E.B.132. Inf. Doc. X. WHO Hosted Partnerships

INTRODUCTION

As discussed in Document EB 131.(X) *"Report on WHO's Hosting Arrangements of Health Partnerships and Proposals for Harmonizing WHO's Work with Hosted Partnerships*", a detailed description on each of the eight hosted health partnerships, further elaborating on the rationale for their establishment, mandate, major accomplishments, governance structure, programmatic complementarity with WHO, extent of country level actions, staffing and budget levels, as well as pertinent findings of independent evaluations, has been prepared and are included in this document as a background for the deliberations on E.B. agenda item no. X.

ALLIANCE FOR HEALTH POLICY AND SYSTEMS RESEARCH (AHPSR)

The Alliance for Health Policy and Systems Research (AHPSR) is an international collaboration hosted by WHO. It has its origins in the recommendations of the 1996 report of WHO's Ad Hoc Committee on Health Research, which identified lack of health policy and systems research as a key problem impeding the improvement of health outcomes in low and middle income countries. AHPSR aims to promote the generation and use of health policy and systems research as a means to improve the performance of health systems in developing countries.

AHPSR currently focuses on specific high priority themes to sharpen its resources and to ensure that its work has maximum impact. These themes reflect the concerns of interested parties, , including the needs of decision-makers at country level. AHPSR promotes global health systems strengthening through initiatives in the health workforce, health financing, and the role of the non-state actors in health, access to medicine and implementation research to achieve the MDGs 4 and 5 .

For some years now it has been providing grants to postgraduate institutions in low and middle income countries to strengthen their teaching of health policy and systems research and support students working in its field. AHPSR promotes the exchanges between researchers and policy makers and is supporting selected countries to prospectively evaluates the interventions aimed at promoting evidence-informed policy making.

The Alliance Secretariat conceptualises, develops and implements the work plan approved by its Board, where WHO is a permanent member. Other Board members are academic /researchers, thought leaders and representatives of Alliance funders.

The Alliance counts over 300 partners (Member States, Foundations, NGOs/Communities, Private Sector and Academic/research institutions). As a network, these members actively participate in the Alliance consultations and workshops, giving them a strong voice in the Alliance's programming and strategic decisions and showcasing their work to a broader audience.

www.who.int/alliance-hpsr/en/

EUROPEAN OBSERVATORY ON HEALTH SYSTEMS AND POLICIES (OBS)

The European Observatory on Health Systems and Policies (OBS) is the oldest hosted partnership in WHO. It brings together national governments, international organizations and other main players in health systems and policies to generate evidence for decision-makers. It has prompted innovation in evidence generation, knowledge brokering and in how WHO works with partnerships.

The Observatory Partners understand from direct experience the complexity of the choices policy-makers face and the lack of accessible evidence. Together they identify the priorities that are most relevant to policy-making in the European Region. The Observatory's core staff and its networks provide country and topic specific research and analysis to meet those priorities. They help Europe's policy-makers and their advisors understand what works better or worse in different contexts and equip them with the frameworks, information and comparative evidence they need to take the best choices possible.

The Observatory has four core functions country monitoring; analysis, assessing the comparative performance of health systems and dissemination.

- Country monitoring consists of a series of profiles (HiTs) which systematically and consistently describe health systems capturing issues of public health, access, quality, regulation, physical and human resources and so on. An innovative Health Systems and Policies Monitor Network is now in place and updating HiTs online
- Analysis uses methods tailored to enhance policy relevance to explore core health system and policy issues in depth. The Observatory brings together academics and practitioners from different institutions, countries and disciplines to ensure really authoritative meta-analysis and secondary research
- Performance marshals comparative and methodological work to address the uses and abuses of performance measurement and seeks to strengthen the field by providing an overview of the issues, and a series of domain reports and methodological papers
- Dissemination is the key to making the evidence generated useful to policy makers. It combines an extensive publications programme with face to face work (including policy dialogues, evidence briefings and a Summer School) and electronic dissemination (the web site, list serve and twitter account) to engage with decision makers and communicate effectively.

The Observatory is based around a number of hubs (offices) and governed by its partners. These are the WHO Regional Office for Europe .the Governments of Belgium, Ireland, Finland, the Netherlands, Norway, Slovenia, Spain and Sweden, the European Commission, European Investment Bank and the World Bank, UNCAM (Union Nationale des Caisses d'Assurance Maladie) France, the London School of Economics and Political Science, London School of Hygiene and Tropical Medicine. They have therefore shaped the Observatory to be policy relevant and to communicate the evidence, so as to bridging the gap between 'scientific research' and the practical demands of decision-makers.

The Observatory's unique characteristics as a partnership and its wide networks of experts and practitioners allow it to fill an important niche in the European arena bridging gaps between theory and practice and between evidence and action. It is a public good for all those that take decisions for Europe's health and for the people that use Europe's public health services.www.euro.who.int/en/who-we-are/partners/observatory

GLOBAL HEALTH WORKFORCE ALLIANCE (GHWA)

The Global Health Workforce Alliance (GHWA) is a partnership dedicated to identifying and implementing solutions to the health workforce crisis.

The Alliance's beginnings are anchored in prior work and investigation. The report of the Joint Learning Initiative (JLI) on Human Resources for Health (HRH), supported by the Rockefeller Foundation, launched in 2002, brought together 100 health professionals and experts from academia, countries and international agencies to examine the problem in greater depth. The decision to create the Alliance to address the health workforce crisis was taken during a Consultation held in Oslo in February 2005, where a special technical working group was formed.

During the winter of 2005-2006, work started on the Strategic Plan of what would become GHWA .The Working Group met in January 2006 to put final touches on it and gear up for the launch of the Alliance later in the year, subsequent to the launch of the World Health Report 2006, focused on the HRH crisis, which has served as the scientific basis for GHWA's work ever since.

A new strategy 2013-2016, which positions GHWA to be responsive and relevant to an evolving global health landscape, and which addresses the issue of optimal synergy with WHO operations, has been developed through an inclusive participatory process involving its members and partners, and was recently launched in July 2012.

The Alliance was officially launched on 25 May 2006, during the 59th World Health Assembly. It draws together Member States, academic and research institutions, Foundations, NGOs/Communities, and private sector entities.

In its first phase (2006–2012) the Alliance actively contributed to an HRH movement in line with its purpose of spurring a "Decade of Action" in this neglected key component of health systems. During this period, collective activities and inputs resulted in significant progress for health workforce development. In March 2008 the Alliance Secretariat convened the First Global Forum on Human Resources for Health, which resulted in the adoption of the Kampala Declaration and Agenda for Global Action (KD-AGA); this has become an overarching framework of reference for HRH development at all levels. The Second Global Forum on Human Resources for Health, held in Bangkok, Thailand in January 2011, provided an opportunity to reconvene the global HRH community to review progress since the First Global Forum, and renew the momentum and commitment to health workforce development and the principles and strategies of the KD-AGA.

As a result of these efforts, national, regional and global leadership now recognize the critical importance of investing in and developing a supported health workforce to improve health outcomes.

In its mission, the Alliance assists countries with their efforts to carry out the ten-year plan for scaling up the health workforce outlined in the World Health Report 2006: " Working together for health"; raises awareness and political visibility; serves as an information hub, watchdog and monitoring body; provides an enabling environment for accelerating country action through evidence-based advocacy and action; engages in global problem solving on resource mobilization, macroeconomics and fiscal space, migration, research, harmonization

and alignment; trains and supports a new generation of local leaders prepared to develop and implement sound health workforce plans.

Its Governance is overseen by a Forum of all members meeting biennially. A representative board appointed by the Forum implements decisions of the Forum.

Regional Networks such as the African Platform on Human Resources for Health, the Asian Action Alliance and the Pan American Health Organization Observatory on Human Resources in Health are key partners of GHWA.

The Alliance has a broad base of members and partners which are central to its work:

- Members are the organizations that joined the Alliance through an application process (voluntary) and whose objectives and work programmes are related to, or supportive of the health workforce.
- Partners are recognized as partners due to their strategic role beyond that of a member organization, which may be funding support or other strategic support in the cause of HRH (partners can also be members).

Halfway through its mandate, GHWA has undertaken an independent external evaluation, which has shown that its work is very relevant, its country support approach highly effective, and the operations it conducted during its first five years represented as a whole good value for money.
www.who.int/workforcealliance/en/

HEALTH METRICS NETWORK(HMN)

Health Metrics Network (HMN) is a global partnership that facilitates better health information at country, regional and global levels. Partners include developing countries, multilateral and bilateral agencies, foundations, other global health partnerships and technical experts.

Launched in 2005, HMN operates as a network of global, regional and country partners. This first achievement was to assist countries assess and improve their health information, through the use of the HMN Framework. HMN's current priority strategic initiative aims to improve monitoring of vital events — births, deaths and causes of death — through innovation and the use of information technologies. HMN is the primary partner for the implementation of Recommendation 2 of the Commission on Information and Accountability for Women and Children's Health.

Tens of millions of births and deaths go unrecorded each year and reliable data on causes of death are lacking for the majority of the world's population. HMN MOVE-IT project aims to contribute to reversing the lack of progress over several decades by supporting the development of standards and tools, advocacy, and innovative country projects. Momentum is building in a number of committed countries and regions, backed by HMN's partnering development agencies, for improved civil registration and vital statistics systems.

HMN has an organizational structure composed of an Executive Board and a Secretariat. The HMN Executive Board is the highest coordinating and decision-making body for the Network. The Executive Board provides overall strategic direction to the Network and Secretariat. Board membership comprises key stakeholders in health information, including health and statistical experts, developing countries, technical and development partners and funding

agencies. The Board's primary functions relate to strategy and accountability for HMN. It approves the strategic vision, direction and policies of HMN.

The HMN Secretariat is hosted by WHO and its roles and responsibilities are to mobilize, coordinate and support the Network's partners.

HMN has benefited from grants from the Bill and Melinda Gates Foundation and additional contributions from other donors including the United Kingdom Department for International Development (DFID), the U.S. Agency for International Development (USAID), and the Danish International Development Agency (DANIDA), European Commission, The Netherlands, The Paris 21 partnership, Rockefeller Foundation, Systems Research Institute of Thailand, United States Centres for Disease Control and Prevention (CDC) and World Bank.
www.who.int/healthmetrics/en/

INTERNATIONAL DRUG PURCHASE FACILITY (UNITAID)

Representatives of 44 countries agreed in 2004 that new and stable resources were needed to finance health development, and committed themselves to developing innovative financial mechanisms. In particular, Brazil and France drew attention to the need to improve access to medicines for the world's poorest people as part of the global fight against the three major pandemic diseases HIV/AIDS, malaria and tuberculosis.

UNITAID is an innovative global health initiative largely financed by a levy on air tickets. It was established in 2006 by the governments of Brazil, Chile, France, Norway and the United Kingdom to increase access to medicines in developing countries. It provides sustainable funding to boost market availability of affordable medicines and diagnostics for HIV/AIDS, TB and malaria.

UNITAID is a unique actor in global health through its market-based approach. By identifying market shortcomings and securing lower prices for quality medicines otherwise out of reach of poorer populations, UNITAID promotes better treatment for more people.

UNITAID – through its international partners – focuses on three main objectives:

- Ensuring affordable and sustainably priced medicines, diagnostics and prevention products, made available in sufficient quantities and with fast delivery to patients.
- Increasing access to safe, effective products of assured quality.
- Supporting development of products targeting niche markets and specific groups, such as children.

In this regard, UNITAID relies on its partners for instance World Health Organization, UNICEF, UNAIDS, The Global Fund, Roll Back Malaria, Stop TB Partnership, Clinton Health Access Initiative, FIND, Esther, I+ Solutions, Population Services International and Médecins Sans Frontières.

The Executive Board is the decision-making body for UNITAID. It comprises 12 members, one representative nominated by each of the five founding countries (Brazil, Chile, France, Norway, and the United Kingdom); one representative of African countries designated by the African Union; one representative of Asian countries; one representative of Spain; two representatives of relevant civil society networks; one representative of the constituency of foundations and one representative of WHO.
www.unitaid.eu/

PARTNERSHIP FOR MATERNAL, NEWBORN AND CHILD HEALTH (PMNCH)

The Partnership for Maternal, Newborn and Child Health (PMNCH) is a global health partnership launched in September 2005 to accelerate efforts towards achieving Millennium Development Goals (MDGs) 4 and 5. PMNCH is the result of a merger of three existing partnerships: Partnership for Safe Motherhood and Newborn Health, Child Survival Partnership and Healthy Newborn Partnership.

PMNCH aims to intensify and harmonize national, regional and global action to improve reproductive, maternal, newborn and child health (RMNCH). It focuses on raising the profile RMNCH on political agendas; promoting effective innovations, with a focus on reducing inequalities in access to care; and monitoring and evaluating progress.

The Partnership is not an independent entity, but a collaborative mechanism between its more than 450 Members. PMNCH is made up of seven constituency member groups with the private sector added as a constituency in 2012. The seven constituencies include: (i) Academic, research and teaching institutions; (ii) Donors and foundations; (iii) Health care professionals; (iv) Multi-lateral agencies (WHO is full Member); (v) Non-governmental agencies; (vi) Partner countries; (vii) Private sector.

Its Board is the Partnership's governing body, with decision-making authority. The Board is supported by an Executive Committee and a Finance Committee. The Members of the Board represent a balance among the members subscribing to The Partnership – each constituency has more than one member on the Board at any time. The Board has a Chair and two Co-chairs who act in support to, and in the absence of, the Chair. As far as possible, the Chair and co-Chairs reflect a balance between Reproductive, Maternal, Newborn and Child Health interests and represent different constituencies and geographical areas.

The Secretariat, hosted by WHO, supports the execution of workplans and decisions of the Board and It is led by a Director and has nine full time staff members. The Partnership also acts as a Secretariat to two important initiatives – Countdown to 2015 and the Innovation Working Group of the Global Strategy for Women's and Children's Health.
www.pmnch.org

ROLL BACK MALARIA PARTNERSHIP (RBM)

Roll Back Malaria Partnership (RBM) is is a global health initiative created to implement coordinated action against malaria. It mobilizes for action and resources and forges consensus among partners. The Partnership is composed of a multitude of partners, including malaria endemic countries, their bilateral and multilateral development partners, the private sector, nongovernmental and community-based organizations, foundations, and research and academic institutions. The partners join the RBM Partnership on a voluntary basis through their commitment to "rolling back malaria".

The RBM Partnership provides value to Partners through the following three roles and responsibilities[1]:

[1] It is NOT the role and responsibility of the Partnership or its mechanisms to implement. The Partnership has not been set up or funded at a level that would allow it (through its mechanisms) to run or lead the actual work needed globally and at country level to "roll back malaria" (*e.g.* organise bednet distribution, set up effective drug manufacturing, supply, & distribution systems). Implementation is a role for the individual partners – alone or collectively – to undertake.

a) Convene: The Partnership brings together all interested parties (public and private sector) to jointly work together to "roll back malaria" and to overcome challenges to that goal.
b) Co-ordinate: The Partnership, through its mechanisms, co-ordinates the work of the individual partners to ensure that each partner's efforts are aligned with those of the others, duplication and inefficiencies are avoided, collaboration between partners is facilitated, and common challenges are addressed co-operatively.
c) Facilitate Communication: By bringing together partners, the Partnership can ensure that partners are communicating with one another, sharing experience and best practice, and ensuring that challenges or bottlenecks identified are brought to the attention of the entire Partnership as appropriate. Where partners are failing to meet their commitments to the Partnership, this facilitation role will allow the other partners to hold them to account. It will allow the Partnership to work with them constructively to find ways to overcome the challenges that are preventing them from meeting their commitments.

It is led by the Executive Director, and served by a Secretariat. The Secretariat works to facilitate policy coordination at a global level.

RBM Partnership comprises hundreds of partners organized in seven constituencies, Member States, nongovernmental organizations/Communities, donors members to the Organisation for Economic Co-operation and Development (OECD), intergovernmental organizations, foundations, academic/research institutions and private sector.

The major funding includes: the Department for International Development (DFID), the United States Agency for International Development (USAID), Bill and Melinda Gates Foundation, Abu Dhabi HAAD, the State of Kuwait, the Kuwait Fund, UNICEF, PATH and World Bank.

The Partnership constituencies are represented (for two years, once renewable) by 21 voting Board members. The Board also includes 5 non-voting ex officio members (GFATM, UNITAID, Malaria Envoy of the UN Secretary General. Alliance Leaders against Malaria in Africa (ALMA), Executive Director RBM). The Board members serve as representatives of their constituencies. Members may appoint one alternate member to serve in their stead. Constituencies determine rotational or renewable status.

Regional mechanisms such as Regional Economic Communities such as the Southern African Development Community (SADC), the Intergovernmental Authority on Development (IGAD), the Economic Community of Central African States (ECCAS) and the Economic Community Of West African States (ECOWAS) of the African Union, the South Asian Association for Regional Cooperation(SAARC), the Association of Southeast Asian Nations (ASEAN) and also WHO Regional Committees are used for the identification of representatives of the malaria endemic country constituency.

Under the RBM umbrella there are 7 Global Working groups. These are:

- Malaria Advocacy Working Group
- Procurement and Supply Chain Management Working Group
- Monitoring and Evaluation Reference Group
- Case Management Working Group
- Vector Control Working Group
- Malaria in Pregnancy Working Group

- Harmonization Working Group

The Working Groups convene to generate Partner alignment or to provide coordinated implementation support on a specific issue or a set of issues critical for scaling up malaria control efforts and are made up of representatives of the key partners in the fight against malaria.
www.rollbackmalaria.org/index.html

STOP TUBERCULOSIS PARTNERSHIP (STBP)
The Stop TB Initiative was established following the meeting of the "First ad hoc Committee on the Tuberculosis Epidemic" held in London in March 1998. The Stop TB Initiative produced the "Amsterdam Declaration to Stop TB" in March 2000, a defining moment in the restructuring of global efforts to control TB, which called for action from ministerial delegations of 20 countries with the highest burden of TB. In May 2000 through its resolution WHA53.1, The World Health Assembly endorsed the establishment of a Global Partnership to Stop Tuberculosis.

The Partnership's mission is to serve every person who is vulnerable to TB and ensure that high-quality treatment is available to all who need it. The Partnership represents the main platform for partners interaction and coordination and is coordinating the development of the Global Plan to Stop TB. Currently, the Partnership develops a new Operational Strategy to guide the work for the period 2013 – 2015.

With 1200 partners as of September 2012, STBP represents a collective force that is endeavoring and transforming the fight against TB globally. These partners include Member States, NGOs/Communities, IGOs, Academic/Research institutions, and Private Sector.

STBP operates through its secretariat hosted WHO and seven working groups whose role is to accelerate progress on access to TB diagnosis and treatment; research and development for new TB diagnostics, drugs and vaccines; and tackling drug resistant- and HIV-associated TB.

It is led by the Executive Secretary and the stakeholders are represented in the Coordinating Board by 34 voting Board members. The Board members serve as representatives of their constituencies. Members may appoint one alternate member to serve in their stead.
The major funding includes: USAID, CIDA/Canada, UNITAID, Bill and Melinda Gates Foundation, DFID, Government of Germany, the Netherlands, World Bank.

WHO has a dual role in the Stop TB Partnership. As a leading partner, WHO provides guidance on global policy and has permanent representation in the Coordinating Body.
www.stoptb.org