Global Health Partnerships: Assessing Country Consequences

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Executive Summary

Global Health Partnerships, or GHPs, have become the dominant organizational model for addressing today's complex global health issues. They produce benefits beyond what individual partners could achieve, including attracting attention and funding to diseases, spurring countries to craft smarter policies that plan for the future, encouraging countries to strengthen program monitoring and accountability, and boosting wider stakeholder participation. Early evidence suggests that GHPs work.

This assessment, undertaken by the Bill & Melinda Gates Foundation and McKinsey & Company, looks at what GHPs can do to reduce the burdens they place on countries, and so serve these countries more effectively.

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Unfortunately, the gains GHPs have made have come at a cost. Introducing vertically oriented resources into horizontally organized health systems in a resource-constrained environment creates two likely expected consequences for countries.

- **Countries struggle to absorb GHP resources because GHPs do not provide adequate support, technical and other, to implement programs**
- **Countries are burdened with parallel and duplicative processes from multiple GHPs, because GHPs often bypass the processes that countries already have in place.**

In addition, **GHPs have not adequately or effectively communicated with countries and partners.** Communication between GHPs and countries is often one-way and the feedback loop from countries is weak. Poor communication complicates the issues described above.

Our interviews with 350 stakeholders in 20 countries raised these issues that countries encounter when working with GHPs. Stakeholders told us that GHPs do not adequately support shifts in policy and technology, do not provide adequate implementation assistance, and that GHPs have created too many and inadequately structured country coordination forums for such forums to be effective. Interviewees in country told us that GHPs' "one size fits all" processes do not recognize country diversity, and that GHPs often stumble when dealing with system-level issues. We heard that countries have neither the power nor the appropriate channels to communicate with or push back on GHPs. Furthermore, partners are unclear about their roles and responsibilities as they relate to GHP activities.

Fortunately, there are many emerging opportunities for countries and GHPs to address these consequences and reduce the costs associated with working together. Countries must nurture strong leadership and management capacity to improve their health systems.

GHPs first must ensure that their grants are accompanied by the resources required to make such assistance work. To do that, GHPs should:

- Let countries lead discussions on the optimal timing, pace, and scale of new technology adoption and policies,

- Allow countries to include overhead costs in grants to provide implementation support,
- Provide a searchable database of technical assistance solutions and providers (e.g., experts who have set up clinics or designed patient advocacy campaigns), and
- Provide administrative support for coordinating mechanisms.

Second, GHPs should design their processes and systems to complement those countries already have in place. Specifically they should:

- Be flexible with countries that maintain good track records,
- Collaborate with other GHPs to ask countries for one unified multi-year health sector plan, and
- Create a single, unified mission and a single, unified report in each disease area to reduce the burden on country officials.

Finally, GHPs should establish a minimum set of communications norms. For instance, they could commit to respond to queries in three days and resolve issues in 30 days. This could facilitate conversations with countries and partners. They should clarify when partners are the face of the GHP and when requests should go through the global administrative level. To adhere to these norms, GHPs may need to boost their own administrative staffing levels and clarify roles and responsibilities of partner organizations at a global and country level.

These opportunities represent the "here and now" actions that GHPs can directly take to strengthen their interactions with countries. It must be recognized, however, that GHPs operate in highly resource-constrained environments with limited infrastructure, weak basic health systems (e.g., financing and monitoring) and severe shortages of managerial and healthcare service delivery talent. Addressing these cross-cutting health system constraints is absolutely critical to capture the full benefits of GHPs, but beyond the mandate and ability of any one GHP. The global health community urgently needs to collaborate to address these health system issues.

Together, these changes will enable GHPs to better help countries address major public health challenges – HIV/AIDS, malaria, tuberculosis and vaccine-preventable diseases – which threaten to prevent countries from developing to their full potential.

Introduction

In the last decade, over 70 health alliances, or Global Health Partnerships (GHPs) have been created to address today's complex global health issues. GHPs are now the dominant model of organization in this space. In 2002, the Bill & Melinda Gates Foundation and McKinsey conducted an assessment of GHPs, and identified five benefits. When compared with individual partners, health alliances:

- Avoid duplication of investments and activities,
- Produce economies of scale,
- Pool resources to enable higher-risk activities than any partner would undertake alone,
- Share knowledge and resources to improve effectiveness, and
- Create momentum and attract funding by building a common "brand" that gains legitimacy and support.

We believe these benefits should enable GHPs to tackle major public health challenges such as HIV/AIDS, malaria, tuberculosis and vaccine-preventable diseases more effectively than individual players.

Indeed, our research suggests that these alliances have made progress in preventing and fighting diseases. They have won attention and financing for public health challenges at the highest political levels. Countries have boosted access to antiretroviral therapy for HIV/AIDS patients, raised vaccination rates and increased the use of directly observed therapy, or DOTS, for tuberculosis. The Working Group on Global Health Partnerships established by the High-Level Forum on the Health Millennium Development Goals also found that GHPs attract new partners into the global fight against specific diseases and spur innovation.[1]

We know that GHPs work. The discussion, therefore, needs to shift from "Do we need such partnerships and what value do they add?" to "What will it take to increase their effectiveness and reap their full benefits?"

To answer these questions, the Bill & Melinda Gates Foundation and McKinsey & Company have conducted an assessment of country-level perspectives on GHPs. **This study focuses on the issues that recipient countries struggle with when working with GHPs individually and collectively, in the context of the benefits GHPs deliver.** Specifically:

- What are the transaction costs and other consequences for recipient countries as a result of interactions with multiple GHPs?
- How can GHPs and countries address these consequences?

1 Working Group Paper on Global Health Partnerships, sponsored by the High Level Forum on the Health MDGs, April 2005

About the research

We conducted field research for this study during the summer of 2005 in 20 countries, listed in Exhibit 1. We chose these countries because:

- At least two major GHPs are active in each of them,
- Both the Global Alliance for Vaccines and Immunization (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria have made grants to these countries, and
- They reflect a variety of geographies, development/health spending levels, and population sizes.

Our team of eight people gathered evidence primarily through in-person and phone interviews. We used a structured, but not quantitative, interview guide. Examples of questions we asked are:

- How do GHP plans relate to national and district level plans and priorities?
- What should GHPs do to improve coordination and/or reduce the burden of current coordinating mechanisms?
- Has national monitoring and evaluation capacity changed as a result of GHP activity, and how has that been demonstrated?

We interviewed over 350 stakeholders from ministries of health, finance, and planning, multilateral agencies, bilateral development agencies, NGOs, district health management teams and local health facilities. We sought out people whose work lets them see the costs and benefits of GHPs directly. This includes people responsible for making policies, applying for grants, designing budgets and financial stability plans, attracting health care workers and strengthening health systems.

We sought the perspectives of the public, private, and civil society sectors. The findings are primarily in the public sector, however, since most GHPs choose to interact with governments. Where possible, we have tried to verify our perceptions with facts and/or cross-check these views with multiple stakeholders. We supported survey findings with data analysis and a review of secondary literature, including assessments of GHPs conducted over the last two years.

Our assessment focused on the major GHPs and global initiatives. These include:

- The Global Fund to Fight AIDS, Tuberculosis and Malaria
- The Global Alliance for Vaccines and Immunization (GAVI)

- The Stop TB Partnership
- Roll Back Malaria
- The Global Alliance for Improved Nutrition (GAIN)
- The World Bank's Multi-Country HIV-AIDS Program (MAP)
- The President's Emergency Plan for AIDS Relief (PEPFAR)

Interviewees were most familiar with high-profile, grant-making GHPs such as the Global Fund and GAVI, but while most of the issues in this paper arise in the context of large GHPs, they are not unique to large GHPs. GHPs that are smaller and/or do not provide funding can also create distortions and extract similar costs. Therefore, the cost drivers and opportunities we identify apply across the spectrum of GHPs.

This report will look at what GHPs do right, issues that arise in their relationships with countries, and what GHPs can do better. It is structured in three parts:

- Overview of GHP benefits
- Consequences stemming from GHP interactions
- Innovative practices and emerging opportunities to address these issues

Exhibit 1

ASSESSED COUNTRIES VARIED ACROSS MULTIPLE DIMENSIONS

	Number of shortlisted GHPs present	Ratio of annualized GHP allocation: 2002 health expenditure	Ratio of annualized GHP allocation: 2002 ODA received	Geographical region	Population 2004 Millions	GDP per capita USD	Health expenditure per capita USD
Zambia	6	1.6	0.3	Sub-Saharan Africa	11	332	11
Uganda	6	1.6	0.3	East Africa	26	251	5
DRC	3	1.3	0.1	Central Africa	14	990	5
Ethiopia	5	1.0	0.1	East Africa	71	98	2
Tanzania	6	0.7	0.2	East Africa	42	242	6
Mozambique	5	0.6	0.0	Sub-Saharan Africa	19	238	8
Burkina Faso	4	0.4	0.0	West Africa	12	234	5
Guinea	3	0.3	0.0	West Africa	8	417	4
Nigeria	6	0.3	0.5	West Africa	125	412	5
Cambodia	3	0.3	0.0	Southeast Asia	13	303	6
Laos	2	0.3	0.0	Southeast Asia	6	335	5
Ghana	4	0.2	0.0	West Africa	21	261	7
Angola	3	0.2	0.1	Sub-Saharan Africa	14	760	17
Yemen	3	0.1	0.0	Middle East	22	479	5
Bangladesh	3	0.1	0.0	Asia	140	356	3
Vietnam	4	0.1	0.0	Asia	83	432	6
Kyrgyzstan	3	0.1	0.0	Central Asia	5	283	7
Chad	2	0.0	0.0	Central Africa	9	189	6
Indonesia	3	0.0	0.0	Southeast Asia	217	824	11
China	3	0.0	0.0	East Asia	1,300	965	19

Source: GHP Web sites and annual reports; Global Insight; WHO World Health Report; UNDP Human Development Report

Overview of GHP benefits

In addition to the two major benefits of bringing much-needed attention and funding to critical diseases, GHPs have helped countries in three key ways.

GHPs HAVE SPURRED COUNTRIES TO CRAFT SMARTER POLICIES AND PLAN FOR THE FUTURE:

The GHP grant application process encourages countries to improve their capacity to plan and anticipate future needs. GHP feedback has also helped countries craft plans for key diseases that might otherwise have been neglected.

Angola, for example, recently emerged from nearly three decades of civil war. The government historically allocated less than 5 percent of its budget to health. GHP funding has allowed Angola to look beyond these basic efforts. This has been especially crucial as the country transitions to peace. The civil war kept HIV/AIDS prevalence rates low (less than 5 percent reported incidence) because populations were often isolated. Development partners recognized that in the post-war environment, HIV/AIDS could spread as Angolans began to move freely. Donor and GHP funding from the Global Fund and the World Bank has been critical in controlling this epidemic before it starts.

In some countries, a combination of funding and procurement capability has increased vaccination rates. **Vietnam,** for example, had a limited hepatitis B vaccination program before GAVI offered its support. The country now vaccinates newborns for hepatitis B within 24 hours of delivery.

Exhibit 2

BENEFITS FROM GHP INTERACTIONS – SELECT EXAMPLES

Increased funding	• **Laos:** "GFATM has increased total aid flows in the areas of health, particularly in malaria and TB" • **DRC:** "There are more funds for the DRC now due to GHPs. There is a very different spirit now versus three years ago. GFATM is to be commended for providing money despite DRC's crisis status."
Smarter policy	• **China:** Round 4 GFATM grant addressed sensitivity around HIV/AIDS and helped shape the direction of policy by funding HIV harm reduction efforts for drug users and sex workers • **Cambodia:** GFATM money is "helping people think long term and big picture . . . it has allowed the country to test innovative practices in addressing the three diseases," e.g., use of long-lasting insecticide-treated nets for malaria
Stronger planning capacity	• **Burkina Faso:** Work done to prepare GAVI's financial sustainability plan was leveraged and expanded to more easily create its medium term expenditure framework • **Vietnam:** Planning conducted for GAVI helped with long-term country planning in vaccination programs • **Chad:** "Country staff learns about processes, outcomes, and how to cost activities"
Improved transparency	• **Angola:** "TB M&E has improved in quality and consistency because continued GDF drug supplies are contingent on reporting" • **Bangladesh:** Partners consortium in SWAp is planning to replicate GFATM performance-based funding for 25% of SWAp money
Catalyzed technical assistance	• **Bangladesh:** WHO provided support to country for GFATM grant application process for all five rounds, which included developing a regional mock TRP to review proposals prior to submission • **Zambia:** RBM partnership helped galvanize in-country partners to design five-pronged malaria strategy and accelerated progress in developing this strategy

GHPs HAVE ENCOURAGED COUNTRIES TO IMPROVE TRANSPARENCY BY STRENGTHENING PROGRAM MONITORING:

In **Zambia,** for example, clinics monitor vaccination rates to report back to GAVI and other donors. This data is then used by districts when designing vaccination programs and targeting outreach (e.g., child health weeks and booster campaigns).

GHPs HAVE BOOSTED STAKEHOLDER PARTICIPATION:

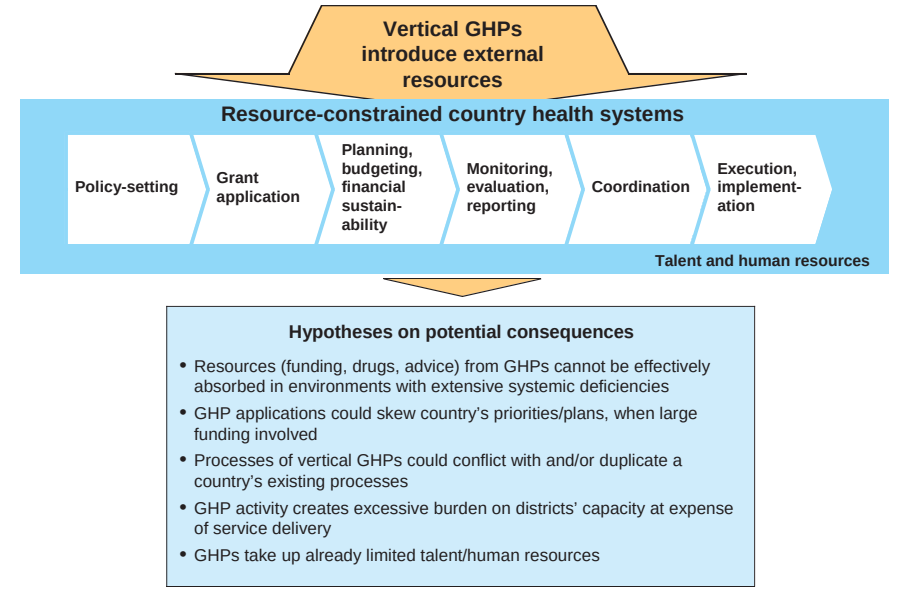
Because GHPs interact with all players in the health sector, they have helped increase the profile of non-governmental stakeholders and the private sector. In **Zambia** and **Bangladesh,** for example, where over 50 percent of health care services are delivered outside of public institutions, NGOs have applied for and been accepted as principal recipients for several of the Global Fund's grants.

Consequences stemming from GHP interactions

These benefits, though, are not without their drawbacks. As the development community has known for years, introducing vertically oriented external resources into horizontally organized health systems in resource-constrained environments is never easy. Given the expansion of GHPs during the last few years, we started this study fully expecting to encounter a range of issues arising from GHP interactions with countries (Exhibit 3).

Exhibit 3

INGOING HYPOTHESES ON POTENTIAL CONSEQUENCES OF VERTICAL RESOURCES INTRODUCED INTO RESOURCE-CONSTRAINED HEALTH SYSTEMS



Our study identified two major consequences for countries, and one compounding factor due to GHP interactions:

1 Countries continue to struggle to use the new resources, given inadequate country systems and infrastructure. Though funding from GHPs has increased, **GHPs do not provide adequate support, technical and other, to countries to meet the challenge of absorbing funds and implementing programs.**

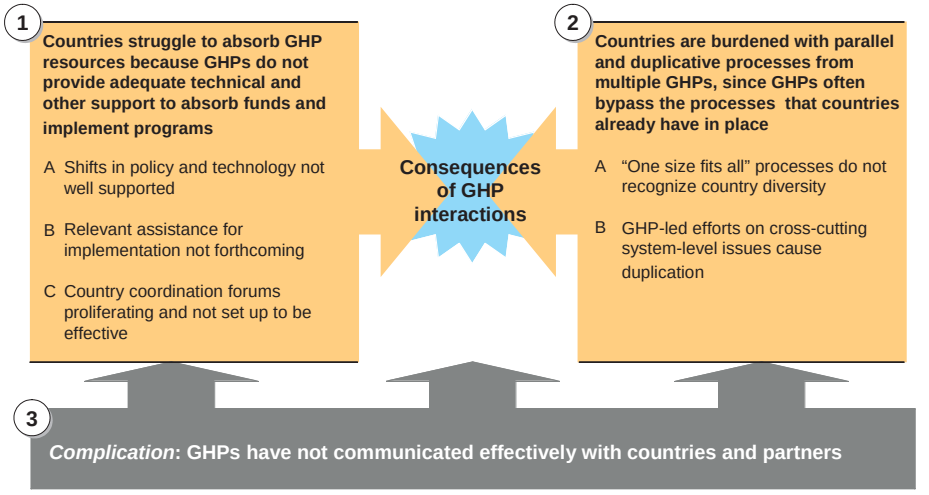
2 Because external resources, by default, arrive with their own processes attached, integrating GHP processes with those of recipient countries can be difficult. **Unfortunately, countries are burdened with parallel and duplicative processes from multiple GHPs, because GHPs often bypass the processes that countries already have in place.**

3 To complicate matters, **GHPs have not communicated adequately or effectively with countries and partners.** Communication between GHPs and countries is often one-way and the feedback loop from countries is weak. Furthermore, because GHPs are relatively new aid vehicles, relationships between GHPs and their partners at the global and country level have not been solidified. Indeed, this weakness amplifies all other problems.

In this section, we describe GHPs' deficiencies in each of these three areas (Exhibit 4).

Exhibit 4

STUDY FINDINGS: MAJOR CONSEQUENCES OF GHP INTERACTIONS WITH COUNTRIES



1. COUNTRIES STRUGGLE TO ABSORB GHP RESOURCES BECAUSE GHPs DO NOT PROVIDE ADEQUATE SUPPORT, TECHNICAL AND OTHER, TO IMPLEMENT PROGRAMS

Our research found that country stakeholders believe that GHPs do not adequately support shifts in policy and technology, do not provide adequate implementation assistance, and have created too many country coordination forums for such forums to be effective.

1A. GHPs do not adequately support shifts in policy and technology

GHPs often explicitly or implicitly tie technology and policy recommendations to their grants. For example:

- GAVI has pushed countries to use the pentavalent hepatitis B vaccine.
- PEPFAR requires countries to use FDA-approved antiretroviral medicines.
- The Global Fund puts its weight behind the WHO policy on Artemisinin Combination Therapy (ACT) use for malaria.
- The Stop TB Partnership/Global Drug Facility favors the four-drug fixed-dose combinations for TB treatment.

These recommendations are based on what these GHPs and international agencies like the WHO believe are the most effective approaches. However, such tying has had some negative consequences and countries report concerns with the way GHPs make policy and technology decisions.

Tying funding to policy/technology shifts has created uncertainty and a sense, as one interviewee told us, of "being forced without discussion." In some cases, when a policy has shifted toward a newer technology or treatment guideline, key stakeholders have received mixed signals about the decision. Often, they don't receive evidence, such as cost-benefit analyses, to support the change. Neither the policy rationale, nor whether there is room for flexibility is communicated. Some GHPs do not adequately discuss the trade-offs and logistics of using new technologies. Finally, in some cases, country officials and local NGOs report that GHP-chosen policy/technology solutions were not the most appropriate for their countries given financial and health system constraints.

Consequently, stakeholders are insufficiently bought-in, rendering the process of adopting recommended technologies more difficult than necessary.

Case study: The need for quicker responses to policy shifts in Burkina Faso and Angola

African countries have long battled malaria, struggling with both costs and resistance. In 2002, domestic research in **Burkina Faso** demonstrated chloroquine, a relatively inexpensive therapy, was more than 90 percent effective in treating malaria, and had a 10 to 15 percent rate of resistance. The national health policy therefore supported using chloroquine for malaria treatment. The government applied to the Global Fund for a Round 2 malaria grant for the use of chloroquine, amodiaquine, and sulphadoxine-pyrimethamine to fight this disease.

After the grant application was approved, though, the WHO and the Global Fund made policy changes favoring ACTs. That, coupled with new reports showing that the rate of chloroquine resistance was under 15 percent in several districts, led Burkina Faso to develop a national policy of ACT use, even though ACT treatment is roughly 20 times more expensive than chloroquine. The country applied for full transition funding in Round 5, but in the meantime, Burkina Faso did not receive additional funds to cover the increased costs.

Country interviews during the summer of 2005 revealed that stakeholders remain concerned about these costs. They worry that the country succumbed to pressure to adopt the new technology in the absence of meaningful long term planning, and they worry whether the program will be financially sustainable.

Stakeholders in other countries expressed similar sentiments. In **Angola,** ministry officials found the Global Fund to be slow to change the country's malaria grant from amodiaquine to ACT after new surveillance data showed higher levels of resistance to non-ACT therapies. Although the country eventually submitted a grant application for additional funding to cover the higher cost of ACTs, officials were frustrated that the change in treatment had to be implemented without clear financial sustainability planning or support.

1B. GHPs do not provide adequate implementation assistance

Countries invest heavily in writing applications for GHP funding. They often hire external consultants, but these experts do not always understand what is feasible, and tend to leave before implementation begins. As a result, plans can be difficult to execute because no one has planned for what to do after the check arrives.

Across countries, we found ample technical assistance available for applications. Recent secondary literature supports these findings.[2] In 2003, UNAIDS provided technical assistance to all countries that wanted help writing Global Fund grant applications. Forty-seven countries asked for assistance and 27 (57 percent) were successful in obtaining grants – a success rate more than four times that of proposals developed without UNAIDS technical assistance.

But what happens after a country receives a grant? Country ministers repeatedly told us that GHPs did not provide them with adequate support for implementation. For example, for the Round 4 Global Fund HIV/AIDS application in **Angola,** UNAIDS invited three foreign consultants to write the application. These consultants have since left the country, but work plans have been inconsistent and no one can clarify assumptions used in budgeting and program design. The principal recipient for Angola, the United Nations Development Programme (UNDP), is midway through the process of rewriting work plans for the grant that was approved as part of Round 4.

Countries may also not understand what kind of funds they will need for implementing programs,or what programs they can realistically implement. GHPs note that targets are often overly ambitious, timelines unrealistic, and capacity inadequate. In **Tanzania,** bilateral donors reported that the country had issues with the scale of the Round 4 application for HIV/AIDS funding from the Global Fund – originally proposed at $1 billion. At the time of application, in-country partners asked the government to scale back because "they did not think the Global Fund had that kind of money and that the country could not absorb that much money." The country scaled back the proposal by cutting back on the amount of money requested instead of spreading it out over a longer period to adjust for the time needed to ramp up new programs. As a result, after one year, the program has reached 10,000 people on treatment as a result of Round 4 money but now Tanzania is looking for additional financial support to scale up the program.

Inadequate support for implementation is a real threat to countries' ability to meet performance metrics. **Laos,** for example, a country with weak infrastructure and scarce talent, risked not meeting disbursement targets for its Global Fund grant and having its Global Fund funding held back until financial and monitoring and evaluation system issues were resolved. This would have created a negative cycle for the country.

To best serve countries, GHPs need to provide more and better technical assistance for implementation (Exhibit 5). Interviewees said they needed assistance in the following areas:

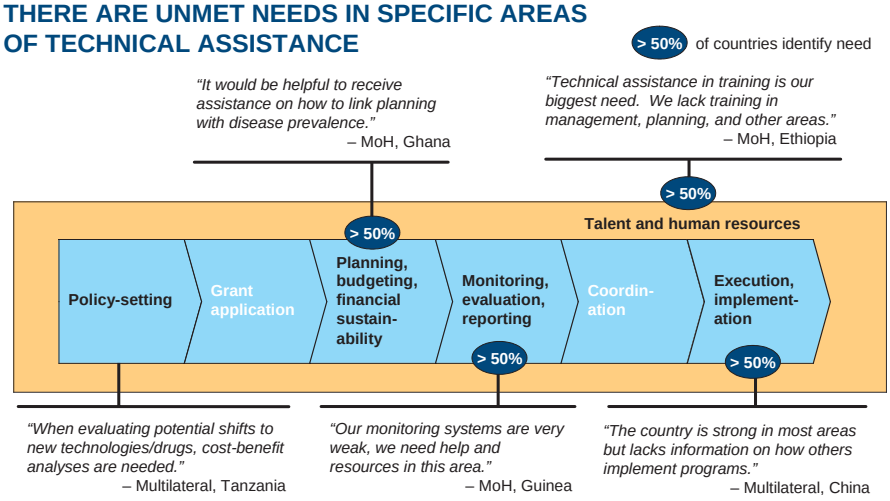
- Planning, budgeting and achieving financial sustainability – including financial planning, financial management, training in broad-based health planning and linking epidemiological data to medium- or long-term planning;

2 Global Task Team WG2 on Harmonization of Technical Support (2005); UNAIDS at Country Level – Progress Report (Sept 2004)

- Monitoring, evaluation and reporting – including strengthening existing systems, general monitoring and evaluation procedures, financial reporting, health management information system (HMIS) development, and commensurate funds to implement and support these activities;
- Talent and human resources – including training in managerial skills, health planning and clinical skills; and
- Execution and implementation – including aspects of program design, procurement, logistics and access to best practices from other countries.

Exhibit 5

THERE ARE UNMET NEEDS IN SPECIFIC AREAS OF TECHNICAL ASSISTANCE



Source: Country interviews; team analysis

GHPs do offer some technical assistance, but our research found several problems with current provisions:

- First, countries report that **the technical assistance they do receive is inadequate.** This hinders their ability to use GHP funds effectively.
- Second, country partners report that **ministry officials are often unable or reluctant to ask for specific technical assistance to implement the program that goes beyond basic needs.** For example, in **Zambia** we observed that everyone from the central level down to the district level knew there was a need for assistance, but this need was discussed vaguely as "capacity building" rather than becoming an actual request for help. In both **Indonesia** and **China,** partners noted that government officials were reluctant to demand forward-looking technical assistance, such as help in designing drug resistance surveys. This finding is supported by the Global Task Team report on technical assistance: "In many cases where implementation has been slow or sub-standard, the information deficit (on country's technical assistance needs) is compounded by countries' reluctance to engage in technical collaborations beyond support in the preparation of proposals for funding"[3].

3 Global Task Team WG2 on Harmonization of Technical Support (2005)

- Third, **countries are unfamiliar with the kinds of technical assistance available** beyond basic application support and training. They don't know what to ask for, so aid arrives without countries' input. Consequently, there is a lack of ownership. In **Zambia,** our interviewees expressed a belief that technical assistance is often pushed onto the country and draws on non-locals. Interviewees in **Mozambique** noted that the country has been given technical assistance that does not fit its needs.
- Fourth, **most technical assistance takes the form of advice and reports with recommendations instead of the long-term, hands-on support countries need to fight diseases effectively.** For example, in **Laos,** we heard that "GHPs tend to send people in for intense bursts of activity and leave reports with a lot of 'shoulds' but not a lot of 'hows'."
- Last, **in-country development partners feel that they do not have the staff or funds to support GHP programs.** In **Vietnam, Zambia** and **China,** for example, partners expressed concern about their ability to support an increasingly "unfunded mandate" for technical assistance. Furthermore, technical assistance needs to be backed by additional funds to revamp systems like M&E and lab infrastructure. However, funding substantial cross-cutting systems development is beyond the mandate or ability of any single GHP.

1C. GHPs have created too many inadequately structured country coordination forums for such forums to be effective

In the past few years, numerous country-level coordination groups, committees and programs, particularly in the field of HIV/AIDS have been created. However, country interviews suggest that there is very little actual coordination to show for this proliferation.

First, every GHP wants its own coordination mechanism, but the roles and responsibilities of these coordinating bodies are not clearly defined. An interviewee in **Mozambique** said that GHPs did not take the time to understand other programs in order to prevent duplication. "PEPFAR does not ask, 'What are you doing for [the World Bank's Treatment Acceleration Project]?'," the official said, "so we do not go into that."

In **Angola** there are many coordinating bodies, but none meet the country's needs (Exhibit 6). In **Tanzania,** there are at least four committees focused on HIV/AIDS, and although there is a clear division of labor, there is little communication between the groups. Activities occur as if the other committees do not exist. Similarly, in the **Democratic Republic of Congo,** four separate committees focus on HIV. **Ugandan** officials say they would rather have folded the Country Coordinating Mechanism (CCM) into an existing HIV committee rather than create an entirely new group.

Exhibit 6

HIV/AIDS COORDINATING BODIES IN ANGOLA HAVE PROLIFERATED, BUT NONE FULLY MEETS ANGOLA'S NEEDS

Body	Disease area	Purpose/background	Comments on degree of functionality
National Commission on AIDS and Endemic Diseases	• HIV/AIDS • Other endemic diseases	• Coordinate activity in all disease areas • Started Oct. 2002 by President of Angola • Theoretically will be used to coordinate World Bank HAMSET activities	• "It exists in name only. It hasn't been functioning" • "It doesn't work because it's too high level – it's all Ministers of the various sectors"
CCM	• HIV/AIDS • Malaria • TBD	• Started for GFATM applications in May 2002	• "It's a very political body" • "It's a joke – no one speaks out against the MoH"
UN HIV/AIDS Theme group	• HIV/AIDS	• Developed prior to NAC – served as forum in absence of coordinating body • Pushed for creation of National Strategic Plan	• Only focused on UN activities, unconnected with other activities
ANASO	• HIV/AIDS	• Coordinates only NGO activity within Angola on HIV/AIDS	• Perceived to be a strong leader in the NGO community

- Although there are several coordinating bodies for HIV/AIDS, none of them achieves the full degree of coordination required across key donors and stakeholders
- Theoretically the Government-sponsored National Commission should be coordinating, but it is dysfunctional
- As more money for HIV/AIDS begins to flow into the country, need to ensure that the money is effectively used

Source: Interviews in Angola; team analysis

Second, coordination meetings achieve little real progress. Country officials lack experience in running such meetings, and many countries hardest hit by the diseases GHPs fight lack experience with the good governance practices, like transparency, required to run effective meetings. Compounding countries' limited experience with coordination meetings, countries also often have limited or non-existent budgets for basic administrative services. Moreover, because countries lack senior managerial talent, the same people tend to serve on several coordinating bodies. For instance, in **Burkina Faso, Tanzania, Bangladesh, Vietnam and Angola,** we discovered that many of the same people who served on the CCM for the Global Fund served on the Interagency Coordinating Committee (ICC) for GAVI, and other national committees. These managers' talents are spread too thin for them to be fully effective.

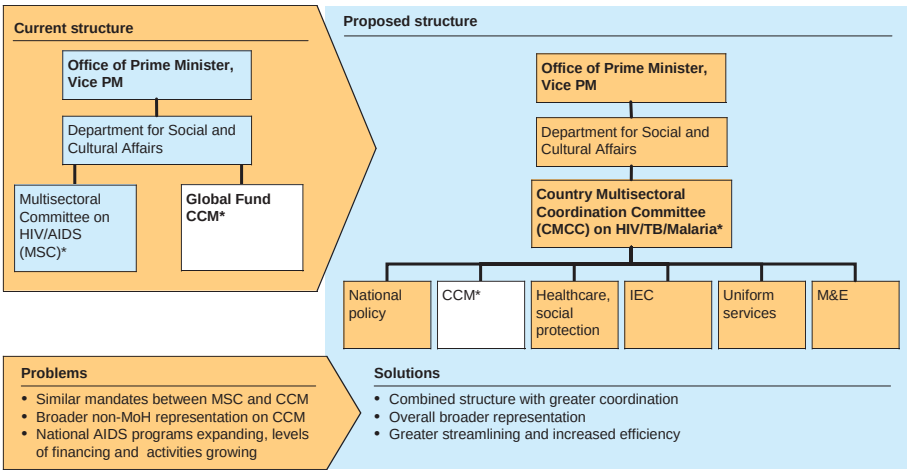
The costs of poor coordination at the central level wind up falling on front-line district health management teams. NGOs (including those funded by the GHPs) do not consistently share plans with or disclose finances to districts. In **Zambia,** for example, experts estimate that 50 percent of activities in the field are not known to national planners before they happen.

The situation is not completely dire, though. Many countries reported that the ICC functions better than the Global Fund's CCM. The ICC has a narrower and less political scope, a clear operational role beyond application submission to ensure that EPI targets are met, and greater flexibility in composition and meeting norms.

In addition, some countries are addressing the issue of proliferating coordination forums in innovative ways. The **Kyrgyz Republic,** for instance, is attempting to merge the CCM and an existing health coordination committee to form a new umbrella structure (Exhibit 7).

Exhibit 7

KYRGYZ REPUBLIC PROPOSES AN INNOVATIVE CCM COORDINATION STRUCTURE



* Groups with originally similar mandates

Source: Country stakeholder interviews; team analysis

2. COUNTRIES ARE BURDENED WITH PARALLEL AND DUPLICATIVE PROCESSES FROM MULTIPLE GHPs, SINCE GHPs OFTEN BYPASS THE PROCESSES THAT COUNTRIES ALREADY HAVE IN PLACE

Interviewees told us that the "one size fits all" processes GHPs find tempting to impose on countries do not recognize their diversity, and that GHPs have trouble dealing with system-level issues.

2A. "One size fits all" processes do not recognize country diversity

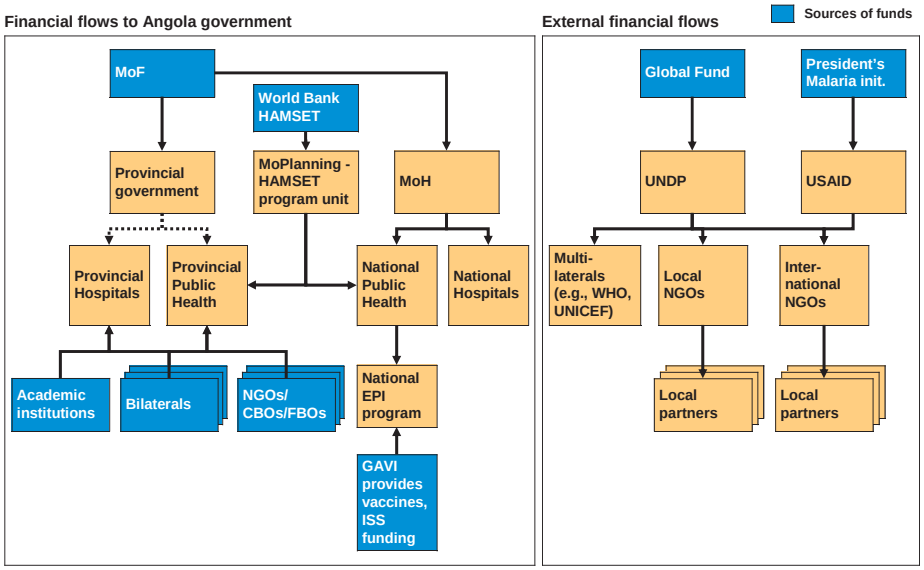
GHPs aim to support country efforts and processes, but they sometimes fall short. More often, GHPs overlay their processes on country processes. This "one size fits all" approach can duplicate and undermine a country's processes in key areas:

Planning: GHP planning timelines are often different from those of countries. In **Ethiopia, Vietnam, and Bangladesh,** for example, interviewees told us that the clashing schedules have led to duplication, confusion and misalignment between proposals and plans. On balance, however, this is a cost countries are willing to accept given the magnitude of the accompanying funding and the infrequency of the planning exercise. Some have adopted a mid-year review process to assess new sources of funding. In **Bangladesh** for example, if GHP grants start in the middle of the annual operational health plan, the annual plan is changed mid-year to accommodate new funding and activities.

Financing: For the most part, GHP financing mechanisms are separate from country mechanisms. As a result of this separation, it is difficult for countries to track financial flows, plan medium-term expenditures and think about financing health sector priorities in a holistic manner (Exhibit 8). Some GHPs and donors do not finance through health baskets, while others finance outside of the government entirely. While separate systems are sometimes justified, separate mechanisms for financing through GHPs create fragmentation and increase the administrative burden in already resource-constrained environments (Exhibit 9).

Exhibit 8

FRAGMENTATION MAKES TRACKING FINANCIAL FLOWS DIFFICULT, THOUGH PARTIALLY JUSTIFIED BY GOVERNANCE CONCERNS



- Donors have adopted variety of routes to fund the health sector. Many do so because of good governance concerns in Angola
- It is currently impossible for national or provincial level government to know how much money flows through its region because many donors work outside of the central MoF/MoH structure. Even if it had the capacity to do so, government cannot push donors to fund gaps or reduce duplicative activities. Also, it is difficult to think about sustainability when no one has a complete picture of the country's health financing
- The proliferation of donors focusing on the same programs has also complicated funding flows (e.g., in addition to bilaterals, WB and Global Fund both fund HIV/AIDS, TB and Malaria – but through different routes (i.e., MoP and UNDP, respectively). Donors should consider focusing on their "comparative advantage"

Exhibit 9

GHPs ARE NOT ADEQUATELY SUPPORTING COUNTRY FINANCIAL MECHANISMS

	Country mechanism	GHP outside of mechanism	Difficulties created by GHPs
Bangladesh	SWAp called HNPSP with >80% of budget from government and donors falling under single financial and reporting system	GAVI; Global Fund	• GHPs equal 2.5% of budget but each add reporting requirements • Outside of SWAp GHP funds viewed as nice to haves and not integral to health program
Burkina Faso	Emerging SWAp – PADS – integrates single report for all donors and provides decentralized funding to districts	GAVI; Global Fund	• Does not support MoH driven systems • Limited engagement with district efforts and demand led funding to districts from GHPs
Mozambique	Established SWAp with 10 major partners, including Global Fund, contributing to common fund with single reporting system	GAVI; PEPFAR	• Does not support MoF fund management process • Funds managed by representative or MoH (burdensome)

Source: Country stakeholder interviews

Monitoring & evaluation: Officials often collect surveillance metrics for GHP-funded programs in a fragmented manner. These metrics are not consistently integrated into national systems, and consequently GHPs may be duplicating efforts to collect metrics (e.g., through NGOs). In **Zambia,** two of the four principal recipients of Global Fund resources are NGOs and do not currently share the metrics they collect for Global Fund programs with the National Statistics Program. Officials in the Office of Statistics report, "Collecting data outside of the national systems undermines our planning efforts." Beyond disease-specific surveillance metrics, GHPs often require programmatic metrics. This type of monitoring can increase program effectiveness and foster a performance mindset. In some cases, though, GHPs do not align with the country on reporting formats and timing, even when the content is similar. Furthermore, writing reports and hosting missions takes up scarce capacity at the district level.

Procurement systems: Some observers report that GHPs have encouraged countries to use procurement systems that duplicate efforts and deplete resources, but in other cases GHP procurement systems have helped prevent gaps in service delivery (see Case study: Procurement systems in Burkina Faso, Bangladesh and Angola).

Case study: Procurement systems in Burkina Faso, Bangladesh and Angola

The government of **Burkina Faso** was rejected for two Global Fund TB grants because the Local Funding Agent (LFA) had concerns about the country's procurement system. No formal feedback was available, and officials misinterpreted the rejections as a message that they were required to use the Stop TB Partnership's Global Drug Facility (GDF) for procurement of TB drugs. Indeed, when Burkina Faso submitted a third application using the GDF for procurement, it was approved. Unfortunately, using the GDF reduced the country's bulk purchasing power. In addition, after GDF drugs were delayed for several months (delivered mid-February 2005 rather than November 2004 as expected by the country), Burkina Faso had to dip into the health budget to replenish depleted stocks, creating a deficit of 3 to 5 percent for that year's procurement budget.

Similarly in **Bangladesh,** after two unsuccessful Global Fund TB applications, the country believed it needed to procure TB drugs through the GDF. Even though Bangladesh had been procuring through the private sector, government officials are now dividing the supply chain between the GDF and the central procurement mechanism/private sector suppliers.

In cases where country systems are weak or non-existent, though, creating a parallel system may be warranted to reach program targets. **Angola** has succeeded in preventing the usual stock outs of TB drugs this year due to procurement through the GDF.

2B. GHPs often stumble when dealing with system-level issues

The influx of GHP funding has highlighted challenges and gaps in country health systems, including problems with infrastructure, procurement, logistics, health information and financial systems and human resources. GHPs have not created these system-level issues. Addressing them is outside the core mandate of GHPs.

However, these issues do present serious barriers to realizing the full value of GHPs. Hence, GHPs such as the Global Fund, (through its Round 5 grants for health systems strengthening) and GAVI (through grants for Immunization System Support (ISS) and financial sustainability planning) have started to address these system-wide gaps. Similarly, many GHPs are undertaking program-specific sustainability planning efforts, for both talent and financial resources.

These efforts do make sense for GHPs individually – but the cumulative effect of such efforts by multiple partners could overwhelm countries with weak systems for several reasons.

- First, **countries often lack the necessary expertise or mechanisms to develop system level plans.** A CCM member in **China** stated that "We did not submit a HSS grant because the CCM is divided into disease specific sub-committees for applications and there was no mechanism to create a broad HSS grant."
- Second, **GHP-led health systems strengthening could result in verticalization.** A CCM member in **Zambia** noted that "We did not apply for HSS funding in Round 5 because the Global Fund does not fund

through basket/pooled funds and that is where we need support." In **Indonesia,** we heard that the Stop TB Partnership's efforts to strengthen lab diagnostic capabilities, M&E and drug management can have benefits for the broader health system, at least in theory. However, "the reality is that TB is still a vertical program and HSS is happening largely in disease-specific contexts."

- Third, **in the absence of sound technical assistance or planning mechanisms, GHPs may inadvertently encourage countries to develop HSS plans that are technically weak and too complex.** An interviewee in **Mozambique** told us, "Don't create a complex set of interlinked programs and call them systems strengthening."

  Any good sustainability plan must address talent and funding. In both areas, GHPs encounter system-level issues.

- In talent, **GHPs may be underestimating the human resources required for healthcare delivery to implement grants.** Furthermore, the scarce managerial and administrative talent available is sometimes consumed by program-specific project management units.

- In funding, **the large gap between most countries' current financial situations and the funding required to sustain GHP programs causes three problems.** First, because sustainability planning discussions are held at the program-level and not at the health sector-level, plans may become ineffective. Second, because GHPs often provide support for only a three-year horizon, countries find it difficult to develop long term sustainability plans. Third, because multiple GHPs aim for countries to sustain the costs of programs after grants expire, the collective expense of these programs may be difficult for countries to bear. A Ministry official in Tanzania noted that, "In three years, we know that we need to take over the HepB vaccine. But in addition to HepB, we're supposed to take over ACTs and ARVs. We can't sustain the expense of all of them. ARVs alone will cost $34 MM annually, which is one-third of Tanzania's entire public sector budget."

3. GHPs HAVE NOT COMMUNICATED ADEQUATELY AND EFFECTIVELY WITH COUNTRIES. THIS WEAKNESS COMPLICATES ALL OTHER ISSUES

Communication across GHPs, partners, and countries is deficient in two ways.

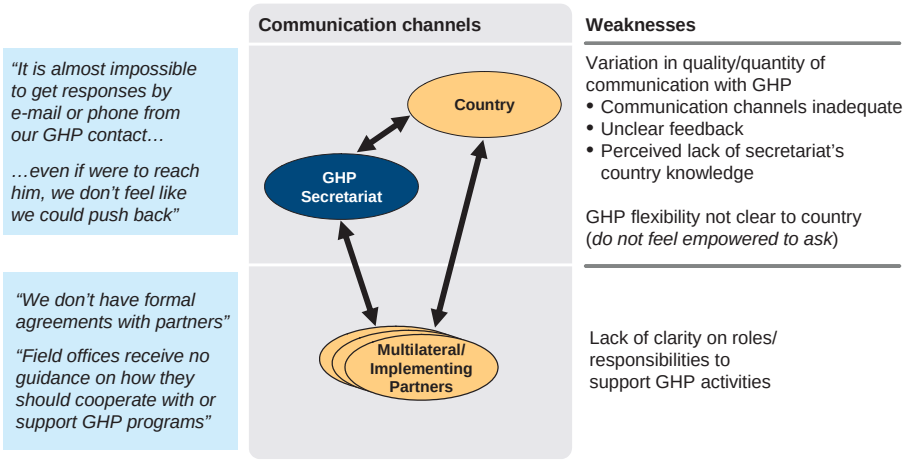
Countries have neither the power nor the appropriate channels to provide feedback to or push back on GHPs:

One of the most common misunderstandings between GHPs and countries is the level of flexibility available for applications and plans. Most countries do not feel empowered to ask GHPs to tailor their approach. They never broach the topic. For example, a ministry official in **Ghana** told us, "We changed our SWAp [Sector Wide Approach] to accommodate the Global Fund. We did not think about asking them to change – that would be impossible."

In some cases, country officials suspect that the GHP representatives in the country are not senior enough to discuss policy and flexibility issues. In **Tanzania,** for instance, donor partners were reluctant to approach

Exhibit 10

GHP COMMUNICATION IS WEAK ON MULTIPLE LEVELS, ESPECIALLY WITH COUNTRIES



the fund manager for the Global Fund given reservations about his influence or ability to change elements of that country's Global Fund grant.

Some countries also reported that the time it takes for GHPs to respond to countries' queries is not conducive to having a productive conversation. When countries don't receive answers for months, they tend to make decisions on their own. In the **Kyrgyz Republic,** for example, confusion and slow communication about GAVI support for the pentavalent vaccine resulted in the government turning down GAVI support except for some safety supplies.

Perhaps the worst result, though, is that poor communication leads to the propagation of myths about GHP policies. One Asian country's officials told us that GHPs consider African countries to be a higher priority than countries in their region. In **Ghana,** we heard that the country felt that GHPs "probably already knew which countries would receive money before anyone applied. They should have just told us that Ghana was not on the list – it would have saved a lot of effort that went into the application." Similar myths about priority programs exist, including the perception that "The first grant was for HIV/AIDS because that is the biggest priority for the Global Fund. The next one was for TB. Now it is malaria's turn." None of this is true, but in the absence of good communication, countries don't hear differently.

Partners are unclear about their roles and responsibilities as they relate to GHP activities:
GHPs tend to operate with lean central administrative staff and minimal or even no in-country staff. They reason that GHPs should harness the power of partnerships and not duplicate partner resources, since many of these partners have a country presence. For the most part, however, countries express frustration in dealing with GHPs in the absence of a "country face."

In-country partner agencies are not prepared to be the face of GHPs in the country for a variety of reasons.

GHPs, for the most part, have not structured clear agreements about country interactions with their partners. Global-level memoranda of understanding have a limited impact in defining the role of partners on a country-by-country basis. While country agency staff support grants in some countries, our interviews found a growing sentiment that this support is often ad-hoc and depends on individual personalities to make it work.

GHPs also tend to rely on in-country development partners to provide technical assistance for GHP-funded programs. However, with the expanding scale of GHP-funded programs, country partners told us they lack the resources to support countries' expanding technical assistance needs. One partner in **Vietnam** noted, "We are simply unpaid workers of GHPs like the Global Fund and GAVI. While there is more and more work, our staffing capacity has not been increased at all. We do all this support because we are here to assist the country."

Furthermore, country agencies feel as ill-equipped to work with GHPs as the countries themselves. For example, in-country WHO and UNICEF staff trying to help countries with GHP applications or programs often can't answer key questions or even tell countries where to turn for help. For example, one interviewee from a multilateral agency said, "It was a slap in the face that the Global Fund originally wanted to sidestep working with UN agencies…. Now the Global Fund expects us to help with their programs, and it works in [this country] because the personalities here have made it work…. The UN agencies have tried to be a silent partner, but we'd love to see a formalized partnership with the UN agencies to articulate the specifics of what role each partner should play. We think it would be mutually beneficial." In the absence of such clarity, GHPs run the risk of not harnessing the power of these partnerships and becoming yet another donor entity with a vertical program in the country.

We see this risk most clearly in the area of monitoring and evaluation. Few GHPs have been able to streamline the M&E requirements of partner organizations into one report. As a result, districts have to write multiple reports, taking health officials' time away from more pressing matters. (see box below and Exhibit 11 on following page).

Case study - The burden of monitoring and evaluation in Angola

Reports help donors know whether their programs are working, but they also add to the workload of in-country officers. In theory, GHPs should reduce this burden by streamlining reporting requirements, but in Angola, we found that for the Expanded Program on Immunization (EPI) officer, this is not the case.

The WHO/UNICEF Joint Reporting Form (JRF), the GAVI report, and Government of Angola EPI program monitoring form all track progress with immunization, and so the EPI officer is responsible for all three. The JRF uses some data from the country EPI report, but still requires additional indicators not tracked in the country system. The GAVI report has some overlap with the two reports for historical data but also focuses on financial data, projected immunization targets and qualitative progress.

This results in major differences in report formats for all reports. Furthermore, these reports are all due at different times.

Exhibit 11

HOSTING MISSIONS AND REPORT WRITING ARE MAJOR BURDENS AT THE DISTRICT LEVEL

TANZANIA DISTRICT EXAMPLES

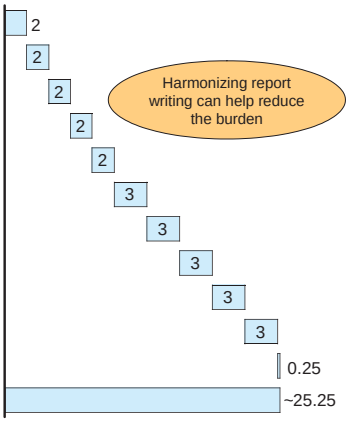
Missions can consume 10-20% of a DMO's time

Number of one day missions to Temeke during last 6 months

PEPFAR	4
GFATM	2
NTLP	2
Gates Foundation	1
Norwegian TB	1
EPI	1
UNICEF	1
WHO	1
NACP	1
NMCP	1
London School	1
Total	**16**

Report writing can consume even more time

Number of full days per quarter spent on writing reports (Morogoro)



We visited several districts in Tanzania to assess the burden of monitoring, evaluation, and report writing at the district level. Interviews conducted with the DHMT and vistor logs were scored.

It was found that report writing can take 40-50% of the time of the District Medical Officer (DMO). Reports written in the previous quarter in Morogoro District included a majority written for the Ministry of Health (over 60%). Hosting missions was an additional burden on DHMT time that could be spent implementation. In Temeke district, hosting missions absorbed 10-20% of the time of the DMO. Missions included those from PEPFAR, the Gates Foundation, the Global Fund, as well as multilaterals, research institutions, and bilaterals. Predominant reasons for missions included audits, evaluations, and assessment of new program feasibility.

* Assumes around 50 working days per quarter and 100 per half year although reported to work in excess of that

Source: In-country interviews; DMO visitor log; team analysis

Innovative practices and emerging opportunities to address the issues countries face when working with GHPs

While all the countries we surveyed face some of the issues raised in this assessment, the magnitude of the costs vary. Some countries are better at managing interactions with GHPs than others. Similarly, some GHP practices have helped mitigate costs and smooth interactions with countries. Exhibit 12 summarizes innovative practices used by countries and GHPs.

Exhibit 12

INNOVATIVE PRACTICES USED BY COUNTRIES AND GHPs TO REDUCE TRANSACTION COSTS

Providing resources commensurate with challenge of absorbing aid	Complementing existing country processes/systems	Improving communication
Providing resources beyond commodities of funds/drugs (e.g., Gates/Path MACEPA supporting full scale-up of Zambian malaria program, in part by co-locating MACEPA staff in National Malaria Control Center to transfer skills/build capacity) ***Developing coordinating mechanisms suited to local context but which still meet global needs*** (e.g., Krygyz Republic proposing to merge Global Fund's CCM with Multisectoral Committee on HIV/AIDS)	***Experimenting with other models*** even with potential risk of losing GHP financing and resources (e.g., Mozambique and Uganda discussing pooled health baskets funding mechanisms with Global Fund) ***Pushing back against vertical GHP funds for health system strengthening until in-country mechanisms for funding such cross-cutting issues can be developed*** (e.g., Zambia did not apply for health system strengthening money in Round 5 Global Fund application because the funds would not be channeled through health baskets)	***Clarifying roles and responsibilities through official MoUs between GHPs and partners*** (e.g., the Global Fund and Stop TB Partnership established an MoU to leverage technical expertise of Stop TB Partnership with resource mobilization of the Global Fund) ***Investing in understanding the local context*** (e.g., the FPM for Mozambique makes in country visits on a regular basis and has 1-2 day turnaround on emails from CCM)

WHAT COUNTRIES CAN DO: NURTURE STRONG LEADERSHIP AND MANAGEMENT CAPACITY IN ORDER TO MITIGATE CONSEQUENCES OF GHP INTERACTIONS

In our research, we discovered that countries that work well with GHPs have a few defining characteristics:

- They have strong, integrated health plans.
- They have established funding mechanisms in which donors participate.
- They clearly establish the roles of central and district governments.

For example, in countries with strong plans – such as **Vietnam, Bangladesh, the Kyrgyz Republic, China, Tanzania and Ghana** – we found that GHP funding supported execution of an existing health strategy or brought focus to under-funded priorities like HIV/AIDS. Such countries saw little or no distortion of existing priorities. In **Mozambique,** the government was able to work with the Global Fund to route funding through its existing, functioning, donor-supported SWAp. Countries such as **Tanzania, Zambia, and Vietnam,** where policies are set at the national level and action plans are determined at the district level in accordance with national priorities, were better able to fit GHP resources into their health activities.

In all these cases, leadership and management capacity have been crucial to creating positive outcomes.

In these countries, local knowledge and evidence allow country governments to independently plan, design and execute programs and hold a two-way dialogue with GHPs to ensure outcomes that are optimal for the country.

To leverage GHPs to reach health outcome targets, countries need to nurture their homegrown talent. It is critical to success.

WHAT GHPs CAN DO: OPPORTUNITIES TO REDUCE COSTS ABOUND

We know GHPs operate in a tough and diverse environment.

- Developing country health systems are often inadequate and opaque.
- There are tensions with partners at global and country levels.
- Country situations vary significantly.
- Multiple priorities compete for scarce leadership, management time and resources.

Despite the challenging environment, we believe there are several opportunities — **within the control of GHPs** – to reduce the costs they impose on recipient countries while retaining the benefits they create. In fact, many of the opportunities suggested below come directly from country stakeholders. The High Level Forum to advance Health Millenium Development Goals could make these opportunities part of a monitored action plan for GHPs.

To reduce costs, there are steps that GHPs can take both individually and collectively. GHPs can:

A. Ensure GHP funding is accompanied by the resources required for implementation

Address shifts in policy and technology: The pace of policy and technology shifts will only accelerate in the coming years. These shifts are pivotal but difficult events for countries to manage and will have long-term ramifications for countries' health outcomes. To achieve their policy goals, GHPs must, over the long-term, **let countries lead discussions on the optimum timing, pace, and scale of new technology adoption.** For instance, instead of immediately adopting ACT therapy for malaria, as GHPs pushed, some countries might have phased in ACT use, focusing on the neediest districts first.

Provide adequate implementation support: Countries shoulder the costs of implementing GHP programs, so GHPs should **allow countries to include overhead costs in their grants.** This will allow countries to build the management capacity and technical infrastructure needed to implement grant activities. GHPs could suggest what percent of a grant would be appropriate for implementation and infrastructure support. Encouraging countries to explicitly budget for and access support will stimulate demand for such assistance.

Collectively, GHPs should collaborate to **develop an easily accessible database of providers of technical assistance and technical solutions.** These providers should have expertise across diseases, health

systems, geography and solutions areas (e.g., installing and upgrading health IT systems, opening new clinics and designing patient-advocacy campaigns). The database should contain experience profiles and track records.

True collaboration means **sharing best practices.** GHPs should create a knowledge management tool to share information across countries, regions and partners - a service that several countries have asked for.

Make country level coordination effective, particularly in the area of HIV/AIDS: GHPs active in HIV/AIDS are responsible for addressing the lack of meaningful coordination in this disease area, and must be held accountable for the resulting costs for countries. GHPs and other international HIV/AIDS initiatives can help by **providing tangible support for coordination mechanisms.** This includes facilitating meetings or workshops, establishing communication norms, and earmarking part of the grant to support the coordination mechanism's activities. This can be led by an in-country partner or supported by GHPs' administrative teams. In addition, **GHPs should develop memoranda of understanding between partners in coordination mechanisms** that clarify roles and responsibilities.

B. Design processes and systems so they complement each country's own processes and systems

Realize "one size fits all" processes don't work: GHPs must tailor their approaches, requirements and processes to work better with specific country health systems. Most GHPs do want to strengthen and work through existing country systems, and several are doing just that. They are using continuous funding cycles or funding system wide approaches. They are changing their mindsets to "becoming the best provider" instead of "not being the worst offender." Specifically, **GHPs need to be flexible with countries, and let countries know that, if they achieve a good track record and develop strong health systems, flexibility is an option in areas including:**

- Frequency of and level of detail in grant applications
- Grant size
- Use of existing country systems and timelines in areas like planning, monitoring and evaluation, procurement or coordination
- Pace of ramp-up and duration of support for sustainability planning
- Nature of interactions with central, state and district-level decision makers

We understand that tailoring processes, while helpful, will exacerbate the challenges of communication by making the rules less clear for both countries and potentially for GHP partners. Hence, GHPs will have to communicate the boundaries of flexibility and establish clear standards for country interactions with GHPs.

Moreover, **GHPs should use technical assessments to provide concrete feedback to countries.** This feedback could address areas such as procurement systems and HR capacity. Transparent feedback will

help countries decide where to invest in system improvements. Stronger systems, in turn, will allow GHPs to be more flexible.

Stop duplicating efforts:

- GHPs need to collaborate to ask countries for **one unified multi-year health sector plan.** This plan would cover priorities, programs, infrastructure requirements and expected financial flows and funding. This plan should cover all health sector actors including the national health system, the private sector and NGOs.

- Countries and GHPs should **evaluate alternative models of funding health system strengthening** instead of individual GHP efforts. For example, **countries could incorporate overhead charges in individual grants to fund shared health system investments.**

- Collectively, GHPs should reduce the burden of missions and reporting by **creating a single unified mission** for all partners in a disease area, and **creating one unified report** for country officials to complete.

C. Improve communication with countries

Boost communication between GHPs, partners and countries: Delayed and patchy communications dilute program quality and create a negative perception of GHPs. Fortunately, GHPs can change this quickly. They can:

- Increase the size and quality of GHP global level administration to **ensure prompt and qualified dialogue with countries** on administrative and technical topics. This would allow GHPs to **establish basic norms for communication** (e.g., promise to answer queries in three days and resolve issues in 30 days).

- **Clarify when partners are the face of the GHP.** Because countries do not know when a partner represents the GHP and because partners don't fully align their policies and technical support with relevant GHPs, countries look to global level administrators for information and support when they could ask questions closer to home. To this end, GHPs should **develop country-specific memoranda of understanding with lead partners** about local planning and implementation activities that make roles and responsibilities clear.

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Abbreviations – Glossary

ACT	Artemisinin combination therapy
ARV	Anti-retroviral
CCM	Country Coordinating Mechanism (for the Global Fund)
DHMT	District Health Medical Team
DMO	District Medical Officer
EPI	Expanded Program on Immunization
FPM	Fund Portfolio Manager (at the Global Fund)
GAIN	Global Alliance for Improved Nutrition
GAVI	Global Alliance for Vaccines & Immunization
GDF	Global Drug Facility (of the Stop TB Partnership)
GFATM	Global Fund to Fight AIDS, TB and Malaria
GHP	Global Health Partnership
HLF	High Level Forum
ICC	Interagency Coordinating Committee
MAP	Multi-Country HIV-AIDS Program (of the World Bank)
M&E	Monitoring and evaluation
MoF	Ministry of Finance
MoH	Ministry of Health
MoU	Memorandum of understanding
NGO	Non-governmental organization
PEPFAR	President's Emergency Plan for HIV/AIDS Relief
RBM	Roll Back Malaria Partnership
STB	Stop TB Partnership
SWAp	Sector-wide approach
TA	Technical Assistance
TRP	Technical Review Panel (at the Global Fund)
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization

November, 2005
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