they provide (such as access to management consultancy and business world). As a small group managing this constituency should not be problematic – and attempts are underway to use the UN foundation more regularly in such a role. For many GHPs the most pressing questions surround succession planning, particularly when staff from the Gates foundation need to move on.

7.2 Approaches to improved constituency management and communication

A number of the GHPs have developed or are experimenting with organisational models and processes to improve the two way communication with stakeholders who may not be well represented on governing bodies. For example, they might:

- Establish a consultative body such as a Partners' Forum.
 - Many of the GHPs have established Partnership Forums – often to increase two way communication between Board and stakeholders. Those that have done so include, naturally, the coordination GHPs such as Stop TB and RBM, but also GAELF, GAVI and GFATM (as well as non target GHPs such as the GATBDD);
 - These bodies typically meet every one or two years and bring together representatives from the variety of organizations which may not have formal membership in the governing body. Consultative bodies may serve to raise profile of the health issue generally and of the partnership activities more specifically (and thereby encourage buy-in), comment upon and/or endorse plans, review progress, identify barriers and solutions, coordinate action. Some GHPs invest more responsibilities in these bodies. For example, the GATBDD nominates members to the Board and its Scientific Advisory Committee, has the power to call special meetings of the Board and its president serves ex-officio on the Board.
 - Although experience suggests that they are somewhat unwieldy they do provide a very useful mechanism. The evaluation of Stop TB Partners Forum (Caines et al 2003) concluded that it provided value for broad and participatory consensus building, partnership-wide endorsement of policies, strategies and plans, and high level advocacy. It also made the very useful recommendation that the schedule of meetings should coincide with the business planning cycle of the GHP – that is meeting to endorse the draft five year strategic plan, then at the mid-term review, then to review evaluation and next five year plan
 - Although there is as yet no experience in harmonising/coordinating relevant GHP Partners Forums, a more structured set of constituency relationships covering a number of global health partnerships might provide both economies of scale and wider input into GHPs.
- Establish a focal point for each constituency which is funded to attend Board meetings and receives all communication that Board member and alternate receive (as per GFATM);
- Improved constituency management (CM). In recognition that more effective constituency functioning will improve quality of deliberations at the Board and increase ownership for Partnership not only among partners but also among constituencies, a number of GHPs are experimenting with mechanisms to improve CM. For example, some provide support for constituency functioning, including guidelines for constituencies covering issues like succession planning and communication (GFATM has useful set of guidelines and requests constituencies to complete a statement explaining how the constituency functions to provide transparency on how the constituency is constituted and operates), assisting in distribution of materials, providing free meeting rooms on day prior to Board meeting, moderating electronic communication forum (GFATM has moderated online discussions in English with parallel discussions in French, Spanish and Russian), etc.

Although, ultimately it is up to the constituency to manage its own affairs, there are a number of steps that GHPs can take to facilitate the effectiveness and efficiency of communication

within constituencies and between constituencies and board members. In that many groups of constituencies may lack resources for dense communication and some key stakeholders may be material constrained from attending meetings, GHPs – or their donors – may need to provide financing earmarked to support these sorts of expenditures. This already happens in some (e.g., GFATM provides scholarships) but is not universal.

The premise is that effective constituency engagement will increase the effectiveness of the GHP (both in terms of improving relevance of Board discussions and in delivering buy-in) and that these investments will provide value for money. Again, like other aspects of GHP governance there is little empirical evidence and hence it would make sense to review experience as it unfolds so as to identify good/practice and to gather evidence to inform value-for-money judgements.

Recommendation. In that effective constituency management provides a tool for representation and may represent an important input into partnership effectiveness, DFID should support nascent efforts to improve constituency functioning. Support could take the form of TA and lesson-learning through comparative analysis.

8 TRANSPARENCY

Timely access to relevant information about decision-making processes and substantive evidence and information on the matter under consideration is essential to hold an organisation to account and to enable participants, stakeholders and constituencies to make meaningful contributions to deliberations. Open and effective communications are particularly critical to create trust in dispersed organisational forms, such as partnership, and trust is critical to partnership functioning.

To date, research has not been undertaken to assess the perspectives of GHP partners on the level of transparency in different GHPs – although a number of evaluations have pointed to repeated concerns in this area. For example, one of two major themes which was flagged by the Stop TB Partnership evaluation team (Caines et al. 2002) was the need for more transparency, and the need for greater transparency was among the key recommendations of the GDF evaluation (McKinsey 2003). Similarly the GAVI evaluation called for increased transparency, particularly in relation to appointments to the GAVI Board, Working Group and Task Forces; partner resource contributions – in kind and in cash; decision-making (Caines et al 2003). Regrettably, none of the evaluations defined transparency, yet a number of specific recommendations were made, at least in the evaluations of the Stop TB Partnership and GAVI. For example, the Stop TB report suggested, among other things, that its website include full set of processes for the election of Board officers; that for each substantive Board meeting item, Board members should be provided with a concise paper giving key facts (including resource implications if relevant), issues, options and, wherever appropriate, recommendations; that Board papers be available ten days in advance; that Secretariat should provide brief written progress report on past Board decisions for each Board meeting; that all meetings should be documented and details available on the web; and so on. It would appear that Stop TB has acted on these recommendations.

An analysis of the websites of target GHPs undertaken for this assignment identified areas of strength and weakness in relation to transparency (using web available information as a proxy measure). The results are presented in Annex 5. Some of the notable findings are:

- One GHP did not have a dedicated website (WPRESS);
- Less than one third of the GHPs post either their strategic or annual plan;
- Two-thirds of the GHPs posted an Annual Report;
- Only two of the GHPs post an Annual Budget;
- Just over half of the GHPs post information on their sources of income – but many of these are not explicit;
- Less than a third post their annual expenditures or audited accounts;
- Very few of the GHPs post minutes or decisions of the proceedings of their governing bodies. Good role models are GAVI, GFATM, Stop TB and RBM;
- The majority of GHPs provide some information on their governing and organisational arrangements (only GAEL, GPEI, GWEP provide none). The level of detail varies from the membership of the Board and other bodies to full copies of bye-laws and charters (with DNDi, GAVI, and Stop TB providing useful role models).

Some partnerships are actively using the Internet to enhance the transparency of their operations, particularly GAVI, GFATM and Stop TB. Some GHPs have made notable improvements to certain aspects of their operations, for example, RBM launched a website and made more widely available material critical to improved transparency, including minutes and decisions of Board meetings, Secretariat and Partnership work plans. Many other GHPs could do a lot more to improve transparency by improving their Internet access to information. It was evident that little progress has been made overall in relation to Internet-based transparency since the Buse (2003) review.

Information that is arguably the most important relates to: (1) strategic and annual plans and budgets; and (2) Board meeting agendas, background papers and subsequent decisions; (3) governance arrangements including mandates, processes and membership of decision-making bodies; (4) detailed information on how constituencies are managed; and (5) annual performance reports against objectives (as opposed to glossy advocacy pieces).

Recommendation: DFID should include transparency in its list of criteria for engaging with GHPs. In particular, GHPs should make freely available through the Internet: (1) strategic and annual plans and budgets; and (2) Board meeting agendas, background papers and subsequent decisions; (3) governance arrangements including mandates, processes and membership of decision-making bodies; (4) detailed information on how constituencies are managed; and (5) annual performance reports against objectives.

9 AUDITS

Audits play an important governance function in that they facilitate accountability of GHP secretariats to partner organizations and their constituencies. Buse (2003) found distinct variations in audit requirements and procedures between legally independent partnerships and those hosted in other organizations.

- The legally independent partnerships each adopted a similar audit procedure: namely the contracting of annual audits to specialized external commercial auditing companies such as PriceWaterhouseCoopers. They may also have internal procedures to audit different aspect of the partnership, such as product monitoring system checks used by the ITI.
- The NGO-hosted partnerships rely upon internal auditing services provided by the host agency (with the exception of the Malarone DP which had an audit which included staff from WHO and DFID).
- Audits of partnerships hosted by the multilateral organizations present a more mixed picture. The WHO-hosted partnerships have adopted a variety of mechanisms. Coartem provides for WHO to contract a mutually agreed 3rd party to audit Novartis manufacturing costs (as the provision of drugs at cost represents the centerpiece of this partnership). The activities of GAELF are not audited per se, as the different partners each adopt their own audit rules. Agreements between RBM and its donors stipulated an external evaluation. GAVI was also subject to an external review – apparently the evaluators encountered “strongly divided views about the need” for it with some stakeholders favoring an internal consideration of issues among partners (Gaines et al 2002). Stop TB and GDF are audited by the standard WHO audit, a similar practice has been adopted by UNAIDS for the AAI.
- Problems with internal audits by host organization are that they usually meet needs of host rather than broader partnership – as highlighted by the GDF evaluation.

External annual audits would appear to represent good practice. Internal audits and periodic and regular performance evaluations (which are necessary for other reasons) are not suitable substitutes for accounting/probity/systems audits. DFID could insist on annual independent audits as a condition of its financial contributions to GHPs. Moreover, the auditor should be briefed by the Chair and report to the governing body (i.e., not the executive).

10 SCREENING COMPANIES FOR CORPORATE SOCIAL RESPONSIBILITY

Screening potential partners for good corporate practices (i.e., according to set criteria, for example, generating significant revenue from sale of arms, tobacco, gambling, or use of child labour, etc.) is both a tool to exercise due diligence (e.g., protecting the GHP and its partners from negative reputation effects) and a potentially powerful mechanism to leverage the power of the resources of development cooperation organisations to change the behaviour of firms, in ways that support development aims (e.g., which further global goals on human rights, the environment, human health and so on).

The review by Buse (2003) suggested that only four of the 18 GHPs studied had undertaken a formal assessment of the background of commercial partners against explicit criteria (two of the GHPs were embedded in a multilateral organization; one was hosted by an NGO; and one was free standing). For each of these partnerships, screening was conducted by a multilateral organization (WHO, UNAIDS and UNICEF).

The findings revealed that guidelines of the multilateral organizations governing corporate selection were not widely adhered to by the GHP hosted by them. WHO-hosted partnerships including GAEL, GAELF, Stop TB and WPESS reported that they had not screened commercial sector partners as stipulated in corporate guidelines.

The general neglect of corporate screening reflects three underlying issues:

- The topic is highly polarized and it is difficult to gain consensus. The GAIN Board devoted considerable time to resolving differences among members on what is essentially a value-laden area;
- Relative power imbalances within some GHPs. When the commercial sector has a monopoly position with respect to a product, or the GHP requires critical assets from a particular corporation, the GHP is not in a strong position to dictate principles of good corporate ethics;
- Corporate involvement in GHPs is taken at face value as a proxy for corporate social responsibility.

Despite these challenges, establishing standards to gain entry into partnerships has two benefits: (1) diminishes a variety of risks for the GHP and its partners; and (2) sends clear signals about ethical corporate behaviour.

While many multilateral organisations have adopted guidelines, criteria and procedures for screening corporate members, widespread traction is only likely if funding agencies, such as DFID, make this a criterion for GHP support.

Recommendation: DFID should include CSR in its list of criteria for engaging in GHPs. In particular, GHPs should adopt principles and a list of criteria for screening corporate partners. DFID should promote a list desirable negative and positive criteria, should identify any which are non-negotiable, and should encourage GHPs to adopt both the criteria and procedures for implementing them.

11 REVIEWING, MONITORING AND EVALUATING GOVERNANCE ISSUES

Given the considerable problems posed in managing voluntary and horizontal relationships among independent actors (and the multiplicity of their constituencies), who may at times also have differing corporate agendas and conflicts, it is not surprising that governance often represents a considerable challenge for GHPs. Moreover, the challenge shifts continuously as the context changes along with goals and actors. Some GHPs proactively attempt to anticipate and manage these governance issues by investing resources in reviewing governance issues and arrangements and proposing solutions. For example:

- GAIN has established a standing Board Development and Governance Committee;
- The Board of the GFATM has a very active standing committee on Governance and Partnership which reports to the Board on a regular basis on issues as they arise and have provided detailed guidelines and procedural processes for Board and Secretariat – for example Board Operating Procedures, ‘Guidelines on Constituency Processes’, Policy on Ethics and Conflict of Interest, Additional Safeguard Policy, Global Fund Document Policy, Partnership Policy etc.
- as Policy on Ethics, Conflict of Interest and Constituency Management; while
- GAVI has a history of periodically reviewing and evaluating its governing and organisational arrangements. It recently constituted a sub-committee on governance which has a mandate to evaluate experience of its year old Executive Committee.

Recommendations: DFID should encourage and support efforts aimed at reviewing and engineering appropriate governance structures in GHPs. DFID should also support properly financed research, not merely consultancy in this area.

Caveat emptor

There is a need to strike a balance between gold standards in relation to good governance (encompassing effective organisational and managerial structures and processes) with the resources required to deliver them. Many secretariats complained that they didn’t have the resources to deliver on the tasks set by the Board and that practices of good governance (e.g., timely distribution of background papers for constituency consideration), although desirable are unrealistic – particularly in those GHPs with small secretariats. Moreover, a number of informants were concerned that many GHPs are establishing overly elaborate governing arrangements which drain resources from programmes on the ground. The APOC review, for example, advised that it reduce its governance and management structures (in particular to make them less rigid and top heavy) as these created an overload on the executive.

This reinforces the principle that governance mechanisms have to be appropriate to the scale and purpose of the collaboration, but also that adequate resources have to be allocated to support activities which are consistent with good governance practice.

Some of the partnerships are finding that a secretariat which is too lean for its required purpose as set by the GHP governing body is a false economy. This is because it is not possible to satisfy the needs of the partners and because it makes the partnership too reliant on the contributions of the partners. The more the Partnership relies on its partners to conduct the activities of the partnership, as opposed to undertaking activities in house or contracting them to other parties, the less control the Partnership Board has over the results and the greater the need for partner buy-in for success.

12 GHPS AND ACCOUNTABILITY TO THE INTERNATIONAL/GLOBAL HEALTH ARCHITECTURE

12.1 Background and problem

Notwithstanding the benefits and achievements of individual GHPs, as enumerated in the overarching project report (Caines 2004) and, specifically in relation to this component, the benefits of collaboration among public, private and civil society sectors (particularly in shared decision making), the proliferation of GHPs over the past 5-10 years has given rise for concern (in some quarters at least). Concerns have been aired over the increasing fragmentation of the global health landscape, poor coordination and duplication among GHPs and with other relevant global health programmes; certainly the potential for overlap exists (see Buse 2004a).

Partnerships themselves recognize that they have increasing numbers of potential partners and competitors and that they have to 'position themselves' to find a suitable niche to attract resources which are inevitably increasingly spread among GHPs (see Pearson report of this study). Many evaluations spoke of a competitive funding environment, particularly with the launch of the GFATM. While it could be argued that the process of niche specialisation may work to avoid overlap and duplication with other GHPs and global disease programmes, it is likely that these efforts will, in the first instance, be oriented more toward fund raising than substantive coordination unless explicitly encourage to do so.

In light of the proliferation of GHPs, questions arise as to how to set priorities, ensure priorities are funded and aggregate resources 'allocated' in a somewhat rational manner (e.g., according to burden of illness), coordinate activities among the many GHPs, and take stock of progress against global goals in relation to particular diseases, specific targets (e.g., MDGs), particular approaches (financing R&D for vaccines), particular cross-cutting issues (e.g., community vaccine preparedness) as well as development and or use of common systems at country level. While these concerns are not necessarily uniquely associated with GHPs⁴, GHP proliferation may have intensified or exasperated existing problems. Proliferation has also highlighted the problem of the lack of accountability of GHPs beyond their partners' organisations and/or host institution.

Meanwhile, past approaches to promoting global level coordination are increasingly less effective. They tended to be international in their scope in that they focussed on member states and inter-governmental organisations and failed to embrace non-state actors in meaningful ways. These approaches were often characterised by international meetings which issued international declarations and goals. All too often there appeared to be insufficient buy-in and insufficient specificity in relation to roles and responsibilities of key players. Certainly, with the advent of GHPs and numerous civil society groups, such state-centric approaches to coordination appear likely to be increasingly inadequate and ineffective even if, in themselves, they are necessary in the absence of alternatives.

The nature and extent of the impact of GHPs on the UN has become a matter of debate. While highly contested, discussion is usually based on anecdote and ideology instead of empirical evidence. It is not possible to draw robust conclusions on present evidence.

There is a strong case to be made for focussed research on the principal issues, including:

⁴ It is worth noting, that GHPs do raise unique issues and challenges, for example, as discussed above, in relation to new types of potential conflict of interest or in relation to potential threats to the technical authority of WHO as GHPs increasingly develop technical norms and standards.

- the increased interaction between the WHO and the commercial sector. For some, this renders protecting the public interest more challenging (Richter 2004). Although safeguards are being developed; how effective are they in practice?;
- the impact of GHPs on the funding situation of UN organizations, particularly WHO;
- whether or not, and how, GHPs support or undermine WHO's normative role. This is an important question that would benefit from early research;
- the impact of hosting arrangements on the work of host organisation, most commonly WHO but also including UNICEF and NGO bodies. There is little empirical information available upon which to either comment or make recommendations – which will in any event likely differ between GHPs and, within WHO, between WHO programmes;
- the impact of GHPs on UN reform processes. One might speculate that the option of working through GHPs has diminished some actor's appetite to engage in WHO reform efforts and discussions. Yet it is certainly also the case that most bilateral organizations and the important foundations continue to pay close attention to reform efforts and leadership in the Organization. And, as highlighted in section 4.3, a number of WHO-hosted GHPs have pursued reform in a number of procedural areas which may set precedents for the organization (e.g., involving the commercial sector in governing bodies).

12.2 The absence of formal vertical accountability

At the heart of this problem lie two issues. The first is the absence of formal vertical accountability of GHPs to an international or global architecture and the second is the question of the appropriateness of existing institutions to provide a locus for such accountability. GHPs are not accountable to any higher authority (beyond their partners, funders or hosts). Consequently, as the institutional framework is not in place, GHPs can not be held responsible for their actions within a framework which is capable of harnessing efforts towards agreed overarching goals, monitoring performance and rewarding and sanctioning behaviour. Some of the options mooted which might facilitate such vertical accountability include:

- Reporting/discussing/approving GHP plans and assessments/reviews at the World Health Assembly (WHA). While it may be possible to report and discuss either plans or assessments, it is debatable whether or not the venue is well suited for that task. The idea that the WHA approve GHP plans and budgets seems improbable and, in any event, the WHA has no formal mandate to do so (even its work with member states relies for the most part on non-binding recommendations);
- Reporting/discussing GHP plans and assessments/reviews at relevant WHO Meetings of Interested Parties (MIPs). While MIPs are increasingly thematic in content, it is debatable whether or not the venue is well suited for discussions on GHPs -- although it might merit further consideration;
- Reporting/discussing/approving GHP plans and assessments/reviews at the People's Health Assembly (PHA) (www.phmovement.org). The rationale for the PHA is to develop a more representative global body than the WHA (which is limited to formal participation of member states as well as non-voting participation of non-governmental organisations in official relations with WHO). At present, the PHA is a fledgling body which lacks widespread support. It would not command the legitimacy required.

It is unlikely, at least within the present context, that formal vertical accountability will arise -- principally for three reasons. First, it would require the identification or establishment of a body which could take on such a function. Second, there would likely be much resistance to the idea of an overarching authority with a mandate to hold GHPs to account - for institutional and ideological reasons (i.e., the fear of world government argument). Third, it would require that GHPs submit to such authority.

Despite such pessimistic prognosis, it is worth noting that the recently published draft 'Global Plan to achieve the MDGs', authored by the Millennium Project led by economist Jeffrey Sachs, recommends that the UN Secretary-General report in 2006 on a number of global initiatives, among them a number of GHPs including GFATM, Stop TB and RBM (Millennium Project, 2004). Then again, such an effort has to be distinguished from accountability of GHPs to the global health community. The Secretary General's report will likely focus on the extent to which member states have fulfilled their commitments to financing these GHP and the contribution of the GHPs to the MDGs (although the Plan concludes that many have fallen short of their targets) which they may or may not have set out to achieve. Although welcome, any eventual report by the Secretary General on these GHPs does raise questions of the locus of the Secretary General's office in partnerships that run much wider than the UN -- some of which are independent of its organs (e.g., GFATM).

12.3 Possible approaches to ameliorating the GHP accountability gap

In the absence of an overarching authority to which GHPs are accountable, a number of ad hoc mechanisms and initiatives, mainly horizontal and voluntary in nature, are being developed which may address a number of the concerns that arise due to the lack of vertical accountability (beyond the partners) and proliferation:

- **Cross-board representation.** A number of GHPs have extended representation on their Boards to executive staff of other GHPs (non-voting) (e.g., GFATM is represented on the RBM Board) and of global programmes (e.g., UNAIDS has seat on GFATM Board). It appears that efforts have also been made to consider Board appointments in light of involvement in other relevant GHP Boards (although this may be more fortuitous than strategic). Such cross-Board representation and fertilisation is likely to increase the level of coordination among initiatives;
- **Coordinated board meetings.** GAIN and MI, for example, not only have cross board representation of their Executive Directors, but are moving to a system whereby their boards will meet back-to-back and will overlap for a period so as to discuss issues common to both;
- **Overarching coalitions.** While RBM and Stop TB are themselves major coordination initiatives (Stop TB has over 300 partners), other smaller initiatives are also joining together. For example, eight global alliances working in the micro-nutrient field have formed the Wakefield Coalition so as to encourage the alliances, in the first instance, to hang together and read off the same hymn sheet. The ultimate aim is to develop a common and shared global strategic plan with country-by-country business-plans which would include the roles, responsibilities and activities of the various initiatives (and partners within them);
- **Coordinated and consolidated partner work planning and review.** What is important in relation to these initiatives is, on the one hand, developing robust, medium-term disease- or issue-specific global strategies and plans which support detailed country-by-country plans and, on the other, mechanisms for reviewing progress against these. Consolidated planning would provide a process for agreeing shared priorities, coordinating inputs and for reviewing each partner's contribution in light of commitments. Perhaps, partly as a result of increased engagement with the commercial sector, there appear to be increased use of business planning tools which encourage strategic planning, role specification and accountability in some GHPs;
- **Inter-GHP Memoranda of Understanding (MOU).** A number of GHPs are signing MOUs (e.g., RBM and GFATM; Stop TB and GFATM). This has the potential to encourage strategic thinking about comparative advantages and coordinated action, but also provides a mechanism to encourage horizontal accountability between initiatives;
- **Improved constituency management.** It was suggested above that improved constituency management would improve accountability to, and engagement of, GHP stakeholders. While this may have little impact on improved overarching coordination and

- resource allocation it may contribute to improved GHP accountability to stakeholder beyond the immediate partners and funders;
- **Coordinated partners' forums.** It may be prudent to experiment with joint meetings of relevant GHP Partners' Forums. Over time these might evolve into issue-specific bodies in which authority to set overarching goals within which to situate the activities of individual GHPs;
 - **Resist temptation to establish ever more GHPs.** While there may be good reasons to establish GHPs, they carry both risks and costs with externalities beyond the immediate partners. These costs should be considered when considering establishing an additional venture. These costs are not unique to GHPs but the proliferation of GHPs amplifies problem of coordinating multiple autonomous units.

In light of the above experimentation within GHPs, and notwithstanding the fact that individual WHO programmes may have been accountable to the WHA, it is arguably the case, that in some instances and taken from the view of coordinating multiple organisations, the very emergence of partnerships has led to improved accountability. For example, in relation to Stop TB, the individual organisations (WHO, KNCV, IUATLD, GBATDD etc) are accountable as organisations in exactly the same way as they were before. However, these individual organisations are now subject to much closer peer oversight, and they are collectively accountable as the partnership, publishing progress updates, holding Partners' forums etc. A similar argument could be made in relation to GAVI.

12.4 Moving forward

The absence of formal vertical accountability of GHPs beyond the partners (and hosts) is not amenable to a magic bullet solution over the short term. It would seem reasonable to suggest that the issue and possible solutions be discussed among interested parties at both the technical and political levels. In the short to medium term, the voluntary formal arrangements to improve coordination are likely to be the best way forward. Donors should be supporting voluntary, formal coordination among GHPs. GHPs need to understand that improved coordination is in their enlightened self-interest. Although it would be futile to insist on shotgun weddings or encourage marriages of convenience, donors could at no cost, support initiatives such as cross-board representation and back-to-back board meetings or development of MOUs among GHPs as warranted. Donors could also seed fund and provide technical support to relatively inexpensive mechanisms which encourage joined up and coordinated approaches. For example, supporting the meeting costs of periodic overarching coalitions of GHPs, and financing the costs of joint GHP planning and reviews. The initiatives which are under experimentation require independent review and assessment which would also benefit from external support. If the carrot approach doesn't bear fruit, the stick of funding conditional upon coordination action could be entertained, but this carries risk as well. Yet, however desirable improved horizontal coordination may be, it is not a perfect substitute for vertical accountability. More discussion on how to achieve the latter is certainly desirable.

12.5 Beyond GHPs?

It has been argued that GHPs arose due to problems (or perceptions thereof) with traditional development and technical cooperation approaches. For example, there was increasing recognition that many global health problems couldn't be resolved by individual organizations operating relatively independently nor by the public sector working independently of the commercial sector. The McKinsey study (2002) seems to have validated such perspectives: "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'. The study authors stressed that in many instances a solitary approach was not feasible, given the

initiative's objectives (although it is not clear whether the conclusions of the study were based on a study design which could make definitive claims on the matter). The impetus for GHPs also came from more specific concerns about the capacity and competence of WHO and the perceptions that prospects for major reforms over the short- to medium-term were poor. As a result, many foundations and bilateral organizations stepped up their funding of GHPs. With the positive impact of many GHPs, public-private health partnerships are now seen as the way to scale up the global response to health needs and to achieve various targets.

Scaling up GHPs and possibly establishing additional GHP to respond to health needs raises a number of issues. First, this report has noted a number of limitations to the ways GHPs are governed both at the global level (which are largely solvable) and at the country level (which will be more of a challenge). Second, improving the accountability of GHPs to the international health architecture presents the global health community with largely uncharted waters which will become increasingly choppy as more GHPs are launched. While some efforts at horizontal accountability are being experimented with, there is little analysis nor discussion of how to improve these initiatives nor how to address the black hole of vertical accountability. Third, there are the potentially problematic impacts of GHPs on WHO (discussed in section 12.1). These issues raise broader questions of the circumstances under which a GHP is warranted (i.e., when does it provide value for money in comparison, for example, to WHO), how to ensure that a GHP (and their proliferation) doesn't undermine WHO or other existing efforts, whether or not and how GHPs can be used to support and develop capacity in WHO, and, for some, whether or not GHPs are (or ought to be) a transient phenomenon en route a more effective and orderly global health architecture.

At this stage, these questions have been aired by many analysts yet they have not been the subject of serious high-level discussion nor subject to dedicated analysis which might inform such discussions. While analysis of these issues was beyond the scope of the current review, a few generalisations can be offered. First, it will remain difficult to compare the value for money of a GHP with a WHO programme as they will likely have different aims and objectives. Second, GHPs and WHO will often add value in different ways. At present, for example, GHPs offer the private sector with a more flexible instrument to engage in international health than working with WHO. Third, both GHPs and WHO each have comparative advantages which should be supported and tapped. Fourth, organizational reforms can be identified which could improve the performance of both GHPs and WHO. Fifth, the suitability and nature of an appropriate GHP response will depend on a number of factors – and it is these factors which need to be identified on a case by case basis.

Recommendations: DFID should convene a meeting among interested parties to review issues arising from: (1) the relationship between GHPs and international structures; and (2) experience with tools aimed to improve coordinated GHP action; and (3) explore alternative mechanisms. DFID should support, with finance and TA, existing efforts at coordinated and consolidated partner work planning and review, encourage such action among other initiatives, and attempt to learn lessons from emerging experience through support to evaluation.

ANNEX ONE**DFID's List Of 19 Core Ghps And Matrix Typology (4 Types, With Designation Of GHP Principal (P) And Secondary (S) Roles)**

	Financial	R&D	Technical	Global Public Good
GFATM	P			
GPEI	P			S
GAVI	P		S	
DNDi		P		
IAVI		P	S	
IPM		P	S	
MIM		P		
MMV				
MDP				
MVI				
APOC				
SCI				
GAELEF				
ITI				
GAEL				
GWEP				
RBM			P	S
Stop TB		S	P	S
WPRESS				

Billy Stewart, DFID, 30 July 2004

ANNEX TWO

1. To provide a description of the governance arrangements of the selected sample of GHPs (maximum 15) at the global level with particular reference to the following organisational features and processes:
 - a. Organisational structures of governing bodies including size and roles of executive, advisory and consultative (e.g., Partners Forum or association) and/or other bodies;
 - b. Representation/participation in governing bodies at the global level. This will include information on which organisations are represented and the basis of decision-making. Special attention would be paid to representation and participation of developing country governments and civil society, with illustrations of mechanisms to enable direct member inputs as well as any arrangements that have been developed to facilitate networks through which constituencies can be represented indirectly. This component will also characterise the nature of commercial and civil society representation and participation on governing bodies;
 - c. Accountability: (i) of Secretariats to members (indicator: appointment and line management of senior secretariat staff); (ii) of members to Secretariat (legal obligations and sanctions); (iii) of members to one-another (indicator: systems which encourage member compliance with governing body decisions); and (iv) of GHP to international governance structures such as the WHA (processes which facilitate flow of information of information to WHA and coordination with other relevant international programmes);
 - d. Transparency. Transparency would be described in relation to proxy indicators consisting of Internet availability and timeliness of: (i) strategic plans or equivalent; (ii) annual performance report; (iii) data on funding sources; (iv) annual expenditures; and (v) minutes of governing bodies; governance and appointment processes;
 - e. Oversight. This will be assessed by using the proxy of policy and practice of screening potential commercial partners for social corporate responsibility (based on information on Internet site).

This objective will be achieved through the following methods: (i) a review of GHP articles of incorporation or equivalent documents including standing orders of committees and bodies (assuming that DFID can make those available in relation to the GHPs which DFID supports or on whose Board DFID sits); (ii) reviews of evaluations and existing studies; (iii) data available in relation to structures and processes on GHP websites.

2. To elicit the perspectives of experts (i.e., evaluators) and stakeholders on the governance issues and concerns which arise in relation to the above-mentioned governance variables. More specifically, to seek views on why some seemingly 'bad' practice exists and how to encourage good practice in relation to representation; accountability; transparency; and oversight. Furthermore, in keeping with DFID's expressed interests, this component will also canvas views on good practice within the governing bodies of the sample of GHPs in relation to: (i) incorporating the views of developing country stakeholders; (ii) facilitating participation of developing country representation; (iii) modifying procedures to compensate for capacity constraints among partners from resource poor settings or efforts to develop capacity to enable potential partners from resource constrained environments to be involved in the GHP; (iv) countering domination of the governing body by individual partners; (v) facilitating improved bilateral participation; (vi) facilitating input from

country level representatives of northern partners; and (vii) accountability to international governance structures and coordination with relevant international programmes.

This objective would be achieved by: (i) synthesising concerns raised and best practice identified in various evaluations and literature; and (ii) polling a sample of stakeholders of the selected GHP (e.g., secretariats and partner organisations) on their views of governance issues and practices good and bad. GHPs and informants would be selected on the basis of an evaluation or the above descriptive exercise having turned up good or poor practice. The poll would be conducted on the basis of a short questionnaire instrument emailed to 15-20 respondents followed up by brief phone interview with a sub-sample to elicit their views on governance practices.

3. An exploration of the governance features which encourage positive partnering processes and outcomes in the selected GHPs. In particular, to synthesise existing information and stakeholder perspectives on what accounts for good or bad: (i) information sharing; (ii) common goal and strategy specification coordination; (iii) agreed, explicit and complementary roles and responsibilities (i.e., coordination); and (iv) skills transfer.

This objective would be achieved by: (i) synthesising information in existing evaluations; and (ii) polling the views of a sample of stakeholders of the selected GHPs (these questions would be included on the above-mentioned questionnaire instrument).

ANNEX THREE

Key Informants

Mr Rolf Carriere, Executive Director, GAIN

Dr Coll-Seck, Executive Secretary, RBM

Mr Derrick Deane, Coordinator, Government and Private Sector Relations, WHO

Dr. Denis Daumerie, Exec Director, GAEL

Dr Xavier Descarpentris, Government and Private Sector Relations, WHO

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ANNEX FOUR

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ANNEX FIVE**Internet Availability of Information**

GHP	Strategic or Annual plans	Annual report	Annual Budget	Funding sources & amounts	Annual Expenditures or audit	GB minutes	Governance Info
APOC	No	No	No	No	No	No	Name of governing body
DNDi	Business Plan	Too early		Yes – in business plan	No – too early	No	Organogram Charter
GAEL	No	Progress report	No	No	No	No	*
GAELF	No	2002 WHO report	No	No	No	No	TAG TOR RPRG TOR
GAVI	Yes 2004-05 Work Plan	Yes	No	Yes	Via VF 2002 annual report	Yes	Basic information on board functions, responsibilities, operations, procedures for new members
GFATM	Yes	Yes	Yes	In detail	Yes	Yes	Bylaws available
GPEI	Strategic Plan 04-08	Yes	No	Yes – but difficult to analyse	No	No	No
GWEP	No	Yes	No	In part	No	No	No
IAMI	Strategic Plan 05-07	Yes	No	Yes	No	No	Membership of bodies
IPM	No	No	No	In part	No	No	Org Overview Board Membership
ITI	No	Yes	No	In part – named	Yes	No	Membership of

							contributors				Board/TEC
MDP	No	No	No	No	No	No	No	No	No	No	Membership of MEC
MIM	Strategy 03-05	No	No	No	No	Sources not amounts	No	No	No	No	Organogram Membership of SAB and other bodies
MMV	No	Yes	No	No	Yes	Yes	Yes	Yes	No	No	Membership of Board, ESAC
MVI	No	No	No	No	No	No	No	No	No	No	Mentions but no info on SAC and TAGs
RBM	Programmatic (not partnership) Strategy 04-08	No	No	No	No	No	No	No	Summary of proceedings and decisions	Summary of proceedings and decisions	Membership of Board
SCI	No	Yes	No	No	No	No	No	No	No	No	Membership of Advisory Board & TP
Stop TB	Global Plan 01-05 Annual budget	Yes – progress report	Yes	Yes	Yes	Yes	Yes	Yes	Board decisions Report from a Forum mtg in 2001 can be ordered	Board decisions Report from a Forum mtg in 2001 can be ordered	Basic Framework Institutional arrangements TOR for Board and other organs Membership of Board
WPSS	No dedicated website										*

* No governance structure