GLOBAL HEALTH

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Developing *Successful* Global Health Alliances

BILL & MELINDA GATES *foundation*

"As one measure of their importance, alliances represent nearly 80 percent of the value of global health investments made by the Bill & Melinda Gates Foundation."

Alliances play a central role in the battle to improve public health in developing countries. Simply put, there are few global public health challenges where any single player has the funding, research, and delivery capabilities required to solve the problem on a worldwide scale. Alliances have been formed to reduce the burdens of AIDS, tuberculosis, malaria, polio, river blindness, and many other diseases. As one measure of their importance, alliances represent nearly 80 percent of the value of global health investments made by the Bill & Melinda Gates Foundation.

The Global Polio Eradication Initiative, spearheaded by the World Health Organization (WHO), Rotary International, the Centers for Disease Control (CDC), and UNICEF, has shown the success achievable through collaboration: the number of polio cases has been reduced to 150 reported cases in 2000, down from more than 500,000 cases in 1988. Likewise, the Onchocerciasis Control Program, an alliance of more than 30 institutions, governments, and companies, has worked for the last 25 years to eliminate river blindness as a significant health problem throughout a major sub-region of West Africa. According to the World Bank, the alliance has prevented 600,000 cases of river blindness and has added 5 million years of productive labor to the economies of 11 countries.[1]

Global health alliances face unique challenges, however. They typically involve multiple partners from very different institutions, and their objectives are challenging and long-term in nature. Success requires effectively spanning national borders to work on an international or even global scale. The lack of hard-and-fast guideposts for setting up or managing such alliances only adds to these challenges.

Given the importance of global health alliances, McKinsey & Company, at the request of the Bill & Melinda Gates Foundation, conducted a brief but intense study aimed at (1) assessing whether alliances were "working"—i.e., whether an alliance was the appropriate choice given the situation, whether initiatives were progressing toward their stated goals, and whether the partners were accelerating, improving, or reducing the cost of initiatives as a result of being in the alliance—and (2) identifying the best practices that can maximize an alliance's chances for "success." Our findings on these two questions, summarized below, are based on a review of more than 30 current global health alliances as well as an assessment of other global health alliances during the past 20 years. The reviewers looked at case studies and interviews with more than 50 public health leaders in foundations, multilateral and bilateral development agencies, other nonprofit organizations, private companies, and academic institutions. This article focuses primarily on implementation alliances, but our study also assessed alliances among donor organizations. (See Exhibit 2, "About the Research," for more details on scope and methodology.)

WORKING BUT UNDER-PERFORMING

How successful are global health alliances? Our interviews and analyses indicate that more than 80 percent of public health alliances appear to be working. In this case, we define the "success" of an alliance as an acceleration, improvement, or reduction of the cost of initiatives aimed at reducing disease burdens in comparison to what could be accomplished on a solitary basis. Moreover, in most cases a solitary approach was not even feasible given the objectives of the initiative. This stands in sharp contrast to the private sector's experience with alliances, where a success rate of 50 percent (measured vs. financial and strategic objectives)

[1] Source: OCP website.

We would like to thank the many people who provided valuable comments and information to us during our interviews between August and October 2001. We also urge readers to review the extensive literature on this topic, including the perspectives of James Austin of Harvard Business School, Roy Widdus at Initiative on Public-Private Partnerships, and Michael Reich of Harvard School of Public Health.

is the norm, and where there is often a very real choice between alliances and solitary approaches.

Yet many global health alliances are not reaching their potential. Some are not fully capturing the potential value from working together while others are off to a slow start. For example, some alliances spend the first six to 18 months doing little more than developing operating plans rather than attacking the disease burden. And other alliances, even after being launched, are hamstrung by limited resources or difficulties in arriving at decisions among the various partner organizations.

MAXIMIZING SUCCESS

Our research and interviews suggest that the alliances that are most capable of reaping the benefits of collaboration and that demonstrate progress against relevant output or outcome measures tend to be characterized by certain best practices (Exhibit 3).

To begin with, successful global health alliances will have a clear and compelling overall goal (e.g., reduce the incidence of malaria by 50 percent by 2010), as well as a clear scope, as defined in terms of geography, patient populations, functional activities, and time. Indeed, many successful global health alliances, including the International Trachoma Initiative and the Mectizan Donation Program, start with a narrow scope and then expand as success accumulates.

Beyond ensuring clear overall goals and a focused scope, managers and donors seeking to maximize the odds of success in global health alliances should ask five questions:

- Is there a clear understanding of the added value that comes from being in an alliance—and what is required to capture this value?
- Have the partners selected an appropriate alliance structure? As on the racetrack, it is best to choose "horses for courses." Simpler and looser structures are appropriate where the level of integration or coordination is limited; more complex, tighter structures should be used where the potential value is substantial, and where a higher degree of coordination or integration is required.
- Have the partners gone beyond a statement of shared objectives—also agreeing on specific success metrics, milestones, and partner contributions?
- Have the "alliance architects" resisted the urge to have equality for all, instead creating governance models that allow input by stakeholders while ensuring effective decision making?
- Are the alliances characterized by a sufficient number of operating staff whose primary objective is the alliance's success? Or, by contrast, are several busy people in different organizations sharing the "CEO" role? Are operating staff or secretariat staff contributing to the alliance on a predominantly part-time or even "nights and weekends" basis?

These five questions are addressed in the balance of this article.

1. WHERE'S THE VALUE?

Successful alliances will clearly define the most important benefits of collaboration, and what the partners have to do to capture these sources of value. Unfortunately, our work shows that this is often not being done. As one interviewee told us: "It seemed obvious that an alliance was the only way to solve the problem, so we never tried to demonstrate its value." Another added: "Each of the partners has its own very detailed plans—isn't that enough?"

Alliance benefits. A quick scan of the global health landscape shows that alliances have the potential to create many different types of value. Alliance benefits can be grouped into five main types:

Avoiding duplication of investments and activities. The Rollback Malaria program, for instance, serves as a platform for partners to share information and establish a common agenda to attack malaria through many means (e.g., drugs, bed nets, education). This coordination reduces costs by avoiding duplication of efforts, improves efficiencies, and creates other benefits such as enhanced awareness. Similarly, partners in the Global Alliance for TB Drug Development have "divvied up" the research landscape to enhance their overall productivity and avoid duplication of activities.

Gaining scale economies. The Global Alliance for Vaccines and Immunization (GAVI) is one of many alliances using its partners' added scale to secure purchasing and other volume-related discounts. Of course, scale economies can go well beyond commodity purchasing. For example, the single standard application required by GAVI reduces the costs to countries that are applying for funding of vaccines programs.

Sharing or reducing risks to allow new initiatives to take place, which individual partners or donors might not have been able or willing to take on alone. In the International AIDS Vaccine Initiative (IAVI) and the Medicines for Malaria Venture, donors are able to pool their capital to invest in a portfolio of high-risk research initiatives.

Sharing knowledge and resources to improve effectiveness. For example, the partners in the Alliance for Cervical Cancer Prevention (ACCP) routinely share their individual experiences from work in countries like South Africa, Thailand, India, and Peru, allowing the other partners to accelerate their overall progress. They are also pooling their data to develop a cost model that will allow better decisions to be made about cervical cancer screening and treatment protocols than would have been possible without the alliance.

Accelerating momentum and attracting funding by building a common "brand" that gains legitimacy and funding support. The Global Polio and Rollback Malaria programs have gathered many different initiatives under a common umbrella, increasing the awareness and support for these causes.

Beyond these benefits, alliances can also reduce unnecessary or detrimental competition between institutions and individuals by co-opting potential rivals as members of a single unified team.

It can be an extremely useful exercise to value the benefits of cooperation—i.e., quantify the benefits in terms of cost, time, or effectiveness gains. One way to do this is to create an Alliance Value Scorecard (Exhibit 4) that identifies the specific collaborative activities within the alliance and articulates very concrete benefits that come from working together. While the partners should not attempt to quantify all of the benefits of the alliance, it can be extremely helpful to identify the top 10 ways where the partners are—or will be—working together, and the magnitude of the benefits. Done well, this will help the partners prioritize their joint work, define specific actions, and understand what sorts of resources each partner needs to provide in order to secure these gains.

Alliance costs. A true picture of alliance value must also include a view on what additional costs will result from being in an alliance. While there are many ways to think about alliance costs, partners in global health alliances are best served by focusing on the basic operating costs of the alliance—that is, the quantifiable costs associated with coordinating and convening the partners.

Our review of the operating budgets of more than 10 global health alliances revealed two interesting observations. First, few global health alliances are rigorous in assessing alliance-related costs. Most alliances lump these costs into more general categories, such as administration or communication, obscuring a true picture of the costs of the alliance. A second observation is that a number of alliances seem to look for ways to control costs that at best would generate modest savings at the expense of overall program effectiveness—for example, trying to keep alliance convening, communication, and staffing costs down, but in the process severely limiting the upside of the alliance. The costs of launching an alliance may be material, and these expenses and resources need to be budgeted for up-front in order to ensure a robust launch and effective management.

2. WHICH STRUCTURAL MODEL?

Developing and managing a successful alliance depends on more than understanding the sources of collaborative value. To succeed, the partners must create—and revise as necessary as the alliance evolves—an appropriate organizational structure. The structure needs to appropriately fit the overall goals to the goals and complexities of the particular alliance at hand. For example, the "looseness or tightness" of the alliance needs to be based on how closely the alliance partners must work together in order to capture the main sources of value (among other considerations). Some of the other dimensions affecting the choice of structure include the need for a dedicated alliance organization such as a secretariat or new corporate entity, and the existence of an acknowledged "leader."

Our work suggests that five basic patterns—or structural models—are common to global health alliances (Exhibit 5):

Simple affiliation. A simple affiliation is the loosest form of alliance. It has no formal structure or staff and depends on simple mechanisms such as a board/steering committee, technical working groups, and informal communications to make decisions. In most cases, the partners operate as equals.

At many levels, a simple affiliation is an extremely attractive model. It introduces limited costs and

promotes fast, personalized, and flexible decision-making. It is particularly appropriate where informal collaboration, for example, sharing of knowledge and data, is the primary mode of interaction. But since a simple affiliation lacks dedicated staff, and typically will lack a single accountable leader, the model may not always be appropriate. This is often the case when an alliance involves a large number of partners or where deeper gains are possible through working more closely together.

Lead partner. The lead partner model is characterized by one partner assuming a strong—but not dominant—leadership role. A recent example is Harvard PARTNERS, an initiative focused on conducting operational research into multi-drug resistant tuberculosis in Peru. As lead partner, Harvard Medical School assembled the partners, defines the strategic and technical agenda, and works with the other partners (the CDC, WHO, the Peruvian National Tuberculosis Program, and others) to make operational decisions.

The lead partner model is often appropriate when a moderate number of partners (e.g., four to six) are involved, when the alliance is seeking deeper coordination or combination gains, and when one partner is a natural but not necessarily dominant leader (e.g., has recognized expertise in the field and the alliance is part of its core mission).

General contractor. In the general contractor model, one partner is the clear leader, decision maker, and controller of funds—and its staff operates the alliance. Columbia University, in the Averting Maternal Death and Disability initiative, acts as general contractor, working with partners such as CARE and Save the Children to help deliver emergency obstetric care in countries like Bangladesh, Egypt, and Morocco.

Since the general contractor model places substantial power in the hands of one partner, it can be highly effective in environments requiring speed and risk-taking. This model can be especially favorable where it is important to have one partner play the project manager role, and where one partner has specific and crucial skills (e.g., emergency obstetric care expertise). To function effectively, however, the general contractor must be a leader that others are willing to follow or work with as "subcontractors."

Secretariat. The hallmarks of a secretariat are a quasi-formal alliance organization and staff, a group of partners operating as more or less equals, and generally having centralized funding. GAVI and the Global Polio Eradication Initiative are both examples of secretariats. In each case, there is a core group of partners that has established a small alliance office (the secretariat) and has dedicated a number of skilled managers to support key alliance functions (e.g., country coordination, advocacy, and application screening).

Since a secretariat can be somewhat more expensive—both in dollars and management time—to create and maintain, the model is often most appropriate when the partners seek deeper combination gains, when a large number of diverse partners are involved, and when separation from the parent institutions is desirable.

Joint venture company. A joint venture model is one in which the partners create a separate legal entity with its own staff and resources, and allow the entity to operate more or less independently. Examples include the International Trachoma Initiative and the African Comprehensive HIV/AIDS Partnership in Botswana.

Joint venture companies require more effort to create and roll out, but can offer a number of benefits, including added focus and separation from the parent institutions. As such, the model is best used when the partners seek deep alliance gains while valuing risk taking and operating speed. They are also used frequently when a private company is directly involved, since they provide for some formal separation of the not-for-profit activities from the private company's for-profit activities. However, the success of joint venture companies requires overcoming the minimum hurdles of establishing a separate entity and providing the joint venture with sufficient independence and resources.

We do not assert that all global health alliances will fit neatly into one of these models. Nor is there one best solution for collaboration; each of these models has pros and cons.

Rather, we offer these models as starting points for productive discussions on how to structure new initiatives, after it has been concluded that partnering is essential. This debate should include some key questions: Do the partners need to work side-by-side in order for the alliance to succeed, or will a looser approach work? Does the alliance need a dedicated management staff and organization? What are the benefits and costs of creating separation from the parent institutions? Will the alliance work best if the partners operate as equals, or should one partner take the lead? Should funding flow to the alliance, or is it better for each partner to receive its own check?

(This discussion of structural models has focused on implementation alliances. See Exhibit 6 for profiles of alternative funding models available to donors.)

3. ARE THE "MINIMUMS" OF OPERATIONAL PLANNING AND PERFORMANCE MANAGEMENT IN PLACE?

Global health alliances—like all alliances—can go a long way to raise their odds of success if certain minimums are met in the areas of operational planning, partner commitments, and performance setting and monitoring. We found that many global health alliances are lacking elements that are fairly common in corporate alliances, often leading to significant losses in time and efficiency. For example, many alliances get off to a slow start because the partners do not have a detailed operating plan in place at launch or shortly thereafter. Others, including one prominent global consortium, encounter management problems such as slow decision making and insufficient access to parent resources.

To avoid these problems, it can be useful to focus on meeting a set of "operating minimums" at different phases of the venture life cycle. For example, it is essential that the partners define their roles and make specific commitments as to what resources (e.g., staff, technology, money, facilities) each will contribute to the alliance very early on. Likewise, the partners should share a concrete view of what "success" will look like at different points in the future—for instance, at the end of years two and five—by implementing specific performance metrics.

The operating minimums will change as the alliance gets underway. For example, within 100 days after launching the alliance, the partners should have developed a detailed workplan with specific activities attached to each workstream. In addition, the partners should have translated the general performance goals into a simple but powerful performance scorecard. Our work suggests that it can be very helpful to develop such a scorecard that tracks alliance performance across three "fitness" dimensions: outcome performance, activity performance, and relationship performance (Exhibit 7).

4. DOES GOVERNANCE BALANCE POWER WITH PARTICIPATION?

Another hallmark of successful alliances is good governance—and in particular, decision making that balances the need for speed with the benefits of wider participation. Creating such a decision-making system is difficult in global health alliances, where there may be anywhere from a handful to several dozen partners with very diverse operating and decision styles. Consider an alliance that ran into some early problems because of too many decision makers being at the table. As one interviewee told us: "I was one of 35 people recently invited to a board meeting, which is indicative of the whole alliance. There is a lack of leadership and courage, the alliance is always trying to please and include everyone."

How do alliances avoid these and other problems and create a governance structure that promotes fast and strong decision making while involving a large number of people and institutions? Our work shows that three actions can go a long way to reaching this goal:

> *Limit the number of main decision-making bodies—but not communications channels.* Well-developed global health alliances tend to be characterized by a dense and complicated web of committees, subcommittees, and interest groups. These committees can be an important mechanism that facilitates communication and collaborative work among the partners, especially when the alliance lacks a full-time staff. But it is essential to limit the number of decision-making bodies to one or two; a common practice is to establish a board that makes most policy decisions in tandem with a technical committee that oversees major scientific decisions.

Keep the number of people on the main governance bodies small—and "representative" if necessary. The Global Alliance for Improved Nutrition (GAIN) has done just this. To develop the vision and structure for GAIN, which is an alliance of more than 30 institutions, the partners appointed representatives to an eight-member structuring team. This meant that the main multilateral partners—the World Bank, WHO, and UNICEF—appointed one person to represent their collective interests.

Develop a decision-making roadmap. Effective decision making depends on a clear understanding of who will be involved in what decisions. Global health alliances, with their desire for consensus, are prone to having too many people involved in decisions, too little individual accountability for decisions, and therefore slow decision-making. To overcome this problem without putting too much power in the hands of a few, it can be quite useful to develop a roadmap for how the alliance will make its 10 to 15 most important decisions. If well defined, such a decision-making protocol will spell out which decision makers (e.g., alliance director, alliance operating team, steering committee, parent institution president) will review, vote on, or decide each major decision (e.g., approval of the annual plan and budget, expansions in geographic scope, funding of programs, etc.).

5. DOES THE ALLIANCE HAVE ENOUGH DEDICATED "HORSEPOWER"?

Finally, strong alliances depend on people, so it is essential to have the right mix of skilled, credible, and committed individuals to drive the alliance forward. While getting the "people part" right is a complicated and idiosyncratic task (and alliances remain vulnerable to personalities), it can be useful to think about staffing on three levels:

Senior champions. This is the one person from the leadership team of each parent institution who "owns" the relationship, works hard to secure the resources and commitments, and is constantly on the lookout for new opportunities.

The alliance leader. This is the individual clearly on the hook for the overall success of the alliance. The best alliances, including GAVI and IAVI, will recruit an individual leader with the skills, contacts, and personality to make things happen, and structure their role to make them personally accountable for the venture's overall success. Importantly, the alliance leader should see the success of the alliance as his or her top priority—not a "nights and weekends" job.

The alliance working staff. This staffing dimension is the most often overlooked—and it is the operational horsepower of the alliance. Global health alliances, especially those that go beyond the loose affiliation model, are much more likely to succeed when a small but deeply committed team drives day-to-day activities. As a general rule, an alliance should have a team of operating managers who are at least 50 percent dedicated to the alliance. The total size of this group will vary according to the nature of the alliance: some alliances may need only two or three dedicated people, whereas larger alliances like Global Polio and GAVI, or more freestanding ventures such as the International Trachoma Initiative, may need more. Having a dedicated team in place will create the individual motivation, accountability, and esprit de corps needed to make alliances succeed.

SUMMARY

Alliances are crucial to the effort to improve health conditions in developing countries. Our review of over 30 such alliances indicates that most alliances are advancing the cause by accelerating, improving, or reducing the cost of global health initiatives. However, as our research has shown, a more disciplined approach to structuring and managing these alliances can lead to even greater impact from the limited resources that are available. Global health alliances that follow industry best practices, such as having a clear and compelling overall goal along with a clear scope for the work to be undertaken, stand to achieve higher levels of success. Those alliances willing to ask and answer the five questions outlined in this article can capitalize on their strengths and identify their weaknesses to better position their organizations for greater success in the future.

ABOUT THE RESEARCH

Exhibit 2

During the fall of 2001, McKinsey & Company, at the request of the Bill & Melinda Gates Foundation, conducted a research study on global health alliances. Our aim was to understand general performance patterns and key success factors in forming, launching, and managing global health alliances.

For our research, we defined "alliance" as an initiative involving two or more institutions characterized by shared goals and decision making, coordination or combination of resources, and some shared accountability.

We did not limit our work to public-private partnerships. Rather, we considered alliances that involved partners of various types: multilateral organizations such as the World Bank and WHO, bilateral government donors such as the Agency for International Development, for-profit companies in the pharmaceutical sector, other nonprofits such as Save the Children and Program for Appropriate Technology in Health, and foundation donors. Although the perspectives from our work are applicable to public-private alliances, we are well aware that alliances between public institutions and private companies need to meet additional hurdles.

Our scope included a range of alliance objectives, health problems, geographies, and partners. We looked at alliances focused on basic and operational research as well as delivery of drugs, vaccines, and care. The sample included alliances aimed at TB, malaria, AIDS, and most of the other leading diseases.

To conduct the research, we drew on existing public literature as well as McKinsey's knowledge base and experience with alliances in healthcare, emerging markets, and the nonprofit sector. The main engine of our research, however, was a set of interviews with more than 50 leading experts in public health. These interviewees, from multilaterals, governments, foundations, pharmaceutical companies, and non-governmental organizations, are among the most prominent and experienced people in the field, and graciously contributed their time and candid insights into more than 30 global health alliances. Given the confidential nature of many of these discussions, the specific examples cited in this article are based on public sources, or are provided with the permission of interviewees.

In our interviews and case analyses, we assessed the progress of alliances on two dimensions: (1) whether they were on track to achieve the scientific or public health objective and (2) whether the alliance partners had captured benefits of combining resources or coordinating efforts (i.e., has the existence of an alliance accelerated progress, improved the quality of outputs or outcomes, or reduced costs relative to a go-alone approach?). We also identified a number of best practices for global health alliances. Note that in our study, and in this article, we are not addressing the underlying scientific merit or relevance of the specific outcomes being pursued by each alliance. Also, the conclusions in this article should be viewed as indicative because of the "newness" of many of the alliances and the limited sample.

BEST PRACTICES—How does your alliance stack up?	Exhibit 3	
	YES	NO
OVERALL GOALS AND SCOPE		
Simple and compelling overall goal	___	___
Clearly defined and focused scope (e.g., geography, disease, patient population, functional activities)	___	___
ALLIANCE VALUE		
Clear rationale for using an alliance vs. alternatives	___	___
Crisp articulation of alliance benefits and costs	___	___
STRUCTURAL MODEL		
Appropriate choice of alliance structural model	___	___
OPERATIONAL PLANNING AND PERFORMANCE MANAGEMENT		
Clear partner commitments (e.g., people, money, technology)	___	___
Performance metrics and milestones in place	___	___
Detailed operating and funding plans, updated as needed	___	___
GOVERNANCE AND DECISION MAKING		
One or two primary governance boards with small number of members—"representative" if necessary	___	___
Clear decision-making rights for 10 to 20 most important decisions	___	___
STAFF		
Senior champions in partner organizations, actively engaged	___	___
Accountable alliance leader with strong skills, contacts, and authority	___	___
Focused working team (e.g., more than 50 percent dedicated) to structure, launch, and manage the alliance	___	___

ALLIANCE VALUE SCORECARD

Exhibit 4

AREA AND INITIATIVE	ESTIMATED VALUE		
	COST SAVINGS	TIME SAVINGS	OTHER VALUE
AVOIDING DUPLICATION Partners avoid or combine overlapping initiatives or assets to reduce costs, increase speed, and improve quality. Initiative 1: _____ Initiative 2: _____			
GAINING SCALE ECONOMIES Partners use their added scale to secure purchasing and other volume-related discounts. Initiative 1: _____ Initiative 2: _____			
SHARING OR REDUCING RISK Partners pool capital or other resources to reduce or spread risks and thus allow new initiatives to take place, which individual partners or donors might not have been able or willing to take on alone. Initiative 1: _____ Initiative 2: _____			
SHARING KNOWLEDGE TO IMPROVE EFFECTIVENESS Partners share detailed information and insights from their own initiatives (field tests, etc.), improving their partners' effectiveness or efficiency as a result. Initiative 1: _____ Initiative 2: _____			
ACCELERATING MOMENTUM TO ATTRACT FUNDING Partners build a common "brand" that gains legitimacy and funding support. Initiative 1: _____ Initiative 2: _____			

ALLIANCE STRUCTURAL MODELS

Exhibit 5

	FACTORS FAVORING USE	EXAMPLES
SIMPLE AFFILIATION 	• Alliance aimed at simple coordination gains • Low to moderate investment • No single leader	• Alliance for Cervical Cancer Prevention
LEAD PARTNER 	• Moderate (four to six) number of partners • Alliance aimed at deeper coordination or combination gains • One partner is natural but not dominant leader	• Harvard PARTNERS
GENERAL CONTRACTOR 	• Alliance aimed at coordination and rationalization of multiple independent initiatives • Strong need for risk-taking or speed • One partner is undisputed leader in the field	• Averting Maternal Death and Disability
SECRETARIAT 	• Moderate to high (4 to 30) number of partners • Moderate to high investment • Alliance aimed at deeper coordination and combination gains • Need to create focused team/resources • Multilateral institutions often involved as core partners	• Global Alliance for Vaccines and Immunization • Global Polio Eradication Initiative
JOINT VENTURE COMPANY 	• Strong need for risk taking and/or operating speed • Alliance aimed at combination gains • Private company often involved • Moderate to high investment • Clear benefits of separation from partners' institutions	• International Trachoma Initiative • African Comprehensive HIV/AIDS Partnership

ALTERNATIVE FUNDING MODELS

Exhibit 6

Our work shows that there are three basic funding models in global health—single funders, multiple funders, and funding alliances—each of which is appropriate in certain situations (Exhibit A).

Single funders. A single funder model should be considered when the problem is focused, easily solvable, when the cost is low, or when the need for speed is critical. For example, the Bill & Melinda Gates Foundation funded the Oxford Tak Malaria Initiative between Oxford University and Mahidol University. The goal of the alliance is to evaluate and then roll out a new malaria regimen in Thailand. The level of investment is modest ($5 million) and the need for speed is high because of the rapid development of malarial resistance.

Multiple funders. Under some conditions it may be more appropriate to use a multiple funder model, in which a group of donors support a grantee but do not work closely together to shape the strategy. Multiple funder alliances tend to be best used to solve significant problems with fairly clear solutions. The Alliance for the Elimination of Iodine Deficiency Disorders is a case in point: the challenge is to improve the levels of salt iodization in developing countries. The solution to the problem, while broad in geographic and financial scope, was clear. As such, there is less need for funders to work closely together to resolve thorny issues of how to attack the problem.

Funding alliances. Launching and sustaining a successful global health initiative often demands more than an implementation alliance—in many cases, it also means creating and maintaining an alliance of funders. GAVI, IAVI, and the Global Alliance for TB Drug Development are three prominent initiatives that have benefited from close ties among a network of donors.

Consider the Global Alliance for TB Drug Development. Formed in 2000, its basic premise is to identify and invest in promising TB-related research initiatives that otherwise lack support owing to limited commercial prospects. The initial idea for the alliance came from the Rockefeller Foundation (which was also seminal in creating IAVI). Rather than invest alone, the Rockefeller Foundation understood that significant benefits stood to be gained from taking the time to build a funding alliance.

To do this, the Rockefeller Foundation convened key stakeholders around a common vision and drove them to agreement on the core issues of the venture. The funding alliance has created broad-based support in the community. It has also improved access to valuable resources since many institutions now have "skin in the game." Additionally, it has reduced the costs of governance and oversight since funders are able to delegate certain monitoring activities to a subset of partners.

In simple terms, a funding alliance is best used when there is a complex and broad problem, often without an agreed upon solution. Funding alliances are also important when sustainability is key—i.e., solving the problem will take a large investment over a sustained period. The Global Alliance for TB Drug Development met all these conditions.

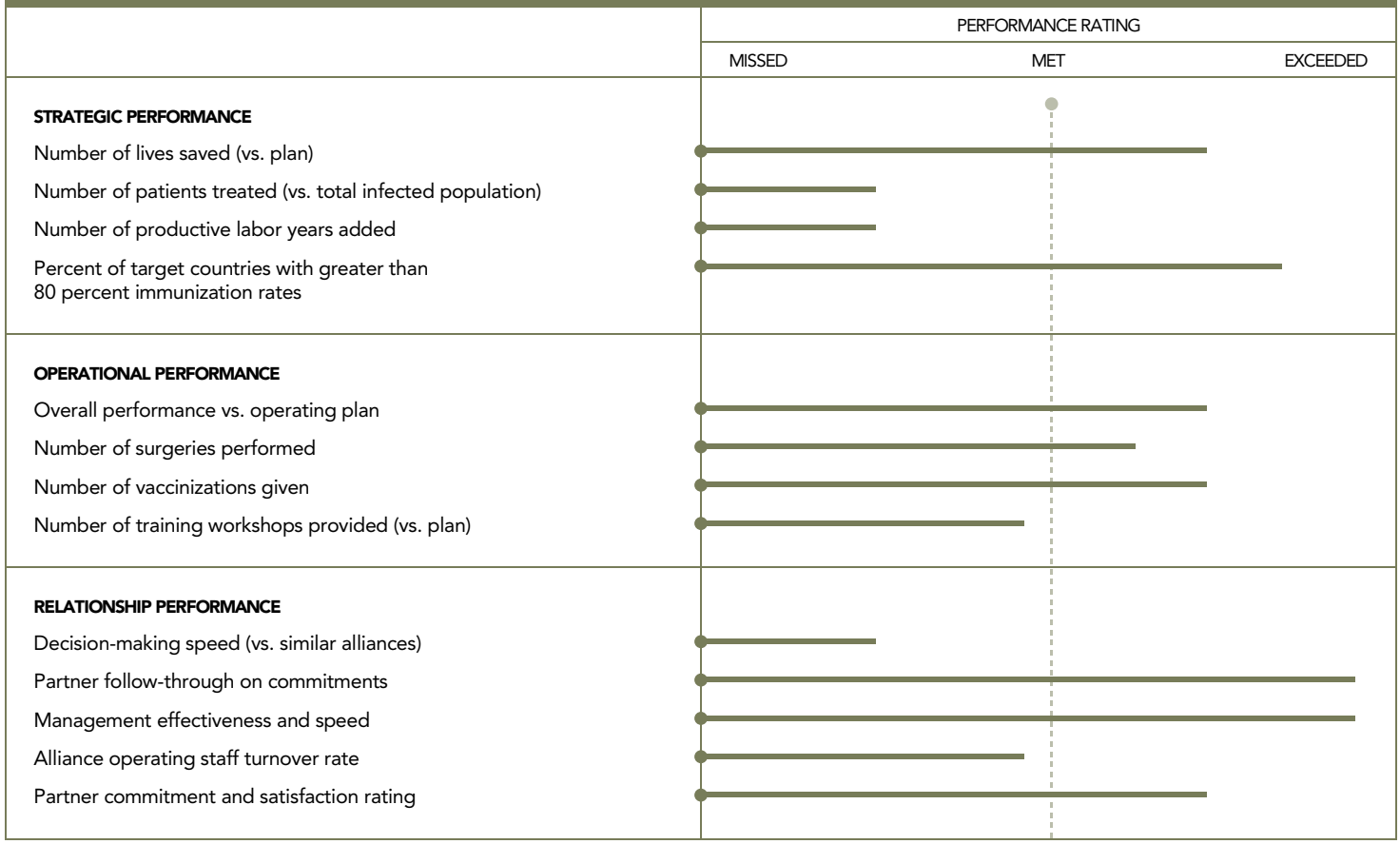
FUNDING MODELS

Exhibit A

	FACTORS FAVORING USE
SINGLE FUNDER One funder supports the initiative	• Discrete, solvable problem • Low/moderate cost • Other players not willing or able to make investment now • Speed more critical than buy-in
MULTIPLE FUNDER Multiple funders support an initiative, but do not work together to shape the initiative	• Initiative is "ready to go" but money needed to execute • Fundraising process in place • Buy-in from multiple donors important • Executive independence from funders beneficial
FUNDING ALLIANCE Multiple funders work together to shape the strategy and/or implementation of the initiative	• Complex problem • Investment larger than any one funder willing or able to make alone • Broad involvement of donors more important than speed • Desire to avoid redundant activities of co-funders (e.g., oversight, due diligence)

ALLIANCE PERFORMANCE SCORECARD

Exhibit 7



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BILL & MELINDA GATES foundation

PO Box 23350
Seattle, WA 98102-0650
USA
V *206.709.3100*
F *206.709.3180*
www.gatesfoundation.org