

WHO hosted partnerships

1. The present report complements the report on WHO's arrangements for hosting health partnerships and proposals for harmonizing WHO's work with hosted partnerships.¹ It provides a detailed description of eight hosted partnerships, 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.

ALLIANCE FOR HEALTH POLICY AND SYSTEMS RESEARCH

2. The Alliance for Health Policy and Systems Research is an international collaboration hosted by WHO that promotes the generation and use of health policy and systems research as a means of improving the performance of health systems in developing countries. It has its origins in the recommendations of the 1996 report of the Organization's Ad Hoc Committee on Health Research, which identified the lack of health policy and systems research as a key problem that impeded the improvement of health outcomes in low-income and middle-income countries. The Strategy on Health Policy and Research Systems was launched on 1 November 2012 at the Second Global Symposium for Health Systems Research (Beijing, 31 October–3 November 2012).²

3. The focus of the Alliance for Health Policy and Systems Research is on specific high-priority themes to ensure that its resources are invested effectively and its work has maximum impact. These themes reflect the concerns of interested parties, including the needs of decision-makers at country level. The Alliance promotes global health system strengthening through initiatives in the health workforce, health financing, and the role of non-State actors in health, access to medicine and implementation research to achieve Millennium Development Goal 4 (Reduce child mortality) and Goal 5 (Improve maternal health).

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

¹ Document EB132/5 Add.1.

² See the web site of the Alliance for Health Policy and Systems Research at: <http://www.who.int/alliance-hpsr/en/> (accessed 6 November 2012).

5. The Alliance secretariat conceptualizes, develops and implements the workplan approved by its managing board, of which WHO is a permanent member. Other board members include academics, researchers, and representatives of donors to the Alliance.

6. The Alliance comprises 300 partners (Member States, foundations, nongovernmental organizations and communities, private sector establishments, and academic and research institutions). As a network, these members participate actively in Alliance consultations and workshops. This participation gives them a strong voice in the Alliance's programming and strategic decisions, and showcases their work to a broader audience.

EUROPEAN OBSERVATORY ON HEALTH SYSTEMS AND POLICIES

7. The European Observatory on Health Systems and Policies is the oldest hosted partnership in WHO, and supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.¹ It brings together national governments, international organizations and other main players in health systems and policies in order to generate evidence for decision-makers. It has prompted innovation in evidence generation, knowledge brokering and in how WHO works with partnerships.

8. The Observatory partners understand from direct experience the complexity of the choices policy-makers face and the lack of accessible evidence. Together, the partners and policy-makers identify the priorities that are most relevant to policy-making in the European Region. The Observatory's core staff and its networks provide country-specific and topic-specific research and analysis to meet those priorities. The Observatory staff help Europe's policy-makers and advisers understand what works in different contexts.

9. 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 (the series comprises health system reviews, referred to as "health systems in transition" or "HiTs"). These profiles systematically and consistently describe health systems that focus on issues including public health, access, quality, regulation, and physical and human resources. An innovative Health Systems and Policies Monitor Network is now in place and updates 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 authoritative meta-analysis and secondary research.
- Assessing 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.

¹ See the web site at: <http://www.euro.who.int/en/who-we-are/partners/observatory> (accessed on 6 November 2012); it is hosted by the WHO Regional Office for Europe, see: <http://www.euro.who.int/en> (accessed 6 November 2012).

- 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 (for example, through the web site, list serve and twitter account) to engage with decision-makers and communicate effectively.

10. The Observatory is governed by its partners and is based around a number of hubs (offices). Included in the list are the following: the Regional Office for Europe; Member States, namely, Belgium, Finland, Ireland, Netherlands, Norway, Slovenia, Spain and Sweden; intergovernmental organizations including the European Commission, the European Investment Bank, the World Bank; and other institutions, as follows: London School of Economics and Political Science, London School of Hygiene and Tropical Medicine, and L'Union nationale des caisses d'assurance maladie of France. Such partners have therefore shaped the Observatory to be policy-relevant and to communicate evidence, so as to bridge the gap between "scientific research" and the practical demands of decision-makers.

11. The Observatory's unique characteristics as a partnership and its wide network 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 that provides support to decision-makers whose involvement centres on public health in Europe and to those who use Europe's public health services.

GLOBAL HEALTH WORKFORCE ALLIANCE

12. The Global Health Workforce Alliance is dedicated to identifying and implementing solutions to the health workforce crisis.¹ It is a partnership of national governments, civil society, international agencies, finance institutions, researchers, educators and professional associations dedicated to identifying, implementing and advocating for solutions. In response to recommendations in *The World health report 2006*, the Alliance was launched officially during the Fifty-ninth World Health Assembly. That report, which focused on the human resources for health crisis, also provided the scientific basis for the Alliance.

13. A new strategy for 2013–2016 positions the Alliance to be responsive and relevant to an evolving global health landscape, and aims for optimal synergy with WHO operations. The strategy, launched in July 2012, was developed through an inclusive participatory process involving its members and partners.

14. In its first phase, from 2006 to 2012, the Alliance actively contributed to a movement focused on human resources for health, in line with its purpose of spurring a "decade of action" in resources and health systems. During that period, collective activities and inputs resulted in significant progress for health workforce development. The Alliance secretariat convened the First Global Forum on Human Resources for Health (Kampala, 2008), which resulted in the adoption of the Kampala Declaration and Agenda for Global Action. That has become an overarching framework in the development of policy concerning human resources in health at all levels. The Second Global Forum on Human Resources for Health (Bangkok, 2011) provided an opportunity to bring together once again the global human resources for health community, to review progress since the First Global

¹ See <http://www.who.int/workforcealliance/en/> (accessed 6 November 2012).

Forum, and to renew the momentum and commitment to health workforce development and the principles and strategies of the Kampala Declaration and Agenda for Global Action.

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

16. In its mission, the Alliance supports countries in their efforts to carry out the 10-year plan, “Working together for health”, for scaling up the health workforce outlined in *The World health report 2006*. In addition, the Alliance raises awareness and political visibility; it serves as an information hub, watchdog and monitoring body; it provides an enabling environment for accelerating country action through evidence-based advocacy and action; it engages in global problem-solving on resource mobilization, macroeconomics and fiscal space, migration, research, harmonization and alignment; and it trains and supports a new generation of local leaders prepared to develop and implement sound health workforce plans.

17. The Alliance’s governance is overseen by a Forum of all members that meets biennially. A representative board appointed by the Forum implements decisions of the Forum.

18. Key partners of the Alliance include regional networks such as the African Platform on Human Resources for Health, the Asian Action Alliance, the Pan American Health Organization, and the Observatory on Human Resources in Health.

19. The Alliance has a broad base of members and partners that 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 such due to their strategic role beyond that of a member organization, which may be funding support or other strategic support in the cause of human resources for health (partners can also be members).

20. Halfway through its mandate, the Alliance 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.

HEALTH METRICS NETWORK

21. The Health Metrics Network, hosted by WHO, is dedicated to strengthening national health information systems. It 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.¹

22. Launched in 2005, the Health Metrics Network operates as a network of global, regional and country partners. Its first achievement was to support countries in assessing and improving their health

¹See <http://www.who.int/healthmetrics/en/> (accessed 8 November 2012).

information, through the use of the Health Metrics Network Framework. The current priority of the network, in terms of strategic initiative, is to improve monitoring of vital events – births, deaths and causes of death – through innovation and the use of information technologies. The Health Metrics Network is the primary partner for the implementation of Recommendation 2 of the Commission on Information and Accountability for Women’s and Children’s Health.¹

23. 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. The Health Metrics Network 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 the network’s partnering development agencies, for improved civil registration and vital statistics systems.

24. The Health Metrics Network has an organizational structure composed of an executive board and a secretariat. The executive board is the highest coordinating and decision-making body for the network, and provides overall strategic direction. 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 the network, and it approves the strategic vision, direction and policies.

25. The secretariat of the Health Metrics Network is hosted by WHO, and its roles and responsibilities are to mobilize, coordinate and support the network’s partners.

26. The Health Metrics Network has benefited from grants from the Bill & Melinda Gates Foundation and additional contributions from other donors, including the Netherlands and the following government agencies: the Danish International Development Agency, Thailand’s Health Systems Research Institute, the Department for International Development (United Kingdom of Great Britain and Northern Ireland), Centres for Disease Control and Prevention (United States of America), the United States Agency for International Development; two intergovernmental organizations: the European Commission and the World Bank; and two independent entities: Paris21 Partnership and the Rockefeller Foundation.

INTERNATIONAL DRUG PURCHASE FACILITY (UNITAID)

27. UNITAID is an innovative global health initiative.² It was established in 2006 by the Governments of Brazil, Chile, France, Norway and the United Kingdom of Great Britain and Northern Ireland to increase access to medicines in developing countries. It provides sustainable funding to boost the availability of affordable medicines and diagnostics for HIV/AIDS, malaria and tuberculosis.

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

¹ The Commission’s 10 recommendations can be found on the web site and are published in its report, *Keeping promises, measuring results* (see <http://www.everywomaneverychild.org/resources/accountability-commission/implementing-recommendations> (accessed 13 November 2012)).

² See <http://www.unitaid.eu/> (accessed 8 November 2012).

29. UNITAID, through its international partners, focuses on three main objectives:
- To ensure affordable and sustainably-priced medicines, diagnostics and prevention products, made available in sufficient quantities and with fast delivery to patients.
 - To increase access to safe, effective products of assured quality.
 - To support the development of products targeting niche markets and specific groups, such as children.
30. In this regard, UNITAID relies on its partners, which include WHO; UNICEF; UNAIDS; the Global Fund to Fight AIDS, Tuberculosis and Malaria; Médecins Sans Frontières; Roll Back Malaria Partnership; Stop TB Partnership; Clinton Health Access Initiative; Esther; Foundation for Innovative New Diagnostics (FIND); I+ Solutions; and Population Services International.
31. The decision-making body for UNITAID is its executive board, which comprises 12 members, one representative nominated by each of the five founding countries (Brazil, Chile, France, Norway and the United Kingdom of Great Britain and Northern Ireland); 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.

PARTNERSHIP FOR MATERNAL, NEWBORN AND CHILD HEALTH

32. The Partnership for Maternal, Newborn and Child Health is a global health partnership launched in September 2005 to accelerate efforts towards achieving Millennium Development Goals 4 and 5.¹ The Partnership for Maternal, Newborn and Child Health is the result of a merger of three existing partnerships: Partnership for Safe Motherhood and Newborn Health, Child Survival Partnership and Healthy Newborn Partnership.
33. The Partnership for Maternal, Newborn and Child Health aims to intensify and harmonize national, regional and global action to improve reproductive, maternal, newborn and child health. It focuses on raising the profile of reproductive, maternal, newborn and child health on political agendas; promoting effective innovations, with a focus on reducing inequalities in access to care; and monitoring and evaluating progress.
34. The Partnership is not an independent entity, but a collaborative mechanism that has more than 450 members. It 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) multilateral agencies (WHO is a full member); (v) nongovernmental agencies; (vi) partner countries; (vii) the private sector.
35. The Partnership's governing body is its board, which 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.

¹ See <http://www.who.int/pmnch/en/> (accessed 8 November 2012).

As far as possible, the chair and co-chairs reflect a balanced perspective of the interests concerning reproductive, maternal, newborn and child health and represent different constituencies and geographical areas.

36. The Partnership's secretariat, hosted by WHO, supports the execution of workplans and decisions of its board. The secretariat 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.

ROLL BACK MALARIA PARTNERSHIP

37. The Roll Back Malaria Partnership is a global health initiative created to implement coordinated action against malaria.¹ It mobilizes resources for action and forges consensus among partners. The Partnership is composed of a multitude of partners, including countries endemic for malaria, their bilateral and multilateral development partners, the private sector, nongovernmental and community-based organizations, foundations, and research and academic institutions. The partners join the Roll Back Malaria Partnership on a voluntary basis through their commitment to "rolling back malaria".

38. The Roll Back Malaria Partnership provides value to partners through the following three roles and responsibilities:²

- **Convening:** 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.
- **Coordination:** the Partnership, through its mechanisms, coordinates 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 cooperatively.
- **Facilitating 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.

39. The Roll Back Malaria Partnership is led by an Executive Director and served by a secretariat. The secretariat works to facilitate policy coordination at a global level.

¹ See <http://www.rollbackmalaria.org/index.html> (accessed 8 November 2012).

² 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" (for example, organize bednet distribution, set up effective drug manufacturing, supply, and distribution systems). Implementation is a role for the individual partners – alone or collectively – to undertake.

40. The Partnership comprises hundreds of partners organized in seven constituencies: Member States, nongovernmental organizations/communities, donors members to the OECD, intergovernmental organizations, foundations, academic/research institutions and the private sector.

41. The sources of major funding include: Kuwait and the Kuwait Fund; the Department for International Development (United Kingdom of Great Britain and Northern Ireland); the Health Authority – Abu Dhabi; the United States Agency for International Development; UNICEF; the World Bank; the Bill & Melinda Gates Foundation; and PATH.

42. The Partnership constituencies are represented (for two years, once renewable) by 21 voting members of the board. The board also includes five non-voting ex officio members (that is, the Executive Director, the Malaria Envoy of the United Nations Secretary-General, and representatives of the following: UNITAID, Alliance Leaders against Malaria in Africa, and the Global Fund to Fight AIDS, Tuberculosis and Malaria). 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.

43. Regional mechanisms that include regional economic communities, such as the Southern African Development Community, the Intergovernmental Authority on Development, the Economic Community of Central African States and the Economic Community of West African States of the African Union, the South Asian Association for Regional Cooperation, ASEAN, as well as WHO Regional Committees are used for the identification of representatives of the countries endemic for malaria.

44. Under the Roll Back Malaria umbrella, there are seven global working groups, as follows:

- 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

45. 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.

STOP TB PARTNERSHIP

46. The Stop Tuberculosis Initiative was established following the meeting of the First ad hoc Committee on the Tuberculosis Epidemic (London, March 1998).¹ The Stop Tuberculosis Initiative produced the Amsterdam Declaration to Stop TB in March 2000, a defining moment in the restructuring of global efforts to control tuberculosis, which called for action from ministerial delegations of 20 countries with the highest burden of tuberculosis. Subsequent to the adoption by the Health Assembly of resolution WHA53.1 in May 2000, the global Stop TB Partnership was established.

47. The Partnership's mission is to serve every person who is vulnerable to tuberculosis and ensure that high-quality treatment is available to all who need it. The Partnership represents the main platform for the interaction and coordination of partners and is coordinating the development of the Global Plan to Stop TB 2006–2015. Currently, the Partnership is developing a new operational strategy to guide the work for the period 2013–2015.

48. With 1200 partners as of September 2012, the Stop TB Partnership represents a collective force that is endeavouring to transform the fight against tuberculosis globally. These partners include Member States, nongovernmental organizations and communities, intergovernmental organizations, academic and research institutions, and the private sector.

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

50. It is led by an Executive Secretary and 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 sources of funding are from two Member States: Germany and the Netherlands; a number of government agencies: the Canadian International Development Agency, the Department for International Development (United Kingdom of Great Britain and Northern Ireland) and the United States Agency for International Development; and a number of entities including UNITAID; the World Bank; and the Bill & Melinda Gates Foundation.

51. 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.

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¹ See <http://www.stoptb.org/> (accessed 8 November 2012).