

High-Level Forum on the Health MDGs

**Best Practice Principles for Global Health
Partnership Activities at Country Level**

Paris, 14-15 November 2005

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Best Practice Principles for Global Health Partnership Activities at Country Level

Report of the Working Group on Global Health Partnerships

1. Introduction and summary

The **Working Group on Global Health Partnerships** was tasked by the High Level Forum in Abuja in December 2004 to identify opportunities for synergies and harmonization between different global health partnerships and review cross-cutting issues; and to support further analytic work to provide greater clarity about guiding principles and actual practices, and assist the development of common principles of engagement and systems for monitoring their application. Brief details of the Working Group's activities are in Annex 1.

The overall aim of the High-Level Forum on the Health MDGs is to secure the sustainable **scaling up of priority health interventions and investments, improved health outcomes** and **faster progress** towards achieving the health and poverty reduction MDGs.

Global Health Partnerships (GHPs) have a **major role** to play in this endeavour. Indeed, a key reason for establishing such partnerships and funds stemmed from global concern about the growing burden of disease pandemics, particularly in Africa, and the need to accelerate action substantially if global targets were to be achieved. A fundamental strategy of GHPs has been to work in new ways to expand effective collaboration – including promoting greater participation by civil society and the private sector - and increase access to resources to serve those in need.

Overall **GHPs have contributed many benefits**. The major GHPs have been instrumental in advocating for, or providing, large-scale new financing. They have raised the profile of their target diseases at the highest political levels globally and nationally. Other key areas of success have been to accelerate progress; attract new partners and increase the profile of non-governmental stakeholders, including NGOs and the private sector, in the global fight against specific diseases; provide a means of supporting global public goods; secure substantial economies of scale (eg in drug procurement); and in some cases lead innovation. Development of a clear strategy, building a consensus around it, and coordinating partner efforts are fundamental added-value objectives for technical GHPs.

At the same time, the proliferation of global health partnerships and funds over the last few years - alongside traditional donor activity - has raised new issues. GHPs are **highly diverse** in nature, scope and scale, and any attempt to compare them with the same yardstick has considerable limitations. Most are relatively small or very specialised. The main concerns at country level relate to a few **major global health partnerships**. Overall the collective impact of GHPs has created or exacerbated a series of problems at country level including: **poor coordination and duplication** among GHPs; **high transaction costs** to government and donors from having to deal

with multiple initiatives; **variable degrees of country ownership**; and **lack of alignment** with country systems. The cumulative effect of these problems is to risk undermining the sustainability of national development plans, distorting national priorities, diverting scarce human resources and/or establishing uncoordinated service delivery structures.

In addition, without increased support to help build **health system capacity** in almost all developing countries, the resources mobilised by global health partnerships and initiatives are unlikely to achieve their full potential. Longer-term there will be need to sustain the achievements realized through shorter-term support from GHPs.

Evidence from studies of GHPs¹ suggests a gap between the overall practice of GHPs at country level and internationally-recognised principles of effective aid, as set out most recently in the Paris Declaration on Aid Effectiveness (March 2005). Successful scaling up will require **more aligned and harmonised approaches** (for example, in relation to GHP application procedures, transfer of funds, management, monitoring, reporting and auditing).

There are opportunities within the control of GHPs to make changes in their approach and processes to reduce the costs they impose on recipient countries. Most of the Paris Declaration principles are already being practised by some GHPs in some countries – which suggests that there may be challenges but no insuperable barriers. Yet no single GHP appears to practise all in all environments. A key message for GHPs is the importance for them to act with speed and flexibility:

- to **endorse and enact some best practice principles** for the engagement of GHPs at country level, primarily relating to alignment and harmonisation, in the belief that better harmonized and aligned aid from GHPs will ultimately lead to better results; and
- to work with countries, and with other agencies and GHPs, rapidly to get in place solutions to the simpler problems raised, while at the same time developing approaches to the more challenging problems.

Draft best practice principles have been derived from a GHP-specific adaptation of the five key areas of the Paris Declaration on Aid Effectiveness:

- **ownership:** *GHPs respect partner country leadership and help strengthen their capacity to exercise it;*
- **alignment:** *GHPs base their overall support on partner countries' national development strategies, institutions and procedures;*
- **harmonisation:** *GHPs' actions are more harmonised, transparent and collectively effective, and GHPs collaborate at global level with other partners to address cross-cutting challenges such as health system strengthening;*

¹ including provisional findings from a large-scale current study by McKinsey & Co., commissioned by the Bill and Melinda Gates Foundation to provide an up to date assessment of the country-level perspective on global health partnerships and initiatives. The study focuses on the transaction costs at country level of multiple GHP interactions.

- **managing for results:** *GHPs work with countries to adopt and strengthen national results-based management*
- **accountability:** *GHPs provide timely, clear and comprehensive information.*

In addition, a few best practice principles on **GHP governance** are proposed. In the interest of public accountability, GHPs should ensure that their purpose, goals and objectives are clear; procedures are transparent; and key documents should be publicly available on the internet.

If best practice principles are agreed, the intention is to move forward swiftly to practical action. Further work in collaboration with individual GHPs is required to explore fully the **implications for GHPs of operationalising the best practice principles**, which are likely to be different for each GHP. The full paper lists in paragraph 92 examples of the kinds of issues that are likely to emerge.

Given the need to tailor approaches to different settings, these principles are primarily to be operationalised at country level. Countries may wish to set their own targets and indicators. There is scope for the development of country-level mechanisms to support compliance through **country-specific agreements between all partners** on rules of engagement.

An issue-focused global **forum** should be held on a regular basis to provide an opportunity for key players from major GHPs, recipient governments and donors to review principles, practice and progress; and address issues of joint concern, including overlaps, gaps and systems issues. Ideally such a discussion would take place within the wider context of taking stock of developments in the health sector as a whole.

The High Level Forum is invited to:

- i) review **a set of best practice principles for GHPs** based on the Paris Declaration on Aid Effectiveness (paragraph 89);
- ii) consider whether there is need for further principles on **GHP governance** (paragraph 90);
- iii) recommend that selected major **GHPs** - GFATM, GAVI, Roll Back Malaria, the Stop TB Partnership, the Health Metrics Network and the Partnership on Maternal, Newborn and Child Health - **begin a process of more formal endorsement** by their own Boards;
- iv) consider the proposed means of fostering compliance, through **country-specific agreements and a periodic global forum**.

If best practice principles are adopted, **follow-up action from GHPs** should include a self-assessment of individual GHP practice in relation to the principles; development of proposals for action; and consideration with countries and other partners of those wider issues needing collective action.

Enabling action will also be required from other partners, including countries, and bilateral and multilateral agencies.

2. Health and the OECD/DAC Paris Declaration on Aid Effectiveness

2.1 The Paris Declaration on Aid Effectiveness: General

Global Health Partnerships operate within a wider health and development context. Best practice principles for GHPs should be set within the framework of existing agreements to streamline, harmonise and strengthen development cooperation.

As early as the 1980s, there was concern that a proliferation of donor projects (combined with differences in donor policies, operational procedures and reporting mechanisms) were hindering the effectiveness of aid, creating an unsustainable administrative burden on countries and reducing local ownership. Recognition of these problems led to the emergence, in the late 1980s and early 1990s, of budget support, sector-wide approaches and Poverty Reduction Strategy Papers (PRSPs). These new approaches were guided by the idea that aid should be provided more flexibly; that government (rather than donors) should set priorities and allocate resources; and that the transaction costs of aid should be reduced.

The movement towards better aid resulted in two *High Level Forums on Aid Effectiveness* - in Rome in February 2003 and Paris in March 2005. Donors and partner countries defined the 'aid effectiveness' agenda and committed to implementing it. At Rome, donors agreed (among other things) to ensure that development assistance is delivered in accordance with partner country priorities, including poverty reduction strategies; reduce the number of missions; streamline conditionalities; and simplify and harmonize reporting procedures.

Earlier this year in Paris, a new Declaration on Aid Effectiveness was issued which moved the agenda on by adding indicators and targets to the commitments. It has the support of over 100 developing and donor countries, and organisations including the African Development Bank, Asian Development Bank, European Bank for Reconstruction and Development, Inter-American Development Bank, Development Assistance Committee of the OECD, UN system organizations (through the UNDG), and the World Bank.

The five key areas of the Paris Declaration are:

- i. **ownership:** *partner countries exercise effective leadership over their development policies and strategies, and coordinate development actions*
- ii. **alignment:** *donors base their overall support on partner countries' national development strategies, institutions and procedures*
- iii. **harmonisation:** *donors' actions are more harmonised, transparent and collectively effective*
- iv. **managing for results:** *managing resources and improving decision-making for results*

- v. **mutual accountability:** *donors and partners enhance mutual accountability and transparency for development results and the use of resources.*

‘Alignment’ refers to efforts to bring the policies, procedures, systems and cycles of the donors *into line with those of the country* being supported, and ‘harmonisation’ refers to efforts to streamline and coordinate approaches *among donors*.

Within these five areas, the Paris Declaration has some 50 commitments to improve aid quality, involving action by both donors and partner countries. These will be monitored by twelve indicators and specific targets for the year 2010 (set out in Annex 2).

Examples of targets for 2010 include:

- at least 85% of aid to be reported on government budget(s);
- 66% of aid flows to be provided through programme-based approaches;
- 40% of donor missions to the field, and 66% of country analytic work to be joint;
- parallel project implementation units to be reduced by two-thirds.

2.2 *The significance for health*²

From a health perspective, the move towards more streamlined and predictable donor support has a number of implications. For example:

- The concept of country **ownership** over development policies and poverty reduction strategies should extend to the health sector. This has two aspects: first, health sector plans should be country-owned and developed. There remains, however, a role for development partners (including GHPs) to challenge and help strengthen country plans which do not adequately prioritise the health needs of the poorest people. Second, health ministries should engage in framing ‘upstream’ development strategies, as these impact on (for example) health workers’ pay and sector budget ceilings. There is need therefore to build capacity within ministries of health to engage with ministries of finance and planning, and with poverty reduction strategy (PRS) processes. Ideally the PRS should build on a sound health sector plan and expenditure framework.
- Development assistance for health should be **aligned** with national systems, including health service delivery systems; information and monitoring systems; and national procurement systems. Multi-year commitments on aid flows are essential if countries are to make sustainable plans to scale up health provision, for example by employing more health workers or beginning long-term treatment programmes. Multi-year commitments on budget support are seen by many as a way of increasing predictability. However, as donor support moves upstream, it will be important to maintain government-partner dialogue

² This section is based on: Dodd R and Cassels A *Applying the Paris Declaration to the health sector and to Global Health Partnerships*, WHO (2005)

to ensure that health remains a priority within overall development efforts, and that improved health service delivery and better health outcomes are being achieved.

- **Harmonisation** and simplification of donor practice are particularly important to the health sector, which is typically characterized by a large number of actors (bilateral, multilateral and GHPs), many with a particular disease or age focus (eg malaria, or child health). At present, coordination mechanisms in health are highly variable from country to country.
- Improved, accessible information is key to measuring performance and ‘**managing for results**’. There is need to strengthen health information systems, particularly in low-income countries, and to agree on a set of process indicators that can help policy makers assess health system performance.
- Innovative approaches to strengthen direct accountability between health providers and clients are needed, as well as **mutual accountability** between donors and partner countries. Experience is needed of effective ways to tackle corruption, fuelled by low pay and constrained resources in the health sector.

The Declaration is already providing at least part of the context for other relevant action in the health and related sectors, for example the work of the UNAIDS’ *Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors* which reported in June 2005³.

3. Paris Declaration commitments and GHP Practice at country level

This section identifies target GHPs and provides a general overview of findings on GHPs from recent studies. It then examines study evidence about GHP practice at country level in relation to the main areas of the Paris Declaration commitments: ownership, alignment and harmonisation (with relevant indicators like aligning aid flows on national priorities, using country systems, avoiding parallel implementation units and making aid more predictable), managing for results, and accountability.

3.1 Target GHPs

Estimates suggest there are from 75-100 GHPs, depending on definition. The main types have been classified as:

- *research and development*: GHPs involved in product discovery and development of new therapies (vaccines, treatments etc.);
- *technical assistance/service support*: GHPs providing drug donations, support improved service access and/or give technical assistance;
- *advocacy* (national and international levels): GHPs advocating for increased international and national response to specific diseases, fund-raising for specific control programmes etc.
- *financing/funding*: GHPs providing funds for specific programmes.

³ *Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors*. Final report 14 June 2005, UNAIDS.

They are **highly diverse** in nature, scope and scale, and any attempt to compare them with the same yardstick has considerable limitations. Most are relatively small or very specialised.

Studies suggest that the main concerns at country level relate to a few **major global health partnerships** (GFATM, GAVI, the Stop TB Partnership and Roll Back Malaria). Most either channel significant resources and/or coordinate major health partners in key areas.. Two further Partnerships - the Health Metrics Network and the Partnership on Maternal, Newborn and Child Health - are too new to provide country-level evidence but are likely to form part of future collaboration among major GHPs. There are significant differences in function and operation between GHPs providing funding (GFATM and GAVI) and those concerned with coordination, advocacy and technical support (Roll Back Malaria and the Stop TB Partnership). Proposals for best practice principles would, however, have relevance to all global health partnerships.

3.2 General overview of findings on GHPs from recent studies

Overall most studies agree that GHPs have contributed many benefits. The major GHPs have:

- been instrumental in advocating for or providing large-scale new financing;
- raised the profile of their target diseases at the highest political levels globally and nationally;
- accelerated progress (though it remains unclear whether some GHP targets will be delivered on time);
- attracted new partners and increased the profile of non-governmental stakeholders, including NGOs and the private sector, in the global fight against specific diseases;
- encouraged the use of evidence-based approaches to public health (such as harm reduction and substitution therapy) which may be neglected by governments;
- provided a means of supporting global public goods;
- secured substantial economies of scale (eg in drug procurement); and
- in some cases led innovation.

Development of a clear strategy, building a consensus around it, and coordinating partner efforts are fundamental added-value objectives for technical/coordination GHPs.

A study currently being finalised by McKinsey and Co.⁴ provides up to date evidence of findings at country level. Given the speed of developments, most findings in this paper are drawn from its provisional report unless specified otherwise. The study agrees with earlier work that **GHPs are achieving their goal of increasing focus and activities on specific health priorities that may have been marginalised or under-resourced.**

⁴ This study was commissioned by the Bill and Melinda Gates Foundation. Members of the HLF Secretariat participated in the study's Technical Advisory Group, and the study's provisional findings were presented to the HLF GHP Working Group on 28 September 2005.

Besides getting much-needed attention and funding to fight diseases, countries have benefited from GHPs' interactions in a variety of ways. For example, GHPs' requests have caused countries to increase planning capacity and GHP feedback has helped countries craft robust plans for key diseases. Countries have strengthened the rigour of programme monitoring and improved accountability for use of funds and overall transparency.

At the same time, there is a striking consensus among recent multi-GHP studies that - alongside the many important contributions made by GHPs - their collective impact has created or exacerbated a series of problems at country level. For example:

- **poor coordination and duplication** among GHPs and with other agencies. For example, several GHPs - in addition to multilateral and bilateral agencies – are undertaking programme-specific sustainability planning for both human and financial resources.
- **high transaction costs** to government and donors from having to deal with multiple initiatives.
- **variable degrees of country ownership**; and
- **lack of alignment** with country systems.

The cumulative effect of these problems is to risk undermining the sustainability of national development plans, distorting national priorities, diverting scarce human resources and/or establishing uncoordinated service delivery structures. This has been a long-running concern and GHPs have made efforts to minimise transaction costs. Even so, the most recent study still finds that there are multiple opportunities for GHPs to reduce the burden on countries further. Countries also have opportunities to improve the way they deal with GHPs.

Delayed, patchy and weak communication between some GHPs, countries and partners can seriously dilute program quality and create a negative perception of the GHP. In some cases, countries have faced delays in getting clear feedback, advice and technical assistance from the GHP headquarters. The rationale for policy and technology shifts has not been sufficiently communicated. The problem may stem in part from the emphasis on GHPs operating with lean secretariats. In-country partner agencies are not always prepared to be the face of the GHP in the country, and conversely some GHPs are not always comfortable about being represented by partner agencies.

The influx of money from GHPs has highlighted existing problems in the basic health systems in many recipient countries. Without increased support to help build **health system capacity** in almost all developing countries, the resources mobilised by global partnerships are unlikely to achieve their full potential. Critical components include prevention, system capacity building (reflected most dramatically in shortages of professional health workers), surveillance, research, monitoring and evaluation, other essential public health functions, and the role of non-health sectors. GHPs are now planning to put substantial funds into systems building, but their plans and activities need to be coordinated within wider national and global efforts rather than creating a multiplicity of individual GHP efforts.

GHP programmes may under-estimate the human resources required to implement grants, although this may be changing. In a recent application to the GFATM from the Democratic Republic of the Congo, only 5% was allocated to human resources; this subsequently increased to 20% when UNDP as the Principal Recipient requested a reallocation of the budgets. There is also an acute shortage of skilled managers. In these circumstances, GHPs often attract scarce talent from government activities, and the cumulative impact of GHPs amid multiple partners in-country may well overwhelm countries. In some cases, GHPs have allowed significant salary inflation to occur, particularly for programme managers. This undermines countries' ability to deal with retention, and can become even more problematic if donors escalate salaries to compete with each other for talent, as has happened in Viet Nam and Cambodia.

While GHPs have mobilised technical assistance to help countries prepare applications for funding, post-application technical assistance is neither well-articulated by countries nor well-supported by partners. **Inadequate funding of technical support for implementation** – as well as management capacity to execute and oversee scaled up programmes – is a real threat to countries' ability to meet performance measures. In the short-term, there is increased and urgent demand at country level for aligned and harmonised technical assistance for implementation. Coordinated and expanded support is needed from throughout the UN system. There is also a role for foundations and the private sector. All technical assistance should be demand-led by countries and capacity-building in nature. The long-term aim must be to develop good quality competence and infrastructure at country level, with diminishing need for external assistance. This is likely to run beyond the scope of individual GHPs and require an institutional base.

In general, these **cross-cutting system-level issues have neither been directly caused by GHPs nor are they unique to GHPs**. Solutions will require collective consideration and action from a broader set of stakeholders. It is imperative upon GHPs both to help build country ownership of health programmes and support development of country systems, and to work with others to address key challenges, for example in relation to human resources.

3.3 *Ownership*

National ownership is fundamental since national partners are accountable to their own societies for the services they provide. As a matter of principle, GHPs need to ensure that their **activities are coherent with national development strategies**, as well as sectoral strategies.

Equally, national development plans should acknowledge the contribution of GHPs to achieving health sector goals. GHP activities often involve a wide stakeholder group (including civil society, private sector and government), which is in line with commitments to increase participation in national development strategies.

In practice, studies suggest **variable degrees of country ownership**. For example, the recent *Final Report of the Global Task Team on Improving AIDS Coordination*

*among Multilateral Institutions and International Donors*⁵ found that progress towards realizing this vision of national ownership has been uneven, hindering progress towards realisation of the ‘Three Ones’ principles for AIDS. It judges that relatively few of the existing national AIDS strategies meet the requirements of one national AIDS action framework, as defined within the ‘Three Ones’.

Conversely there was little evidence of international partners supporting nationally-owned plans and policies, and ensuring that their own activities are included in national plans. The Global Task Team report challenges countries to secure ownership by developing capacity to identify problems, set priorities and establish accountable systems to enable the rapid scaling up of a multisectoral response to AIDS. It also challenges multilateral institutions and international players (which include relevant GHPs) to be accountable for providing **support to national plans, policies, procedures, systems and cycles**, including through aligning with them and harmonising with each other. The underlying principles would apply equally to GHPs in other health areas.

National coordination of GHPs is the key to better performance, for which **capacity to manage external partners** is critical. There are several countries that exemplify how this can be done effectively. However, there are others where the institutions of government function poorly or are on the point of collapse. Strategies for better co-ordination in these circumstances require attention.

The GFATM, through its Country Coordinating Mechanisms (CCMs), is frequently cited as having increased the involvement of the private and civil sectors, and improved transparency. Countries are piloting innovative ways of strengthening coordination bodies.

Overall however, countries are seeing a **surfeit of coordination mechanisms**, with little effective coordination to show for it. The costs of poor coordination at the central level fall on the districts at the front line of execution. NGOs (including those funded by GHPs) do not consistently share plans with districts, nor disclose finances. The McKinsey study notes an estimate that in Zambia, 50% of activities at district level are unplanned, mostly as a result of NGO activities.

In Burkina Faso, Tanzania, Bangladesh, Viet Nam and Angola among other countries, many of the same people are stretched across the main coordinating bodies, including the CCM for the GFATM and the Inter-Agency Coordinating Committee (ICC) for GAVI, in addition to various national committees. Many countries report that ICCs function better than CCMs, perhaps because of their more limited scope, clear operational role beyond application submission, and lack of formality. Despite the ‘Three Ones’, HIV/AIDS has seen a proliferation of coordinating bodies and national bodies where HIV/AIDS is a major agenda item, with little evidence of increasing coordination.

⁵ *Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors*. Final report 14 June 2005.

3.4 *Alignment and Harmonisation*

The current multiplicity of disease-specific GHPs, together with the activities of traditional international organisations (which are a mix of disease-specific and system-wide interventions), carry **high transaction costs for developing countries**. GHP requirements – for preparing proposals, reporting progress, procuring supplies, or in terms of institutional arrangements – differ significantly from programme to programme. A particular feature of some GHPs has been their pressure on countries to respond urgently to a very tight timeframe.

The technical/coordination GHPs already provide a vehicle for harmonisation in relation to their specific disease. Among the first products of the coordinated work of country authorities, donors and technical partners coming together as the Stop TB Partnership were DOTS Expansion Plans - generally formulated as part of larger 2-5 year development plans of Ministries of Health - and the Global Plan to Stop TB 2001-2005, (shortly to be succeeded by the Global Plan to Stop TB 2006-2015). Similarly the Roll Back Malaria Partnership has this year produced a Global Strategic Plan 2005-2015 to coordinate partners' activities, and a small task team is preparing proposals for discussion at a global RBM forum in November 2005.

However, there remains **scope for greater harmonisation and collaboration across GHPs**, including the smaller GHPs. There is already an initiative to secure greater integration of GHP programmes for schistosomiasis, lymphatic filariasis, trachoma, onchocerciasis, intestinal helminths, and the micronutrient initiative, in countries in which they are co-operational.

3.5 *Aid flows are aligned on national priorities*

The rationale for the creation of GHPs was precisely to focus attention on specific areas regarded as requiring greater attention by partners acting in concert at the global level. Both stimulated and accompanied by effective advocacy programmes, GHPs have led to a major increase in resources for communicable diseases.

The issue of the extent to which GHPs are aligned on, or distort, national priorities has been a matter of vigorous debate not fully resolved by past studies. The current McKinsey & Co. study describes a distinction between countries based on the strength of their health plan (which may itself be an indicator of institutional capacity in the health sector).

In those countries **where a strong health plan exists** and is utilised, (for example, Viet Nam, Bangladesh, Kyrgyzstan, China, Tanzania and Ghana), priority areas have not been affected by the availability of additional funding. In some cases, the influx of HIV/AIDS funding has increased the priority given to the disease where countries might otherwise ignore it. For example, in Bangladesh the team heard that “given the social stigma of HIV/AIDS, government will to address the potential health epidemic would not exist in the absence of donor funding and focus on the disease”. Moreover, the study found that countries set incoming funding against execution of their health strategy.

In other - often resource-scarce - **countries with weak health plans**, (for example, Chad, the Democratic Republic of the Congo, Angola, Cambodia, Zambia, Guinea and Laos), the **limited capacity in-country is drawn to areas with financial resources**, such as HIV/AIDS. In these countries, there is no spillover from funded areas into other areas. Areas such as maternal and child health remain highly under-resourced, despite need. The Partnership on Maternal, Newborn and Child Health is too new for impact yet to be seen at country level. In Chad, for example, while active diversion of resources is not occurring, donors' lack of focus on certain health areas reinforces their low prioritisation. Furthermore, even where areas of GHP activity are prioritised, lack of resources can result in fragmented implementation (for example, in relation to malaria control in Zambia).

Overall, some countries seem better able to work with GHPs, withstand shifts in priorities and handle some of the associated transaction costs. Contributory factors include the existence of a strong, integrated health plan; an established funding mechanism in which donors participate; and the clear delineation of roles between central and district governments. Countries in which policies are set at the national level and action plans determined at the district level in accordance with national priorities (for example, Tanzania and Viet Nam) are better able to fit GHP resources into activities.

This reinforces the wider need for GHPs and donors to help strengthen country processes, especially an integrated health plan. Where GHPs require applications (most notably the GFATM), the application process itself – though it can be time-consuming and intense - has often led countries to develop or strengthen health plans.

GHPs often explicitly or implicitly **tie policy recommendations to grant-making**, with some negative consequences. In some cases, countries perceive that they have been encouraged to replace policies that were most appropriate for them, given local financial and health system considerations. More generally, communication about policy rationales and GHP flexibility seems poor, and new technology adoption is not well-supported. Potential funders need to announce their policies earlier and more consistently so that countries can plan appropriately (ie, both for programmatic and financial sustainability purposes). GHP new technology requirements include GAVI pentavalent/Hep B vaccine; Stop TB Partnership/Global Drug Facility 4-drug combination product; PEPFAR FDA-approved antiretrovirals; and GFATM support for artemisinin combination therapy (ACT) only where indicated by WHO guidelines.

3.6 Use of country systems

Alongside the push for better health outcomes, much of the global debate around GHPs has been about the need for alignment and harmonisation at the country level, in order to **reduce the burden on countries** from multiple, parallel financing, planning, management, procurement and reporting systems and **secure better health outcomes**.

Most GHPs do profess to want to strengthen and work through existing country systems but this is not the case in practice. GHPs have often overlaid a standard set of their practices on countries (NB this is likely to apply mostly to the funding GHPs,

especially the GFATM). This results in duplication of effort and undermining of country processes. GHPs must continue to **tailor their approach, requirements and processes** to better reflect country capacity.

Planning: GHP planning timelines and scope differ from those of the country, for example in Ethiopia, Viet Nam and Indonesia. This leads to duplications, confusion and misalignment between proposals and plans. On balance, this is a cost countries are willing to accept given the magnitude of the accompanying funds and the infrequency of the exercise. Some countries have adopted a mid-year review process to assess new sources of funds and resources that come outside their planning cycle (eg in Bangladesh).

Financing: For the most part, financing mechanisms for funding GHPs are still separate from the country’s mechanisms, leading to planning complexity and administrative costs in tracking funds. While there are circumstances which justify separate systems (eg governance concerns, a budget ceiling for health, or funding for the private or NGO sector), separate mechanisms for financing through GHPs creates fragmentation. For example, in Angola where there are concerns about lack of good governance, it is currently impossible for national or provincial level government to track financial flows, since donors have adopted a variety of routes to fund the health sector. The proliferation of donors focusing on the same programmes but through different financing routes has further complicated funding flows. Thinking about sustainability is also difficult when there is no complete picture of the country’s health financing.

Several GHPs are experimenting with proposals to adapt processes to the needs of individual or segments of countries e.g. continuous cycles, funding SWApS and baskets. But overall the McKinsey study finds that GHPs are not adequately supporting country financial mechanisms. In those countries with Sector Wide Approaches (SWApS) with pooled funding, GHP participation remains very limited. The Global Fund, for example, has to date formally joined SWApS only in Malawi and Mozambique.

McKinsey & Co. study findings:

GHPs are not adequately supporting country financial mechanisms

Country	Country mechanism	GHP outside mechanism
Bangladesh	SWAp (HNPSP) with >80% of budget from government and donors falling under single financial and reporting system. GHPs funding equals 2.5% of budget but each GHP adds reporting requirements.	GAVI GFATM
Burkina Faso	Emerging SWAp – PADS – integrates single report for all donors and provides decentralised funding to districts. Limited GHP engagement with districts.	GAVI GFATM
Mozambique	Established SWAp with 10 major partners, including GFATM, contributing to common fund with single reporting system.	GAVI PEPFAR

A GFATM report on Harmonization of Global Fund programs and Donor Coordination⁶ provides four case studies with a focus on HIV/AIDS. They describe action to improve harmonisation and alignment, but also the reality of the challenges. For example, in Mali a broadly representative body (HCNLS) has been established to take responsibility for leading the country's multisectoral response to HIV/AIDS, and its role as Principal Recipient for three large HIV/AIDS programmes has begun to show potential for alignment on the part of the World Bank, the GFATM and the African Development Bank. UNAIDS and other partners have provided funding to develop a common monitoring and evaluation (M&E) system and database. The GFATM expects to use the National Program for Social and Health Sector Development and HCNLS audit procedures at the end of the first year of its grant. Nonetheless, the study identifies challenges in ensuring that the common monitoring and evaluation system is fully implemented; aligning procurement and supply management plans; strengthening the capacity of the new HCNLS; and further defining the HCNLS' relationship with the CCM.

In Mozambique, joining the SWAp has prompted the GFATM to explore ways in which its requirements for assessments of Principal Recipient capacities, approval of procurement and supply management plans, audit reports, and monitoring and evaluation plans can be adjusted to use the mechanisms already established by the SWAp.

The overall conclusion is that GHPs should be working towards much greater use of national systems for disbursement of funds, procurement, monitoring and evaluation. The fact that the funding GHPs have been able to find ways to participate in SWAps with pooled funding in some countries – for example, the GFATM in Mozambique and GAVI in Uganda – suggests that there are challenges but no insuperable barriers. For their part, countries should be aiming to strengthen systems so that donors are more comfortable relying on them. In the short-term, while such systems are weak, GHP activities should be 'shadow aligning' with countries systems and contributing to building their capacity.

3.7 *Avoiding parallel Project Implementation Units*

Implementation conducted vertically through Project Management Units (PMUs) may allow greater focus and increase the individual programme's potential for success, but it can also fragment implementation efforts within a disease area, create parallel structures and consume scarce resources.

For example, a 2004 study in Uganda⁷ found that a separate Global Fund Project Management Unit ('the Ugandan Global Fund for AIDS, TB and Malaria') had been established with 20 staff. Instead of adopting a more integrated approach and making use of existing MoH resources and structures, it required the MoH national disease programmes at both national and district levels to submit separate workplans from

⁶ Hacopian P., *Harmonization of Global Fund Programs and Donor Coordination: four case studies with a focus on HIV/AIDS*. GFATM, 2005

⁷ Carlson C. et al (2004) *Assessing the impact of Global Health Partnerships: Country case study report*. DFID Health Resource Centre.

their own MoH workplans, and established its own procurement facility and a parallel transport system. The study noted a lack of clarity about links between the PMU and the CCM, and between the PMU and the MoH decision-making and monitoring bodies under Uganda's health SWAp.

3.8 *Predictability (and sustainability) of aid*

GHPs are delivering large-scale new financing for communicable diseases and other global public goods, against a backdrop of strong growth in development assistance for health over the last three decades⁸. However, in 2004 GHPs had not achieved their aim of attracting new funding sources with the exception of Foundations, especially the Gates Foundation. Most funds continued to be provided by traditional donors, who were then providing 97% of pledges for the GFATM. There were and remain concerns about the uncertainty of future levels of funding for the GFATM, and hence for the disease areas it supports⁹.

Uncertainty in disbursement leads to difficulty in short and medium-term planning. In some cases (e.g. Ghana) where Government identified GHP-funded proposals as part of its national strategies, distortions were created when GFATM applications were not approved¹⁰.

Tackling the challenges of controlling major diseases requires sustained long-term financing to support sustained, long-term action. In a demonstration project in Zambia, the Gates/PATH Malaria Control and Evaluation Partnership in Africa (MACEPA) programme, funding has been committed for nine years. But replicating this model would be challenging on a number of fronts, not least that it requires longer-term commitments than are typically made today.

If GHPs were to move towards direct budget support, the trade offs in terms of measuring additionality and impact of GHP money would need to be recognized. The general move from sector-based aid to direct budget support raises issues about ensuring that governments allocate sufficient resources to health in their expenditure frameworks, and the skills needed in Ministries of Health to prepare scaled-up budgets and negotiate with Ministries of Finance.

Sustainability is a recurring concern in studies. GHPs have had a prominent role in introducing high value goods (eg antiretrovirals) into under-resourced health systems. Most interventions funded by GHPs are potentially highly cost-effective – except antiretrovirals where there are social justice arguments. Even so, low-income countries are unlikely to be able to meet ongoing costs themselves. This has major implications for sustainability of health sector expenditure. For example, in several countries external funding for HIV/AIDS (most of which has been provided by GHPs) is already equivalent to or greater than the public health budget. (This issue is dealt

⁸ Increases in real donor spending on health and population have been of the order of 3% per annum since 1975. Pearson M., GHP Study Paper 2: *Economic and Financial Aspects of the GHPs*. DFID Health Resource Centre, 2004

⁹ Waddington C. et al, *Trends in International funding for TB Control*. HLSP Institute and Stop TB Partnership Secretariat, London 2005; and Waddington C. et al, *Trends in International funding for Malaria Control*. HLSP Institute, London 2005

¹⁰ Pearson, *ibid*

with in greater detail in another paper prepared for the High-Level Forum: Fiscal space and sustainability from the perspective of the health sector.)

Planning for financial sustainability is often seen as difficult to achieve and not taken seriously. Countries perceive that the magnitude of funding is too large to plan for a handover. For example, in Vietnam, the Ministry of Health supports just 10% of the HIV/AIDS budget in 2005. By 2010, there is a forecast funding gap for HIV/AIDS of at least US\$ 56 million compared to 2006 peak levels as funding from global health initiatives, partnerships and other donors tapers off.

3.9 *Managing For Results*

There is need for **common reporting on country results** as defined in overall national plans rather than the results attributable to a particular GHP programme. This might be an indicator of progress in relation to good practice. Some GHPs do use only existing national metrics systems, and in the case of GAVI have provided additional resources to improve their quality and audit¹¹. GFATM and PEPFAR have agreed on joint reporting.

The McKinsey study found that **surveillance metrics** for GHP-funded programmes are collected in a fragmented manner and not consistently integrated into national systems. In Zambia, two of the four Principal Recipients of GFATM funding are NGOs who do not currently share the metrics they collect for GFATM programmes, since they are not required to do so. This undermines national planning efforts.

Programmatic monitoring and reporting take significant amounts of valuable time from district and health facility staff. **Major variations in reporting indicators and formats** (eg in Angola, between the country Health Management Information System (HMIS), the WHO/UNICEF Joint Reporting Form (JRF) and the GAVI report) make the system very cumbersome. In some cases the **frequency and timing of GHP reports may also be misaligned**, creating additional burdens. For example, in Viet Nam all national health/donor reporting is aligned with Ministry of Health quarterly and biannual reporting, except for GFATM quarterly financial and activity reporting on a TB grant. The latter's financial report is off cycle by just one month, resulting in the need to recompile all the quarterly financials rather than use existing data.

Most countries do not feel sufficiently empowered to ask GHPs to tailor their approach. For example, Ghana changed its SWAp to accommodate the GFATM without asking the Fund about flexibility. This is part of the picture of weak – and on the part of GHPs, unresponsive - communications between GHPs, partners and countries. An unfortunate side-effect is the propagation of myths about GFATM intentions and policies.

Funding GHPs like GAVI and the Global Fund have adopted principles of **performance-based funding** or disbursement. Stronger information and accountability systems are needed to inform judgements in relation to performance-

¹¹ GAVI bases its financial support to countries on national reporting systems verified by the Data Quality Audit. The Data Quality audit is a specific mechanism to evaluate and strengthen country reporting systems that measure immunized children.

based funding. Tying funding to performance creates greater incentive to deliver outcomes and increases accountability of some programmes. There is, however, an issue as to how to balance this with the need for more predictable funding, especially given concerns specific to the health sector. If long-term treatment programmes are started with short-term funding, or if such programmes are “switched off” because performance is judged to be poor, there are ethical and public health implications (for example, drug resistance).

When a country’s Health Management Information System (HMIS) is strong, GHPs should use it. When it is weak, they should invest to improve it rather than develop parallel systems. There should be investment in training of country level staff to improve analytical capability, and ability to make decisions based on data, which would in turn increase the sense of ownership of the data. Helping countries improve their health information systems and use their data will be a key task of the Health Metrics Network.

3.10 Accountability

At present the accountability of a GHP is generally judged in relation to its own objectives. Judging its impact on overall health sector and PRS objectives is also required.

Several GHPs already make considerable amounts of information available on their websites. As a matter of principle, in order to ensure public accountability, all GHPs should publish key documents on the internet: annual plans, budgets and performance reports (including income and expenditure reports); evaluations; standing orders, including processes for appointments of Board members and Chairs; and papers and reports of key meetings, especially Board meetings. Funding GHPs should provide timely, clear and comprehensive information on GHP assistance, processes, and decisions (especially decisions on unsuccessful applications) to partner countries requiring GHP support.

This paper addresses itself to best practice principles for GHPs but, as with the Paris Declaration, the logic would be that success would require mutual accountability, with complementary commitments from countries and other partners (see paragraphs 93-95 below).

3.11 Conclusions

Country studies have for some time now consistently concluded that the undoubted benefits of GHPs are accompanied by high transaction costs – costs that are the direct result of interventions by at least the major GHPs, especially those concerned with funding. The growing human resource gap in some countries implies that they can even less afford the transaction costs imposed by GHPs.

At global level, there is a marked acceleration in action to address some key problems and challenges directly caused by GHPs. For example, various activities are being taken forward urgently as a result of the Global Task Team report, including:

- The GFATM and the World Bank intending to work together to review and improve their alignment with national cycles and action plans; undertake joint annual reviews as primary evaluation where their Principal Recipient of funding is the same (in at least three countries by June 2006); pilot joint fiduciary assessments; foster communications, information-sharing and joint action, for example by regular meetings and sharing reports, terms of reference and mission reports; identify procurement and supply bottlenecks in the implementation of grants; define problems between National AIDS Commissions and CCMs.
- Establishment of a joint UN System/Global Fund problem-solving team and national task-specific problem-solving teams.

Other actions are underway:

- GAVI in its second phase will base support on country's multi-year plans (immunization and health sector plans). Long-term (5-10 year) predictable funding will be a legal requirement in the case of the IFFim, and is likely to provide greater security for governments than current bilateral donor financing which studies have shown to be surprisingly volatile. Coordination mechanisms other than for technical matters (ICC) will fold into sectoral or programmatic processes.
- The Stop TB Partnership is working closely with the GFATM.
- The last few months have seen the launch of the Health Metric Network, action to create a Health Workforce Alliance, and broader WHO-led collaboration - involving GAVI, the GFATM and Stop TB among others - on health systems strengthening issues (including a sub-group on the non-state sector).

One crucial importance of the McKinsey study, which is only just being finalised, is its demonstration that the problems associated with GHPs still figure very large at country level, despite the perception at global level of shifts of attitudes, increased flexibility and progress having been made towards alignment and harmonisation. A possible reason for the gap between global level expressions of support to the principles of alignment and harmonisation and the country findings may simply be the time-lag. Most of the global progress described has been made within the last few months.

Against this background, a key message for GHPs is the importance for them to act with speed and flexibility:

- to endorse and enact some best practice principles for GHPs, primarily relating to alignment and harmonisation; and
- to work with countries, and with other agencies and GHPs, rapidly to get in place solutions to the simpler problems raised, while at the same time developing approaches to the more challenging problems.

4. Proposals for Best Practice Principles for GHP activities at country level

4.1 *Proposals for best practice principles*

The Paris Declaration on Aid Effectiveness is directly relevant to the health sector, and application of its commitments should improve the effectiveness of health development assistance. While there is need to keep GHPs free of unhelpful bureaucracy, they too should honour its commitments since they are now a key part of the global health architecture¹². The Paris Declaration generally offers an **appropriate framework** for developing best practice principles for GHP activity at country level, though it notably did not cover technical assistance which is an important issue in relation to the success of GHP support for countries.

The table below therefore sets out proposals for best practice principles for global health partnerships and initiatives which are active at country level¹³. These are intended not as an end in themselves but as a means to improve health outcomes and accelerate progress towards achieving the health and poverty reduction MDGs.

The principles will need to be interpreted in light of the specific circumstances of each GHP and each partner country. The evidence suggests that most of the principles are already practicable for some GHPs, but no single GHP appears to practise all. If the principles are agreed, GHPs may wish to review policies and practices, and prepare an action plan for operationalisation.

¹² The same considerations apply to initiatives like the US President's Emergency Plan for HIV/AIDS Relief (PEPFAR) and the World Bank's Multi-country AIDS Program (MAP) which share similar characteristics to the major GHPs (large-scale new funding, a focus on a single disease, and a drive for swift results) and raise similar issues about impact at country level.

¹³ The best practice principals were updated following the 3rd High Level Forum. The final version now appears in this report.

Best Practice Principles for Engagement of Global Health Partnerships at Country Level	
Global Health Partnerships (GHPs) commit themselves to the following best practice principles:	
OWNERSHIP	
1	<p>To respect partner country leadership and help strengthen their capacity to exercise it.</p> <p>GHPs will contribute, as relevant, with donor partners to supporting countries fulfill their commitment to develop and implement national development strategies through broad consultative processes; translate these strategies into prioritised results-oriented operational programmes as expressed in medium-term expenditure frameworks and annual budgets; and take the lead in coordinating aid at all levels in conjunction with other development resources in dialogue with donors and encouraging the participation of civil society and the private sector.</p>
ALIGNMENT	
2	To base their support on partner countries' national development and health sector strategies and plans, institutions and procedures. Where these strategies do not adequately reflect pressing health priorities, to work with all partners to ensure their inclusion.
3	To progressively shift from project to programme financing.
4	<p>To use country systems to the maximum extent possible. Where use of country systems is not feasible, to establish safeguards and measures in ways that strengthen rather than undermine country systems and procedures.</p> <p><i>Country systems in this context would include mechanisms such as sector-wide approaches, and national planning, budgeting, procurement and monitoring and evaluation systems.</i></p>
5	To avoid, to the maximum extent possible, creating dedicated structures for day-to-day management and implementation of GHP projects and programmes (<i>eg Project Management Units</i>)
6	To align analytic, technical and financial support with partners' capacity development objectives and strategies; make effective use of existing capacities; and harmonise support for capacity development accordingly.
7	To provide reliable indicative commitments of funding support over a multi-year framework and disburse funding in a timely and predictable fashion according to agreed schedules.

8	To rely to the maximum extent possible on transparent partner government budget and accounting mechanisms.
9	To progressively rely on country systems for procurement when the country has implemented mutually agreed standards and processes; and to adopt harmonized approaches when national systems do not meet agreed levels of performance ¹⁴ . To ensure that donations of pharmaceutical products are fully in line with WHO Guidelines for Drug Donations ¹⁵ .
HARMONISATION	
10	To implement, where feasible, simplified and common arrangements at country level for planning, funding, disbursement, monitoring, evaluating and reporting to government on GHP activities and resource flows.
11	To work together with other GHPs and donor agencies in the health sector to reduce the number of separate, duplicative missions to the field and diagnostic reviews assessing country systems and procedures. To encourage shared analytical work, technical support and lessons learned; and to promote joint training, (<i>eg common induction of new Board members</i>).
12	To adopt harmonized performance assessment frameworks for country systems.
13	To collaborate at global level with other GHPs, donors and country representatives to develop and implement collective approaches to cross-cutting challenges, particularly in relation to strengthening health systems including human resource management.
MANAGING FOR RESULTS	
14	To link country programming and resources to results and align them with effective country performance assessment frameworks, refraining from requesting the introduction of performance indicators that are not consistent with partners' national development strategies.
15	To work with countries to rely, as far as possible, on countries' results-oriented reporting and monitoring frameworks.
16	To work with countries in a participatory way to strengthen country capacities and demand for results-based management, including joint problem-solving and innovation, based on monitoring and evaluation.
ACCOUNTABILITY	
17	To ensure timely, clear and comprehensive information on GHP assistance, processes, and decisions (especially decisions on unsuccessful applications) to partner countries requiring GHP support.

¹⁴ Countries themselves may choose to take advantage of procurement pooling mechanisms or third-party procurement, in order to obtain economies of scale.

¹⁵ see <http://www.who.int/medicines/library/par/who-edm-par-99-4.pdf>

Some key issues relating to GHP governance are not covered by the Paris Declaration. The High Level Forum may wish to consider some best practice principles on this issue, derived from earlier work by DFID and in line with findings from studies.

Best Practice Principles for Engagement of Global Health Partnerships at Country Level	
GOVERNANCE	
The governance principles are intended for larger partnerships with formalized governance arrangements. Partnership activities must be consistent with the regulatory framework of their host arrangements	
18	To make clear and public the allocation of roles and responsibilities within the management structure of the partnership or fund. The governing board or steering committee should have broad representation and a strong developing country voice.
19	To make clear and public the respective roles of the partnership and relevant multilateral agencies, including how the partnership relates to the host organization.
20	In the interest of public accountability, to ensure that GHP purpose, goals and objectives are clear; procedures are transparent; and timely and comprehensive information is provided publicly.
21	There should be a strong commitment to minimizing overhead costs and achieving value for money; each partnership should have an evaluation framework.
22	To be subject to regular external audit. For hosted partnerships, the auditing procedures of the host UN organization would apply. A copy of the relevant portion of the external auditors certification of accounts and audit report should be made available to the partnership board.

4.2 *Implications of Best Practice Principles*

Implications for GHPs

The intention is to move forward swiftly to practical action. Further work in collaboration with individual GHPs is required to explore fully the implications for GHPs of operationalising the best practice principles, which are likely to be different for each GHP.

The following points may serve as useful examples of the kinds of issues that are likely to emerge:

- GHPs should not normally be active in countries where the target disease or condition is not an identified priority in country-owned and -led strategies such as the poverty reduction strategy (PRS) and/or health sector plan. However, there are cases where these plans do not adequately reflect health or prioritize health issues. In such cases, GHPs (like other development partners)

have a role in supporting countries to ensure that health is appropriately reflected in PRSs, Sector plans, MTEFs and budgets;

- GHPs without a country presence should consider reaching explicit agreement, possibly backed by formal MOUs, with partner agencies able to represent them in-country, in order to address some current problems about communication and speed of response issues. It may be helpful to extend any such agreement to providing support for implementation;
- Disbursement of funds should be aligned to the government budget cycle, and resources pledged 5 years in advance in order to support health sector planning;
- The implications for fiscal space and fiscal sustainability of introducing (expensive) new technologies should be discussed with ministries of health, finance and planning, and with development partners;
- GHPs should be represented at regular health sector partners' meetings, either directly or through representatives;
- Sustainability planning (for a realistic timeframe) should be coordinated across GHPs, based on a unified discussion with ministries of health, finance, planning and any other relevant national bodies;
- Individual GHPs may need to adapt the indicators used to monitor progress at country level, in line with the development of national health information systems;
- Wherever possible, GHPs should use existing robust analytical work and appraisals of management systems, for example relating to procurement;
- GHPs should allow countries to experiment with the organisation of coordinating bodies to increase efficiency and participation (and countries should ensure appropriate leadership of such bodies);
- GHPs should provide guidance which clearly states that technical assistance for implementation can be an explicit part of proposals;
- GHPs should regularly review their work at country level to see which elements could be handed over to government (eg procurement), and develop where appropriate a plan for disengagement (as in the case of some GHPs working to eliminate specific tropical diseases);
- GHPs and countries should review the need for specific Project Management Units, with a view to disbandment;
- Greater GHP flexibility and tailoring processes to individual country needs will be helpful, but may also make the ground rules less clear for countries and potentially for GHP partners. GHPs will need to invest in communicating proactively the scope and boundaries of flexibility. They could also usefully

institute some basic service norms for day-to-day communication (eg a 3-day turnaround time to respond to communications and 30 days to resolve issues).

Enabling conditions

The corollary to these best practice principles for GHPs would be some complementary commitments on the part of countries and other partners to assist in providing the enabling conditions.

For countries, commitments would include as a minimum to:

- develop clear national health sector strategies, with a medium-term expenditure framework and a health sector plan, within the framework of a broader national development strategy such as a poverty reduction strategy.
- exercise leadership in coordinating partner actions
- have procurement and public financial management systems that either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.

Bilateral and multilateral partners have both joint and differentiated responsibilities in contributing to the enabling conditions. These include:

- Supporting countries to ensure that health is appropriately reflected in PRSs, sector plans, MTEFs and budgets;
- Adopting a coherent position to individual GHPs in their various roles as funders, GHP partners/Board members, and when operating at country level. They should produce clear guidance for field staff, to be widely-publicised within their organisations, about their role in, and important contribution to, GHPs. Engaging substantively in GHPs will have implications for how staff time and effort is spent;
- Seeking to ensure that no new GHP is established unless the value it adds is demonstrably clear, and that continued support is dependent on continued need;
- Providing increased and urgent support for technical assistance for implementation. Multilateral agencies are themselves likely to require additional support from donors in this area. Further work is required to explore different models for more demand-driven technical assistance. This should consider issues including: agreement on the need; identification of possible sources (local, regional, international); establishing quality standards; agreeing on actual costs; and determining selection procedures.
- Specific consideration should be given to providing organisational, facilitative or administrative support to Country Coordination Mechanisms (CCMs) to allow them to fulfill their oversight functions adequately.
- Working with GHPs to enable them to put some of the principles into effect, eg being subject to external audit when housed by a UN body.

- As a matter of urgency, developing technical guidance on health systems, including work on human resources and health financing mechanisms, to guide GHPs in their work on health systems strengthening. This could include work by countries, GHPs and other partners to evaluate alternative models to fund health systems strengthening instead of individual GHP efforts. Current parallel streams of work on this topic should be brought together.

Future follow up of progress

Given the need to tailor approaches to different settings, these principles are primarily to be operationalised at country level, and in that context, countries may wish to set their own targets and indicators. There is scope for the development of country-level mechanisms to support compliance through **country-specific agreements between all partners** on rules of engagement.

A practical example of the kind of agreement envisaged is provided by the Memorandum of Understanding between the Government of Uganda and its development partners, in support of the National Health Policy and the second Health Sector Strategic Plan 2005-2010, through a sector-wide approach. It sets out the obligations of all parties (for example, for partners to use Government systems including the Health Management Information System; synchronise planning, review and monitoring processes with those established to monitor the Health Sector Strategic Plan; and negotiate with the Ministry of Health all new health/health service programmes to be implemented in districts). It also details approaches, eg to procurement and to the provision of technical assistance (which is to be determined on a demand-driven basis, and encourage the use of Ugandan or regional consultants for short-term assistance).

The HLF Working Group on GHPs feels that no additional global mechanism for coordination or monitoring is required or appropriate. A preferable alternative would be for a light-touch and issue-focussed **forum** to be held on a regular basis. Its purpose should be to provide an opportunity for key players from major GHPs, recipient governments and donors to review principles, practice and progress; and address issues of joint concern, including overlaps, gaps and systems issues. Ideally such a discussion would take place within the wider context of taking stock of developments in the health sector as a whole. If the High Level Forum on Health MDGs continues beyond 2005 or some similar mechanism is established, that would provide an appropriate forum for discussion of GHP issues.

Such a meeting would be informed by reports from countries and any newly-available studies. The detailed 2005 studies of countries undertaken by McKinsey & Co. could provide the baseline for **periodic review of developments and of lessons learned**.

This annual forum should be supplemented by **more informal liaison** and information-sharing between the 5-6 large GHPs on a regular basis.

Action points

The High Level Forum is invited to:

- i) review **a set of best practice principles for GHPs** based on the Paris Declaration on Aid Effectiveness (paragraph 89);
- ii) consider whether there is need for further principles on **GHP governance** (paragraph 90);
- iii) recommend that selected major **GHPs** - GFATM, GAVI, Roll Back Malaria, the Stop TB Partnership, the Health Metrics Network and the Partnership on Maternal, Newborn and Child Health - **begin a process of more formal endorsement** by their own Boards.

If best practice principles are adopted, **follow-up action from GHPs** should include a self-assessment of individual GHP practice in relation to the principles; development of proposals for action; and consideration with countries and other partners of those wider issues needing collective action.

Enabling action will also be required from other partners, including countries, and bilateral and multilateral agencies.

ANNEX 1

THE WORKING GROUP ON GLOBAL HEALTH PARTNERSHIPS

The High Level Forum on the Health MDGs (HLF) in December 2004 in Abuja held a session on Global Health Partnerships and Funds (GHPs). It identified the need for action to:

- review cross-cutting issues and identify **opportunities for synergies and harmonization between different initiatives and partnerships**
- support **further analytic work** (building on studies and evaluations already carried out by DFID and its Health System Resource Centre, the World Bank, the European Commission and DAC) to provide greater clarity about guiding principles and actual practices, draw out lessons about best practice, and support the development of common principles of engagement and systems for monitoring their application.

To consider these issues further, a **High Level Forum Working Group on Global Health Partnerships** was established to bring together representatives of recipient countries, donor countries, partnerships, foundations, and multilaterals. It met twice, in April and September 2005.

At its first meeting, the Working Group reviewed available evidence on the role, impact, operation and aid effectiveness of Global Health Partnerships¹⁶.

It concluded that a **new country-level study** would add value to current knowledge. The Bill and Melinda Gates Foundation was already commissioning a study of GHPs to be undertaken by McKinsey & Co. who have since surveyed 20 countries and undertaken field visits to six. Members of the HLF Secretariat participated in the study's Technical Advisory Group, and the study's provisional findings were presented to the HLF GHP Working Group meeting on 28 September 2005. The study provides an up to date assessment of the country-level perspective on global health partnerships and initiatives. It focuses on the **transaction costs at country level of multiple GHP interactions** (on top of existing donor communities), in the context of the benefits provided by GHPs. The study is now in its final stages. A preliminary study report will be tabled at the November meeting of the High Level Forum.

The Working Party examined the relevance of the Paris Declaration on Aid Effectiveness for the health sector generally and GHPs in particular. In the light of previous studies of Global Health Partnerships and provisional findings and conclusions from the McKinsey & Co. country study, it noted a gap between these internationally-recognised principles of effective aid and the practice of major GHPs at country level. It therefore developed proposals for **best practice principles** for GHP activities at country level and their follow-up, with examples of practical implications and enabling actions required from other parties.

¹⁶ Caines K., *Key evidence from major studies of selected Global Health Partnerships*, DFID Health Resource Centre, April 2005. Background paper for High Level Forum on the Health MDGs Working Group on Global Health Partnerships.

ANNEX 2

THE PARIS DECLARATION OF AID EFFECTIVENESS: INDICATORS OF PROGRESS AND TARGETS

To be measured nationally and monitored internationally

Indicators		Targets for 2010	
OWNERSHIP			
1	Partners have operational development strategies	At least 75% of partner countries have operational development strategies.	
ALIGNMENT			
2a	Reliable public financial management (PFM) systems	Half of partner countries move up at least one measure (i.e., 0.5 points) on the PFM/ CPIA (Country Policy and Institutional Assessment) scale of performance.	
2b	Reliable procurement systems	One-third of partner countries move up at least one measure (i.e., from D to C, C to B or B to A) on the four-point scale used to assess performance for this indicator.	
3	Aid flows are aligned on national priorities	Halve the gap — halve the proportion of aid flows to government sector not reported on government's budget(s) (with at least 85% reported on budget).	
4	Strengthen capacity by co-ordinated support	50% of technical co-operation flows are implemented through co-ordinated programmes consistent with national development strategies.	
5a	Use of country public financial management systems	For partner countries with a score of 5 or above on the PFM/CPIA scale of performance (see Indicator 2a).	All donors use partner countries' PFM systems; and Reduce the gap by two-thirds – A two-thirds reduction in the % of aid to the public sector not using partner countries' PFM systems.
		For partner countries with a score between 3.5 and 4.5 on the PFM/CPIA scale of performance (see Indicator 2a).	90% of donors use partner countries' PFM systems; and Reduce the gap by one-third — A one- third reduction in the % of aid to the public sector not using partner countries' PFM systems.

5b	Use of country procurement systems	For partner countries with a score of 'A' on the Procurement scale of performance (see Indicator 2b).	All donors use partner countries' procurement systems; and Reduce the gap by two-thirds — A two-thirds reduction in the % of aid to the public sector not using partner countries' procurement systems.
		For partner countries with a score of 'B' on the Procurement scale of performance (see Indicator 2b).	90% of donors use partner countries' procurement systems; and Reduce the gap by one-third — A one-third reduction in the % of aid to the public sector not using partner countries' procurement systems.
6	Avoiding parallel implementation structures	Reduce by two-thirds the stock of parallel project implementation units (PIUs).	
7	Aid is more predictable	Halve the gap — halve the proportion of aid not disbursed within the fiscal year for which it was scheduled.	
8	Aid is untied	Continued progress over time.	
HARMONISATION			
9	Use of common arrangements or procedures	66% of aid flows are provided in the context of programme-based approaches.	
10a	Missions to the field	40% of donor missions to the field are joint.	
10b	Country analytic work	66% of country analytic work is joint.	
MANAGING FOR RESULTS			
11	Results-oriented frameworks	Reduce the gap by one-third — Reduce the proportion of countries without transparent and monitorable performance assessment frameworks by one-third.	
MUTUAL ACCOUNTABILITY			
12	Mutual accountability	All partner countries have mutual assessment reviews in place.	

Notes:

1. The targets, in accordance with the Paris Declaration, are: “designed to track and encourage progress at the global level among the countries and agencies that have agreed to this Declaration. They are not intended to prejudge or substitute for any targets that individual partner countries may wish to set.” They are subject only to reservations by one donor on (a) the methodology for assessing the quality of locally-managed procurement systems and (b) the quality of public financial management reform programmes.

2. The universe for the purpose of targeting is limited to ODA eligible countries that have already endorsed the Paris Declaration or will have endorsed it by 31 December 2005. The universe for the purpose of monitoring is open to all ODA eligible countries that have already endorsed, or will endorse in the future, the Paris Declaration.

3. **Note on Indicator 9** — Programme based approaches are defined as a way of engaging in development cooperation based on the principles of co-ordinated support for a locally owned programme of development, such as a national development strategy, a sector programme, a thematic programme or a programme of a specific organisation. Programme-based approaches share the following features:

- (a) leadership by the host country or organisation;
- (b) a single comprehensive programme and budget framework;
- (c) a formalised process for donor co-ordination and harmonisation of donor procedures for reporting, budgeting, financial management and procurement;
- (d) efforts to increase the use of local systems for programme design and implementation, financial management, monitoring and evaluation.

For the purpose of indicator 9, performance will be measured separately across the aid modalities that contribute to programme-based approaches.