Geneva Board Retreat
September 13th – 14th, 2008

The Partnership for Maternal, Newborn & Child Health

Issues Paper

CONTENTS

1. INTRODUCTION

1.1. Background and context

This issues paper is intended to inform the Partnership for Maternal, Newborn and Child Health (PMNCH) Board discussions on its future role and structure to take place at the Geneva Retreat on 13th and 14th September 2008. It has been prepared by CEPA (a UK-based consulting firm) taking account of initial consultations with Board members and input from the Retreat Planning Group as well as the Secretariat. The paper should be read alongside the draft annotated agenda prepared by CEPA for the Retreat.

1.2. Immediate context

Key points of context as far as we understand them are as follows (these are not exhaustive):

- In 2005, the PMNCH was formed through the merger of three existing partnerships with different modes of work and different constituencies; since that merger, there has been a perceived loss of momentum in some of the activities that were being carried out by those previous partnerships.
- In 2007-8, the PMNCH largely focused on a series of global advocacy activities.
- A grant for "catalytic" country level work in three countries, supported with funds from the Bill & Melinda Gates Foundation grant to the PMNCH and implemented by UN partners (UNFPA, UNICEF, WHO), created some unexpected complexities in implementation, and some concern over the approach at country level and the role of the PMNCH Secretariat.
- In 2007 a number of global health initiatives emerged including: Global Campaign for the Health MDGs (and the 'Deliver Now' advocacy drive[1]); the International Health Partnership (IHP); and the CIDA-led Catalytic Initiative. A fuller description of our understanding of these processes is set out in Annex A.
- The emergence of these various initiatives, and perceived overlap, has been a contributory factor to the current discussion about the value added, key functions, and business model of PMNCH.
- In 2008 PMNCH Board commissioned an external evaluation of the PMNCH. The purpose of the evaluation was to assess the main strengths, achievements, weaknesses and missed opportunities of PMNCH to date, and the options for addressing them. The evaluation report was presented at the July 2008 Board Meeting.

[1] Being implemented by PMNCH, through the Secretariat and selected partners.

- The July Board discussed the evaluation report; the potential roles of PMNCH and the way in which it might function going forward. We understand that there was in-principle agreement on the need for partnering or some form of a partnership, but there was not full consensus or clarity about what are the outcomes that PMNCH should be aiming to contribute towards and what activities, and related outputs, it should pursue. The Board therefore agreed to meet again to discuss these issues at a facilitated Retreat**.** The work on this Retreat has been led by a Retreat Planning Group**.**

1.3. CEPA approach

Given this context Board members will note that:

- We take as given the scale and importance of improving maternal, newborn and child health (MNCH); the importance of the continuum of care; and the fact that more needs to be done to achieve greater improvements in MNCH.
- The focus of the paper is therefore on the potential role of MNCH partnerships in contributing towards the achievement of MDG 4 and 5 and specifically the role and structure of PMNCH.
- We distinguish between activities that are best taken forward in partnership, working through informal collaboration of the partners or through other existing MNCH partnerships from those activities best taken forward within PMNCH. Here the term 'partnership' (without a capital 'P') refers to partnership working either via informal collaboration or working within existing formal partnerships. This is to be distinguished from PMNCH.
- We understand that a key aim of the Retreat is to clarify the outcomes and outputs for PMNCH as well as the activities that should be taken forward in PMNCH to achieve these. This will require agreement on: (i) outcomes; (ii) outputs (sometimes referred to as deliverables); and (iii) criteria/ principles that can inform decisions about which activities should be undertaken in PMNCH.
- Our approach in this document is to seek to present a framework for thinking about the various issues facing the Board. We therefore attempt to present issues and options in a balanced way to provide a basis for Board discussions. We do not seek to come to a position on any of the substantive issues that the Board needs to address.

1.4. Structure

The paper is structured as follows:

- Section 2 provides a framework for considering the functions and structure of global health partnerships. It suggests an approach for defining activities and discusses the link between activities and the appropriate partnership structure in general terms.
- Section 3 then provides CEPA's observations on the key issues that need to be tackled either at the Retreat or subsequently if some form of partnership is to be taken forward successfully.
- Section 4 offers a synthesis of the PMNCH Board member priority outcomes survey.
- Section 5 presents a range of possible outputs and activities for MNCH partnerships and PMNCH more specifically and links them to potential outcomes that might be expected from them. All of this is intended to be illustrative.
- Section 6 sets out a small number of illustrative options for PMNCH going forward in terms of possible activities, structure, membership and governance.

2. CHARACTERISTICS OF GLOBAL HEALTH PARTNERSHIPS

2.1. Introduction

In this section we provide our understanding of the characteristics of the role, structure and function of different types of global health partnerships (GHP). It is intended to provide PMNCH Board members with a shared approach to:

- defining the characteristics of an MNCH partnership in general and of PMNCH specifically; and
- classifying the range of partnership structure options and the circumstances in which different options might be appropriate.

Subject to Board members' agreement, we would propose to use this broad approach in our discussions at the Geneva Retreat.

2.2. Framework for defining partnership activities and structure

2.2.1. Objectives and functions of Global Health Partnerships (GHPs)

Board members are familiar with the existence of a range of global partnerships (primarily although not exclusively in health).

The trend over recent years to establish global health partnerships is a relatively new development in terms of the global aid architecture. The reasons for establishing the partnerships vary case by case. But in general the founding partners' objectives have involved seeking to improve health outcomes by:

- increased sharing and exchange of knowledge/ networking;
- better accountability of public and private sector delivery partners to each other and to donors and/ or developing country partners;
- improved co-ordination of global, regional and national activities and/ or approaches; and
- increasing financing (by partners, countries, and others) and use of new financing mechanisms for shared programme activities and objectives.

However, in order to make a partnership effective it is essential to convert these high-level objectives into concrete activities and outputs aimed at contributing to achievement of specific outcomes. A primary objective of the Geneva Retreat is therefore to determine what the specific outcomes that PMNCH should aim to contribute to and which outputs and related activities would best be taken forward in PMNCH.

In order to do this we propose that Board members should approach the issue by defining the value-added of the partnership as being where partnership activity has the potential to either:

(i) achieve things that could not be achieved by partners on their own; and/ or

(ii) improve the outcomes of partner activities.

In this sense, we agree with the approach suggested at the July Board meeting that it is appropriate to distinguish between activities that can be undertaken by partners alone and those that can be done in partnership. Having decided which activities are best undertaken in partnership, the next question is which of the activities are best undertaken in PMNCH. These are the questions for Day 1 of the Retreat. The structure of the PMNCH, role of Board members and the Secretariat are important (but secondary) issues that follow from the decisions that are taken about the appropriate outputs and related categories of activities to be taken forward in PMNCH. These are the subject of Day 2 of the Retreat.

2.3. Types of Global Health Partnerships

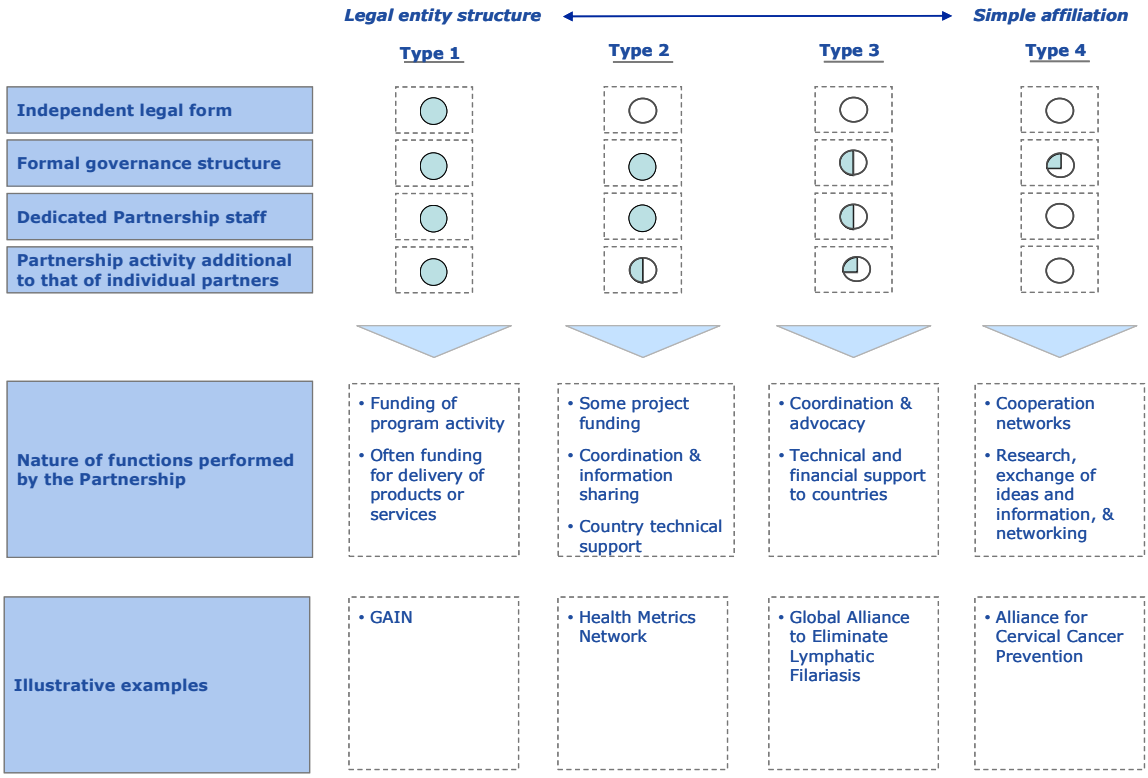
Figure 3.1 provides a simple classification of types of global health partnerships. It shows a spectrum of partnership structures defined in relation to four characteristics:

- the legal form (whether the entity has a separate legal personality, is hosted within a multilateral organisation, or is better defined as a 'network' or loose affiliation);
- the existence and extent of formal governance arrangements;
- the existence of dedicated staff (e.g. secretariat) who are tasked with supporting the partnership/ carrying out the activities of the partnership (as opposed to the partners); and
- the extent of partnership activity that is additional to that of individual partners.

We provide one example of a GHP to fit with each type. Annex C provides more information on each. None of them may be appropriate for PMNCH, although our understanding of the original intentions of PMNCH suggests that Type 2/ Type 3 are most relevant comparisons.

The key point to note from this classifications is that there is a link between the functions carried out by the partnership and the appropriate structure. This is why we propose to address, first, the outcomes, outputs and activities to be pursued in PMNCH and then, second, the appropriate structure and functions of Board members and the Secretariat.

Figure 3.1: Types of global health partnerships



Other points that should be noted are as follows:

- The nature and balance of membership of partnerships vary – and what is appropriate depends on the partnership's functions. It is important to recognise that a diverse membership tends to make GHP's more difficult to operate effectively – given possible differences of view about key issues (including the value and purpose of the partnership).
- The appropriate approach to structuring a partnership is related to the complexity of the problem/ issue(s) that the partnership focuses on. An example of this is the Polio Eradication Initiative – which might be thought of as a Type 4 arrangement in Figure 3.1. Compared with other initiatives, the single disease focus and the existence of an easily administered vaccine arguably have made this more amenable to a loose partnership/ partnering arrangement.
- Finally for some potential partnership activities (e.g. co-ordination/ harmonisation) the need for a partnership may only arise because of a real or perceived failure of partners acting separately (either to coordinate their activity/ or to achieve satisfactory outcomes). In thinking about the appropriate nature of partnerships, it is important to question why a new partnership is needed and whether the causes of the perceived failure can be effectively addressed through a new formal partnership.

3. CEPA ASSESSMENT OF KEY ISSUES

3.1. Introduction

In this section, we set out our initial observations on the issues facing PMNCH. These observations reflect our consultations with Board members and the Secretariat.

In our view, for a partnership to be successful, it is necessary (although not sufficient) for there to be:

(i) a broadly shared understanding of the nature of the objectives and outcomes that the partners are seeking to achieve through the partnership;

(ii) a shared understanding of which activities/ deliverables the partners should be undertaking together and which separately;

(iii) a willingness on the part of the partners to commit time and effort to the activities of the partnership;

(iv) a willingness to be accountable to the partnership for activities that are undertaken together, and to share experience and views openly on areas of activity that are carried out separately by the partners, but which contribute to the shared objectives of the partners;

(v) a recognition on the part of partnership members that different partners have different mandates and different institutional structures and constraints;

(vi) an appropriate structure, including agreement and clarity on the roles and responsibilities of the partners, Board members and (where they exist) staff/ secretariat;

(vii) fit for purpose and effective governance arrangements; and

(viii) willingness on the part of donors/ partners/ members to provide funding for the activities of the partnership.

In what follows, we consider each of these principles or success criteria in the context of our understanding of PMNCH.

3.2. Issue (i): a shared understanding of the objectives and desired outcomes of the partnership

Our understanding is that there is a reasonable degree of consensus across Board members and constituencies about the importance of working in partnership to achieve MNCH goals both at the global and national level. There is also a strong shared recognition of the importance of a continuum of care. However, the recent priority outcomes survey and the discussions with the members suggests that different members and constituencies prioritise different outcomes and articulate these outcomes differently. Moreover there does not

appear to be agreement about the specific outcomes that should be pursued in partnership within PMNCH.

3.3. Issue (ii): the activities to be carried out separately and together

There appears to be a reasonable degree of consensus on where PMNCH has achieved success to date including, for example:

- Its contribution to advocacy. Examples include the increased profile of the continuum of care concept in the Global Campaign for the Health MDGs, as well as the Countdown 2015 etc.
- Its role as a neutral broker in taking forward harmonisation work on health costing tools.
- Its role in organising a series of multi-country workshops for healthcare professionals in some of the high burden countries.

However, there does not appear to be a consensus on the appropriate activities that should be taken forward in PMNCH – particularly the role on Country Support and Facilitation (Area 2), but also to a lesser degree Increasing Aid Effectiveness (Area 3) and Monitoring (Area 4).

Section 2 has set out a proposed framework for thinking about activities of other global health partnerships. In Section 5, we list a range of possible future partnership activities and suggest criteria/ principles that could be applied to decide which of them are best taken forward in PMNCH.

Two more general observations are appropriate here as follows.

Different expectations of different constituencies

We note from our consultations that partner constituencies place a different emphasis on the value of certain PMNCH activities:

- NGOs, health professionals and academics value the opportunity to have a forum to meet, exchange ideas, and to some extent influence multilaterals and donors.
- Multilaterals/ donors are more likely to emphasise the importance of advocacy and co-ordination of activities within the global aid architecture. However, there is also a general recognition of the value that a partnership might have in allowing partners to hold each other to account.
- Developing country representatives (including Southern NGOs) see the need to better coordinate the activities of various MNCH implementing agencies, partners and multiple global partnerships to improve effectiveness of MNCH policies, programmes, and resource allocation.

We believe that it is important for Board members to recognise these differences at the Retreat. The appropriate role, structure and membership of PMNCH will depend on the outcomes, outputs and activities to be included within its mandate. These differences of view appear to be a legacy of the differences in membership and focus of the original three Partnerships that were amalgamated into PMNCH.

Scope and realism in definition of outcomes and milestones

Significant amounts of work have gone into the 2008 Value-Added Work Plan – and this is evidenced in its clarity. However, in our view, the differences in view about outcomes/ outputs/ activities in PMNCH are exacerbated by:

- an overly wide definition of the goals of PMNCH; and
- unrealistic milestones in some of the priority work areas (particularly Area 2: Country Support and Facilitation), given the resources available and the relative roles of PMNCH and its partners.

3.4. Issue (iii): willingness to commit time and effort to PMNCH activities

We have appreciated the way that Board members have been willing to make time for us as part of the Retreat planning process. Our sense is that most Board members take their role seriously and are willing to commit time and effort to PMNCH. However we note that Board members have:

- drawn our attention to a reduced enthusiasm to participate in the PMNCH activities by some partners, due to unclear direction and outcomes of PMNCH, which some believe has led to the reducing seniority of the individuals representing the partners on the Board;
- expressed a sense of frustration at the lack of participation and Board meeting attendance of the developing country government partners; and
- expressed disappointment at what it has been possible to achieve in Country Support – including the level of work/ commitment of partners.

In our view, there is a 'vicious circle' here. Perceived failure/ lack of trust results in reduced engagement of partners and therefore reduced potential for achievement of objectives. Clarity about the outcomes and activities of PMNCH, and about the roles and responsibilities of the partners/ Board members/ Secretariat are likely to be essential to correct this.

3.5. Issue (iv): willingness to be accountable/ share practice/ change approaches

As noted above, the level of accountability that is appropriate varies according to the particular activities undertaken and the nature of the membership:

- For 'partnership activities' (where there is agreement that it is appropriate for the partners to work together), partners need to be accountable to each other through the partnership governance structure (e.g. the Board and other committees). In order to make a reality of this, partners need to ensure that their representatives (subject to appropriate internal processes) are able to commit their organisations to agreed actions. Invariably this requires a relatively senior level of engagement. (It is easier to elicit commitment and to achieve change in partnerships with significant funding. For a partnership like PMNCH, the challenge is for Board members to 'persuade' their institutions to modify priorities/ change practice.)

- For activities carried out independently by the partners but which contribute to the wider objectives of the partnership, partners should ideally be prepared to collaborate on their own initiative, and share experiences and views openly.

On the basis of our limited experience of PMNCH, we are not in a position to judge the extent to which there is a willingness to be accountable and share ideas. However, we note that the very wide membership of PMNCH (whilst a strength in some respects) makes achieving this openness and accountability more difficult. One issue for the PMNCH partners to consider at the Retreat is whether some functions of PMNCH might be best achieved with a different mix of partners.

3.6. Issue (v): recognition of different mandates and institutional constraints

The recognition of different mandates and institutional constraints, capabilities, and resources, and accordingly framing the role and contributions of the different partners to recognise those differences are, in our view, particularly important in the context of a partnership with very wide membership. Again, we are not in a position to judge whether or not there is an appropriate recognition of this within PMNCH. We simply note the issue for Board members' consideration.

3.7. Issue (vi): appropriate structure

What follows from differing views about the appropriate outcomes, outputs and activities is differing views about the appropriate structure or business model for PMNCH – including the appropriate activities and the related roles of the partners, partnership and secretariat. One area in which this manifests itself in PMNCH, in our view, is the relationship between the Secretariat and the Board (although see also the observations below in relation to governance).

3.8. Issue (vii): challenges in relation to governance

Our understanding is that relationships between Board members are generally good and that the opportunity for representatives of different organisations to work together on the Board has in itself been a positive aspect of PMNCH.

However, there are a number of areas where there may be potential to improve effectiveness if PMNCH continues. Annex B to this paper provides CEPA's view of key features of good governance in the context of global partnerships. On the basis of our initial consultations and our experience working with the GHPs, we note the following issues that may need to be addressed by the Board.

- There is a lack of clarity about the relative roles and responsibilities of stakeholders (members), Board members and the secretariat. The Board is arguably too large to allow effective debate and decision making. We have been told that Board members frequently come away from Board meetings with different understandings of conclusions reached on key issues.
- The limited frequency of Board meetings and level of engagement of partners in the other committees of the Board make it very difficult for the Board to provide coherent direction and oversight to the Secretariat[2]. This has been exacerbated by the apparent differences in view about the nature of the partnership between Board members themselves and with the Secretariat.
- As with most other organisations (profit and not-for-profit), decisions are generally taken through consensus. However, (linked to the size issue), the collegiate culture of the Board means that there is a tendency to shy away from conflict and leave areas of tension/ difference unresolved.

Although all partners are intended to have the same voting powers, there is a strong feeling among some Board members that donors and multilaterals exert greater influence – i.e. that in reality there is a 'two tier' membership. In our view, depending on the intended function of a MNCH partnership, and reflecting the very different scale and scope of partner activities, this need not be a problem per se. But whatever the reality it needs to be recognised explicitly in the structure of the organisation, along with acknowledgement of constituencies' different roles in different activities. There needs to be clear rules and procedures for decision making, including mechanisms to deal with potential conflicts of interest.[3] However, these issues can only be resolved when the primary question of the desired outcomes and activities of PMNCH have been agreed.

[2] Although we note that it is not necessarily the case that Board as is currently defined should be the body that provides this. It could for example be a subset or existing Board committee(s).

[3] We understand that there is an outstanding action to write a Board manual, which covers some of these issues and which has been put on hold, subject to the conclusions of the evaluation and the Retreat.

3.9. Issue (viii): availability of funding

As part of our review, we have not asked Board members about their organisations' willingness to provide funding for partnership activities or PMNCH itself. However, it is clearly essential for partners to have an shared view on the level of funding that is required for agreed activities and how these resources should be accessed.

4. PRIORITY OUTCOMES AND ISSUES

4.1. Introduction

In August 2008 the Retreat Planning Group requested that Board members respond to a short survey seeking views on the value added outcomes or products that a MNCH partnership should be responsible for within the next 2-3 years, both generally and within PMNCH.

12 out of 23 Board members responded. Within this total, Board members have answered questions in a number of ways. Broadly speaking:

- one group has sought to answer the questions in relation to what needs to be done in MNCH (i.e. not necessarily by PMNCH) (5 members);
- another group has focused more on the activities/ or value added that PMNCH might provide (4 members); and
- others have provided observations on both (3 members).

4.2. Survey results

In this section we provide a listing of responses and the number of Board members that responded in the same or a similar way.

Table 4.1 provides details of the responses that relate to the general priority outcomes (i.e. not relating to PMNCH potential activities). Table 4.2 provides details of the responses that relate to PMNCH priority activities.

Table 4.1: Priority MNCH outcomes[4]

Outcome	No.
Increased financial flows and other resources (including medicines) available to high burden countries. Including specific proposals that relate to: the number of countries/ investments: new MNCH investments in 10 countries in next 2 years, 25 in 4 years; the sources of funding: national/ donor.	7
Increased availability of skilled human resources for both planning and delivery at the country level.	2
Improved high level political commitment and leadership for MNCH.	1
Integration of MNCH planning and delivery activities with wider health system strengthening (HSS) and reproductive health (RH) activities.	1
Harmonisation of policy and programme tools (and by extension harmonisation of norms, guidelines and technical capacity building to strengthen policy and operational decision making).	1

[4] Please note that the wording of these outcomes are largely taken from the responses to the survey.

Outcome	No.
Greater information sharing on effective interventions (and by extension effective knowledge sharing (lessons learnt, success stories) and research priorities).	1
More evidence based decision making.	1
More accountability of national and global decision makers and improved transparency.	3
Development of detailed/ costed MNCH strategies (not just high-level plans) at global, regional and national level, that involve all relevant partners.	3
Improved capacity of national and international CSO organisations (particularly health professionals and health provider associations).	2
Addressing inequities of service access.	1
Greater coordination at national level particularly – involving all stakeholders (e.g. through government led coordination committees or existing mechanisms already in place and functioning).	5

Table 4.2: PMNCH Role

Role	No.
Advocacy continued and strengthened	3
Harmonisation role (e.g. on tools)	2
Monitoring and evaluation of country performance/ Countdown (supporting accountability)	3
Research on policy issues (financing mechanisms/ Advanced Market Commitments, economics of investing in MNCH, climate change and health)	2
Research on best practice at national level (e.g. service delivery mechanisms in countries with weak health systems)	3
Coordinating role of all partners at national level (e.g. through annual meetings)	6
Coordinating with other global health partnerships to ensure MNCH gets share of funding	2

5. PMNCH FUNCTIONS/ ACTIVITIES

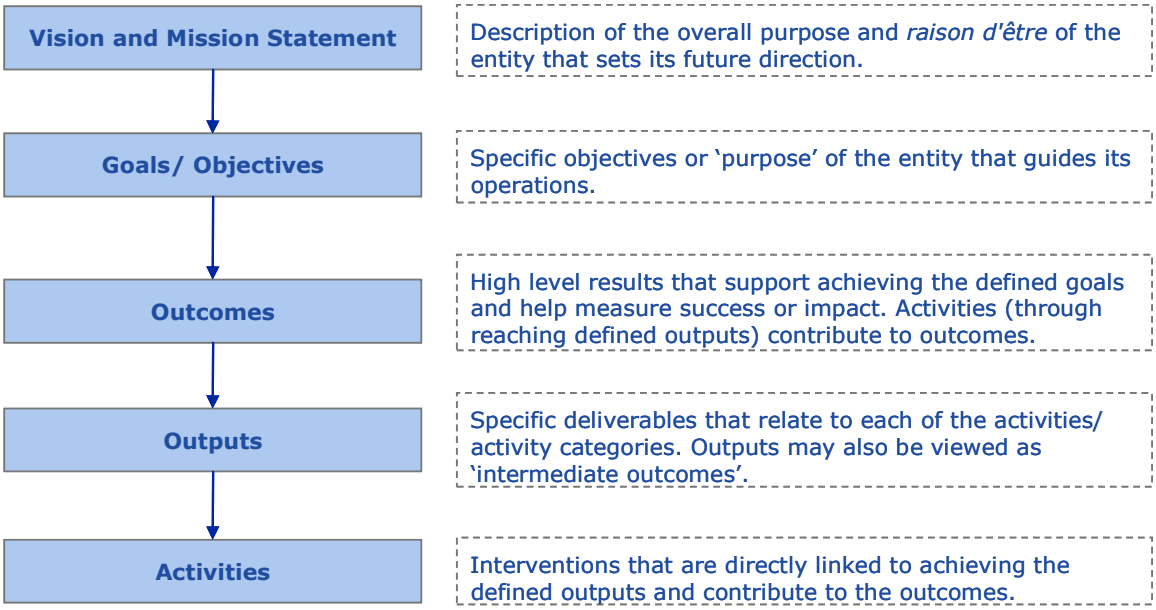
5.1. Definition of outcomes, outputs and activities

A common view that has emerged from our various consultations with the Board members is the need to translate the vision of the PMNCH into tangible outcomes, i.e. the measures that will form the yardstick for measuring PMNCH's success and performance. Once these outcomes are agreed, they would form the basis for identifying the specific outputs and value-added activities of PMNCH that need to be carried out in order to contribute to these outcomes.

Typically, outcomes may not be directly attributable to activities – which are more linked to their immediate outputs/ deliverables. For example, the *activity* of canvassing G8 members and policy makers may result in the *output* of MNCH issues being included in the G8 Health communiqué, which can contribute to the *outcome* of increased resource mobilization for MNCH.

The logical framework depicting this 'waterfall' approach is presented in a simple schematic in Figure 5.1.

Figure 5.1: Strategic framework



The vision and goal of PMNCH as set out in its 10-year strategy paper are as follows:

Vision: A world where all mothers and children receive the care they need to live healthy, productive lives.[5]

Goal: To invest in, deliver and advance maternal, newborn and child health, and there-by put 50% of the 60 high-burden countries "on track" to achieve MDGs 4 and 5 in five years.

In principle, there are two approaches to defining the outcomes, outputs and activities of a partnership:

(i) *Top-down approach:* as per the 'waterfall' chart above, to identify the desired outcomes required to achieve the stated vision/ goal, and then to define the outputs (that are over and above the outputs of the individual partners and/ or other health partnerships) and finally specify the activities the partnership may engage in to deliver these outputs and accelerate progress towards the outcomes.

(ii) *Bottom-up approach:* to first develop a realistic listing of value-added activities that can be undertaken in partnership in the MNCH space, and related outputs that contribute to the achievement of the outcomes.

In practice, a combination of the two approaches may be necessary to arrive at an answer. Our proposed approach to the Retreat involves using both approaches.

Section 5.2 sets out a possible list of possible priority outcomes for a MNCH partnership – drawing on the Board survey results set out in Section 4. This will be the subject of one of the Board sessions at the Retreat.

Section 5.3 sets out categories of activities that the partnership would engage in. These activities are indicative and are meant to serve as inputs for deliberation by Board members in the day 1 break-out session. (See the annotated agenda for the Retreat). Section 5.3 also sets out criteria/ principles for deciding which of these categories of activities should be taken forward in PMNCH – distinguishing between the general case for partnership and the specific case for taking activities forward in PMNCH.

5.2. Priority outcomes of an MNCH partnership

Drawing on the priority outcomes outlined in the Board survey (see Section 4) and our consultations with Board members, we set out below an illustrative list of five priority outcomes of an MNCH partnership.

(i) Higher profile of MNCH and the adoption/ acceptance of the 'continuum of care' framework at global and national level **('Profile raising')**.

(ii) Increased resource mobilisation at global and national level for MNCH activities to achieve the MDGs 4 and 5 **('Resource mobilisation')**.

[5] The Vision and Goals of the Partnership have been drawn from the 10-year strategy paper.

(iii) To standardise MNCH tools and potentially norms, guidelines and approaches to technical capacity building to strengthen policy and operational decision making **('Harmonising tools and approaches')**

(iv) Improved coordination of partners' investments and support for programming and policy in high burden countries. **('Coordinated approach')**

(v) Greater accountability of partner organisations and improved effectiveness of their investments, activities and support for reaching the MDGs 4 and 5 **('Accountability')**.

5.3. Activities in partnership/ in PMNCH

Scope of section

In this section:

- we have defined a list of potential activities that a partnership could undertake and sought to define value added through partnering (not specifically in PMNCH); and
- identified a series of questions/ key issues on the activities that the Board needs to consider at the Retreat in relation to the value add as well as the potential role of PMNCH.

This list of activities is not intended to be exhaustive. It is meant to stimulate discussion as well as reflect the activities that have been noted in PMNCH documentation and in our consultations with Board members and the Secretariat.

For the avoidance of doubt: (i) our observations on the value-added for each activity are intended to articulate a possible case – we do not seek to conclude whether the case is sufficient to justify either partnership activity or a specific PMNCH role; (ii) we have not sought to define specifically the outputs from the activities. Both of these key issues are for Board members to decide at the Retreat discussions.

Activity groupings

We recognise that these activities/ outputs could be organised/ grouped in different ways. In this paper, however, we have organised them in four categories, which we believe provide some degree of clarity:

1. Advocacy;
2. Learning, Knowledge Sharing and Monitoring;
3. Harmonisation; and
4. Facilitation, Coordination and Brokerage.

We would ask Board members not to focus unduly on these groupings (which have been referred to as functions in earlier PMNCH documents). Rather the focus should be on the underlying activities and associated outputs.

Some of the activities that we list (for example within the Advocacy grouping) are already being undertaken by PMNCH. However, the list also attempts to include activities that may present new opportunities and which draw on the strengths of the combined partners. Board members may wish to add to this list of activities.

Criteria for defining 'value add' of PMNCH

At the Retreat, we will ask Board members to discuss and develop a series of potential partnership activities, PMNCH activities and related outputs. In order to support this process, we provide here a set of criteria that can be used to inform where there is value-added in the partners undertaking the activities in PMNCH (see also Section 2 of this report):

- Where activity in partnership has the potential to either: (i) achieve things that could not be achieved by partners on their own or working together in informal collaboration; and/ or (ii) improve the efficiency/ effectiveness of partner activities. This involves establishing the counterfactual that these activities may remain undone/ or would be done less effectively in the current global health landscape.
- Where PMNCH, as opposed to any other global health partnership or partnering arrangement is the most appropriate location for the activity.
- Where the outputs of the activity are (where possible):
    - measureable;
    - innovative/ bold (to capture the imagination of the executive leadership of partners in working together); and
    - deliverable in a reasonable time frame (say 3-5 years maximum).

5.3.1. Advocacy

The activities under this category are defined as those that use existing and new information to proactively influence stakeholders that are *external* to the partnership. The stakeholders include, but are not necessarily limited to:

- the general public, both internationally and in high burden countries;
- developed and developing country politicians, policy-makers and other decision makers more generally (e.g. decision makers within in large corporations);
- the wider donor community;

- other global health partnerships;
- health practitioners (including public and private sectors); and
- stakeholders outside the health sector but related to MNCH goals, such as those operating within the labour, education, transport and social protection sectors.

The advocacy outputs and activities of the partnership are intended to contribute primarily to the 'Profile raising' and 'resource mobilisation' outcomes.

Possible activities within Advocacy

We provide in Table 5.1 below a list of advocacy activities, and an articulation of the possible value added through partnership.

Table 5.1: Possible activities within the Advocacy category

1. Advocacy activities	**Value added through partnership**
1a. Actively canvassing members of G8 and other international groups to ensure inclusion of MNCH into their health communiqués.	• Joint influence of executive leadership level of partner organizations, through direct access to decision-makers. • Strengthening of the advocacy efforts as a result of a unified message and efforts at global and national levels. • Applying the combined "mass" of partners and using their various communication/ media/ influence channels to reach key target audiences (e.g., UNICEF, large international NGOs).
1b. Actively canvassing relevant donors for a greater provision of financial resources to MNCH issues.	
1c. Strategic mapping of key decision-makers and of channels and opportunities to reach them in coordinated actions by multiple influential partners	
1d. Promote the adoption of and support with evidence, where possible, the 'Continuum of care' concept in global and national health policies.	
1e. Maintain regular communication with international, regional and national media and contribute to relevant MNCH focused fora.	
1f. Establish contacts with key individuals and institutions in non-health sectors (e.g. labour, education, transport) with a view to influence relevant policies to the benefit of MNCH.	

Key questions to identify PMNCH role/ value added activities

(i) Is there a strong enough case for partnership advocacy activity of this sort? What would it involve? Or, is the activity required limited to informal coordination of messages/ approaches?

(ii) Would a partnership approach be capable of (a) engaging senior leadership of key partners; (b) identifying specific 'tactical' approaches to reach decision-makers (not just 'emitting' messages)?

(iii) Is PMNCH, as opposed to other partnerships/ partners well placed to undertake this activity at global, regional, and/ or national levels?

(iv) Assuming that the answers to the above questions are yes, what are the appropriate activities, do they sufficiently 'stretch' the existing advocacy efforts?

(v) In case of differences of view among the partners on the advocacy messages and the role of the partners in proactively advocating them, is PMNCH a suitable forum to resolve these and agree a common agenda? Could it be strengthened to take on this role?

5.3.2. Learning, Knowledge Sharing and Monitoring

Activities in this category could include:

- gathering and sharing information on best practice;
- facilitating (and possibly funding) new MNCH research; and
- monitoring and following-up on MNCH programmes and projects undertaken by the partners individually or in groups.

These activities might be expected to contribute to the 'Coordinated approach' and 'Accountability' outcomes.

Possible activities within Learning, Knowledge Sharing and Monitoring

Table 5.2 sets out possible activities in this category and a possible explanation of the possible value added through partnership

Table 5.2: Activities within the Learning, Knowledge Sharing and Monitoring category

2. Learning, Knowledge Sharing and Monitoring activities	**Value added through partnership**
2a. Collate/ compile and make available up-to-date MNCH information and knowledge, including information being developed by the Countdown 2015.	• Central repository of MNCH knowledge currently split across partners, and proactive role in dissemination. • Unified platform for exchange of views/ information among all MNCH constituencies, and also across developed and developing countries. • Enable monitoring and evaluation of MNCH activities that involve multiple partners, and provide a forum for
2b. Organise or coordinate the development of best practice and case studies drawing on the partners' global and national reach	
2c. Organise and participate in conferences and workshops that improve MNCH knowledge capital and disseminate it to the relevant partner constituencies.	
2d. Ascertain any knowledge or data gaps in the high burden countries, and where practical, work with partners to conduct tailored seminars/ training workshops at regional/ national level.	

2. Learning, Knowledge Sharing and Monitoring activities	Value added through partnership
2e. Facilitate (through, for example, access to data, relevant contacts) new MNCH research – on both technical and financing/ implementation issues (e.g. Advanced Market Commitments for MNCH).	constructive feedback and accountability.
2f. Develop a monitoring framework for a selection of partner programmes and projects, and work with relevant partners/ stakeholders to evaluate activities and outputs and hold partners accountable.	

Key questions to identify PMNCH role/ value added activities

- Relevant activities along these lines will be carried out by some partners or groups of partners, outside a PMNCH context – can partners better communicate about and coordinate these activities to get greatest benefit to the whole community?
- Subject to that, is there a role for PMNCH contribute to MNCH learning and knowledge, e.g. to identify knowledge/ data gaps and allocate responsibility to the right partners for the activity, or to commission research and/ or develop knowledge-hub type activities?
- What are the extent of resources available for the partnership to undertake this activity, and in particular any new research?
- What kind of incentives will be required for the participating partners and countries to share information on their MNCH interventions activities and existing research?
- To what extent are the partners and countries open to the PMNCH providing a monitoring/ evaluation role on selected MNCH activities? How do we get better methodologies for generating credible evidence from country-level programs operating at scale.
- The in-country workshops conducted by the healthcare professionals constituency have generally been considered helpful and value-adding. Do the partners view this as an appropriate activity for PMNCH to engage in at the regional and national level? What is the rationale for this being run by PMNCH?

5.3.3. Harmonisation

This category contains activities which seek to harmonise MNCH approaches, tools and processes in order to improve the effectiveness of MNCH policies, programmes, and investments. These activities could range from aligning higher level policies (e.g. level of medical care required at birth) to harmonising costing tools and implementation level data

(e.g. health care cost inputs like workers' salaries) in a particular country and/ or across countries.

The expected modus operandi is that partners would identify areas of policy/ practice that require harmonisation. These would then be worked on by partners with independent/ technical support provided from partnership resources (currently the secretariat).

Broadly, the outputs from this activity are likely to contribute to the 'Coordinated approach' outcome, which might lead to greater effectiveness of operations, and fewer occasions of conflicting or duplicated activity.

Specific proposed activities within Harmonisation

Table 5.3 provides a listing of harmonisation activities and the possible value added through partnership

Table 5.3: Activities within the Harmonisation category

3. Harmonisation activities	**Value added through partnership**
3a. Identify and prioritise tool-kits, frameworks & processes used by the different partners which could benefit from greater harmonisation.	• Better access to/ knowledge of tool-kits, frameworks and processes used by the different partners. • Ability to neutrally 'broker' agreement on harmonising approaches and tools, and therefore the national MNCH planning process.
3b. Where practical, lead/ coordinate the harmonisation review and implementation, working with different involved partners.	
3c. Contribute to developing a harmonised MNCH approach to the national planning/ strategy development process in selected high burden countries	

Key questions to identify PMNCH role/ value added activities

- Is it possible to carry out this activity between partners (i.e. without PMNCH) or would this form of partnering/ external partnership (without resources) lack "convening authority."?
- Should the role of PMNCH be restricted to identifying gaps in and priorities of harmonisation; or should it take responsibility for coordinating the harmonisation process?
- In relation to broader sector approaches, there may be resistance to "harmonizing" only MNCH. Is it possible to do this (either in partnership of through PMNCH) in broader context?
- To what extent can PMNCH as opposed to the partners realistically aim to input into the national planning process on MNCH issues? What is the role of existing in-country coordination groups on harmonisation?

5.3.4. Facilitation, coordination and brokerage

The final category of activities is focused on ensuring that the partners, whilst acting individually, sequence and coordinate their activities with each other. This may involve bringing together different MNCH stakeholders to achieve common objectives, and thereby fostering new and innovative 'partnering' approaches around specific outputs to improve MNCH activities in countries.

In general, these activities would support outcomes related to 'Coordinated approach' and better 'Accountability'.

Possible activities within Facilitation, Coordination and Brokerage

Table 5.4 presents the list of activities in this category.

Table 5.4: Activities within the Facilitation, Coordination and Brokerage category

4. Facilitation, Coordination and Brokerage activities	**Value added through partnership**
4a. Convene and facilitate dialogue and 'partnering' on specific projects/ programmes, to agree a coordinated approach	• Ability to convene and catalyse partners/ members for a common agreed goal. • Ability to act as a neutral and honest broker in the MNCH space to identify gaps and coordinate better outcomes.
4b. Play a proactive role in developing new national level stakeholder partnerships for specific MNCH objectives/ deliverables.	
4c. Play a reactive role in 'brokering' consensus and coordinated working among partners on their global, regional or national MNCH initiatives.	

Key questions to identify PMNCH role/ value added activities

- The Paris Principles say country (not partners or a partnership) should convene and lead planning – what role does an external partnership play? If there is a role, how does a partnership engage, and sustain coordination by, partners' in-country offices/ representatives.
- Do Board members see value in a dedicated partnership with a specific mandate to coordinate and facilitate MNCH activities to achieve more timely outcomes?
- There are also views that the partners may be better placed (given their country presence and programmes) to initiate such coordination amongst themselves. Do Board members see any 'additional value added' for PMNCH to contribute in this area? How is this achieved in practice in the absence of programme funding?

6. STRUCTURE OPTIONS

6.1. Introduction

This section is intended to illustrate the point that, once Board members have decided on the appropriate outcomes and activities for PMNCH and related deliverables (outputs) there is a separate discussion on the appropriate structure for PMNCH, i.e. 'form follows function'.

We therefore illustrate possible structure arrangements that might be consistent with a number of possible conclusions in relation to appropriate PMNCH outputs/ activities. The actual structure options for consideration at the Retreat on the second day will depend on the activities agreed for the PMNCH on the first day of the Retreat.

6.2. Structures for alternative PMNCH activities[6]

6.2.1. Knowledge sharing/ networking forum

Table 6.1: "Knowledge sharing/ networking forum"

Structure aspects	Description
Operations	Loose network of stakeholders/ partners who meet once or twice a year to agree common goals, exchange ideas and information, and facilitate networking
Membership	All MNCH constituencies/ or subset of partners
Staffing	No dedicated staff, but one of the partners could volunteer to lead the network and organise the activities
Likely governance structure	No formal governance, only a loose alliance of like-minded partners
Structure typology	Type 4

Possible structure variants for this activity option:

A possible variant to this option could be around the membership – that is, it may be that smaller groupings of stakeholders constitute these loose knowledge sharing networks.

[6] Note that the structure typology classification is simply included as a 'summary' description of the structure.

6.2.2. Knowledge sharing partnership and advocacy

Table 6.2: Knowledge sharing partnership and Advocacy

Structure aspects	Description
Operations	As above (6.2.1) but with the addition of a specific advocacy activity. This activity will involve partners and secretariat in carrying out agreed activities to promote PMNCH and achieve specific advocacy outputs that contribute to the overall outcome of increased resources.
Membership	All constituencies
Staffing	A dedicated staff required to coordinate and undertake advocacy towards influencing the executive leadership level of partner organisations.
Likely governance structure	Formal, but relatively light governance arrangements. Wider membership participating in networking events; small (balanced) Board dealing with specific advocacy issues.
Structure typology	Type 3

6.2.3. Global co-ordination, facilitation and harmonisation

Table 6.3: Coordination, facilitation and harmonisation of partner activities

Structure aspects	Description
Operations	A partnership that responds to partner defined issues (e.g. the need for harmonising different costing tools) where co-ordination or harmonisation of approaches/ activities would improve outcomes (at global, regional and national levels)
Membership	All MNCH constituencies
Staffing	Small dedicated Secretariat staff to coordinate and organise activities/ and to manage any additional technical inputs required.
Likely governance structure	Relatively formal governance structure with a Board that meets twice a year, supported by a small Secretariat. There may be time-limited task teams constituted for specific coordination tasks, working closely with the Secretariat. The composition of task teams would need to reflect the nature of a particular issue. In general, there should not be an expectation that all partners should be equally represented on the task teams.
Structure typology	Type 2/ 3

Possible structure variants for this activity option:

It may be possible to adopt a lead partner approach in this option for each coordination activity, in which case the need for a Secretariat is reduced.

ANNEX A – OTHER INITIATIVES/ CONTEXT

In this Annex, we set out our understanding of the involvement of PMNCH in a number of health/ MNCH initiatives in 2007.[7]

Global Campaign for Health MDGs

PMNCH became heavily involved in drafting the Global Business Plan for MDGs 4 and 5 in early 2007. (The concept of the GBP arose from discussions that Dr. Bustreo had initiated during late 06 with the Government of Norway.) PMNCH was instrumental in bringing in the views, perspectives and experience of countries in their efforts to extend basic health services for mothers and children. PMNCH was also effective in broadening the scope of the Business Plan to incorporate maternal and newborn elements. The GBP is now proceeding outside the view of the overall PMNCH membership and many Board members.

International Health Partnership

By mid year political interest in the health MDGs in Norway and the UK had developed to the point when, in early September, the UK government launched the International Health Partnership. The aim of the IHP is to support governments to achieve health outcomes by agencies working more effectively together, reducing duplication and aligning support behind one national plan (reduced fragmentation). A global compact was signed in Sept 5th, 07 by leaders, donors, agencies and countries. No additional aid funds were announced by the UK; however, new funds were announced around the same time by the Netherlands (125m for health and education) and Norway (one billion over ten years). A secretariat has been established at the multilateral level (WHO, World Bank) and multi-country activities have been initiated. The relationship of IHP to the Catalytic Initiative and the GBP is unclear, and many PMNCH constituencies and partners are not actively engaged in the IHP.

Catalytic Initiative

At the same time, there was discussion - but little concrete information available - of a Catalytic Initiative to be funded by the Canadian Government via UNICEF. This new Initiative would build on an earlier experience that Canada had, again via UNICEF, implemented in some 12 countries in west Africa aimed at accelerating national coverage of selected "high impact" interventions. The aims of the Catalytic Initiative remained largely unknown until later in the year when the Prime Minister of Canada, at a health meeting in Tanzania, unveiled its main features.

[7] Up to date details can be found here: www.norad.no/default.asp?V_ITEM_ID=11720&V_LANG_ID=0

Global Campaign for the Health MDGs ('Global Business Plan')

With these developments, the Global Business Plan was re-positioned -- mostly led by the Government of Norway -- into the Global Campaign for the Health MDGs. This Campaign has a strong emphasis on strengthening health systems as a whole and countries setting their own priorities. The GC sets out to raise awareness of the role that improved MNC outcomes play in the development process, and links a series of practical initiatives including the Global Network of Leaders, which provides high level leadership to ensure that governments make maternal and child health a priority. PMNCH is identified within the GC as the coordinator of the Deliver Now advocacy drive. The Deliver Now advocacy drive is implemented at national level in India and Tanzania in partnership with White Ribbon Alliance, an NGO. Again most PMNCH members and Board members are not engaged in the GC at the institutional level.

ANNEX B - CHARACTERISTICS OF GOOD GOVERNANCE

We set out here what we regard as seven characteristics of good governance. They have been taken from work that we have carried out previously (including for GAVI).

1. **The organisation has written constitution documents, which clearly articulate and codify the mission and purpose of the entity and its approach to governance**.[8] The constitution should be consistent with the relevant law and will depend, in part, on the particular legal form, structure and jurisdiction.

2. **The governance arrangements make a clear distinction between the various levels of governance, the parties involved, and their roles, responsibilities and powers**. In most organisations, there are three levels in the governance arrangements. We refer to these levels as stakeholders, Board members and management. The precise functions of these levels of governance and who performs them varies across organisations. For example, in some not-for-profit organisations, the role of the stakeholders and the Board Members are performed by the same body.

    - *Stakeholders*: It is important to be clear about the definition of stakeholders. In a for-profit company the stakeholders are narrowly defined as the shareholders for the purposes of governance. They are the funders (i.e. equity providers), who own the company and receive its earnings. There are of course wider stakeholders in a private company, including customers, suppliers and the wider community.

      In the context of most GHPs (and other not-for-profit entities or PPPs in development), we use a wider definition of stakeholders to include donors (who provide the funds for the activities); public and private partners (who are involved in the delivery of certain aspects of the service) such as the multi lateral partner bodies, vaccine manufacturers and research institutions; developing country governments; and NGO/ civil society representatives.

      Although there are shared objectives amongst stakeholders in most GHPs there are also important differences which should not be overlooked. These differences reflect the different constituencies and external pressures that determine relative priorities.

    - *Board members:* The first question is whether there should be Board members separate from the stakeholders. The benefit of having a smaller group of Board members is to provide closer oversight of and support to the management and staff (in GAVI's case, the Secretariat) on planning and operations. This is not usually possible if stakeholders only meet annually or semi-annually. The Board members operate in accordance with the policies approved by the stakeholders and are accountable to

[8] Constitution documents refer to the set of legal and other documents that define the way in which the organisation functions including all aspects of its governance.

them. The Board members meet more frequently than the stakeholders (typically not less than quarterly, and usually more frequently).

- *Management (Secretariat)*: The management is responsible for developing and implementing plans and budgets in an effective and economic manner. They are accountable through the Executive Secretary to the Board members and/ or to the stakeholders. Once plans and budgets are approved, the management is typically responsible for implementing agreed plans operating within approved policies and procedures.

Further, many GHP utilise an *advisory panel of experts/committees*. These expert groups may report to senior management but more usually to the Board members. They have no decision-making powers and are purely advisory –sometimes their advice is made available to stakeholders, so that it is clear if and when advice is not accepted.

3. **The body of Board members should be of an appropriate size and composition and there should be clearly defined mechanisms for their appointment.** The number of Board members should be large enough to provide the range of skills necessary to run the organisation and/or represent the interests of the organisation and its stakeholders, but should be small enough to be manageable and cohesive.

   In Europe and the US, 'best practice' guidelines indicate that the number of Board members of private sector and public entities should be between 8 - 12 individuals, each bringing distinctive expertise and experience to the role. The rules for the nomination/ election of the Board members should be transparent and clearly defined, including the appointment of the Chair. Board members usually serve for specified terms but their appointment and renewal are subject to approval by the stakeholders.

   It is usually an explicit requirement for Board members of for-profit and not-for profit entities to act in the best interest of the organisation, and to exercise objective independent judgement. This is true whether the Board members are appointed (i) as representatives of individual or groups of stakeholders; and/ or (ii) in an individual capacity for the skills, experience and contacts that they bring to the organisation.

4. **There are clearly defined mechanisms for decision making, including voting rights, and for resolving differences of view at each level of the organisation.** The absence of differences of view and argument are not necessarily indicators of good governance. Perhaps more important is whether there are clear mechanisms for resolving differences and, in the end, for taking decisions to resolve disagreements in a timely and transparent way.

   These mechanisms typically involve voting and decision making based on a decision rule. In some cases, all decisions may be determined by a majority vote but often 'very important' decisions – such as a significant change in purpose or strategy – may require a higher majority (e.g. 75% support) to be approved. Decision making rules and processes should balance clarity, acceptability to all stakeholders involved, and practicality.

Although the expectation is that the great majority of decisions will be consensual, relying on unanimity in all circumstance is a recipe for gridlock.

A key issue is whether funding stakeholders should have the same rights and powers as non-funding stakeholders. Stakeholder Boards/ councils can have weighted voting with funding stakeholders having proportionately more control over certain key decisions.[9] If this is the case, decisions are needed about (i) what decisions should be subject to weighted voting (and which should not); and (ii) what sort of weighting is appropriate (for different types of decisions).

Rules and processes for Board members' decision making are also essential, and should be specified in the constitution. Sometimes a majority vote, with the Chair having a casting vote, is the agreed decision rule.

5. **There are clear statements and procedures for dealing with conflicts of interest.**

   All Board members and senior executives should be required to disclose whether they, directly or indirectly, have a material interest in any transaction or matter affecting the organisation or its stakeholders. When committees of Board members are established, their mandate, composition and working procedures should be well defined and disclosed by the Board members.

   In a private sector context, particularly Board members should consider assigning a sufficient number of non-executive Board members capable of exercising independent judgment where there is a potential for conflict of interest. Examples of such key responsibilities are ensuring the integrity of financial and non-financial reporting; the review of related party transactions, nomination of Board members and key executives, and Board members' remuneration.

6. **The governance structures provide proper incentives for various parties to pursue objectives that are in the interests of the organisation, as well as facilitate effective performance monitoring and performance improvement mechanisms.**

   The stakeholders typically hold accountable the Board members to act in the interests of the organisation, and the Board members in turn set the performance framework and remuneration for the senior management team. This seeks to ensure efficiency and maintain adequate checks and balances at each level. Performance objectives are agreed annually and both the overall organisation and individual (Board members and management) performance are reviewed periodically to ensure effective functioning.

   In private for-profit entities and some not-for-profits, the remuneration of senior management (and staff) is linked to performance against pre-agreed objectives. This may include having direct links between achievement of specific performance targets and some elements of remuneration.

[9] The World Bank and the UN Security Council both have weighted representation and voting.

7. **Timely and accurate disclosure is made on all material matters regarding the organisation, including its financial situation, performance, ownership, and governance.**

   A strong disclosure regime that promotes real transparency is central to the stakeholders', particularly the donors', ability to retain accountability for donated funds and exercise their powers on an informed basis. A robust disclosure regime can help to attract additional funding and strengthens confidence among different types of donors.

   Similarly, the Board members should have access to accurate, relevant and timely information, including as a minimum, the operational and financial performance against plans and budgets, in order to fulfill their responsibilities. Disclosure requirements should not place unreasonable administrative or cost burdens on the organisation.

ANNEX C – GHP CASE STUDIES

1. Global Alliance for Improved Nutrition (GAIN)	
Overview/ history	GAIN was created at a special UN session for children in 2002, to focus on countries with populations at risk of malnutrition, in particular infants, young children and women in Asia, Sub-Saharan Africa, and Latin America. To date, it has raised US$ 60m in core funding.
Mission/ objectives	Reduce malnutrition through food fortification and other strategies aimed at improving health and nutrition of populations at risk. Target of reaching 1 billion people by 2008, with long-term goal of 2 billion people with nutritional deficiencies
Outcomes/ targets	Target 1: Cost per DALY gained: less than US$15. Target 2: Reduction in deficiency prevalence: more than 30%. Target 3: Reach 1 billion people. Target 4: Coverage of target groups: more than 500m people. Target 5: Cost per target individual: less than US$0.25. Target 6: Raise more than US$50m from donor agencies and leverage more than US$700m in private sector investment
Donors/ resources	Key donors: Gates Foundation; CIDA; USAID. To date GAIN has raised US$60m in core funding.
Members/ partners	Private sector partners: Danone; Unilever; Tetra Pak. NGO/ CBO/ Alliance: Helen Keller International; Micronutrient Initiative; National Fortification Alliance. Multilaterals: UNICEF; World Bank Institute; World Food Programme; World Health Organization.
Activities/ funding	Policy formulation and harmonisation, standard-setting, capacity-building, advocacy, marketing and operational research. GAIN helps build public-private partnerships and supports them financially and technically to produce and market better nutrition to those in need, based on strict quality standards and clear targets, measured against scientific indicators. By 2007, GAIN established 15 national food fortification programs projected to reach 450 million people over three years. GAIN has awarded 23 grants worth US$ 36m. Disbursements of funds are made through annual rounds of grants based on requests for proposal. Proposals are reviewed by the Proposal Review Panel and the GAIN Board makes final selection on grants in the range of US$ 1-3m. Grants are delivered by national institutions or execution agencies.
Structure	Established under Swiss law as a legal entity, whose mission, objectives and approach to governance are clearly specified in the Statutes/ bylaws. Swiss laws, in particular the Swiss civil code, art. 80 et seq, apply to any matters not covered in the Statutes. Headquartered in Geneva, Switzerland and has regional offices in New Delhi, India; Beijing, China; and Johannesburg, South Africa. Organized in five technical programs: Food Fortification; Infant & Young Child Nutrition; Performance Management and Research; Investments & Partnerships; and Communications & Advocacy.
Governance	*Board of Directors:* Comprises leaders from the donor, UN, development, research, business and civil society communities. Meets a minimum of twice a year and is responsible for high-level strategic decision making, appointment of the Executive Director, approving of the workplan, funding decisions, and performance evaluation of the Foundation's activities. The Permanent *Executive Committee* consists of 4 Board members (including the Chair) and is authorised to make decisions between the Board meetings on urgent matters. *Secretariat:* A small team of professionals and support staff who manage the day-to-day operations. The Executive Director leads the Secretariat, reporting to the Chair. He manages the secretariat, appoints senior management and may establish specific working groups reporting to him.

2. Health Metrics Network (HMN)	
Overview/ history	Set up in 2005 as a global partnership to improve health and lives by strengthening and aligning health information systems (HIS) globally. Seeks to bring together health and statistical constituencies to build capacity and expertise, and enhance the availability, quality, dissemination and use of data for decision-making. Initial grant of US$50m from Gates Foundation, with some additional contributions from other donors.
Mission/ objectives	Increase availability and use of timely and accurate health information by catalysing the joint funding and development of core country health information systems.
Outcomes/ targets	Create a harmonized framework for country HIS development (the HMN Framework), which describes standards for health information systems. Strengthen country HIS by providing technical and catalytic financial support to apply the HMN Framework. Ensure access and use of information by local, regional and global constituencies.
Donors/ resources	Initial grant of US$50 million from Gates Foundation, and additional contributions from other donors including DfID, USAID and DANIDA. 2007/8 budget: US$22 million.
Members/ partners	The partnership is comprised of countries, multilateral and bilateral development agencies, foundations, global health initiatives, and technical experts. Partners include: African Population and Health Research Center (APHRC); Gates Foundation; Centers for Disease Control and Prevention (U.S.) (CDC); DANIDA; UK DFID; European Commission; Ghana Health Service; GAVI; Global Fund to Fight AIDS, Tuberculosis and Malaria; Ministry of Health, Mexico; Ministry of Public Health, Thailand; OECD; Statistics South Africa; SIDA; Uganda Bureau of Statistics; UNICEF; UNFPA; UNSD; USAID; The World Bank; WHO. Members are representatives from HMN's constituencies, selected on the basis of commitment during HMN's development phase.
Activities/ funding	Create a common HMN Framework that can define the systems needed at country and global levels, as well as develop the standards, capacities and processes for generating, analysing, disseminating, and using health information. Provides technical and financial support to countries to strengthen their health information systems. Not primarily a fund; its role is to provide technical inputs and catalytic financial support that will enable countries and partners to convene stakeholders, develop plans, mobilize resources, and ensure assessment and monitoring of progress. The bulk of the financial resources required to implement health information system strategies will necessarily come from in-country sources, both national and donor.
Structure	Hosted by the WHO – it is a global partnership and not a legal entity in itself. Organisation structure comprises a Board, a Technical Advisory Group, and a Secretariat.
Governance	*Board of Directors*: Currently the Board has 18 voting members, representing its constituencies and meeting twice a year. Board seats are distributed among 5 developing countries, 4 multilateral agencies, 4 bilateral donors, 2 funds/foundations and 3 NGOs/academic institutions. Renewable members (WHO, World Bank, Gates Foundation and the Global Fund) provide a nomination to the Chair, with the Board determining the nomination. The Board provides leadership and strategic guidance to HMN, and approves the overall budget work plan and the annual report presented by the Secretariat. Currently the Board has a standing Resource Mobilisation and Advocacy subcommittees. *Technical Advisory Group (TAG)*: Provides technical advice on all aspects of HMN's program work and supports Board decision making. The TAG Chair advises the Board in coordination with the Secretariat. *Independent Review Committee (IRC):* Advises on selecting countries for HMN support, and monitoring of the performance of successful applicants.

2. Health Metrics Network (HMN)	
	Secretariat: Supports HMN partners in fulfilling HMN's goals and objectives. The Secretariat consists of an Executive Secretary and core technical and administrative staff. It is functionally accountable to the Board, and administratively accountable to WHO as the hosting agency (also, its operations and staff are subject to WHO's Financial and Staff Regulations and Rules, Manual provisions and practices). *The Partner Forum:* Convened not more than once every two years to permit the involvement of wider stakeholders of the initiative. It reviews progress based on reports from the HMN Board and provides advice on general policies, creates and exploits opportunities for advocacy, information exchange, communication and awareness activities in promoting HMN's aims, consolidates partners' commitment, particularly political commitment, to HMN's objectives, strategy, and targets, and provides a communication channel for stakeholders not represented elsewhere in the governance structure.

3. Global Alliance to Eliminate Lymphatic Filariasis (The Global Alliance)	
Overview/ history	The Global Alliance was formed in 2000 with the sole purpose of supporting the Global Programme to Eliminate Lymphatic Filariasis (the Global Programme), which is based in the newly established Neglected Tropical Diseases Division, Filariasis Unit of the WHO. Received grant of US$11.7m from Gates Foundation.
Mission/ objectives	To bring together a diverse group of private and public health partners to support the Global Programme by mobilising political, financial and technical resources.
Outcomes/ targets	The Global Alliance coordinates activities of partners and concentrates on achieving political, financial and technical support objectives to support the Global Programme.
Donors/ resources	Gates Foundation provided a grant of $11.7 million over 4 years (October, 2006 - October, 2010).
Members/ partners	*National Ministries of Health* of the 83 endemic countries, who lead the Global Alliance by implementing the strategy, identifying operational research needs, and monitoring and evaluating progress. *International Organisations (World Bank and WHO)*, who provide expertise to support national programmes in preparing national plans, mapping disease distribution, training health personnel both in drug distribution and disability prevention and control activities, social mobilisation, and monitoring and evaluation. *Private sector companies (three major international firms),* who provide supplies and drugs, free or at-cost, for mass drug administration campaigns, promote advocacy, support academia and facilitate programme development. A number of *International Development Agencies and Foundations,* who have pledged funds to support the implementation of national LF elimination programmes. A number of *NGOs,* who complement the efforts of the national Ministries of Health in implementing different components of the programmes A number of *academic and research institutions*, who strengthen the scientific basis, test new tools and strategies, provide postgraduate human capacity development and carry out operational research
Activities/ funding	*Political support:* Increasing publicity at an international level (through the media and otherwise) to raise public awareness of LF as a debilitating and disabling, poverty-related disease that is eliminable. *Financial support:* Provision of expertise in fundraising, aiding countries in accessing debt relief and other multilateral funds, encouraging country-level resource mobilisation, and engaging in advocacy activities with potential and current donors. *Technical support:* Developing a network of academic/research institutes, providing expertise in monitoring and evaluation for country programmes, promoting research priorities and strategies, providing country staff training and education, measuring programme costs and cost-effectiveness, measuring the impact on health systems of LF elimination programmes.
Structure	No formal legal structure. Organisational structure includes an Executive Group and a Representative Contact Group. The Liverpool School of Tropical Medicine serves as the Secretariat.
Governance	*Representative Contact Group (RCG):* Comprised of country representatives from each region and representatives from the pharmaceutical companies, academic/research institutions, donors, non-governmental organizations, the World Health Organization and the World Bank. The RCG elected an *Executive Group* of six members who were required to carry out the recommendations made at the third Global Alliance to Eliminate Lymphatic Filariasis meeting. Recommendations are set at the Global Alliance meetings, which are then carried out by the *Executive Group*. The Liverpool School of Tropical Medicine serves as the *Secretariat* for the Global Alliance.

4. Alliance for Cervical Cancer Prevention	
Overview/ history	In 1999, five international agencies launched a major new effort to prevent cervical cancer worldwide. The Alliance received US$50m funding from Gates Foundation.
Mission/ objectives	To clarify, promote, and implement strategies for preventing cervical cancer in developing countries.
Outcomes/ targets	Preventing cervical cancer in developing countries.
Donors/ resources	Gates Foundation provided a grant of $50m over 5 years.
Members/ partners	*EngenderHealth*: One of the largest non-profit organisations dedicated to making reproductive health care accessible globally. *The International Agency for Research on Cancer (IARC)*: An affiliated research center of the WHO. *JHPIEGO*: A non-profit corporation working to improve the health of women and families globally, through advocacy, education, and performance improvement. *Pan American Health Organization (PAHO):* An international public health agency with more than 90 years of experience in working to improve health and living standards of the Americas. *PATH:* An international, non-profit organisation dedicated to improving health, especially the health of women and children.
Activities/ funding	Exploring new approaches for detection of precancerous lesions. Evaluating the effectiveness of combined detection and treatment approaches. Improving delivery of cervical cancer prevention services. Developing the means by which clinicians can be trained in providing quality cervical cancer prevention services. Assessing what women and health care providers need to know about cervical cancer prevention. Preparing key information packages for health care decision-makers. Providing small grants to local agencies working on cervical cancer prevention in their communities. The Alliance Small Grants Program provided funding for 42 small grant projects in 1999-2004. As of August 2003, all funds had been committed.
Structure	A loose alliance of five international agencies. PATH is the coordinating agency of the Alliance, working closely with a steering committee of ACCP members to encourage intra-Alliance communication and collaboration and to coordinate information dissemination.
Governance	No formal governance structure apart from the ACCP members steering committee.