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**Workshop Paper 13
Aid Instruments and the Very Poor: The case of Global Health
Partnerships**

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1. AIM

The aim of this paper is to review the literature around *Global Health Partnerships*¹ and their impact on the health needs of the very poor.

¹ GHP as defined by Buse K. 2004

Partnership: the key criterion is a collaborative relationship among multiple organisations in which risks and benefits are shared in pursuit of a shared goal. The focus is on more formal collaborative ventures and not exclusively on public-private partnerships, although these constitute the majority. Some important global health initiatives that are not partnerships per se, such as the World Bank's MAP, are not included.

Health: The goal of the partnerships has to concern the redress of health problems of significance for the poor in low- and middle-income countries.

'*Global*' is interpreted to capture initiatives that extend across or transcend national boundaries. In this paper for example, APOC – the African Programme for Onchocerciasis Control – is included as a GHP addressing a neglected disease, though technically it operates only within Africa rather than globally. It forms the main operating component of the Global Partnership to Eliminate River Blindness.

2. BACKGROUND

2.1. What are GHPs?

In recent years, a number of new global partnerships and funds have been created to address specific concerns for the environment, health and education. Examples include the Global Environment Facility (GEF); the Commonwealth Education Fund (CEF); Roll Back Malaria (RBM); International AIDS Vaccine Initiative (IAVI) and the Global Fund for AIDS, TB and Malaria (GFATM – known as the Global Fund). Of those whose mandate is primarily health (Global Health Partnerships, or GHPs), the vast majority focus on communicable diseases - 60% of identified GHPs target the big three diseases - HIV/AIDS, TB and malaria - with HIV/AIDS attracting the most GHPs by some margin. However, almost all the 'most neglected' diseases (such as Lymphatic Filariasis and Leishmaniasis) are now supported by at least one GHP, many of which have been established in recent years. No GHPs address non-communicable diseases, or health systems per se.

There has been a proliferation of GHPs recently (there are now more than 70), and few countries are without a GHP presence - many host multiple partnerships. Africa has the highest number of GHPs per country, followed by Asia (East, Southeast and Central), with Eastern and Central European countries having the lowest number.

2.2 Overall aim of GHPs

The majority of GHPs aim to deliver outputs – with measurable results - in five main areas:

- *partner alignment and mobilisation;*
- *raised profile and political commitment* through advocacy at international and national levels; joint governmental commitments
- *shared strategic vision and consensus on policy/technical objectives,*
- *mobilising, pooling and co-ordinating the allocation of resources* (financial, commodity and human)
- *co-ordination of efforts and capacity building at national level*

2.3. Typology

Within the over-riding GHP typology by function, GHPs vary substantially by scale, cost, operational structure and impact on systems at country level.

The recent DFID commissioned study² classified GHPs using the following typology. Some straddle more than one category:

1. *Research and Development.* GHPs involved in product discovery and development of new diagnostics, drugs and vaccines.
2. *Technical assistance/service support.* GHPs which support improved service access, may provide discounted or donated drugs, and give technical assistance.

² Caines K. et al; Global Health Partnership, assessing the impact. December 2004

3. *Advocacy*: GHPs which raise the profile of the disease and advocate for increased international and/or national response, and resource mobilisation.
4. *Financing*: GHPs which provide funds for specific disease programmes.

2.4. Highs and Lows of GHPs:

GHPs are generally considered to deliver positive results in the following areas:

- leverage of additional funds (including from private sector)
- promotion of global public goods
- raising profile of neglected issues
- more inclusive governance
- enhanced aid effectiveness through pooling of resources
- reduced commodity prices

On the other hand, the following are the most common criticisms levelled at GHPs:

Global Level:

- creation of additional complexity in an international aid system that is already overloaded
- (for certain GHPs) poorer countries do not meet eligibility criteria or have capacity to frame successful proposals

Country Level:

- distortion of national priorities
- aid made ad hoc and less predictable
- dysfunctional national coordination mechanisms, parallel structures or added burden on existing national systems
- displacement of existing government services
- disproportionate demands on time of Ministers and senior officials
- national strategic planning and budgeting processes undermined
- political accountability damaged

3. TO WHAT EXTENT DO GHPS TARGET THE POOR?

3.1. At Global Level

The overall picture for GHPs at global level is one of successful leverage of additional funds (particularly from Foundations); reductions in commodity prices and improvement in the overall allocation of resources. GHPs have a right to claim, as they do almost universally, that they are working towards global poverty reduction. They are generally targeted towards diseases that present the largest burden of ill health, and to countries in greatest need in terms of socio-economic status. Typically over 60% of financing GHPs' resources are channelled to Africa, where communicable diseases, maternal, perinatal and nutritional conditions account for over 70% of the burden of disease and infectious and parasitic diseases alone account for more than half. All the big three diseases targeted by most GHPs are closely associated with disadvantage, particularly malaria³. Many of the others at least claim to target diseases that 'exclusively affect people who are too poor to pay for any kind of treatment⁴', such as lymphatic filariasis, endemic in 32 of the 38 Lower Income Countries (LICs).

GHP presence also correlates to the prevalence rate or case number of its target disease. Less fettered by political or historical ties than bi-lateral programmes, GHPs are more able to focus on low-income countries. Although the Global Fund does provide support to higher income countries, its allocation pattern is no less pro poor than existing allocations of development assistance for health, and for malaria and TB is more pro poor than recent allocations for infectious diseases. Other factors that often influence bi- and multi- lateral engagement show no apparent correlation with GHP number or type - such as the type of government (across a range from authoritarian to fully democratic), or the percentage of spending on the health sector coming from the public purse.

A particular success of GHPs at international level has been achieving a reduction in commodity prices for target diseases. Partnerships such as the TB Global Drug Facility and the Green Light Committee for multidrug-resistant TB have successfully secured both commodity price reductions and fostered competition and research. The GLC has managed to achieve 85 - 99% reductions on US prices of the 14 products procured for GLC-endorsed projects. Research and Development (R&D) is now intensifying through the activities of newly-created GHPs – Drugs for Neglected Diseases Initiative (DNDi) is targeting the three diseases generally accepted as being in greatest need of new drugs: Chagas disease, leishmaniasis and sleeping sickness. Other GHPs are working on a vaccine against dengue. The Global Alliance for Vaccines and Immunisation (GAVI) is focussing on securing price concessions and supply, through working closely with vaccine suppliers. Although its success is somewhat controversial (see 4.2), GAVI aims to enhance the overall attractiveness of the vaccine market by stimulating

³ 58% of malaria cases occur in the poorest 20% of the world's population, greater than any other major public health disease (Gwatkin and Guillot)

⁴ Mission Statement, Global Alliance on the Elimination of Lymphatic Filariasis (GAELF)

demand in developing markets, strengthening vaccine delivery infrastructure, and guaranteeing future purchasing of the product, at least in the short term. The Malaria Medicines Supply Service (MMSS) has recently been formed in WHO to address the supply crisis for Artemisinin Combination Therapy (ACT). The MMSS is not yet operative, so its impact cannot be assessed, but the conditions of the ACT market are certainly favourable for a GHP of this kind.

Notwithstanding the generally positive impact on commodity prices, additionality of funding and resource allocation, very few GHP mission statements mention targeting the poor, and few have specific pro-poor objectives. Within those that do, the poverty reference is broad (e.g. GAVI/IF restricts its operations to 'countries with GNP less than \$1000') or vague (e.g. GAELF and GAIN both link their activities to 'poverty-related goals'). Another concern, but rarely mentioned, is that GHPs are crowding out donor support for other pro-poor interventions such as water and sanitation which, whilst equally essential to improvements in health, have seen significant declines in donor funding in recent years⁵.

Recent GHP evaluations have variously picked up on this broad and vague approach to being pro-poor. Reports on several partnerships⁶ have pointed out that donor commitments to poverty reduction are not reflected in the partnership's strategic thinking. Five GHPs⁷ have been noted as lacking a specific strategy for how they are contributing to poverty reduction and 'pro-poor health system strengthening'⁸. Other commentators have a different interpretation. The Global Drug Facility (GDF) evaluation suggests that the facility's focus on poorer countries, together with the additionality of funding, means that they are reaching the poorest. A similar conclusion is drawn about drug-access partnerships, which are felt by many to have facilitated increased access by the poor to necessary drugs. Although data to support this remain limited and indirect, a recent study⁹ found the conclusion reasonable given a) the nature of the diseases; b) generally high levels of programme coverage and c) the fact that the drugs are provided free and in unlimited amounts to recipients. This assumption of a 'trickle down' effect is common to many, but it remains questionable how far this goes, if indeed it occurs at all. The fact that GHPs address diseases and commodity issues around the diseases that affect poor people disproportionately does not mean that they are inherently pro-poor. It is inevitably more complicated than that. This becomes more apparent at country level.

3.2. At Country Level

At country level, there appears to be a correlation between the number of GHPs operating in a country and its per capita GDP - in general, the lower the per capita GDP, the greater the number of GHPs. Allocation of GHP resources follows this trend. The share of GHP funding going to low income

⁵ Pearson M., 2004

⁶ APOC, GAEL and others

⁷ RBM, IAVI, MIM, APOC, GFATM

⁸ Green C., Evaluation of Roll Back Malaria, 2002

⁹ Caines K. and Lush L. 2003

countries is extremely high – over 98% for GAVI and GPEI and almost 78% for GFATM. This compares to around 64% for OECD donors as a whole. Lower income countries tend to get higher per capita allocations than better off ones. In 13 countries the GHPs account for at least 50% increase in health spend and in 3 of these it exceeds 100% (Ethiopia, Malawi and Liberia)¹⁰.

Despite impressive funding flows, GHP claims to meet the health needs of the very poor can be challenged on two levels. The first level is understanding who are meant by the very poor, and the second is generating meaningful data to monitor that claim.

3.2.1. *Identifying the Very Poor*

Whilst GHPs are generally founded on a standard view of what constitutes ‘the diseases of the poor’, there is growing evidence of significant socio-economic differences within seemingly homogenous poor populations¹¹. The majority of GHPs produce evidence of increased general coverage attributable to their work as illustration of reaching the poor. This is a similar approach to that taken by the Millennium Development Goals. Research has shown that the differential in access between rich and poor decreases with increasing average immunisation coverage, and this prompted GAVI to increase targets to (at least) 80% coverage. But as the EPI experience showed, the remaining 20% or less are elusive, and are invariably those most vulnerable. A study of over 40 countries found that interventions generally thought to be especially ‘pro-poor’, such as oral rehydration therapy and immunisation, tend to attain better coverage among better-off groups than among disadvantaged ones¹². Data from the same study show even larger coverage inequalities for other services, such as attended deliveries, that are particularly important for the poor.

Such findings confirm that increased coverage can only ever be a proxy indicator for reaching the most vulnerable. Effectively reaching the poorest quintile of a population is challenging, and requires well-thought out, additional strategies. The ‘trickle down’ assumption inherent to GHPs should not apply to this group. Studies are beginning to show this. Recent research in 22 African countries show only a modestly higher rate of illness among the more poor than the less poor, but a much smaller likelihood of obtaining treatment¹³. The Roll Back Malaria programme has not addressed this, and has consequently been recommended to include adding considerations of equity to programme interventions¹⁴. Proposed ways to reach the poor more effectively at local level include targeting subsidies to lower financial barriers to accessing ITNs. Other GHPs are being picked up on this issue too. A recent evaluation of GAVI’s performance-based Immunization Services

¹⁰ Pearson M; 2004

¹¹ Schellenberg J et al; 2003; Filmer D. 2002.

¹² Gwatkin DR. 2002.

¹³ Filmer D. 2002.

¹⁴ Joint LSHTM/World Bank meeting Sept. 2002

Support (ISS) funding¹⁵ found that “case study countries generally did not undertake any special effort to target the “hard to reach,” except to the extent that a significant portion of funding supported outreach efforts.” It is this absence of ‘special effort’ that suggests that GHPs are not reaching their intended beneficiaries as well as they might believe.

3.2.2. Measuring Impact on the Very Poor

Pressure on GHPs to show relatively immediate impact on the disease in question encourages the creation of broad targets that relate only to a disease-specific goal (e.g. Roll Back Malaria’s ‘reduce global malaria burden by 50% by 2010’). Indicators against such targets are understandably wide, not least from reality of what is available. In most countries there is a lack of even routine data that can be used to measure real impact on the poorest. National surveys often disaggregate data from rural and urban areas, for example, but rarely go further than that. GHP M&E systems are no more capable of generating data on the profile of population covered and the socio-economic impact of the partnership programme operations at country level – yet that information is key to identifying health inequalities. The 2004 DFID study on evidence of GHP impact agreed: “while most GHPs have equity objectives, they tend to lack explicit pro-poor operational approaches, or robust measures to provide evidence of benefit to the very poorest”¹⁶. It concluded that there is a specific need for GHPs to tighten the focus on securing pro-poor and gender-related objectives.

Many partnerships have been recommended by evaluators to address this gap by including an operational research strategy within their monitoring arrangements. IAVI was recommended to build up a work plan for stronger involvement of poor and vulnerable communities at country level, given the necessary focus for a preventive HIV vaccine. The un-researched introduction of cost-recovery programmes for treatment of onchocerciasis in the Cameroon provoked criticism of GDF for posing a significant risk to access by the poorest. A study on successful partnerships in water and sanitation¹⁷ identified the integration of pro-poor objectives as crucial to increasing access to services. Seven of the most effective make explicit reference to having established and delivered a strategy and operational plan for integrating pro-poor objectives (measured in terms of geographical and population-based targets). Collection, analysis and use of disaggregated data are essential to inform the development of effective strategies. Situational analysis can be used to identify factors that inhibit service take-up, implementation strategies must address these bottlenecks, and monitoring and evaluation needs to collect indicators on access by different sub-populations, especially the most vulnerable.

GHPs serious about addressing these concerns might consider basing pro-poor targeting on programme incidence or coverage inequality analysis, ‘the

¹⁵ Abt Associates, 2004,

¹⁶ Caines K. et al, December 2004

¹⁷ ICC 2004

equity analogue to cost-effectiveness'¹⁸. This has similarities with the Multiple-Deprivation Index, used extensively across the UK by the Department of Trade and Industry (DTI) and now being developed in South Africa. Use of a 'Wealth Index', based on assets rather than income or consumption, has made it easier to determine those most vulnerable to health shocks. Although the types of variables and weights given to assets vary across settings, making cross-country comparison difficult, it is currently one of the most effective means available to measure distribution of programme outputs across socio-economic groups. Such investigation is essential if there is to be a determination of what health problems are of greatest importance to the poor, and what programmes are most effective in reaching the poorest groups.

¹⁸ Gwatkin D. 2003

4. TO WHAT EXTENT DO GHPS IMPACT ON THE VERY POOR?

4.1. Relating Global Level Targets to District Level Impact

It is clear that GHPs aspire to target the health needs of the poor, and that there are significant efforts made at global level to achieve this. It is also clear that there are unaddressed issues around the extent to which the main beneficiaries of such efforts are those intended to be so, and who subsequently misses out. This is compounded by the 'one size fits all' approach of GHPs. At country level partnerships necessarily take on different shapes, and this depends a great deal on the country context. The same GHP operating within the different contexts of an established sector wide approach (SWAp); a programme-centred environment or a post-conflict situation will adapt the global level principles as necessary. In addition, the level of resources being brought by the partnership can have a significant impact on allocation on the ground.

It has been argued that at country level, GHPs are in practice only as pro-poor as the policy environment and health systems they operate within¹⁹. Since systems are often far from pro poor, a criticism often levelled at GHPs is that investment in such disease-targeted global programmes is at the expense of investments in more poverty-targeted system strengthening. Not only that, but within health systems that do attempt to specifically target the poor and vulnerable outside of the mainstream, a GHP approach that focuses on the majority may exaggerate existing inequalities. There is evidence that both these situations are occurring²⁰. Regions or populations that are disadvantaged by the current health system, their remote location, or by conflict, do not generally benefit from GHP supported programmes. Yet in situations where governments actually have substantial pro-poor health policies in place to favour women, children and other disadvantaged groups, a GHP presence cannot protect these groups from the introduction of informal charges for using health services and notionally free services such as immunisation.

One area where GHP 'one size fits all' position may not be as problematic is with 'neglected diseases'²¹. For this group of diseases that typically affect those least able to demand services, the added value is more apparent. Support is generally through existing health systems, such as they exist, and resources are not generally given at a level that skews national priorities. In the poorer countries visited in recent studies, GHPs appear to be making a real difference in kick-starting or revitalising programmes for neglected diseases which have typically had a low political profile even at country level²².

¹⁹ Carlson C. 2004

²⁰ *ibid*

²¹ Includes the following 15: Buruli Ulcer, Chagas' Disease (American Trypanosomiasis), Congenital Syphilis, Cysticercosis, Dengue and Dengue Haemorrhagic fever, Guinea worm, Human African Trypanosomiasis (Sleeping sickness), Leishmaniasis (kala azar), Leprosy, Lymphatic Filariasis, Maternal and Neonatal Tetanus, Onchocerciasis, Rabies, Schistosomiasis and Soil-transmitted helminthiasis and Trachoma.

4.2. Unregulated Markets

One of the best-known successes of GHPs at global level - commodity prices – has a mixed impact at country level. On first look it appears positive. In Uganda the MOH has noted a considerable reduction in the cost of TB drugs, due to actions of the Global Drug Facility, while many other commodities continue to be donated to the country. In both Sierra Leone and India GHPs have improved access to vaccine equipment and Hepatitis B vaccine (GAVI), and improved TB drugs (GDF).

However, all three of these countries offer examples of how GHP pro-poor rhetoric at global level is not always apparent at consumer level, where other factors affect the price of drugs and other commodities to the countries. The overall drug price to the TB patient in Uganda has fallen, but primarily because of the abolition of user fees for health services, and not due to any actions by GHPs. For the Ugandan government, the cost of immunisation has actually risen due to GAVI's introduction of the Pentavalent vaccine, which despite the GHP's interventions at international level, remains very expensive. In India most GHPs actually have no downward impact on prices due to a highly competitive domestic manufacturing industry. Meanwhile in Sierra Leone, the country's new-found stability has led to the renewal of user fees at public and NGO health centres, and the population are now having to pay for drugs, vaccines and Insecticide Treated Mosquito Nets (ITNs), previously provided free of charge under 'emergency' conditions.

Although difficult to attribute entirely to GHPs, there is also evidence (mostly anecdotal) that donated or subsidised commodities leak into the informal sector as fast as they enter a country. Unlicensed drug sellers and 'medicine men' often prosper from an influx of commodities into a country with illegal or un-regulated markets. Within cultural contexts encouraging of self-medication, this situation is of particular concern. Not only are poor consumers then paying for drugs that entered the country free or heavily subsidised (and meant for them), but they are also endangering their health further by erratic prescribing. The counter-argument to this is that the provision of drugs at reduced prices will flatten an existing black market, but in countries where health systems do not reach the very poor anyway the demand will remain and will undoubtedly be filled by informal supply.

4.3. Difficult Environments:

Although utilising GHPs as an aid instrument of choice in difficult environments is an attractive idea, there is very little evidence of whether or not they can be effective. Most argue as above that GHP impact at country level depends on the situation. In highly aid-dependent countries and those emerging from conflict, GHPs run the risk of becoming the 'tail wagging the dog'. However, it has been suggested that in difficult policy environments GHPs could deliver wider benefits beyond their specific programme, particularly for communicable diseases that cross national borders²³. With

²³ Caines K. et al 2004

fewer political or historical constraints as bi-lateral donors, GHPs potentially have a comparative advantage in countries where poor governance restricts other aid. Others point to the multi-laterals as already fulfilling that role – examples being Myanmar, where it is UNAIDS who have led the donors into an aid solution acceptable to all; and Zimbabwe, where the Global Fund proposal was turned down, but where the traditional donors are working together on creative funding solutions.

For countries that are politically and socially fragile, a limited capacity for planning and prioritising and very limited absorptive capacity at all levels may present particular barriers to GHP impact on the ground, especially for the very poor. Their situation also increases the potential for access and funding GHPs to exacerbate problems with corruption and accountability. In Sierra Leone, where the national health strategy has been delivered piecemeal over the last decade, the government has been inclined to chase GHP funding rather than spend time first to prioritise the priorities and develop a new national health strategy. With the risk that country spending patterns will be dictated by the GHPs, there is also a particular need in fragile environments for strategies to sustain the activities and services provided by them. Only a few of the drug-access GHPs (eg African Program for Onchocerciasis Control - APOC) provide direct access to operational funding in addition to facilitating drug supply. Failure by the GHP to provide or mobilise funding of this kind can seriously curtail programmes in fragile environments - as happened with Global Alliance for the Elimination of Lymphatic Filariasis (GAELF)²⁴ - or jeopardise the value of past investments.

4.4. The Global Fund (GFATM) and GAVI

The two big financing GHPs are both an attempt to fast-track achievement of the MDGs, but are yet too new to ascertain their impact, particularly on the poorest. The target diseases of the Global Fund, in particular AIDS and to some extent therefore TB, are less clearly correlated with poverty and disadvantage than the 'neglected diseases', yet including the Global Fund AIDS receives around half of total aid flows for health²⁵. Of course, many would argue that the potential consequences of the AIDS epidemic alone warrants urgent, priority status over all else. Nevertheless, the Global Fund application process itself has been charged with excluding the poorest countries, due to low capacity. The same criticism has been levelled at GAVI. GAVI's focus on meeting application criteria then proving coverage achievement has also caused concern at the high transaction costs for countries²⁶. Governments are reported to feel forced into quick decisions on commodity purchasing that are not sustainable or synchronised with existing systems, with potentially negative consequences for the poor.²⁷

To date the Global Fund is having a mixed reception on the ground. Countries that have adopted sector-wide approaches have an uneasy

²⁴ Lorenz N. 2004

²⁵ Pearson M. 2004

²⁶ E.g. in Lesotho, LSHTM 2002

²⁷ E.g. the introduction of Pentavalent vaccine in Uganda, see section 4.2

relationship with the Fund, as the governance and reporting demands are more consistent with project support - an approach that more and more governments are moving away from. As a voluntary ad hoc approach to resource mobilisation, with short initial funding commitments, different country contexts are coping with the tensions of handling the scale and speed associated with these kinds of GHPs in different ways. There is, however, some evidence that the Global Fund in particular is receptive to criticism from country level – e.g. problems arising from non-integrated funding in Uganda prompted a different approach in Mozambique. One of its strengths appears to be fostering wider national participation, and Civil Society Organisations are cautiously optimistic that this will improve the flow of resources to marginalised and vulnerable groups (see section 5). Donors and some national governments, meanwhile, note the burdensome procedures for disbursement of said resources with dismay.

5. TO WHAT EXTENT *SHOULD* GHPS TARGET THE VERY POOR?

If it is accepted that GHPs have a comparative advantage that delivers increased resources, reduced prices and an improved pro-poor allocation globally then there is an argument that this may be sufficient. Making the extra effort locally in an attempt to reach the very poorest may even distract from these achievements. GHPs should stick to headlining, advocacy, and mobilising at global level. The counter-argument is that a GHP presence results in a negative effect on the ground and actually increases the inequalities experienced by hard-to-reach groups then none of the above matters. To what extent these arguments apply to GHPs specifically is not entirely clear, but clearly depends to some degree on country context.

The literature is mixed. A recent paper²⁸ from the secretariat of the International Task Force on Global Public Goods argues that “donors should increase the quantity and quality of their capacity building support [for health systems and] be especially cautious in the implementation of global health programs, which too often erode rather than enhance national capacity.” The recently published Millennium Report makes a similar point: ‘Care should be taken to ensure that the vertical programmes supported by the multilateral funds are themselves properly integrated into the broader MDG-based poverty reduction strategy. For example, the control of AIDS, TB and malaria should be part of the overall development of functional health systems, rather than a stand-alone set of programmes’. By contrast, the recent McKinsey Study found GHPs to be broadly positive and certainly better than the alternatives²⁹.

The Global Fund is being heralded by many grass-roots organisations as a GHP that can cover all bases, at least for AIDS, TB and malaria. Of all the GHPs, the Global Fund has perhaps the greatest potential for reaching the elusive hard-to-reach groups. By inviting all stakeholders to bid for major project funds yet operating primarily through the national strategies there is hope that the additional resources being mobilised to fight these epidemics have a chance of reaching everyone. Despite a generally held view that the proposal process excludes the poorest countries, there is recognition that GFATM requirements and to some extent the PRSP process is engaging civil society to a degree that donors and governments rarely do. In many countries CSOs are saying it’s not ideal but it is more participation than they’ve had before. For those who believe that active civil society participation is an essential pre-requisite to reaching all marginalized and most vulnerable groups, a GHP model such as this is welcomed. Those at policy level are generally much more sceptical, citing slow disbursement and the cumbersome administration with its consequences on fledgling health systems as a grave concern.

Contrary to this viewpoint is the assertion that effective GHPs can catalyse a shift in the ‘public sector’ mindset for health care delivery, broadening access. The Stop TB Partnership’s emphasis on national public-private partnerships, together with its approach to inclusive governance (eg Partners’ Forum) has

²⁸ ITFGPG Working paper November 2004

²⁹ McKinsey and Co. 2003

led to the involvement of civil society and the private sector in delivering TB treatment in India. NGOs are essential partners in community based treatment interventions and wider community mobilisation in several GHPs³⁰. Given that these groups are often the most cognisant of poverty - and gender -related barriers to care, one recommendation for support of future GHPs activity centers around innovative community-based and public-private service models aimed at increasing access to effective treatment.³¹

³⁰ Although, some GHP evaluations (APOC, GAEL) note that smaller NGOs, especially indigenous ones, are limited in their participation at both international and national levels.

³¹ Caines K. et al, 2004

6. CONCLUSION

To some extent GHPs are self-targeting in that they focus on diseases that are mainly faced by the poor or on services that the poor stand to benefit from. At a global level, they have achieved some success, notably in leverage of additional funds; allocation of resources and reduced commodity prices. However, differences in the profile of 'the poor' at country level - such as health-seeking behaviour and access to services - are causing concerns that these most vulnerable groups are not reached by GHPs. Claims that pro-poor targeting actually reaches the very poorest need more creative systems of M&E than coverage figures alone.

A further concern is the 'one size fits all' approach. Global level principles are interpreted very differently in different country contexts. Gains from commodity price negotiations can be irrelevant, undermined or even reversed by a range of situations in country; such as unregulated markets, or a poor 'fit' with existing national strategies. In some cases GHP initiatives may even exaggerate inequity. Where national priorities are significantly skewed towards one particular disease, resulting in the neglect of other priorities, there will be consequences for those least able to cope. Some would argue that for certain causes (i.e. AIDS prevention; polio eradication) it is a risk worth taking. There is a lack of evidence as to whether or not GHPs offer an advantage over other aid instruments in difficult environments. There are also mixed reactions to the new financing partnerships, although there is growing concern about their effects on national planning.

Nevertheless, GHPs are proliferating and are considered by many donors - public and private - as relatively 'safe'. There is an argument for fine-tuning, where possible, rather than grandstanding. Better understanding of their particular strengths and weaknesses should be applied to meeting the health-related needs of the very poor.

7. KEY GAPS

- Difficult environments – evidence that GHPs can work in difficult policy environments more easily than other donors
- Effects of lack of coordination at national level (SWAps, PEPFAR, GAVI, MAP, PRSP etc.) on pro-poor programming
- Impact on leakage of drugs attributable to GHPs into the informal sector

8. QUESTIONS FOR DISCUSSION

1. Global Health Partnerships appear to be relatively well targeted towards diseases which present the largest burden of ill health, towards countries in greatest need in terms of socio economic status and in relation to recent trends in development assistance for health and population (particularly achieving the MDGs). Is this adequate?
2. How far should GHPs be required to include objectives and strategy to ensure high benefit incidence for very low-income groups?
3. In line with its own policy stance on poverty and gender, should one criterion for DFID engagement with a GHP should be an active and explicit approach to mainstreaming pro-poor and gender considerations, including clear equity objectives, and specific measures to demonstrate that the very poorest people are benefiting?
4. As no aid instrument on its own provides a perfect solution, what complementary actions can bi-laterals such as DFID take to ensure the benefits of GHPs do in fact reach the very poor?

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GLOBAL HEALTH PARTNERSHIP ACRONYMS

AAI	Accelerating Access Initiative to HIV Care
ACHAP	African Comprehensive HIV/AIDS Partnerships
AHPSR	Alliance for Health Policy and Systems Research
AMD	Alliance for Microbicide Development
AMP	African Malaria Partnership (GSK)
APOC	African Program for Onchocerciasis Control
CF	Concept Foundation
CICCR	Consortium for Industrial Collaboration in Contraceptive Research
CVP	Children's Vaccine Program at PATH
DPP	Diflucan Partnership Program
DNDi	Drugs for Neglected Diseases Initiative
DVP	Dengue Vaccine Project
EL-MDRTPB	Eli Lilly Multi-Drug Resistance Tuberculosis Partnership
EMVI	European Malaria Vaccine Initiative
FIND	Foundation for Innovative New Diagnostics
GAEL	Global Alliance to Eliminate Leprosy
GAELF	Global Alliance for the Elimination of Lymphatic Filariasis
GAIN	Global Alliance for Improved Nutrition
GAVI	Global Alliance for Vaccines and Immunization
GBC	Global Business Coalition on HIV/AIDS
GCM	Global Campaign for Microbicides
GCWA	Global Coalition on Women and AIDS
GET 2020	WHO Alliance for the Global Elimination of Trachoma
GFATM	Global Fund to Fight AIDS, TB and Malaria
GFUNC	Gates Foundation/U. of North Carolina Partnership for the Development of New Drugs
GMAI	Global Media AIDS Initiative
GMP	Global Microbicide Project
GOARN	Global Outbreak Alert and Response Network
GPEI	Global Polio Eradication Initiative
GPHW	Global Public-Private Partnership for Hand Washing with Soap
GRI	Global Reporting Initiative
GWEP	Guinea Worm Eradication Program
HACI	Hope for African Children Initiative
HATC	HIV/AIDS Treatment Consortium (Clinton Foundation AIDS Initiative)
HHVI	Human Hookworm Vaccine Initiative
HIN	Health InterNetwork
HTVN	HIV Vaccine Trials Network
IAVI	International AIDS Vaccine Initiative
IDRI	Infectious Disease Research Institute
IOWH	Infectious Disease Research Institute
IPAAA	International Partnership Against AIDS in Africa
IPM	International Partnership for Microbicides
ITI	International Trachoma Initiative

LAPDAP	Name of anti-malarial treatment developed in public-private partnership
LFI	Lassa Fever Initiative
MDP 1	Mectizan Donation Program
MDP 2	Microbicides Development Programme
MI	Micronutrient Initiative
MIM	Multilateral Initiative on Malaria
MMV	Medicines for Malaria Venture
MNT	Campaign to Eliminate Maternal and Neo-natal Tetanus
MTCT-Plus	Maternal to Child Transmission
MVI	Malaria Vaccine Initiative
MVP	Meningitis Vaccine Programme
NetMark Plus	<i>(insecticide treated net social marketing programme)</i>
PARTNERS	Partnership Against Resistant Tuberculosis: A Network for Equity and Resource Strengthening
PDVI	Paediatric Dengue Vaccine Initiative
PneumoADIP	Pneumococcal Accelerated Development and Introduction Plan
RBM	Roll Back Malaria
SCI	Schistosomiasis Control Initiative
SF	Secure the Future Initiative
SIGN	Safe Injection Global Network
Step Forward	<i>(international pharmaceutical company initiative to support AIDS orphans)</i>
TROPIVAL	<i>(French based R&D partnership for neglected diseases)</i>
VDP	Viramune Donation Program
VF	Vaccine Fund
Vision 2020	<i>(global initiative to eliminate unnecessary blindness)</i>
VITA	Vitamin A Global Initiative
VVM	Vaccine Vial Monitors
WPESS	WHO Programme to Eliminate Sleeping Sickness