Partnerships –
working together to achieve health for all
Key points

- Improving the health of the people, including health security, is dependent on good partnerships between communities, providers, organizations carrying out interventions, governments, technical agencies and international partners.

- The number of initiatives and the multiplicity of actors involved in health development in the Region have increased, leading to a bigger share of external resources in total health expenditure.

- Countries have been setting compacts (negotiated and signed time-bound agreements in which partners commit to implement and uphold the priorities defined in a country health strategy), which has optimized the gains from health partnerships.

- An increasing number of initiatives aggregate around issues, themes or diseases rather than on more comprehensive approaches to health, such as health systems development.
Good health is a complex state and achieving it requires much more than just one or two simple interventions, but an integrated range of preventive strategies; environmental changes; therapies and technology to diagnose and treat ill health; and provision of opportunities for those who need health care to access it. Making this happen effectively is dependent on good partnerships between communities, providers, organizations carrying out interventions, governments, technical agencies and international partners. Given the substantive proportion of external resources on health as a percentage of total health expenditures (Fig. 2.1), the number of initiatives and the multiplicity of actors involved in health development in the Region, coordination and harmonization of effort is essential to avoid waste and target real needs. This chapter looks at partnerships that operate in the Region to answer the question “what works?”

Few successful health initiatives now depend on a single organization and, as a result, partnerships functioning in the Region have multiplied. A variety of names used to describe them have sprung up, for example “partnership”, “alliance”, “network”, “programme”, “project collaboration”, “joint (advocacy) campaign” and “task force” all describe partnerships of one form or another. The term “partnership” is often – and misleadingly – used to describe a variety of relationships such as sponsor or international partner relationships and the traditional exchange of goods or services for money. In this chapter we use a more narrow definition of “partnership”, using it to describe the relationship between individuals or groups characterized by mutual cooperation and responsibility towards achievement of a specified health-related goal.

Partnerships in the health sector encompass a wide range of organizational structures, relationships and collaborative arrangements, from formal, legally incorporated entities to more informal collaborations without independent governance arrangements. The nature of the participating partners also varies, but they are usually intergovernmental organizations (e.g. Economic Community Of West African States [ECOWAS], Southern African Develop-
The existing partnerships work on different aspects of the health sector using varied modes of intervention. Some of them are targeted at specific diseases, such as AIDS, tuberculosis, malaria and immunization, as well as maternal and child health. Others are working on different aspects of health systems, for example health information systems, drug supply, human resources, etc. With regard to the mode of intervention used by partnerships, there are funding partnerships, technical cooperation, policy and strategic dialogue partnerships, advocacy and joint ventures. Some partnerships have been initiated at global level while others have been established at the regional or country level.
In the last decade, global health partnerships – the biggest being the Global Alliance for Genomics and Health (Global Alliance) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) – have provided substantial funding to support health programmes in Africa (Table 2.1). Global health partnerships have mobilized important new resources for major health threats, and brought much needed political and technical focus to priority diseases and interventions. They have injected new energy into the aid architecture by supporting the private sector and civil society to play a more prominent role in the matters of health development.

However, there are concerns that the increasing number of initiatives aggregate around issues, themes or diseases rather than on more comprehensive approaches to health, such as health systems development. This has increasingly become very difficult for countries to manage and further complicates international partners’ harmonization efforts at the global level and alignment with national systems and priorities.

In particular, there is a risk that global health partnerships may intensify the financing of vertical programmes by focusing large amounts of new funding on specific, relatively narrow programmes and interventions, leaving national governments little flexibility to reallocate funds according to their priorities or to boost health systems’ capacity. Beyond the international partners’ priorities, some of the most significant challenges facing partnerships in the Region include legislative frameworks, policies and operational strategies, and sustainability. Legislation that governs public–private partnerships is often absent and as a result partnerships may work in isolation. Some partnerships do not appropriately ensure that partners are held accountable for the delivery of efficient, effective and equitable services. Furthermore, the question of national capacity-building and long-term sustainability is often ignored.

The original purpose was to simplify the aid architecture, focusing aid on areas of perceived neglect. However, the proliferation of such partnerships (there are an estimated 75–100 global health partnerships) has led to greater complexity and significant transactional costs, such as an increased reporting burden for health staff at both national and district level.

To address these challenges, several mechanisms and initiatives have been put in place at global and regional levels and some of them aim to change and reform existing institutions for more effective partnerships. They include:

- **United Nations Reform.** Since the late 1990s, the United Nations System has been implementing reforms to work in a more unified manner and deliver more effectively at country level in the Delivering as One initiative. The Region is fully involved in the Delivering as One initiative, which initially included four pilot countries (Cabo Verde, Mozambique, Rwanda and the United Republic of Tanzania) that have now been joined by an increasing number of countries in the Region. The United Nations Development Assistance Framework is recognized as the main instrument for United Nations reform at country level and all countries of the Region are fully involved in the roll out or implementation of the Framework.

- **Focus on MDGs.** Along with the launch of the United Nations Secretary-General’s MDG Africa Initiative to mobilize financing and accelerate achievement of the MDGs, Focus on MDGs has created a platform to engage, at the country level, with government entities and local stakeholders.

- **The Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008).** These mechanisms aim to achieve sustainable development by focusing on five principles: country ownership; alignment; harmonization; management for results; and mutual accountability.

- **Harmonization for Health in Africa (HHA),** formally established in 2006, is
Table 2.1. *Examples of global partnerships and initiatives actively involved in health programmes in the WHO African Region*

<table>
<thead>
<tr>
<th>Partnership</th>
<th>Purpose</th>
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<tr>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)</td>
<td>Established in 2002, the Global Fund is an international public–private financing mechanism rather than an implementing agency. However, the Global Fund partners with countries and implementing agencies to improve health outcomes. For example, in 2005, the Global Fund joined other partners in Malawi to strengthen human resources to optimize the implementation of interventions related to Millennium Development Goals (MDGs) 4, 5 and 6. Between 2005 and 2009, health worker density increased by 66% from 0.87 to 1.44 per 1000 population and, using the Lives Saved Tool, an evaluation of four indicators (antenatal care; skilled birth attendance; administration of Nevirapine for prevention of mother-to-child transmission of HIV; and fully immunized children) showed that 13,187 additional lives were saved due to their increased coverage.</td>
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<td>GAVI Alliance</td>
<td>Launched in 2001, the GAVI Alliance is a public–private global partnership that brings together developing countries, private and government partners, international organizations and the vaccine industry in both industrialized and developing countries to increase access to immunization in the world’s poorest countries. Health ministries in developing countries identify their priorities, integrate GAVI Alliance support into their national health and immunization plans, and contribute through cofinancing towards the cost of the vaccines.</td>
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<td>The international drug purchase facility (UNITAID)</td>
<td>UNITAID was established in 2006 to increase access to essential medicines in developing countries. It provides sustainable funding to boost the availability of affordable medicines and diagnostics for HIV/AIDS, malaria and tuberculosis. By securing lower prices for quality medicines that are otherwise out of reach of poorer populations, UNITAID promotes better treatment for more people. UNITAID does not have its own programmes for the distribution of medication but supports programmes by implementing organizations such as the Stop TB Partnership.</td>
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<td>Partnership for Maternal Newborn &amp; Child Health (PMNCH)</td>
<td>Launched in September 2005, PMNCH is a global health partnership to accelerate efforts towards achieving MDGs 4 and 5. It is the result of the merger of three existing partnerships: Partnership for Safe Motherhood and Newborn Health, Child Survival Partnership and Healthy Newborn Partnership.</td>
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<td>Muskoka Initiative on Maternal, Newborn and Child Health</td>
<td>The Muskoka Initiative, which also works to accelerate progress on MDGs 4 and 5, is a funding initiative announced at the 36th G8 Summit that commits member nations to collectively spend an additional US$ 5 billion between 2010 and 2015 to accelerate progress towards the achievement of MDGs 4 and 5, the reduction of maternal, infant and child mortality in developing countries.</td>
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<tr>
<td>Roll Back Malaria Partnership</td>
<td>Launched in 1998, Roll Back Malaria is a global health initiative created to implement coordinated action against malaria. The initiative is composed of a multitude of partners, including countries endemic with malaria; bilateral and multilateral development partners; the private sector; nongovernmental and community-based organizations, etc.</td>
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<td>President’s Malaria Initiative</td>
<td>Launched in 2005, the President’s Malaria Initiative focuses on expanding coverage of four highly effective malaria prevention and treatment interventions to the most vulnerable populations: pregnant women and children less than 5 years of age. These interventions are: insecticide-treated mosquito nets; indoor residual spraying with insecticides; intermittent preventive treatment for pregnant women; and prompt use of artemisinin-based combination therapies after malaria has been diagnosed.</td>
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A regional mechanism comprising the regional directors of United Nations agencies and development agencies involved in the health sector. HHA focuses on providing coordinated support to countries in the Region to achieve the health-related MDGs.

- **International Health Partnership+ (IHP+)** created in 2007, aims to improve delivery of MDG outcomes and universal access to health services. IHP+ is a group of partners committed to improving the health of citizens in developing countries. International organizations, bilateral agencies and country governments all sign the IHP+ Global Compact and commit to putting internationally agreed principles, such as the Paris Declaration principles, for effective aid and development cooperation into practice in the health sector. IHP+ achieves results by mobilizing national governments, development agencies, civil society and others to support a single, country-led national health strategy.

Regional economic communities, such as the Arab Maghreb Union, the Common Market for Eastern and Southern Africa, the Community of Sahel-Saharan States, the Economic Community of Central African States, the East African Community, ECOWAS, the Intergovernmental Authority on Development and SADC, provide coordination at the subregional level. At the regional level, over the past two decades the African health aid landscape has become increasingly crowded, thus WHO interacts with a wide range of partner organizations.

Strong partnerships with national ministries of health are essential for achieving good health outcomes. Other key partners include:

- development partners and United Nations agencies, such as the AfDB, the African Union, the Canadian International Development Agency, the Centers for Disease Control and Prevention (CDC), DFID, ECA, the European Union, France, Luxembourg, NORAD, the Swedish International Development Cooperation Agency (Sida), USAID and the World Bank;
- the regional economic communities described above;

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- nongovernmental entities working in health and development;
- the private sector, including business coalitions;
- academic institutions and researchers;
- foundations such as the Bill & Melinda Gates Foundation;
- public health associations.

Particular efforts have been made to promote technical cooperation between developing countries. WHO is actively engaged in the United Nations Development Group for Africa.

There has also been collaboration between WHO and the African Union, and the first Memorandum of Understanding was signed in September 1969 with the Organization of African Unity. Subsequent to the advent of the African Union, a new Basic Agreement endorsed by the sixty-fifth World Health Assembly was signed between WHO and the African Union in 2012. This Agreement became instrumental in strengthening this partnership by leveraging on the specific mandates and competencies of each institution to influence and drive the continental health agenda. The policy decisions taken by the ministers are now guiding the joint work of the two organizations. Within the framework of the implementation of the above new Agreement, the two institutions are jointly working in key public health endeavours. The landmark joint WHO and African Union ministerial meeting in Luanda, Angola, from 14 to 17 April 2014 adopted commitments in areas of universal health coverage; maternal and child health; prevention and control of communicable and non-communicable diseases; medicines regulation; and nutrition for improved health outcomes on the continent. The meeting also agreed on mechanisms to strengthen accountability for implementation of resolutions and decisions made.

Many countries are working with an ever-growing number of partners to strengthen health systems, improve health outcomes for specific vulnerable groups such as pregnant women and children less than 5 years of age, or are supporting specific disease control programmes. The increasing number of stakeholders working to overcome major infectious diseases such as malaria, tuberculosis, HIV and neglected tropical diseases (NTDs) poses coordination challenges within countries. Country partnerships bring all the partners together to set priorities and agree on roles, responsibilities and activities to implement country and sector plans. Different approaches have been used in different countries at different times, including sector-wide approaches, which set frameworks for planning objectives, financing and monitoring implementation of agreed activities, and include a memorandum of understanding between international partners and the ministry of health. More recently, countries have been setting compacts – negotiated and signed time-bound agreements – in which partners commit to implement and uphold the defined priorities outlined in the country health strategy.

Partnerships with communities that choose their workers and design interventions and strategies yield effective health care. Partnerships capitalize on the strength of tradition that exists within communities (e.g. care for orphans and the elderly); knowledge within the community (e.g. traditional medicine); and community-based prepayment schemes for health care.

However, a community perceptions study found that community members perceived that health systems exclude community members from decision-making. Respondents from urban, semi-urban and rural areas had similar perceptions about, and experiences with, the health system, showing that regardless of location, lack of interaction with and response to communities is a major weakness of health systems in the Region.

National governments have made numerous commitments to meet health targets. Although the community perceptions study found that community members trust their governments to do what is right for the people, a key lesson from
this study is that governments should recognize the importance of meeting commitments to basic needs as a vital tool for increasing people’s trust.

What works?

Some of the major global partnerships and initiatives active in the Region that have yielded health solutions that work are described below.

Optimizing global health partnerships at country level

In Ethiopia, the recruitment and training of 30 000 health extension workers to provide health promoting and disease preventive services and management of diseases at the community level has been supported through the Protection of Basic Services, which is an initiative funded by the World Bank, DFID and other partners, including the GAVI Alliance and the Global Fund. Routine immunization, measured by coverage of the third injection with the diphtheria–tetanus–pertussis vaccine (DTP3 coverage) increased from 69% in 2005 to 86% in 2010.

Similarly, the Government of Rwanda has developed an integrated approach to health delivery and strengthening health system components into grants for global health initiatives (GAVI Alliance and the Global Fund), thus consolidating rather than fragmenting the national health service. This has enabled the renovation and construction of at least 100 health facilities and provided salary support for doctors and nurses to improve their retention, even in rural areas. Based on the Rwanda demographic and health survey 2010, under-five mortality declined substantially from 152 to 76 per 1000 live births between 2005 and 2010.

HHA: a “one-stop shop” for strengthening health systems

The establishment of HHA, a regional mechanism set up in 2006 to coordinate partners’ support for strengthening African health systems, is an achievement in itself. At that time international health partnerships were very fragmented, so bringing all the actors to the same table was a challenge. Led by the WHO Regional Office for Africa, this partnership began with six members and has grown to 16, expanding beyond United Nations agencies (the Joint United Nations Programme on HIV/AIDS [UNAIDS], the United Nations Population Fund [UNFPA], the United Nations Children’s Fund [UNICEF], UN Women
and WHO) and financial institutions (AfDB and the World Bank) to include country partners such as France, bilateral development agencies from Japan, Norway and USAID, and global health partnerships such as the GAVI Alliance, the Global Fund and Roll Back Malaria. The Global Health Workforce Alliance and PMNCH are HHA associate members. The essence of HHA is that the partners sit together and agree on who will fund, implement and support activities to strengthen health systems in Africa. It provides a “one-stop shop” for countries, groups and other agencies wanting to initiate or support a health systems strengthening activity. At the policy level, HHA plays a significant role in the Region in promoting policy dialogue between ministries of health and ministries of finance, parliamentarians and other health sector stakeholders.

IHP+ country compacts

IHP+ compacts have served to enhance harmonization and alignment of resources and activities to agreed sector plans and thus reduce transaction costs. They are used as a tool for mutual accountability by introducing indicators for tracking progress against agreed commitments by governments and development partners. An example is the Millennium Development Fund in Ethiopia. Since its establishment in 2007, 14 international partners have joined and are channelling their support through a common funding mechanism. Nearly 20 countries in the Region now have, or are developing, some form of compact and some countries who have never had any form of partnership agreement are developing “pre-compacts” as a first step.

Meningitis Vaccine Project

The development and roll-out of the meningitis A vaccine in the meningitis belt of Africa represents one of the great public health achievements of this century. Meningococcal meningitis is caused by several strains of Neisseria meningitidis, but it is strain A that causes most (80–85%) of cases in the Region. It kills and disables hundreds of thousands of people in the meningitis belt of sub-Saharan Africa, which stretches from Senegal in the west to Ethiopia in the east, causing a heavy socioeconomic burden in those countries. In the 2009 epidemic season, 14 African countries reported 88 199 suspected cases, including 5352 deaths.

Development of the meningitis A vaccine broke new ground, resulting in a product that was tailor-made for the meningitis belt, and manufactured in a developing country (India) at a price that countries in the Region could afford. The vaccine was developed by the Meningitis Vaccine Project, a partnership between WHO and PATH, with funding from the Bill & Melinda Gates Foundation.

The meningitis A conjugate vaccine (MenAfriVac®) was first introduced in Burkina Faso, Mali and Niger in 2010. More than 153 million people in 12 countries received the vaccine between 2010 and 2013. Since introduction of the vaccine, the number of cases of type A meningococcal meningitis has fallen dramatically. To date, no cases of meningitis due to N. meningitides A have been
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reported in people who have received the meningitis A conjugate vaccine (Fig. 2.2).

**Partnering to end NTDs**

The Regional Strategy on Neglected Tropical Diseases in the WHO African Region 2014–2020 aims to accelerate the reduction of the disease burden by the control, elimination and eradication of targeted NTDs and contribute to poverty alleviation, productivity and the quality of life of affected people in the Region. Strong country commitment has already resulted in major success against several NTDs, most notably leprosy, onchocerciasis (river blindness) and guinea-worm disease (dracunculiasis). The African Programme for Onchocerciasis Control has successfully met its goals and the partnership will continue with the capacity developed being translated into a programme focusing on lymphatic filariasis (elephantiasis) and river blindness elimination, within the wider NTD plan.

It is estimated that at least 35 million people are currently infected and over 300 000 of these are irreversibly blind as result. In total, 120 million people living in 37 endemic countries in the Region are at risk of contracting onchocerciasis. The main strategy used to control onchocerciasis in Africa is the use of the drug ivermectin to kill all the microfilariae infecting people, many of them with no obvious symptoms, in endemic communities. The main partners are the Food and Agricultural Organization of the United Nations (FAO), the United Nations Development Programme (UNDP), WHO and the World Bank. In 1987, the manufacturers pledged to provide an unlimited supply of ivermectin free of charge to all those at risk from onchocerciasis and for as long as necessary. With drug supplies secured, the challenge for onchocerciasis control programmes was to work out a way to deliver the treatment to the people who needed it, and to sustain the delivery for a sufficiently long period to bring about control of the disease.

The solution was community-directed treatment where communities in affected areas were encouraged to direct and manage their own treatment. This strategy took community involvement in public health to a level that no programme had done before.

Guinea-worm disease (dracunculiasis), a cause of severe disability and suffering in rural communities, was endemic in 20 African countries in the 1980s but is now close to eradication. This has been achieved through a partnership between WHO, governments, affected communities in endemic countries and supporting organizations, including the Carter Center, CDC, UNICEF and the World Bank. It will be the first parasitic disease in history to be eradicated through environmental improvement (providing clean water) and behavioural change alone, with no vaccines or medications involved.

In conclusion, partnerships – at all levels – are essential for delivery of good health to the African people. However, a programme is only

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**Fig. 2.2. The meningitis A conjugate vaccine roll out in the WHO African Region, 2010–2013**

The health of the people: what works

as good as the effective action that it generates. In the Region, significant achievements have been made in different areas of the health sector thanks to partnerships at all levels that successfully complement governments’ efforts. The role played by partnerships in strengthening advocacy efforts, by mobilizing a diverse range of stakeholders and focusing attention on specific issues that are essential for the reduction of morbidity and mortality in countries, has been recognized. As platforms, partnerships facilitate the participation and engagement of a variety of stakeholders, including governments, intergovernmental organizations, nongovernmental organizations, civil society and the private sector. Thus, they are considered as opportunities for countries to benefit from synergies from partners and they mobilize additional funding for the health sector.

Partnerships have been useful in strengthening health systems, including maternal and child health programmes, the prevention and control of communicable and noncommunicable diseases, and in tackling the key determinants of health, as will be discussed in subsequent chapters. Harmonizing and aligning partners’ interventions with national priorities helps reduce fragmentation and duplication of efforts.

Bibliography