Global partnerships and Health for All

Towards an institutional strategy

A discussion paper prepared for GPR
by Judith Richter, 20 October 2005

"The overriding purpose of cooperation between the United Nations and non-state actors should be to enable the Organization to serve Member States and their peoples more effectively, while remaining true to the principles of the Charter. Cooperation should be regularly assessed against those objectives. As such, cooperation should be viewed as a means of achieving United Nations goals and enhancing performance, not as an end in itself."

Cooperation between the United Nations and all relevant partners, in particular the private sector. Report of the Secretary-General to the General Assembly, UN 2001

"In developing relationships with commercial enterprises, WHO's values and reputation must be ensured. Scientific validity must not be compromised. Staff should always consider whether a proposed relationship might involve a real or perceived conflict of interest, either for the staff member or for the work of the Organization…."

WHO (2000). Guidelines on interaction with commercial enterprises to achieve health outcomes[1]

Introduction

Collaboration and relations between WHO and non-state actors is as old as the UN specialised organisation itself. Yet, for much of its existence, WHO did not use the term partnership for such interactions.

What started out in the 70s as a rallying call – an appeal to all actors to work together towards Health for All in a 'spirit or partnership' - has taken a fundamentally different connotation since the mid 1990s.Today, the word partnership denotes primarily a trend towards concrete joint initiatives and alliances between UN agencies and non-state actors, with a steep increase of financial, collaborative and policy-related relationships with private-sector actors and foundations under terms such as public-private partnerships (PPP) or global health partnerships/alliances/funds.

At first, discussions centred on how closer engagement with non-state actors would create new synergies and allow to work more efficiently and effectively for health goals by bringing in new partners. Key objectives included gaining access to hitherto untapped resources, giving neglected health issues new prominence, and creating innovative collaborative projects and alliances.[2] Today, questions are increasingly raised about the risks and price of this new policy approach. These questions include queries about the overall impact of the model on the

capacity of WHO and its Member States to unambiguously and efficiently fulfil their public mandates.

The Corporate strategy for the WHO Secretariat suggested in 1999 to "put a new emphasis on "triggering more effective action to improve health… by *carefully negotiating* partnerships and catalysing action on the part of others."[3] According to available information within the agency, the WHO of today is involved in more than 88 global health partnerships (GHPs).[4] This situation turns well-planned management along agreed upon international health goals into a challenge.

WHO and many of its Member States face the question of how to ensure that a further increase of global health partnerships will not lead to fragmentation of health policies and programmes and to the transformation of WHO and state authorities from prime actors into underfunded technical servicing agents. They face the common question whether a certain view of global governance will not result in the marginalization of WHO, its governing bodies and other internationally agreed mechanisms meant to set, advocate and carry through international health policies.

Purpose

The purpose of this policy discussion paper is twofold:

I. Bring the following overarching concerns to the attention of the DGO:

1. Concepts of partnership and public-private partnership are poorly defined and create difficulties with respect to policy guidance and management;
2. The analysis of 88 GHPs, in which WHO is involved, reveals problems of internal guidance, management and supervision;
3. An unregulated increase of global public-private partnerships (GPPPs) may make it difficult for WHO and its Member States to adequately fulfil their public mandates.

II. Identify suggestions which might help ensure that:

- WHO manages current and future global health initiatives (GHIs) and global public-private health initiatives (GPPHIs) according to ethical principles, sound criteria and guidelines; and which treats these arrangements as one public health tool among others and not an end in itself.
- WHO has the information, capacity and political support to fulfil its constitutional mandates of ensuring the "fundamental right of every human being without distinction… to the enjoyment of the highest attainable standard of health" and to "act as the directing and co-ordinating authority on international health work."[5]

Some of the suggestions can be found throughout the text, others at its end. These include a set of elements for an institutional strategy which might help address some of the identified problems in a coherent manner and annexes suggesting operational definitions of global health initiatives and global public-private health initiatives; some fundamental principles and criteria underlying GPPIs for health; and a working typology of GPPIs.

This paper focuses in particular on arrangements which involve relationships with the private sector as the great majority of the identified 88 GHPs involve business actors. However, many of the issues raised and suggestions made also apply to joint initiatives and alliances and financial and policy-related relationships with other actors.

Methodology

This analysis combines a desk review of WHO material, statements, policy papers and guidelines and available relevant material from other UN agencies and the World Bank with a review of material on partnerships/initiatives for health or development written by academics and policy consultants. The analysis focuses on identifying and examining key issues from the perspective of WHO as the UN's specialised health agency.

The limitations of this study reflect partially a relatively short time frame for the task and partially the limits faced by all researchers in this field: The complexity of the issue, coupled with difficult access to key information and documents and lack of data on key aspects of global partnerships, make it difficult to obtain a complete picture. Wherever possible, attempts were made to fill gaps through semi-structured interviews and discussions with WHO officials. However, the internal nature of this paper did not allow for critical peer review by outside experts in the field.

I. Overarching concerns which may warrant attention by the DGO

1. The concepts of partnership and public-private partnership are poorly defined and create problems concerning policy guidance and management

There is no consensus on the meaning of the term partnership means with respect to development and health. Debates about whether partnership is a useful concept in the international policy arena or whether it is a problematic, emotionally-charged, buzz-word centre around two areas:

- Theoretical and operational aspects: Partnership is seen as a too broad term – embracing too many diverse meanings and a too great variety of arrangements and relationships - to be a useful policy and operational concept;

- Political and moral aspects: Partnership is seen as an unsuitable term for relationships between actors which do not share the same fundamental values or who are unequal in terms of political, respectively financial, power.[6]

This discussion paper cannot address these issues in the depth they deserve. Its primary aim is to point out at sub-optimal policy analysis and guidance created by the lack of distinction between the manifold meanings and levels of use of the term partnership as well as by the definition of partnership currently used in UN circles coupled with the absence of an official definition public-private partnerships.

a. Partnerships and public-private partnerships: terms with many meanings

In today's UN fora and policy debates, the terms 'partners' and 'partnership,' are used in a variety of ways. They are used, for example,

- in motivational rallying calls to denote a spirit of solidarity; or as a kind of implicit or explicit social contract (such as in the 1969 Pearson Commission's *Partners in Development* report; and the Millennium Development Goal No. 8);
- as a term for contractual relationships between or with for-profit actors; [7]
- as a term encompassing a variety of most diverse relationships between UN agencies and other actors (spanning from financial relationships, over policy relationships, to operational relationships).

The term public-private partnerships, moreover, is used at three fundamentally different levels. It can denote:

- a policy paradigm (including the underlying framework of thought);
- various categories of public-private partnerships or interactions (PPPs/PPIs), such as drug donation programmes, or multisectoral global health funds; [8]
- specific public-private partnerships or interactions, such as the Malarone® Donation Programme, or GAVI, GAIN and GFTAM.

These examples show why attention to clarity of language is an essential precondition for policy analysis on the matter.

b. A UN definition of partnership

The most frequently referred to definition of partnerships in UN circles stems from the Secretary-General's 2003 report on *Cooperation between the United Nations and all relevant partners, in particular the private sector:*

> "Partnerships are commonly defined as *voluntary* and *collaborative relationships between various parties*, both State and non-State, in which all participants agree to work together to achieve a common purpose or undertake a specific task and to share risks, responsibilities, resources, competencies and benefits."[9]

Many of the qualifiers in the UN partnership definition are problematic when it comes to relationships and collaborative arrangements which should be guided by public interests as defined in UN mandates and international public policies.

What, for example, is the meaning of the qualifier 'voluntary' with respect to collaborative relationships between UN or other public agencies and business or public-interest centred non-state actors? In arrangements which often involve business actors it seems much more relevant to stress that such arrangements are 'contractual' or 'non-contractual'.[10] This would help indicate that global health initiatives range from arrangements which need firm contracts to alliances of a more informal nature which can primarily be held together by clarity on a few guiding values and goals.

Can one work in the public interest(s) if one '*shares* risks, responsibilities, resources… and benefits' with actors who are guided by profit interests or a business philosophy? Risks and benefits are of a profoundly different nature from a public sector and private sector perspective. They are not commensurable.[11]This does not mean that other actors involved in global public-private initiatives do not incur certain risks, have no responsibilities, need not put in resources or are not allowed to benefit from such relationships. It means that actors who have fiduciary duties towards the public need to ensure that their acts – as well as the activities of the public-private hybrid arrangements they are involved in – are in unequivocal accord with public interest goals, principles and standards. It means that they need to be clear which agreements and compromises can be made with other parties in collaborative arrangements and which ones are not permissible and need to be re-negotiated. It also means that public interest actors need clarify which arrangements and relationships are not in accord with the public interest and the mandates they stand for and therefore not acceptable.

Finally, will 'sharing' of 'responsibilities' not result in a blurring of responsibilities and roles between intergovernmental agencies and other actors? This is the concern of those whose analyses focus on conflict of interest issues and/or the relationship between the promotion of global public-private partnerships and what some see as the emergence of a new structure of global governance.[12] It has been pointed out that the notion of seeing industry as 'stakeholders' or 'partners' in public policy-making is the expression of a form of neo-corporatism which advocates the idea of tri-partite decision making processes in all kind of policy-related fora.[13] One analysis of this ongoing shift within international relations stated:

> "It is problematic to use the term 'partnership' to characterize the relationship between state and non-state actors, because what the term suggests is an … equal status for the actors involved. This relativizes both, the special political status of governmental institutions under international law and their (democratic) legitimacy. The use of terms like 'partnerships' is … not just a matter of stylistics, it has eminently political significance. It implicitly downgrades the role of governments and intergovernmental organisations and

> upgrades the (political) status of private actors, in particular of the transnational corporations involved in these cooperation models."[14]

c. 'Shared decision making' – a key feature of partnerships?

Requests of UN Member States for a specific definition of public-private partnerships have not yet been answered. Neither of the UN Secretary-General's 2003 and 2005 reports on *Enhanced cooperation between the United Nations and all relevant partners, in particular the private sector* contain such a definition.

However, efforts were made to answer another recurring question which Member States had asked during the introductory time of the PPP policy model. They wanted to know what exactly distinguished a 'partnership' from other types of cooperation and relationships with the private sector. According to a Global Compact commissioned book on UN-business partnerships, a key feature of partnerships is the *"shared process of decision making."*

> "In the most strategic partnerships, the partners will work together at all levels and stages, from the design and governance of the initiative, to implementation and evaluation." [15]

An implicit or explicit view that partnerships with commercial actors are characterized by closer relationships and shared-decision making processes has influenced the concept and practice of global public-private partnerships in health in many ways.

"In a true partnership, the partners share authority and decision making," states a publication by Managing Sciences for Health.[16] And the very influential, now defunct, Initiative on Public-Private Partnerships for Health (IPPPH) of the Global Forum for Health Research (GFHR) lists among essential characteristics of joint public-private partnerships: "significant representation" of private sector actors on governance or advisory bodies, "joint decision making processes," and "active participation of private sector representatives in implementation."[17]

In keeping with this logic, the long-time manager of this Initiative, Roy Widdus, argued that a number of initiatives which are managed from within intergovernmental organizations should not be called public-private 'partnerships' because of the significant influence which these organizations could have on the rules governing the operations of these PPPs. He felt that some of these arrangements would be more accurately described as "*public sector programmes with private sector participation*."[18]

Also Global Health Funds, which have been modelled along GAVI, are built on the view that industry representatives must be present as 'full partners' at various levels of decision-making.[19]

d. Towards operational definitions and working typologies

WHO may wish to re-examine the use of the term partnerships for global health initiatives and relationships, seen the wide-spread connotation that partnering involves shared decision making with commercial actors if not a profound redefinition of WHO's role from a directing and coordinating UN agency to the role of an organisation which would provide primarily technical and administrative support to global public-private health initiatives.[20]

If WHO decides to use the term partnerships, it may need to specify that this term does not automatically imply a notion of shared decision making among the actors. It may need to specify where shared decision making is inappropriate for conflict of interest and other reasons.

It seems, however, most judicious to replace the term partnership by initiative (or a similar less value-laden term) to denote the arrangements which are currently sub-sumed under the term public-private partnership.

The recent *Report of the Secretary-General on Enhanced cooperation between the United Nations and all relevant partners, in particular the private sector* stresses that its broad definition is insufficient as a guide for United Nations action. This report and other publications stress the need of a more detailed categorization to better describe and assess the variety of arrangements sub-sumed under the term partnership.[21]

WHO may wish to consider adopting institutional, operational, definitions of health initiatives and public-private initiatives which would not contain confusing qualifiers. Such definitions could combine key elements of the definition of partnerships contained in the afore-mentioned Secretary-General's Reports with that of other existing definitions. To be made more operational, WHO would need to spell out the fundamental principles and criteria underlying these arrangements and relationships as well as decide on a working typology (or typologies) which would be most suitable for its purposes (as example, see annexes 1-3).

2. Challenges to internal guidance, management and supervision

When WHO started to advocate an increased engagement with private sector actors, a number of debates on how to guarantee that the 'partnership' arrangements positively contribute to Health for All took place. The principles and processes described in the *WHO Guidelines on interaction with commercial enterprises to achieve health outcomes (2000)* are seen by many as such a guarantee.

However, according to observations of GPR, today:

- global cross-sectoral initiatives and alliances seem to be often created without a thorough prior evaluation of their added value over possible alternatives;
- in general, benefits of GPPIs tend to be overestimated, while their risks, costs and administrative burdens tend to be underestimated;
- duplication of GPPIs is not excluded;
- GPPIs can - and are being - created for other motives than the furtherance of Health for All goals;

This situation seems to have various reasons:

One is an unclarity regarding the scope of the *WHO Guidelines on interaction with commercial enterprises.* From GPR's observations, many WHO staff seem to understand that they apply primarily to initiatives and relationships which involve just two actors: WHO and commercial enterprises. As soon as an initiative involves additional actors these Guidelines and the described Procedures for implementation are not easily applicable. [22]The Guidelines mention more complex arrangements as "multi-party alliances" under the heading *Other forms of interaction*:

> "Proposals for the initiation of work with commercial enterprises on matters not referred to in these guidelines, such as establishment of multi-party alliances or product pricing, should be referred to the Director-General, after due consideration by the Executive Director or Regional Director concerned and the Office of the Legal Counsel." [23]

Theoretically, all complex arrangements involving WHO and commercial actors[24] fall under this requirement. However, this paragraph seems to have lead to the interpretation that only bigger arrangements, such as GAVI, are dealt with at higher management level while 'smaller' tri-sectoral arrangements initiated at departmental level do not fall under the scope of these Guidelines. The Guidelines do also not contain clear and easily applicable advice how to address interactions with commercial actors when complex arrangements are initiated outside of WHO, which often involves in the agency needing to take decisions in an ad-hoc manner under extreme time pressure.

Moreover, the absence of a website on which WHO staff could find an overview of the existing GHIs as well as the lack of a clear directive to the staff to routinely announce any new GPPI it intends to set up contribute to this lack of clarity.

In general, there has been sub-optimal guidance and training to help staff assess whether, when and how to engage into a specific GHI or GPPI, how to maintain it, when to adjust, abandon or terminate it, and how to identify and appropriately address conflict of interest issues and instances where outside actors may want to instrumentalize WHO for their own purposes without regard for HFA values and goals.

This problem is compounded by the fact that there are no mechanisms and structures to ensure regular institutional learning from experiences on best, as well as bad, practices in the management of GHIs and GPPIs.

Mechanisms are not available to ensure that WHO staff cannot create GPPHIs with other considerations in mind than the furtherance of HFA goals and policies. Thus WHO staff members can, for example, catalyse a global health initiative and become a manager or a staff member of that same initiative once it has become legally independent and funding is secured. Similarly, efficient mechanisms are not in place to prevent staff members from financially profiting from their involvement in PPIs. However, it would be wrong to only look at potentially conflicting personal interests.

Challenges brought about by sub-optimal levels of funding for WHO and international public health issues in general may prompt WHO staff - and WHO external actors - to catalyse a new health initiative as a pragmatic, most financially viable, way to move forward. It has been suggested that, for similar reasons, some WHO departments demand staff members to create a pre-determined number of partnerships as part of their results-based work plans.

GPR has repeatedly tried to gain an overview of the situation and provide advice during the formation of new GHIs as well as during their operational phase. So far, GPR has found it difficult to ensure that only high-quality GPPIs were formed.

First measures to redress this situation would consist in: adopting and endorsing a set of fundamental principles and criteria to ensure that any new GHI catalysed from within the agency positively contributes to HFA based policies and programmes; and immediately revoking any incentive to create partnerships which may be in place.

Clearer guidance on prior technical and financial (full opportunity cost) assessment, best management practices, conflict of interest identification and management related to the different categories of global health initiatives would also lead to considerable strengthening of WHO capacity to assess and manage any current or future GHI and GPPI appropriately.[25]

Mechanisms and structures to provide guidance and oversight also need to be strengthened.

3. Challenges to WHO's ability to fulfil its constitutional mandate and missions

Ensuring that GPPIs which are catalysed from within the agency are technically the best possible arrangement is an important step forward. However, it is not sufficient to secure that GPPIs positively contribute to coherent, HFA based, policies and programmes.

Below a few issues which go beyond the technical soundness of the specific arrangements:

Is there a critical number of GPPIs beyond which it might become impossible for WHO to fulfil its constitutional obligations towards its Member States and the broader public?
WHO was mandated to act as the "act as the directing and co-ordinating authority on international health work." A proliferation of GHIs and GPPIs may threaten coherence in health policy making and public health programmes. Many GPPIs are vertical arrangements centring on a particular disease or a health technology. Many of them are placing heavy administrative and management burdens on their public sector partners, including WHO. One challenge is to adopt policy measures to ensure that these approaches do not lead to fragmentation of policies and programmes and the undermining of the public sector actors capacity to fulfil their duties towards the populations they are meant to serve.

Can WHO still retain adequate control over the complex situation?
Even if WHO tried to limit the number of GHIs and GPPIs to those which have a clear added value from a HFA perspective, the level of control of the agency and many of its Member States over the situation is sub-optimal. GPPIs are often founded outside of WHO by a few actors. A number of these GPPIs have a great impact on international policy making even though they were initially presented as mechanisms to raise new, additional, funds for specific issues. There are indications that these GPPIs shift public health priorities, divert bilateral funding from public agencies and sectorwide approaches to health or restructure its nature, and that their lean bureaucratic structures and alleged cost-effectiveness were made possible by their reliance on WHO and other actors for provision of technical and administrative services.[26] Costs, administrative and other burdens for public sector actors are emerging concerns which have yet to be adequately taken into account.[27]

Can WHO fulfil its accountability role towards its Member States and the public?
This question stems from the following considerations:

WHO has, at times, found it difficult to withstand high-level political pressure to join global health initiatives which it found problematic.

A number of GPPIs have decision-making structures build on the notion that business representatives must be accepted as 'full partners' at all levels of decision making while WHO is seen as but one among many partners. A number of these arrangements are legally-independent entities or entities with a

borrowed legal identity which were established without an in-depth consultation with WHO. Yet, once established, WHO is often asked to join these GPPIs as a voting member or observer on decision making boards. The agency has repeatedly pointed at the problem of being seen as just one among a number of board members without due recognition of its special status as an organization representing 192 Member States and without the possibility to duly consult on decisions the Secretariat is asked to take on behalf of its Member States and the world's citizens. WHO has also found it difficult to ensure respect for its public-interest safeguards in these multi-party alliances.

On several occasions, WHO was marginalized when it attempted to bring forward concerns over the erosion of its special role and that of its Member States with respect to international public health policy making. Similarly, the agency's concerns over conflicts of interest related to industry involvement in decision-making tend to be dismissed as out-dated barriers to the development of an environment needed for GPPPs to flourish.[28] The first such situation can be traced back to the time when GAVI was born out of the Children's Vaccine Initiative (CVI).[29]

To remedy this situation, a set of actions could be taken:

WHO and concerned Member States could attempt to take back the initiative by requesting that any major GHI and GPPI be first presented to WHO's governing bodies for discussion and decision, and be subjected to regular reporting on progress.

WHO may wish to elaborate a document outlining some fundamental principles of engagement, as well as relevant technical and legal arguments to be better able to justify its views in the face of outside pressure to engage into arrangements it feels uncomfortable about. WHO could more systematically collect, analyse and publicize literature and data on the impact of GPPIs on public sector actors and HFA based horizontal health policies and programmes. As a first step, it could highlight WHO's costs and burdens of servicing partnerships, starting with the 14 arrangements it is currently hosting.

WHO may find it necessary to discuss internally whether its participation on the decision-making boards of bodies in which it shares its decision-making role on matters affecting public policy with industry representatives having just one, if any, voice is compatible with the role which WHO and its 192 Member States should have in global health governance. Conclusions of such discussions could be brought to the attention of WHO's governing bodies.

WHO may also find it necessary to discuss internally whether it should continue legitimizing such arrangements, for example, through participation as voting board member, or whether it could propose alternatives to some problematic current ways of decision making on and in global health initiatives which might

better ensure democratic procedures and due processes. Such alternatives should be brought to the attention of WHO's governing bodies. They may include: the decision not to participate as visible partner in arrangements in which WHO cannot ensure that its relevant principles, rules and regulations are respected; questioning the role these GPPIs have taken in international public policy-making.

WHO may furthermore consider redirecting its overstretched capacity from participation in a multitude of GPPIHs to leading a few selected public health initiatives and coordinating and evaluating existing global health initiatives and alliances.

II. Elements of an institutional strategy

> "Cooperative arrangements with the business community have often evolved on an *ad hoc* basis. UN organizations should further develop the policy frameworks and institutional capacities needed to manage successfully such arrangements. [U]N organizations that engage business in their work should develop the necessary competencies to properly assess and guide the relationship. Within each organization, a focal point should be nominated to ensure transparency, learning and a better understanding of the role and objectives of business and to ascertain whether they are compatible with the goals of the UN."
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> "Cooperation with the business community must be transparent. Information on the nature and scope of cooperative arrangements should be available within the Organization and to the public at large…"
>
> UN (2000). *Guidelines on Cooperation between the United Nations and the Business Community, Issued by the Secretary-General of the United Nations*, para 19 a and 14 e

The four-subsections below outline some key elements which can serve as a basis of a more comprehensive institutional strategy or policy framework as called for by the UN Guidelines. The overall aim is to ensure that global health initiatives contribute towards Health for All goals and are consistent with principles of scientific and democratic decision making. [30] The elements of this strategy grouped along four main topics: WHO policy; guidance for staff involved in the establishment and management of GPPIs; institutional learning and sharing of knowledge; transparency and accountability. Some of them are already in place, many are not.

1. WHO policy on GHIs, in particular on those involving the private sector:
An institutional policy would need to:
a. Provide institutional, operational, definitions of global health initiatives (GHI) and global public-private health initiatives (GPPHI);
b. Define a working typology;
c. Explain why certain collaborative arrangements, relationships and interactions were not included under the heading GHI and GPPHI, and specify where

relevant policy and technical information can be found; for example, if WHO decided to classify certain funding/financial relationships and policy-related relationships with non-state actors under different headings; WHO may also have to clarify whether or not public-private partnerships related to outsourcing of public health services fall under this policy.
In addition a policy would need to:
d. Spell out the essence of current Health for All based policies within a broad human rights framework;
e. Spell out which GHI and GPPI categories are most likely to most positively contribute to current international health priorities; and which ones are problematic;
f. Spell out the particular responsibilities and role of the various actors, in particular of WHO, with respect to global health initiatives.
g. Remind the readership that cross-sectoral initiatives are but a tool to reach a certain goal which must be in alignement with HFA policies and values; and that the genuine 'added value' of each initiative ultimately depends on a thorough comparative analysis of the envisaged arrangement against alternatives - which may include a variety of cross-sectoral options of closer engagements as well as primarily public public-sector driven public health policies, programmes and campaigns - and its particular context;

Such policy needs to be complemented by structures and mechanisms for its implementation, including a regular review of the policy based on evidence and discussions with WHO staff, Member States, and other relevant, in particular public-interest centred, actors and experts.

2. Produce institutional guidelines and set up mechanisms and structures to provide guidance, support and oversight of staff involved in the establishment and management of GHIs
The overall aim of these measures consists in assisting WHO to assess *whether* and *when* to catalyse or join a specific GHI or GPPHI, and *how* to frame and manage it appropriately. Such measures involve to:
a. Ensure the provision of all relevant data and documents to WHO staff;
b. Define the modalities of institutional examination and approval, such as relevant contractual agreements and registration, financial and other contributions, determination of time-frames, as well as clauses for adjustment, termination or abandonment of GHIs;
c. Help staff assess the need and relevance, comparative value as well as risks, conflict of interest and contextual aspects of specific GHIs before catalysing or joining them;
d. Identify and describe best management practices for the running of the specific types of GHIs and GPPIs;
e. Ensure publication of relevant information on all GHIs with WHO involvement on internal and external websites.

Provision of support would also include:
f. Continuous evaluation of internal and external information on all relevant technical, financial, and political aspects of GPPIs and GHIs, including the impacts on international and national public health institutions, policy making and systems and programmes;
g. Review of current official and informal departmental guidelines on specific initiatives and interactions with private sector actors for their appropriateness, coherence, and consistency with core values of HFA and democratic and scientific decision making;
h. Revision and elaboration of any missing guidelines and model agreements leading to the development of a handbook on GPPIs and GHIs;
i. Fostering of an open climate for debate, possibly by means of regular discussion fora.

In terms of structural support it would involve:
j. The existence of central structures mandated to assist and oversee the selection and management of specific GPPIs and GHIs, including a system of checks and balances;
k. The establishment of a focal point or a team mandated to collect, analyse and consider concerns from staff.

3. Set up mechanisms and structures for learning from experiences and knowledge sharing

The following suggestions would contribute to such learning:
a. Regular institutional trainings to increase staff knowledge on GHIs and GPPIs and their alternatives as well as on the roles of the various constituencies, and to enhance skills to assess, negotiate and manage arrangements along agreed parameters and procedures;
b. Exchange of experiences, possibly by means of regular discussion fora, in a climate of open debate. The process of development of a typology and handbook mentioned under 2.h., if participatory, will facilitate such discussions as well as serve later as a background document in the staff training;
c. The availability and continuous assessment and synthesis of literature on global health initiatives and alliances and other relevant theoretical material from a broad HFA, public-interest centred perspective, including reflections on best options within a specific GHI and GPPI type and reflections about possible broader policy alternatives;
d. A WHO website, with an up-to date, elaborate registry of GHIs; all relevant guidelines, model contracts, and any other information which would allow staff members, as well as Member States and others to learn from WHO's experiences. Focus would be not only on relatively successful but also on failed GHIs so as to learn lessons and exchange views on how to best identify and deal with problems. This element would also be an essential part of the mechanisms to ensure transparency and accountability.

e. Structurally, this might involve the designation of a team mandated to provide regular synthesis of relevant literature and UN material.

4. Provide mechanisms and structures to ensure transparency and accountability towards Member States and the broader public

Such mechanism could include:

a. A publicly accessible registry of all GHIs WHO is currently involved in as well as, to the extent possible, of other relevant global public-private health initiatives; guidelines, model contracts, and any other information which would allow Member States and others to gain an overview and make informed decisions about whether, when and how to engage in existing or in any new arrangements, whether and when to adjust or dissolve them. It would also enable them to provide feed-back based on their experiences, raise questions and point at potential problems;

b. Setting up of a process through which the governing bodies would discuss GPPIs and GHIs prior to their launch and which would ensure regular annual reporting on their progress these arrangements make towards set goals.

c. An independent evaluation of the impacts of GHIs on HFA policy priorities as well as on WHO's and its Members States' ability to fulfil their public mandate and missions. The findings of this evaluation should be made publicly available;

d. And a focal point responsible for contact with Member States and the broader public.

Annex 1: Suggestions for operational definitions for Global Health Initiatives (GHIs) and Global Public-Private Health Initiatives (GPPHIs)

A global health initiative (GHI) can be defined as:

> "A *collaborative relationship* between State and non-State actors, which transcend national borders, and in which all participants agree to work together to undertake a specific task or achieve a defined purpose in furtherance of public health interests."

A global public-private health initiative (GPPHI) can be defined as:

> "as collaborative relationship between public and private-sector and possibly also other non-State actors, which transcends national borders, and in which all participants agree to work together to undertake a specific task or achieve a defined purpose in furtherance of public health interests."[31]

Thus GHI can be seen as the overarching term, which may or may not involve private sector actors. However, as soon as a health initiative involves private-sector actors in any other way than a pure business interaction (such as purchase of goods) it should be classified and dealt with as a public-private initiative.

According to current usage a health initiative or alliance is defined here as global when it transcends national borders. Thus it can span initiatives which operate, for example, only in Africa rather than globally.[32] However, it might be useful to reflect whether in the future is would not be more judicious to use the term inter- or transnational to point at the importance to be more specific about the number or type of countries which are meant to be the beneficiaries of such an initiative.

Annex 2: Suggestions for fundamental principles and criteria underlying global health initiatives and global public-private health initiatives

To qualify as initiatives *for* health, the following principles apply:[33]

1. the initiative must respect the value system of Health for All;
2. it must be based on the protection of WHO's (and other public sector actor's) independence, integrity in decision-making, and reputation;
3. it should strengthen - not weaken - the role of international and national public institutions.[34] In particular it should not undermine WHO's constitutional role "to act as the directing and co-ordinating authority in international health work;"
4. it must be based on transparency;
5. the roles and responsibilities of the specific constituencies should be clearly delineated and well defined;
6. it should not violate accepted principles of conflict of interest.

Fundamental technical criteria:

1. the arrangement should lead to significant public health gains;
2. it should not involve unjustifiable risks; in particular, it should not distort international and national agreed upon public health priorities.
3. the health gains should be worth the efforts and costs involved in establishing and maintaining the specific cross-sectoral relationship;
4. the arrangement should have a demonstrated added value over possible alternatives to address the specific international public health issue.

These principles and criteria could also form the basis of a list of more concrete checklist for global health initiatives.

Annex 3: Suggestions for a working typology of PPHIs

The term global partnership for health encompasses heterogeneity of activities and relationships. As a DFID study recently mentioned on the difficulties to find appropriate typologies: "GHPs are complex beasts and not easily slotted into specific boxes on a table."[35]

Typologies may vary, depending of the purpose of the classification. For example, global partnerships have been classified according to their nature, their goals, their governance arrangements, their legal status and other characteristics.

At the current time juncture, it is suggested to adopt a basic typology of global public-private initiatives in health which tries to most closely describe the nature of the current main types. This allows both, help guide their technical assessment, and help identify and address potential conflict of interest issues. In addition, it may help discussions about whether some currently existing types of public-private interactions are problematic, or whether some of them might be better classified under another title than GHI or GPPHI.

The working typology of PPIs suggested here is a combination based on the three main types of GPPPHs identified by Buse and Walt and that used in WHO's internal list of partnerships in health in which WHO is currently involved in:[36]

1. Resource mobilization from and with the private sector: This includes resource mobilization from and with venture philanthropy foundations;
2. Product-based PPIs: Programmes based on donations of and discounts on health technologies. A current main type are global drug donation programmes;
3. R & D PPIs: This includes PPIs set up to discover and develop medicines and vaccines for neglected diseases, diagnostics, fertility regulation methods, and other health products and technologies;
4. Issue-based PPIs: This type includes Global Health Alliances/ Funds along the GAVI model as well as other health initiatives and alliances which are modeled along disease lines;[37]
5. Policy-interactions: This category encompasses roundtable discussions, so-called multi-stakeholder dialogues, as well as the Global Compact.
6. Others.

Not all GPPHIs fall neatly into one of these typologies. For example, the Global Health Funds could also be classified under and analyzed under resource mobilization for international public health. The same applies to product-based PPIs.

Many of these initiatives encompass more than one activity or purpose. In tables listing such GPPHIs, this could be addressed by distinguishing between P = primary; and S = secondary activity for each type.[38]

This descriptive working typology aims to best capture the categories which are currently subsumed under the term public-private partnerships. Categorization within this working typology does not necessarily mean that the interactions they describe should be sub-sumed under this heading.

For example, questions have been raised whether PPIs which at aim mobilising resources from and with the corporate sector in cash, kind and possibly human power should be classified under the heading partnerships. From a policy perspective it may be more appropriate to discuss and evaluate resource mobilization activities as a class apart, as an element of overall strategies to finance WHO and international public health activities. Similar questions were raised about the classification of policy-interactions with the private sector as PPPs or PPIs. They can as well be classified and analyzed as a special type of relationships of UN agencies with non-State actors and policy guidance could be developed accordingly.

Other arrangements which are currently often classified as partnerships with the private sector may warrant re-classification are interagency technical programmes such as TDR and HDR; and UN-coordinating mechanisms such as UNSCN and UNAIDS.

Of course, suggested definitions and typology, are open to further debate and adjustments. For the purpose of guiding more elaborate assessments of PPIs it may be useful to adopt a matrix which combines categorisations along several typologies. For WHO it might mean to develop a table which would also include, e.g. relevant information on the legal status of a GHI and GPPHIs, their decision-making structures, and more details on hosting agreements and opportunity costs.[39]

Endnotes

[1] Inversion between values and reputation by author

[2] E.g. WHO (1997). Draft: Partnerships for health in the 21st century. 2 + 2 = 5, *Working paper submitted by the Working Group on Partnerships at the WHO/HQ in the context of the Health for All renewal.* Geneva: WHO, July.

[3] WHO (1999). *A corporate strategy for the WHO Secretariat: Report by the Director-General, EB 105/3* Geneva: World Health Organization, para. 9; 15; emphasis added

[4] WHO (2005). WHO in Global Partnerships for Health. *Updated table, 2nd ed.*, June

[5] *Preamble to the Constitution of the World Health Organization & Article 2.*

[6] See e.g. Fowler, A. (2000). *Civil society, NGDOs and social development: Changing the rules of the game* Geneva: United Nations Research Institute for Social Development (UNRISD), pp. 25-27; Zammit, A. (2003). *Development at risk: rethinking UN-business partnerships* Geneva: UNRISD in collaboration with South Centre Zammit, pp.51-55; Malena, C. (2004). Strategic partnership: Challenges and best practices in the management and governance of multi-stakeholder partnerships involving UN and civil society actors, *Background paper for the Multi-Stakeholder Workshop on Partnerships and UN-Civil Society Relations.* Pocantico, New York, pp. 1-3;

[7] Partnership is a particular business form. The *Shorter Oxford Dictionary* defines a partnership as "an association of two or more persons for carrying on of a business, of which they share the expenses, profit and loss," the partners being "the persons so associated collectively." (quoted in Zammit, op. cit,: 54)

[8] In addition, the terms PPP or PPV often denotes contractual arrangements to outsource, if not privatise, health facilities or systems. According to the US General Accounting Office: "Under a public-private partnership, sometimes referred to as a public-private venture, a contractual arrangement is formed between public- and private sector partners. These arrangements typically involve a government agency contracting with a private partner to renovate, construct, operate, maintain and/or to manage a facility or system, in whole or in part, that provides a public service". GAO (1999). Public-private partnerships: terms related to building and facility partnerships. Washington, D.C.: United States General Accounting Office (GAO).

[9] UN (2003). Enhanced cooperation between the United Nations and all relevant partners, in particular the private sector, *Report of the Secretary-General to the General Assembly. Item 47 of the provisional agenda: Towards global partnerships* (p. 20). A/58/227. New York, 18 August, para 9, emphasis added; From the wording it would seem that this definition is a suggestion and not an official UN definition. This definition – with the exception of the word 'competencies' - was also taken over by UN (2005). Enhanced cooperation between the United Nations and all relevant partners, in particular the private sector. Report of the Secretary-General*, A/60/214, New York, 10 August, para 8.*

[10] A Management Sciences for Health publication, for example, refers to public-private partnerships (PPPs) in health as *"*a defined inter-sectoral [better cross-sectoral] *collaboration*, either *non-contractual or contractual*, between two or more organizations." MSH (2001). *Forming*

Partnerships to Improve Public Health Boston: Management Sciences for Health (MSH), p. 4, emphasis added. This publication stresses that even in non contractual PPPs, the parties involved should formalize the relationship in writing. www.erc.msh.org/mainpage.cfm?file=2.2.1.htm&module=planning&language=English.

[11] These qualifiers may have come from definitions employed in the business world. All of them – except for the term voluntary – are used in profit-oriented business-business partnerships. They may have been employed without adequate reflection on their appropriateness in another context.

[12] Such as Zammit, A. (2003), op. cit.; and Richter, J. (2004). *Public-private partnerships and international health policy making: How can public interests be safeguarded?* Helsinki: Ministry for Foreign Affairs of Finland, Development Policy Information Unit.

[13] Buse, K., & Walt, G. (2000). Global public-private partnerships: part I - a new development in health? *Bulletin of the World Health Organization - The International Journal of Public Health*, 78(4), p. 551.

[14] Martens, J. (2003). *The future of multilateralism after Monterrey and Johannesburg.* Berlin: Friedrich Ebert Stiftung, p. 26. A book, co-authored by the Executive Head of the Global Compact, stresses the political significance of the Global Compact. It describes the Global Compact as a framework which "assumes the creation of a UN culture favorable to business values and methods," as a forerider of tripartite governance mechanisms suited to globalisation, which should eventually lead to providing non-state actors with an official representative status in intergovernmental organisations. As similar publications, the book does not adequately distinguish between the rights of citizens to participation in public-decision making processes possibly under a more organized form of a public interest NGO or CSO and of participation in public-decision making by organizations representing powerful economic actors. Tesner, S., with the co-operation of Georg Kell (2000). *The United Nations and business: A partnership recovered* New York: St. Martin's Press, pp. 117-8

[15] Nelson, J. (2002). *Building partnerships: Cooperation between the United Nations system and the private sector* Report commissioned by the United Nations Global Compact. New York: United Nations Department of Public Information, p. 47 It was authored by, Jane Nelson, a senior staff member of the Prince of Wales Business Leaders Forum (now the World Business Leaders Forum).

[16] MSH (2001), op. cit., p. 15

[17] http://www.ippph.org/index.cfm?page=/ippph/about/whatisppp, accessed 29 August 2005

[18] Widdus, R. (2001). 'Public-private partnerships for health: Their main targets, their diversity, and their future directions.' *Bulletin of the World Health Organization*, 79 (8), pp. 713-720. The article focused on partnerships between intergovernmental organizations and commercial pharmaceutical companies. In his attempt to distinguish partnerships from other interactions, Widdus also called for a distinction of PPPs for health from the trend towards privatization.

[19] The Global Fund's website, for example, stated: "Please note that members of the private sector are invited to take part in all Global Fund processes, including taking part in the submission of proposals, joining the Technical Review panel, or applying for the post of the Executive Director." (GFATM 2002)

[20] A second important reason for not using the term 'partnership' for interactions with the private sector is before mentioned fact that in many Member States the term PPP stands for outsourcing - if not privatization - of public-health services.

[21] E.g. UN (2005), op. cit, para 8-10; Zammit (2003), op. cit, p. 238

[22] See WHO (2000). *Guidelines on interaction with commercial enterprises to achieve health outcomes*, Geneva: WHO, 30 November, EB 197/20, Appendix, p. 11. Morover the Procedures described are not relating to the procedures which are currently recommended as, among others, WHO structure has changed.

[23] WHO (2000), op. cit, para 47

[24] As defined in the Guidelines, WHO (2000), op. cit, para 2 & 3

[25] See also the passages on "the strong management of partnerships," in UN 2005 (op. cit), p. 17. For operational initiatives, it might be worthwhile to adapt documents such as WHO/IRM (2000).

Standard format for AFRO project documents. Interagency Resource Management Unit (IRM), WHO, Regional Office for Africa, October. http://www.afro.who.int/irm/reports/project_eng.pdf

[26] Heimans, J.J. (2002). *Multisectoral global funds as instruments for financing spending on global priorities* New York: United Nations Department of Economic and Social Affairs (DESA). Doc. ST/ESA/2002/DP._24. http://www.un.org/esa/esa02dp24.pdf; Ollila, E. (2003). *Global-health related public-private partnerships and the United Nations* Helsinki: Ministry for Foreign Affairs, Department of International Development Cooperation.

[27] Report of the MDG High Level Forum Working Group on Global Health Partnerships (forthcoming October 2005)

[28] See e.g. CMH (2001). *Macroeconomics and health: Investing in health for economic development. Report of the Commission on Macroeconomics and Health* Geneva: World Health Organization, p.100; Buse, K. (2002). WHO's policies on public-private partnership: the need for reform: BMJ, electronic letter, 4 December

[29] See Muraskin, W. (2002). The last years of CVI and the birth of the GAVI. In M. Reich (Ed.) Reich, M. (2002). Public-private partnerships for public health. Boston, MA: Harvard University Press, pp. 115-168.

[30] Some of these elements have been outlined in documents and discussions such as WHO (2001). Public-private interactions for health: WHO's involvement. Note by the Director-General. Executive Board, 109th Session, EB109/4 Geneva: WHO, 5 December; relevant EB discussions; UN (2000) *Guidelines on Cooperation between the United Nations and the Business Community. Issued by the Secretary-General of the United Nations*, 17 July.

[31] This is a norminative definition. A review of current GHPs and GPPPHs may reveal that a number of them may not center on, or result in, furthering public health interests.

[32] For more explanations and this definition of 'global,' cf. Carlson, C. (2004). *Mapping Global Health Partnerships: What they are, what they do and where they operate* London: DFID Health Resource Centre, p. 5

[33] These principles and criteria are partially derived from WHO (1997). Draft: Partnerships for health in the 21st century. 2 + 2 = 5, *Working paper submitted by the Working Group on Partnerships at the WHO/HQ in the context of the Health for All renewal.* Geneva: WHO, July; and Kickbusch, I., & Quick, J. (1998). Partnerships for health in the 21st century. *Rapp. trimest. statist. sanit. mond. 51*, 51, 68-74. Some principles and criteria were also taken from the UN (2000) *Guidelines on Cooperation between the United Nations and the Business Community*, op cit.; WHO (2001). *Public-private interactions for health: WHO's involvement. Note by the Director-General. Op. cit.;* and the WHO (2000). Guidelines on interaction with commercial enterprises to achieve health outcomes, EB107/20, Geneva: WHO, 30 November and other relevant literature and reflections.

[34] This principle is based on the assumption that public sector actors have the duty to act in the public interest.

[35] Carlson, C. (2004). *Mapping Global Health Partnerships: What they are, what they do and where they operate* London: DFID Health Resource Centre, p. 8

[36] Buse, K., & Walt, G. (2000). Global public-private partnerships: part II - what are the health issues for global governance? *Bulletin of the World Health Organization - The International Journal of Public Health*, 78(5), 699-709.

[37] Further sub-categorizations may be needed and useful. For issue-based PPIs, for example, it may be useful to distinguish between whether they center on disease management and eradication; a health risk factor/specific health promotion activity; or broader health advocacy goals.

[38] Based on suggestions by Carlson 2004: 6; 55. This DFID study classified not just along stated objectives of each GPH but also according to the actual *modus operandi* of the specific initiative.

[39] A composite approach is used, for example, in the *IPPPH Partnership database.* Geneva: Initiative on Public-Private Partnerships for Health, Global Forum for Health Research, updated as of 2003-3004, www.ippph.org.