The Effectiveness of Global Health Partnerships
What Determines their Success or Failure?

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1. Introduction[1]

With the advent of the HIV/AIDS pandemic, the resurgence of tuberculosis (TB) and malaria and the realization of the detrimental effects of health threats in developing countries the 1990s witnessed some important changes in international health politics.[2] Within the framework of a globalizing world, to many observers the former *inter-national* efforts to tackle health threats turned *global* (Dodgson/Lee/Drager 2002, Hein/Bartsch/Kohlmorgen 2007, Kickbusch 2000, Lee 2003). This transformation was also marked by a trend to include more and more private actors in global health policy (Buse/Walt 2000). Even before the idea of a "global partnership for development" became part of the Millennium Development Goals (MDGs),[3] public-private partnerships (PPPs) were welcomed as a new and innovative instrument of development cooperation (Tennyson/Wilde 2000). PPPs are especially thriving in the health sector. A survey estimated something between 75 to 100 Global Health Partnerships (GHPs), varying according to the definition (Caines 2005: 6). A wide definition would also include relatively informal forms of cooperation between public (governments, international organizations) and private actors (NGOs, foundations, business). As far as transnational PPPs are concerned, most authors only count institutionalized collaborative relationships between public and private actors as PPP that last for some time and aim at setting norms and standards for their members, try to implement programmes or deliver services to a wider public (Linder/Vaillancourt Rosenau 2000, Börzel/Risse 2005). Based on collective decision-making of public and private actors as the defining criteria a recent assessment identified only 23 initiatives in the global health sector as PPP (Buse/Harmer 2007: 260).

No matter how PPP are defined specifically, as new types of horizontal governance instruments they are rather contested. Proponents favour the inclusion of private actors because they are regarded as enhancing the problem-solving capacities of governance systems and as offering new avenues of participation (Tesner 2001, Nelson 2002, Ruggie 2002). Critics, however, suspect them to determine the agenda of international institutions aiming at an "institutional capture", which will contribute to a commercialization of public goods and

[1] This paper is the outcome and follow-up of collaborative work on determinants of the effectiveness of transnational public-private partnerships (Beisheim/Liese/Ulbert 2007b, 2007a, 2008) within the context of a research project on "Transnational Public Private Partnerships for Environment, Health, and Social Rights" (Beisheim/Liese/Risse/Ulbert 2005), which is part of the Research Centre 700 (SFB) "Governance in Areas of Limited Statehood: New Modes of Governance?" at the Free University Berlin funded by the German Research Foundation (DFG) (see http://www.sfb-governance.de/en/index.html). My special thanks go to Marianne Beisheim, Andrea Liese and Marco Schäferhoff for ongoing discussions on this subject and to Madeleine Koalick for research assistance on the implementation of the Paris Declaration.
[2] For a historical overview on the development of global health politics see Zacher 2007.
[3] See http://www.un.org/millenniumgoals.

thereby undermine the public welfare (Richter 2003, Utting 2000, Zammit 2003). Consequently, assessing the effectiveness of PPP both refers to the theoretical debate on new modes of governance in international relations and to the practical question of how to improve the effectiveness of development cooperation.

This paper aims at combining both perspectives: The following chapter will provide a short discussion of how to define and operationalize effectiveness. Based on a number of empirical studies various groups of factors that determine the effectiveness of GHPs will be introduced. To identify specific determinants that make GHP effective, I will compare two GHPs, the Global Alliance of Vaccines and Immunization (GAVI Alliance), which is considered as a successful partnership, and the Roll Back Malaria Partnership (RBM), which according to an evaluation was looked upon as a failed effort to combat malaria (Malaria Consortium 2002). This empirical illustration will help to specify a number of factors that contribute to the effectiveness of GHPs, which will be summarized in the concluding chapter.

2. The Effectiveness of GHPs: Concepts and Operationalization

For many years, at the centre of research on international cooperation were the questions of how cooperation will come about in the first place, how it can be sustained and how you can explain changes in inter-state cooperation. Theories of international regimes were able to prove that institutions enable and ensure international cooperation – even under the condition of anarchy. Subsequently, from the mid-1990s on the focus shifted to the effects of international cooperation (Levy/Young/Zürn 1995: 268). Empirical research concentrated on the consequences of international agreements with a twofold perspective: on the one hand, there was a lively debate on the compliance of states with international agreements. [4] On the other hand, scholars of International Relations scrutinized the record of states' implementation of international norms and how effective these norms were.[5]

Linked to this were efforts to define and operationalize effectiveness in a more systematic way.[6] It became clear, that "effectiveness" could be defined in many different ways. But what

[4] See Chayes/Chayes 1993, Chayes/Chayes 1995, Brown Weiss/Jacobson 1998, Downs/Rocke/Barsoom 1996, Franck 1990, Koh 1997, Mitchell 1996.
[5] Empirically these studies predominantly dealt with international environmental agreements. See e.g. Keohane 1996, Victor/Raustiala/Skolnikoff 1998 and Miles et al. 2002.
[6] Again, the empirical focus was on international environmental regimes, cf. Bernauer 1995, Helm/Sprinz 2000, Sprinz/Helm 1999, Young 1999a, 2001, 2002.

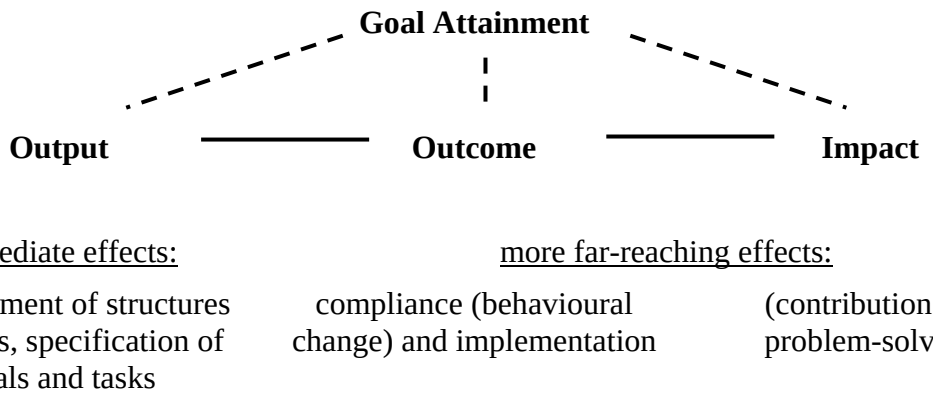
could also be inferred from these discussions was the basic distinction between gaol attainment and problem solving. This distinction relates to every type of institutionalized form of cooperation, not only to inter-state regimes, but also to public-private forms of cooperation. Goal attainment refers to the fact that the actors involved are able to realize the goals they proclaim as essential. Interestingly, this does not necessarily correspond to solving the problem you are targeting with your joint efforts. Therefore – drawing on David Easton's famous definition (Easton 1965) – effectiveness is defined along four distinct dimensions: output, outcome, impact and goal attainment (cf. Underdal 2002; Young 1999b, 2002).

Output refers to specific activities and achievements which are directly related to the performance of the actors who cooperate in any given area. As far as public-private partnerships are concerned this would include to specify the tasks and goals of the PPP, to set rules and standards and create structures and institutions within which the cooperation is embedded. In terms of effectiveness, this output may have even more far-reaching effects. Complying with rules and implementing them may lead to a behavioural change – not only of the partners of the PPP but also of other actors. As a consequence, the activities of a PPP may yield an *outcome*. Indicative for an outcome may be that other relevant actors are aware that an issue has to be tackled, that funding or other material goods will be provided and that new knowledge will be produced to solve a problem. The output and outcome of a PPP may contribute to enhancing the problem-solving capacity in a given area and thereby lead to solving the problem eventually. This kind of achievement is usually defined as *impact*. Methodologically, it may be quite difficult to prove that the actions of distinct actors have contributed to the solution of a problem. Environmental issues are quite instructive in this respect. Usually, any explanation would be underspecified that contributed a change in a single environmental indicator to actions of single actors. Similar to reducing the level of greenhouse gas emissions in the atmosphere, tackling a health threat may be a very complex process that necessitates action not only on a single level.

Because of these methodological problems of establishing a clear chain of causality, many studies focus on a fourth dimension of effectiveness, *goal attainment*. Empirically, in many cases it is easier to decide if a PPP has realized the goals it proclaimed. But these self-proclaimed goals may refer to more "modest" achievements that equal the output or to more "ambitious" levels like outcome or impact (see figure 1). When a PPP is newly founded the first and foremost goal will be to establish institutional structures to get the PPP working.

Later on the focus will shift to produce an outcome or even an impact. Therefore, to some extent there will be a temporal interrelation between these three dimensions of effectiveness. But this temporal sequencing does not follow conclusively. Some PPP might never produce an outcome, let alone any impact.

Figure 1: Dimension of Effectiveness



Source: Beisheim/Liese/Ulbert 2008 (slightly adapted version).

According to recent studies, GHPs show a record of considerable achievements (cf. Dodd et al. 2007, Buse/Harmer 2007): They were able to bring health issues on national and international agendas, which had been neglected before. Moreover, their advocacy helped to mobilize not only new resources for major diseases but also the political will of governments to focus on priority diseases. By including private actors and civil-society organizations in the fight against health threats they created a new momentum for research and development of new medicines and types of interventions. At the same time, GHPs also contributed to improving access to free or reasonably priced medicines and vaccines. These activities helped to establish new international norms and standards, and reinforced the right to health as part of the international human rights law.[7] But what has to be noticed on a more critical note, is that the majority of GHPs concentrate on communicable diseases, particularly on HIV/AIDS, malaria and tuberculosis, i.e. they are very issue-specific and often oriented towards a quick impact (Buse/Harmer 2007).

[7] In 2002 the Commission on Human Rights appointed Paul Hunt as "Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". For more information on his mandate and reports delivered so far see http://www2.ohchr.org/english/issues/health/right. Some GHPs emphasize the connection between the diseases they tackle and the right to health, e.g. http://www.malariaconsortium.org/data/files/human_rights__malaria__final.pdf; last accessed March 12, 2008.

3. Determinants of Effectiveness: Theoretical Considerations and Empirical Findings

When PPPs became a subject of IR research, they were thought of as some new forms of governance that lacked conceptual clarification and empirical analysis. Therefore, besides establishing what should be subsumed under the heading "PPP" (Börzel/Risse 2005, Vaillancourt Rosenau 2000), a number of single case studies tried to provide an insight into particular PPPs.[8] Very soon the effectiveness and legitimacy of transnational PPPs attracted specific attention. Recently, a number of comparative research projects have been launched which systematically analyze the effectiveness of PPPs across a larger number of cases (Andonova 2006, Beisheim/Liese/Risse/Ulbert 2005, Beisheim/Liese/Ulbert 2007a Biermann/Pattberg/Chan/Mert 2007, Huckel/Rieht/Zimmer 2007). Political science and business research offer several assumptions about the effectiveness of PPPs that rather refer to why partnerships develop than to how they can contribute to problem-solving. Along the lines of functionalist theories of international regimes authors assume weak governance structures of intergovernmental arrangements on the one hand, and "state failure" on the other. This leads to a demand for public-private forms of cooperation which serve as functional equivalents to the (assumed) traditional provision of public goods by states only. From this point of view, the sole inclusion of private actors with their resources (funding, knowledge and technical expertise) leads to enhanced problem-solving capacities (cf. e.g. Reinicke/Deng 2000, Tesner 2000). Moreover, as implementation research has shown, including norm addressees in the decision-making process will improve the compliance rate and will subsequently lead to a better implementation of policy programmes (Mayntz 1980, 1983).

Besides functional explanations, another set of assumptions is based on the interests of the actors involved. According to this perspective, private actors have strategic incentives to cooperate in PPPs (Austin 1999) that may range from material benefits (market access, pooling of costs for R & D) to immaterial benefits like an improved reputation. Whenever a win-win-situation will be created for all (or most) partners, the partnership is assumed to become effective. Interest-based explanations are only one type of theoretical strand in IR research. Other rationalist and also constructivist approaches in IR offer further explanatory factors. The enforcement school in compliance research emphasizes sanctions and monitoring mechanisms aiming at increasing the costs for a prospective violation of rules (Downs/Rocke/Barsoom 1996). The management school, however, focuses on unintended

[8] For a review of PPPs in the UN system see Nelson 2002 and Witte/Reinicke 2005, with an emphasis on sustainable development see van Huijstee/Francken/Leroy 2007. For a comprehensive overview on the state of the art on PPPs see Schäferhoff/Campe/Kaan 2007.

rule violation (Chayes/Chayes/Mitchell 1998). Therefore, management capacities become the centre of interest from this point of view. Constructivist approaches, however, focus on learning and processes of arguing (Ulbert/Risse 2005). PPPs are then analyzed as platforms for exchanging knowledge and fora of deliberation.[9]

From the theoretical discussion you can infer that a number of structural and process factors have to be considered when you want to account for the effectiveness of PPP. This general result is confirmed by various empirical studies that tried to establish inductively what made Global Health Partnerships successful.[10] *Stuctural factors* may relate to various aspects of a partnership (cf. Druce/Harmer 2004). This includes the type of partnership (funding, research network or standard-setting), the tasks and goals, the membership or governance structures. As far as *process factors* are concerned, the management of a PPP seems to be quite decisive. Monitoring and evaluating the work of a PPP are at the heart of managing a PPP. But also the way stakeholders are able to participate. "Ownership" has become the catchword in development cooperation when it comes to the inclusion of stakeholders in designing and implementing development projects. To strengthen the principle of ownership is only one element that is used to assess the performance of actors and institutions in development cooperation.

Scrutinizing the performance of the development cooperation community is part and parcel of a multilateral endeavour under the auspices of the Organization of Economic Development and Cooperation (OECD) to improve the effectiveness of development cooperation ("aid effectiveness"). In February 2003 a "High Level Forum on Aid Effectiveness" adopted the "Rome Declaration on Harmonization",[11] which was followed by the establishment of a "Working Party on Aid Effectiveness and Donor Practices" within the Development Assistance Committee (DAC) of the OECD.[12] A very visible outcome of this working party was the adoption of the "Paris Declaration on Aid Effectiveness" by another meeting of the "High Level Forum on Aid Effectiveness" with more than 100 donor and recipient countries as well

[9] The Berlin project on transnational PPP (see Fn. 1) inferred a number of hypotheses from various theoretical approaches which are being tested at the moment. For the research design of the project see Beisheim/Liese/Risse/Ulbert 2005, for first results see Beisheim/Liese/Ulbert 2007a.
[10] In 2004 the Health Resource Centre of the UK Department for International Development (DFID) published a series of papers in which the impact of Global Health Partnerships was assessed (see http://www.dfidhealthrc.org/publications/global_init.html). McKinsey conducted a study on behalf of the Bill & Melinda Gates Foundation on "Developing Successful Global Health Alliances" (Bill & Melinda Gates Foundation 2002), which was complemented by an assessment of country consequences of GHPs (Bill & Melinda Gates Foundation/McKinsey & Company 2005).
[11] For background information and documents see http://www.aidharmonization.org.
[12] See http://www.oecd.org/dac/effectiveness.

as multilateral institutions and NGOs in March 2005.[13] Based on "the lessons of experience" (OECD/DAC 2005: II.13) the Paris Declaration consists of a comprehensive catalogue of commitments related to the five principles ownership, alignment, harmonization, managing for results and mutual accountability. To measure the progress of implementing these principles 12 indicators were developed. For instance, the existence of operational development strategies in recipient countries ("partners" in terms of the Paris Declaration) serves as an indicator for ownership. Aligning aid flows on national priorities and strengthening capacity by coordinating support and avoiding parallel implementation structures will signify the alignment of donor behaviour. Both the use of common arrangements or procedures and the encouragement of shared analysis will indicate the harmonisation of development assistance (cf. OECD/DAC 2005: III). Since the Paris Declaration has been adopted, partnerships increasingly refer to the five principles mentioned above and develop catalogues of indicators that meet their individual requirements. The "High-Level Forum on the Health MDGs",[14] which was established in 2003 by the Canadian Government, DFID and the World Bank, published a summary on "Best Practice Principles for Global Health Partnership Activities at Country Level" (High-Level Forum on the Health MDGs 2005), which is based on the principles of the Paris Declaration and take the empirical findings of various assessments (Caines 2005) into account.

The debates on aid effectiveness and the principles of the Paris Declaration have shifted the focus of the political debate to establishing guidelines for the behaviour of both donor and recipient countries. At the same time, the context, in which development cooperation takes place, was considered essential for its effectiveness. Especially health partnerships are dependent on existing institutions and *capacities* in their partner countries to work successfully. But instead of improving the capacities of recipient countries, critics argue that GHPs aggravate the complexity of the institutional setting of global health and increase the fragmentation of the donor community in this sector, thereby overburdening the – already weak - management capacities of developing countries. A study by McKinsey commissioned by the Bill & Melinda Gates Foundation that dealt with assessing country consequences of GHPs put it quite plainly: Recipient countries have difficulties absorbing the new resources "because GHPs do not provide adequate support, technical or other, to implement programs" (Bill & Melinda Gates Foundation/McKinsey & Company 2005: 1). Moreover, GHPs duplicate and

[13] See http://www.oecd.org/dac/effectiveness/parisdeclaration

[14] For further information on the work of the "High-Level Forum on the Health MDGs" see http://www.hlfhealthmdgs.org.

parallel many structures and processes which are already in existence, i.e. GHPs do not try to align their efforts with countries' needs. This is why, more recently, GHPs also concentrate on strengthening health system capacities (see also Lele/Ridker/Upadhyay 2005), albeit on a limited scale so far.

Combining the theoretical insights with empirical findings on the effectiveness of PPPs indicates which determinants may be crucial for yielding an output, outcome or impact (see table 1).

Table 1: Determinants of Effectiveness of PPPs

Dimensions of Effectiveness	Indicators	Determinants of Effectiveness
Output	Establishment of structures and rules, specification of goals and tasks	Structural Factors
Outcome	Compliance (behavioural change) and implementation	+ Process Management
Impact	(Contribution to) problem-solving	+ Capacity Building

Source: Beisheim/Liese/Ulbert 2008 (adapted version)

Structural factors seem to be quite important for the output of a PPP. Once a partnership is established, the process management contributes to compliance and the successful implementation of measures taken. But having a sustainable impact necessitates that measures of capacity building must be included in the partnership's work. In the following chapter I will illustrate these general observations by referring to two Global Health Partnerships, the GAVI Alliance and the Roll Back Malaria Partnership. Their respective success and failure sheds light on a number of detailed prerequisites for enhancing the effectiveness of GHPs.

4. The GAVI Alliance and RBM – Determinants of Success and Failure of Two GHPs[15]

The two GHPs chosen vary in their degree of effectiveness. The Global Alliance for Vaccines and Immunization (GAVI Alliance) is widely acknowledged as a successful GHP. It was able to deliver some significant output after having been founded in 1999 (goal formulation, establishment of programmes). Moreover, in terms of outcome, GAVI's activities led to an increase of immunization rates among children in those countries in which GAVI operated

[15] This chapter is based on my analyses of RBM and the GAVI Alliance in Beisheim/Liese/Ulbert 2007b, 2008.

(Lu et al. 2006). At the same time, this also meant that by reducing the mortality rate, which had hitherto been caused by certain infectious diseases now targeted by GAVI, the Alliance also had an impact.[16] The Roll Back Malaria Partnership (RBM), in contrast, was looked upon as rather unsuccessful after a first evaluation in 2002 (Malaria Consortium 2002). As far as the output was concerned, the report stated guidelines for a proper treatment of malaria were missing. In addition, with respect to the outcome (provision of medicines and nets, treatment of malaria infections) and the impact (reduction of the number of malaria deaths) especially its performance in Africa was seen as a failure. To account for these differences in effectiveness, we will first have a closer look on a number of structural and process factors that contributed to the output and outcome of GAVI and RBM before turning to their respective strategies to yield an impact.

4.1. Structural Factors as Determinants of Output

Both GAVI and RBM were founded with the aim of establishing model GHPs in their respective issue areas.[17] While RBM concentrates on combating a single disease, the GAVI Alliance aims at improving children's access to vaccines and immunization services in developing countries. GAVI was initiated by the Bill & Melinda Gates Foundation (BMGF) and equipped with the Vaccine Fund having 750 million US-$ at its disposal (Reich 2002: 6).[18] This financial endowment meant that from the beginning there was a win-win-situation for all the partners, thus offering the incentive not only for cooperation (output) but also for compliance (outcome). In addition, GAVI's secretariat was staffed with recognized experts who were able to act independently of a host institution.[19] Due to the influence of the BMGF, GAVI was organized along the guideline to achieve results and therefore should take into account the needs and realities of the recipient countries. Therefore, GAVI obtained a governance structure which was characterized by clear-cut roles and responsibilities of each member (governments, UNICEF, WHO, the World Bank, BMGF, pharmaceutical companies, public health institutions, research institutes, NGOs) (cf. GAVI 2006b).

[16] Data on immunization profiles are downloadable at http://www.who.int/immunization_monitoring/data/en.
[17] RBM was founded in 1998 on the initiative of the then Director-General of the World Health Organization (WHO), Gro Harlem Brundtland. GAVI came into existence in 1999 as successor of the failed Children's Vaccine Inititative.
[18] On the history of GAVI see Muraskin 2002.
[19] For organizational dysfunctions of RBM in contrast to the GAVI Alliance see Schäferhoff 2008.

In contrast, deficiencies in the governance structure seem to be responsible for the fact that RBM members had not been able to adopt treatment guidelines during the first phase of RBM's operation which was marked by an evaluation in 2002. Originally, RBM was constructed as a flexible partnership consisting of a network of loosely connected partners (WHO, World Bank, UNICEF, UNDP, governments, NGOs, Foundations, companies and research institutes). Its goal was not only to provide effective treatment of malaria but also to improve national health systems. The idea of a loose network of partners, however, resulted in a deficit of clear-cut roles and in insufficient leadership. In stark contrast to the GAVI Alliance RBM did not have any mechanisms at its disposal which made transparent how funds were allocated or how projects were monitored and evaluated. This in turn had negative effects on the process management (see below). After having been evaluated in 2002, RBM was restructured institutionally and (partly) programmatically. For the first time, a global strategic plan was adopted in 2005.[20] Since RBM had been criticized for a lack of clear treatment guidelines for diverse situations in recipient countries, the WHO developed recommendations and strategies to combat malaria.[21] A programmatic reorientation consisted in focusing on a smaller number of selected countries.[22] Moreover, a number of projects were designed that concentrated on groups that were especially affected by malaria like children and pregnant women.

RBM and GAVI are interesting examples of the significance of the institutional culture within which a partnership is embedded. RBM was initiated by an intergovernmental organization, the WHO. Therefore, RBM was not only part of the system of multilateral development cooperation. It also suffered from the changing policy of the WHO towards partnerships (Buse/Walt 2002). GAVI, in contrast, was founded by a private foundation with a clear focus on verifiable results and an entrepreneurial spirit. Another crucial structural factor relates to the overall relationship of relevant actors in the particular issue area. It makes a difference if actors compete with each other or if they work together to pool resources for problem-solving. Besides RBM, there are a number of partnerships to combat malaria. Although they have become partners of RBM in the meantime,[23] they still are independent partnerships pursuing their own agenda. Furthermore, still the RBM secretariat does not have the same power-

[20] The document is downloadable at http://www.rollbackmalaria.org/ forumV/docs/gsp_en.pdf.
[21] One report focuses on strategies to combat malaria in the household (WHO 2005b). General guidelines for the treatment of malaria were published in 2006 (WHO 2006).
[22] The number of countries in which projects were conducted was reduced from 40 at the beginning (Roll Back Malaria 2000) to 14. Information on country measures can be downloaded at http://www.rbm.who.int/countrysupport.html.
[23] For a list of constituents see http://www.rollbackmalaria.org/constituencies.html.

ful position like the GAVI secretariat. In contrast, the GAVI Alliance acts like a hegemon in immunization, especially since it disposes of two well-equipped funding bodies that are integrated within its governance structure.[24] RBM did prove successful in securing more funds to combat malaria after it was in operation. But the funding body, which was created with the Global Fund to Fight AIDS, Malaria and Tuberculosis (GFAMT) in 2000 acts independently of RBM and does not only address malaria. Although overall funding increased, there are not enough resources to provide the necessary means for combating malaria in all affected areas, especially in Africa (Yamey 2004).

4.2. Process Factors as Determinants of Outcome

Both GHPs have undergone a number of changes in their process management over time with considerable effects on their outcome. Reporting became obligatory from 2003 onwards with RBM projects and the process of funding became much more transparent. Moreover, RBM also introduced monitoring instruments to control for the results that had been accomplished. In order to devise country strategies, a number of consultations on the ground were carried out. The goal was to find out what was the state of the art on the combat against malaria in each country and identify problematic areas that needed intervention by RBM.[25] This also meant that RBM parted from its original philosophy that countries should decide on their own how the funds which were made available should be utilized. Meanwhile projects are controlled and monitored more closely by the RBM secretariat.

In contrast to RBM, GAVI was characterized by a very formalized, but transparent process management. Especially project funding is dependent on a catalogue of clear-cut criteria.[26] A very innovative instrument was the introduction of so called "Interagency Coordination Committees" (ICC), multistakeholder fora that have to be established in the recipient countries to get support from GAVI. These coordinating mechanism offer a twofold advantage: On the one hand, already existing local expertise can be integrated, on the other hand it is a means to build up (additional) capacities locally. As a very convenient side effect the ICCs

[24] In addition to the GAVI Fund a new financial body, the "International Finance Facility for Immunisation" (IFFIm) was founded in November (see http://www.iff-immunisation.org).

[25] A paper called "The Roll Back Malaria Partnership's Operating Framework" (September 2004) spelt out operational goals (see http://www.rollbackmalaria.org/rbm/Attachment/20041008/ RBMOperatingFrameworkFinalSep2004.doc).

[26] Information on the prerequisites for application and how to apply can be found at http://www.gavialliance.org/support/index.php.

work as anti-corruption mechanism, since the local members of the committees monitor how the funds the government raised are spent (Schäferhoff 2006: 56). The governance structure of GAVI provides for an ongoing monitoring of the project work: It is the task of an "Independent Review Committee" to review project applications to make sure that the pre-requisites for funding are met. A crucial instrument for developing and strengthening immunization services on the ground is the "Immunization Service Support". GAVI allocates the funds for immunizing a certain number of children over a period of three years in advance. How the money is spent, is left to the recipient country. Independent studies demonstrated that these funds – in connection with the ICCs - contributed to increasing immunization rates in GAVI partner countries (Chee/Fields/Hsi/Schott 2004, Lu et al. 2006). Not only defining strategic goals, but also indicators and milestones that are used to assess its performance help GAVI to be successful (cf. GAVI 2006a: 10-27). Meanwhile GAVI has also operationalized the principles of the Paris Declaration for its work (GAVI 2005). Moreover, GAVI uses internal and external evaluations to monitor and adjust – if necessary – its application principles and procedures, its governance structure and its process management.[27]

After RBM had been criticized for its performance and structure it had been undergoing a number of reforms since 2003. But still, RBM partners were not satisfied with RBM's work. Finally, in November 2005 the RBM board launched the "RBM Change Initiative". The aim is to restructure RBM profoundly based on explicit criteria of efficiency.[28] An external evaluation tried to compare RBM with the "design principles" of other "best practice" GHPs (Roll Back Malaria/Boston Consulting Group 2006). Therefore, for improving the communication between partners and the coordination of activities to combat malaria, the former "Harmonization Working Group" was revitalized in November 2006. The types of reforms that have been implemented clearly indicate that RBM introduced similar mechanisms of process management like the GAVI Alliance. Interestingly, both GHPs have taken up the principles of the Paris Declaration in their process management to improve their impact.

[27] For a list of evaluation studies that have been commissioned so far and the actors involved see http://www.gavialliance.org/performance/evaluation/index.php.

[28] See http://www.rollbackmalaria.org/changeinitiative/ci_backgrounder.pdf. This reform process which is funded by private partners and foundations is monitored by the Boston Consulting Group.

4.3. Capacity Building as Determinant of Impact

For having an impact, Global Health Partnerships are dependent on efficient health service systems in recipient countries. But as a matter of fact these are missing in many countries of the developing world. This is why the GAVI Alliance tries to unfold activities on many different levels. Projects aiming at an increase of immunization rates are not restricted to providing vaccines only. From the beginning, GAVI also targeted health system infrastructures and services. In its current strategic plan, the GAVI Alliance focuses on the development of national health systems.[29] Weak national health systems explain why GHPs rarely operate in so called fragile states. Like many other GHPs, the GAVI Alliance and RBM have realized that measures of capacity building have to be integrated as part of their tasks and goals and to be implemented by a process management that takes this into account. Consequently, meanwhile both partnerships deal with the problem of weak states, which very often lack the most basic health service infrastructure.[30] But even if you are not confronted with countries in crisis tackling a health threat is quite a complex process. If you take global health threats like HIV/AIDS, tuberculosis or malaria, you have to target both the global and the national, regional and local level. Consequently, to enhance the problem-solving capacities in these specific issue areas, you may think of a number of indicators that denote the "impact". Figure 2 tries to capture the complexity of this endeavour.

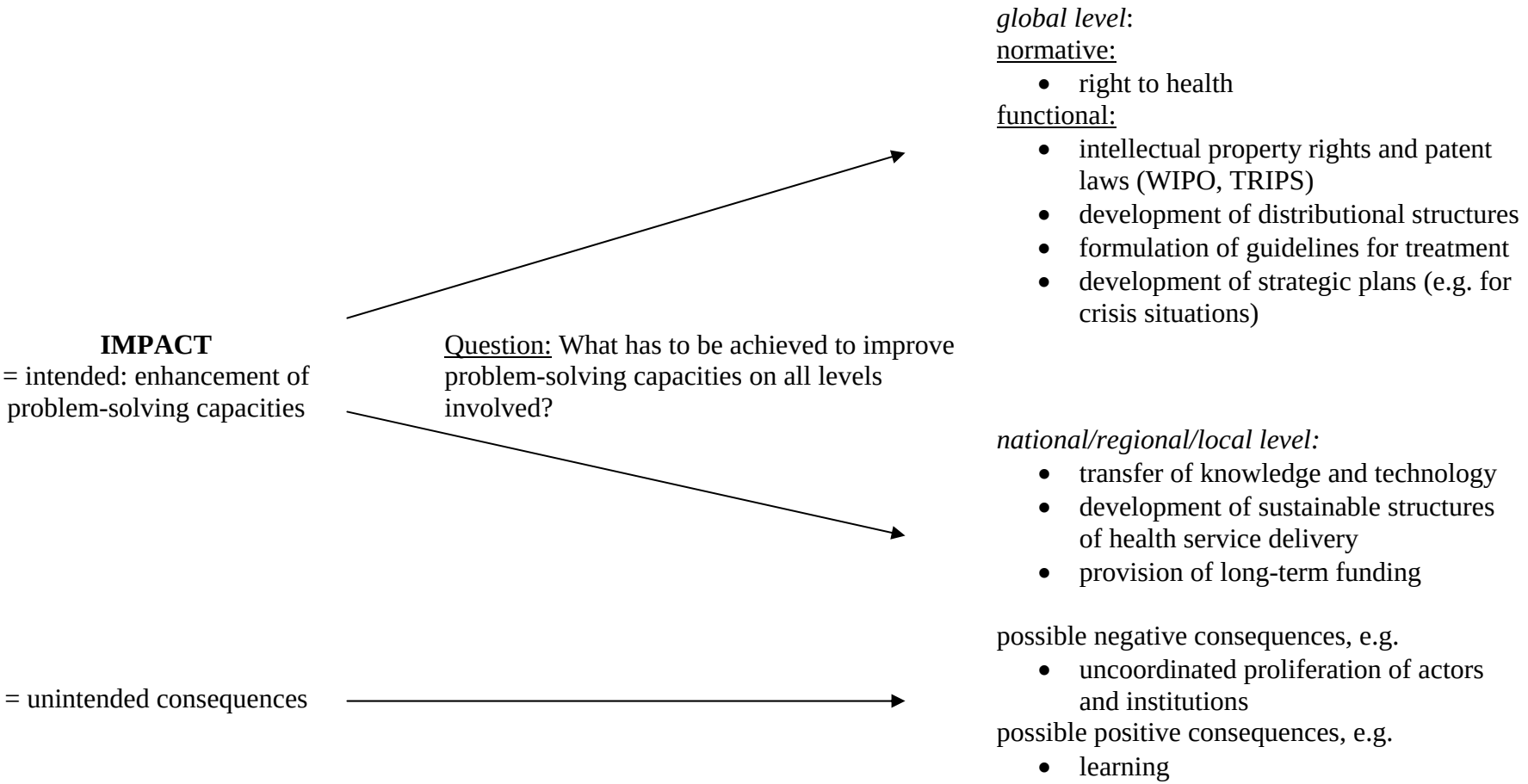
This complexity provides the context in which GHPs like the GAVI Alliance and RBM try to implement the principles of aid effectiveness laid down in the Paris Declaration. For RBM, however, the whole reform process was designed to increase the effectiveness of the partnership also with respect to RBM's output and outcome. Therefore not only its governance structures but also its management processes were put to the test. Implementing the ownership principle at the country level and harmonizing and aligning partner efforts are seen as necessary steps to achieve more impact. The RBM "Working Group on Harmonization" was commissioned to develop instruments to assess "gaps and bottlenecks" in combating malaria.[31] In May 2007 the Working Group proposed to change the focus of RBM "from change manage

[29] See http://www.gavialliance.org/resources/GAVI_Alliance_Strategy__2007_2010_.pdf

[30] The WHO published a handbook with guidelines on how to combat malaria in so called "complex emergencies", i.e. crisis situations (WHO 2005a). In January 2006 the GAVI Alliance installed a special working group on Fragile States that was in operation for some time to make suggestions how to deal with countries in crisis (see http://www.gavialliance.org/about/governance/taskteams/index.php?thetype=former).

[31] See the Terms of Reference for the RBM Harmonization Working Group (http://www.rollbackmalaria.org/partnership/wg/wg_harmonization/docs/tor.pdf).

Figure 2: Required Impact to Combat Global Health Threats



ment to country implementation support"[32] which was endorsed by the RBM Board. Subsequently, the name of the Working Group was changed to "Malaria Implementation Support Team".[33]

As stated above, the GAVI Alliance took a different approach from the beginning. Therefore, it was one of the first GHPs to endorse the principles of the Paris Declaration as guidelines for its work (GAVI 2005). For GAVI observing these principles did not mean a profound redesign of its institutions and processes, since "GAVI's way of working directly reflects the five global health partnership principles, of ownership, alignment, harmonisation, managing for results and accountability**,** applying the process for monitoring required by OECD-DAC" (GAVI 2007: 14). The GAVI Alliance uses some of the indicators spelt out in the Paris Declaration to measure its own performance (see table 2).

Table 2: Implementation of the Paris Declaration by the GAVI Alliance

Indicator	**Target Level (%)**		**Measures/Instruments**
	by 2005	**by 2010**	
Aid flows are aligned on national priorities	100	100	Interagency Coordinating Committees (ICCs): GAVI support is planned for, implemented and monitored by the ICC in line with government plans and priorities
Use of country public financial management systems	75	90	Cash and vaccines management is audited by national mechanisms; GAVI aims to align itself with national budget and planning cycles
Use of national procurement mechanisms	2	No target	GAVI has not set a target for this indicator because most vaccines are procured through UNICEF; only 2% of funds spent by GAVI on new vaccines have gone through national procurement mechanisms
Avoidance of parallel implementation structures	100	100	funds are provided through existing programmes
Aid is more predictable	100	100	GAVI informs countries about approved multi-year support; funds are provided according to an agreed disbursement schedule
Use of common arrangement procedures	100	100	All GAVI support is coordinated through the ICCs; health service system support will be jointly coordinated by Health Ministries and their partners

Source: GAVI 2007: 14 (extended version).

[32] Presentation of the RBM Harmonization Group at the 12th RBM Board Meeting, May 10, 2007 (http://rbm.who.int/partnership/wg/wg_harmonization/ppt/HWG_12pbm.ppt)
[33] See the minutes of the 12th RBM Partnership Board Meeting, downloadable at: http://www.rollbackmalaria.org/partnership/board/meetings/docs/12RBMpartnershipBoardMinutes.pdf

Already in 2005 a study commissioned by the GAVI Secretariat revealed that the obstacles to improve immunization rates were due to deficiencies in the broader health system (HLSP 2005). The study recommended investing not only in new vaccines but also in strengthening delivery mechanism. As a result, the GAVI Alliance devised a new funding window for Health System Strengthening (HSS).[34] The way the GAVI Alliance developed since its foundation and the struggle of RBM to become effective are very instructive for inferring some crucial determinants of success which will be summarized in the concluding chapter.

5. Conclusion: The Key to Effectiveness - Reducing Complexity and Enhancing Health System Capacities

The paper tried to tackle the question what contributes to the effectiveness of a Global Health Partnership. Drawing on a range of theoretical considerations and empirical findings the empirical illustration centred on three factors: structural factors, process management and capacity building. These factors relate to distinct dimensions of effectiveness, the output, outcome and impact (see table 3).

Table 3: Specified Determinants of Effectiveness of PPPs

	Determinants of Effectiveness	
Output	Structural Factors	- clearly defined goals and milestones - clearly defined roles and responsibilities of partners - funding, staffing and position of secretariat - coordination of problem-solving capacities instead of competition between partners - performance subject to criteria of efficiency
Outcome	+ Process Management	- operationalization of goals - emphasis on processes of coordination and communication - integration of stakeholders - monitoring and evaluation - ability to reform
Impact	+ Capacity Building	- transfer of knowledge and technologies - provision of long-term funding - development of distributional structures - strengthening of health system services

Source: Beisheim/Liese/Ulbert 2008 (adapted and extended version).

[34] In November 2007, 29 countries out of 72 that were eligible were granted support from this new line of funding (http://www.gavialliance.org/performance/commitments/hss/index.php).

The output of a GHP will depend on the specification of its tasks and goals, the amount of resources at its disposal, but also its governance structure and the GHP's position in the issue area. To produce an outcome, however, the process management will become quite central. As RBM had to experience, integrating partners and managing difficult coordination and communication processes, can be a tremendous task. But without monitoring and evaluating the performance of the partners, no partnership will ever find out if its work has been be effective at all. Managing a GHP also means to oversee a constant change, because most partnerships are subject to further development and reforms. Learning processes are part and parcel of operating a partnership. But can GHPs have an impact?

From the preceding discussion and the overview on factors that contribute to having an impact in the fight against a global health threat you can infer several conclusions: Firstly, a single project approach, with which development cooperation was associated for so long, will rarely work in global health. Secondly, any structures of health system delivery will hardly be sustainable as long as you do not develop the knowledge and deliver the technologies that are needed on the ground. Besides that, funding has to be provided on a long-term basis. Thirdly, efforts on a national level have to be accompanied by activities on a global level, ranging from developing distribution structures for medicines and formulating guidelines for treatment to patent laws and intellectual property rights that allow for the production of much needed medicines at reasonable prices. This is why so many health experts call for a system of global health governance with strong institutions that help to set the global health agenda according to what is needed and not according to what promises a "quick impact" (cf. Kickbusch 2001). Strengthening the capacities of national health systems seems to be a crucial factor for GHPs to have an impact. But at the same time, their existence aggravates the complexity of an issue area that lacked strong coordination from the beginning. The World Health Organization has never exerted the same influence like the International Monetary Fund (IMF) and the World Bank in global finance and development or the World Trade Organization (WTO) in world trade. Therefore, the principles of the Paris Declaration may contribute to some horizontal efforts of self-coordination in an area with very diverse and numerous actors. It remains to be seen if "simplifying" will be the adequate modus operandi to tackle global health threats.

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