

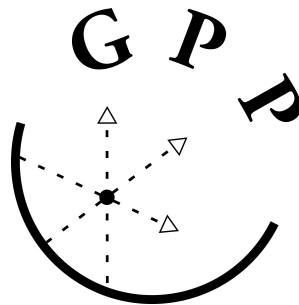
*UN Vision Project on Global Public Policy Networks*

*www.globalpublicpolicy.net*

**ROLL BACK MALARIA:  
A WHO INITIATED NETWORK IN THE FIGHT AGAINST MALARIA**

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Case Study for the UN Vision Project on Global Public Policy Networks



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## INTRODUCTION

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The Roll Back Malaria Partnership (RBM) is a tri-sectoral network engaged in target regions throughout the world, operating on a global, regional and local level in order to decrease the malaria burden. The network is unique in its design and strategies and, if successful, it will provide a blueprint for the control of other diseases such as tuberculosis and AIDS. The network is still in its beginning stage, as the implementation stage will commence in January 2000.

### **Aim of the network:**

The aim of the RBM partnership is to reduce the amount of malaria deaths by 50% in 2010, by using the existing methods for malaria control. RBM will:

- support malaria endemic countries in developing their national health systems
- undertake to develop the broader health sector ( i.e. all providers of health care to the community)
- encourage the needed human and financial investments, national and international, for health system development.

### **The disease:**

The numbers on malaria are nothing but intimidating: a disease endemic to the poorest countries in the world threatening a quarter of the world's population. There are annually between 300 and 500 million cases of malaria and each year one million malaria related deaths occur mainly among children.

In addition to the cost in terms of human lives, the disease has a major social and economic impact as well. Malaria causes repeated school and work absenteeism resulting in short and long term losses in productivity. These costs and the direct costs of malaria prophylaxis amount to 2-3% of GDP in many countries and sometimes even as high as 8% of GDP. Malaria is therefore a serious cause of poverty and it hinders the development of the malaria endemic countries.

Malaria has proven itself as a difficult disease to combat. One of the main reasons for this is that the disease is vector-borne, which means that any change in the habitat of the mosquitoes will have an impact on the prevalence of the disease. Ideally, malaria preventive

measures would be applied whenever causing a disruption of the environment (e.g. the construction of drink water reservoirs or deforestation).

As with many infectious diseases, the dramatically increased mobility of people increases the probability of the emergence of malaria in regions where the disease has been eradicated, the so-called Airport Malaria. Climatic change will also shift the pattern of malaria incidence. The problem is thus not restricted to Africa and SouthEast Asia and the growing awareness of this is likely to be an impetus for renewed efforts against malaria.

Unwise use of both antimalarials and pesticides has resulted in increased resistance of both malaria parasite and its vector(Wirth/Cattani, 1997). Although effective antimalarials are in existence, the price of these drugs is too high for the population in the malaria endemic countries and therefor unsuitable for widespread use. These medicines only have prophylactic properties; a vaccine has not yet been discovered. Our natural resistance against malaria only affects the severity of the disease, but is incapable of rendering us immune. A vaccine would thus have to out perform our natural resistance, which hints at the difficulty of developing such a vaccine; a common estimate is that it will take at least 10 more years to develop it.

As a result of these factors, fighting the disease can no longer be attempted without using all the available tools.

### **Philosophy of the network**

The last global effort to eradicate malaria was attempted in the 1960s. With the discovery of new effective anti-malarials and the possession of the powerful insecticide DDT, the general opinion was that the time was ripe for a full out assault on malaria, hopefully removing this particular scourge on mankind. It failed (Wirth/Cattani, 1997).

The attempt had failed because of a lack of coordination in the implementation phase where the treatment with DDT was not handled correctly in certain regions. All infectious diseases require solid coordination in attempting to reduce the prevalence, but vector-borne diseases require even more coordination due to the mediating effect of the vector. The lack of a vaccine against malaria serves only to emphasize the importance of vector control.

Having learned that lesson, new global efforts to fight malaria would have abide to this requirement. But there was an additional lesson to be learned: whereas eradication campaigns might work in cases like smallpox and polio, where the availability of mass-

immunization lead to a high chance of a successful eradication, cases like malaria are difficult and the initial influx is halted relatively soon in the absence of spectacular success.

To think that one can tackle malaria with a high-intensity campaign, is a fallacy (J. McLaughlin). The complexity of the disease imposes a different dynamism aimed at a sustainable effort to reduce disease prevalence initially short of eradication. Such an approach is warranted even more due to contemporary lack of a “miracle-drug”, necessitating an integrative approach. This marks a qualitative departure from previous strategies.

The philosophy behind the Roll Back Malaria Partnership reflects these lessons. It presents an attempt to coordinate all the previously existing initiatives in malaria control. By harnessing the available resources it is hoped that efficiency and efficacy is increased and that duplication of efforts is avoided. The RBM partnership is also an attempt to integrate research with the application of that research, a feature previously less evident due to fragmentation.

The effects of the second lesson are even more evident in this partnership as it affects the whole structure of the implementation and the mechanisms for funding. The particular structure actually works against eradication as a goal, as it builds upon the initiatives of interested malaria-endemic countries, which is likely to result in a patchwork of malaria-bolstered countries and some which have not. The aim is to build capacity in countries.

## I. INITIATION OF THE NETWORK

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After the failed eradication attempt in the 1960s global attention turned away from malaria. Efforts against malaria were initiated on a bilateral basis or through international organizations. Starting from the nineties we can start to see the momentum increasing again: in 1992 the World Declaration on the Control of Malaria, providing a strategy for the control of malaria; in 1996 the establishment of the Multilateral Initiative on Malaria, linking the research community and strengthening research capacity in malaria endemic countries; and in 1997 a declaration of the Organization for African Unity, calling upon international organizations to give malaria greater priority.

- Timetable for the development of RBM (D. Nabarro 1998; Worldbank 1999: 7):
- Initiated in February 1998, producing a paper draft on 1<sup>st</sup> of March;
- First consultation meeting on the 24<sup>th</sup> of March 1998, producing the second paper draft on the 2<sup>nd</sup> of April 1998;
- Second consultation meeting on the 24<sup>th</sup> of April 1998, producing the 3<sup>rd</sup> paper draft on the 3<sup>rd</sup> of May 1998;
- In 1998 Dr. Brundtland, upon accepting her position as Director-General of the WHO launched the partnership:

“I propose that together we Roll Back Malaria. Not as a revamped vertical program but by developing a new health sector wide approach to combat the disease at global, regional and country and local levels... We have enough knowledge, skills and tools to launch a new concerted effort. Africa is responding. African leaders are committing to a renewed effort to control malaria... I will invite a broad range of stakeholders to join us in this initiative, UNICEF, the World Bank, industry, foundations and all others who have a stake, a commitment and a contribution to make. Let me stress: Roll Back Malaria will not exclude work on other diseases. To the contrary. Successful containment is no endpoint. Rolling Back Malaria is no victory unless health systems are equipped to sustain the gains. That means connecting the services with the primary location for action; the family - the home - and the mother. Efforts against all infectious diseases will benefit. Drawing upon what we learn we will be ready for a fast track on a future Roll Back TB - and a reinvigorated action against HIV/AIDS and the tropical diseases.”

- Presentation at OAU health ministers on May 13<sup>th</sup> 1998;

- Support from G8 Heads at G8 summit on May 17<sup>th</sup> 1998;
- Third consultation meeting on May 27<sup>th</sup> 1998;
- Discussions with WHO HQ and Regional Staff on RBM proposals in June 1998;
- Briefing to government representatives, TDR, CTD<sup>1</sup>, interested parties and WHO staff on RBM proposals on June 24<sup>th</sup> 1998;
- Joint launch of RBM Partnership by WHO/Worldbank/UNDP and UNICEF in October 1998;
- Interim Steering Committee meeting of what is now RBM-Africa (previously the African Initiative for Malaria) in Harare in November 1998;
- The Global Partnership Meeting in Geneva in December 1998;
- The Multilateral Initiative on Malaria Conference in Durban in March 1999 (co-organized with WHO/RBM);
- The RBM Regional Inception Meetings in Abidjan, Nairobi, Yaounde, and Maputo (March-April 1999), Delhi (May 1999), Tashkent (June 1999) and in Cairo (Sept 1999):
- The Second Global Partnership Meeting in Harare in June/July 1999.

### **Analysis**

The immediate source for the emergence of the idea of a tri-sectoral approach were probably the discussions between the WHO and the Worldbank from 1996 onward on the establishment of a long term malaria control program for Africa. As mentioned above, previous experiences had taught the wisdom of finding a sustainable solution for malaria control. Moreover, there were plenty of examples of wasted potential domestic solutions for malaria control, e.g. under-developed local bednet production causing African countries to import bednets from Thailand (Wirth/Cattani, 1997). The problem of under-investment by the private sector in vaccine development is important and poses a constraint on the control of malaria.

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<sup>1</sup> TDR (Special programme for Research and Training in Tropical Diseases); CTD (Centers for Transmitted Diseases).

The immediate justification for WHO involvement in undertaking a major malaria control program is found in the OAU declaration that asked for malaria to be put on a higher priority (also: J. McLaughlin). Other organizations like the Worldbank had also increasingly more interest in malaria, not in the least because field personnel and staff on working visits began to become aware and frustrated with existing malaria control efforts. It is impossible to pinpoint a particular reason why suddenly now malaria became a hot issue; an overall rise of awareness and saliency of the issue gave cause to people within various international organizations pushing for change in malaria control efforts (J. McLaughlin). The fact that high echelon staff members (Brundtland and Wolfensohn) were supportive of such action can only have facilitated the process.

The core organizations already had parts of their machinery working on malaria. However, communication between staff of the various organizations was extremely bad: people often didn't know each other and didn't realize that somebody else was doing something related; this was also a problem on the local level. One direct benefit derived from the various meetings that have been held so far in the context of RBM, is the simple fact that contact has been established between staff members of the various IGOs, NGOs and other actors (J. McLaughlin).

Selection of the actors occurred through invitation, the list of invitation being established with the aim of including as many actors as possible. Although some actors had been left out unintentionally, no actor has refused to participate in RBM (but see below on the structure of the network).

## II. THE ROLES OF THE ACTORS:

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RBM is set up as a tri-sectoral network, including partners from civil society, the private sector as well as the public sector. The following identification of partners for the WHO in RBM was made in 1998 (D. Nabarro, 1998):

*Fig. 1 Who are the partners?*



## **The WHO**

### **Interest in network**

The WHO is the UN specialized agency mandated to tackle such questions. It has an extensive administrative and operational machinery on a global, regional and local level. It has remained active in malaria control and prevention after the failed eradication attempt and it has collaborated in many efforts with other partners. However, the reputation of the WHO has been tarnished, and there are doubts as to whether the WHO is capable of conducting such an operation, a point that shall be addressed later. Increased civil society activity and organization occurred during the 90s, representing the increased saliency of malaria on an international level. The time for increased WHO activity was obviously right, but there is also the thought that the WHO is putting itself back on the map, both in terms of getting a better reputation and as a means to remain the most important actor in the field of malaria. Moreover, the project, if successful, will be applied to other illnesses, constituting a major increase in the WHO's standing and possibilities of attracting resources.

It is necessary thought to keep in mind that the WHO is not a monolithic actor: the RBM secretariat is attempting to conduct a sector-wide approach, which as mentioned before constitutes a significant change from the previous structure and strategy of the WHO. As such the team will have to function as a force of change within the WHO, which entails in the least the transformation of culture of the organization. Theoretically, this might lead to opposition from within the WHO.

### **Role**

The WHO will (RBM About):

- provide strategic direction and catalyze actions;
- provide an RBM secretariat;
- work to build and sustain country and global partnerships;
- arrange the provision of technical endorsement, directly, or through approved resource networks, for both a collective strategy and for individual partners' actions;
- ensure that all aspects of progress of RBM are monitored;

- provide global accountability for RBM;
- broker technical assistance and finance on behalf of those who need it;
- undertake responsible advocacy for the RBM approach to reducing malaria-related suffering

## **Worldbank**

### **Interest in network**

The Worldbank has been active in malaria fighting through its country programs and its support for TDR, albeit that support for TDR goes little further than handing a check ( J. McLaughlin). Malaria presents a major impediment to the development of some of the poorest nations. Some countries spend up to 8% of their GDP annually on malaria. As this presents a solvable problem, the Worldbank is committed to fight malaria.

### **The role**

The World Bank plays an important role in the network as the financier of RBM activities, integrating malaria efforts with other issue areas and thus shaping the form of the local RBM initiatives (more on this when we deal with the implementation).

Its comparative advantages include (World Bank 1999: 9):

- Incorporating malaria objectives into a range of IDA-financed operations is the Bank's greatest potential contribution to the aims of Roll Back Malaria.
- Ensuring that Health Sector Reform initiatives and Sector Wide Approaches in Health appropriately prioritize malaria objectives;
- Inclusion of tax, trade and regulation issues relating to malaria control (e.g., for bednets, insecticides and pharmaceuticals) in policy dialogue, and as areas for fiscal and health policy reforms supported by the Bank and IMF;
- Supporting the involvement of the private sector in malaria control (e.g., fostering partnerships with the IFC, supporting appropriate pharmaceutical policies, and supporting social marketing initiatives);

- Multi-sectoral support for achieving malaria objectives (e.g., mitigating or reducing risk associated with specific agriculture and infrastructure operations, increased access to prevention information and treatment through schools);
- Increasing financing for the inputs required to control malaria

## **UNICEF**

### **Interest in network**

Malaria claims most of its victims among children and pregnant women. Moreover, children affected by malaria are hindered in their development as the recurrent bouts of malaria give cause to school absenteeism. This makes these activities fall within the mandate of UNICEF.

### **Role(RBM About)**

UNICEF has a particular comparative advantage at activities in communities. Other roles include:

- provide support to intensified malaria control efforts via its country programmes;
- strengthen support for community-based and local action to improve health and nutrition
- raise additional funds for country activities;
- mobilize leaders (community, district and national) to make malaria control a priority;
- take lead responsibility for developing an impregnated bednet resource network

## **UNDP**

### **Interest in network**

Malaria causes endemic countries to be stunted in their socio-economic development. For individual people malaria can be very costly as well, spending a substantial portion of their income on antimalarials, medical care, bednets and other forms of prevention. As such malaria is a

### **Role(RBM About)**

The UNDP will commit to the following:

- create capacity for integration of malaria-related action in national poverty eradication policies, strategies and programmes;
- work through the UN Resident Coordinator system to encourage collaborative programming in support of intersectoral action and resource mobilization;
- providing continuous support for the Special Programme for Research and Training in Tropical Diseases;
- strengthening the balance of actions among state, private sector, civil society and communities themselves, to ensure that people have access to basic social services and productive assets;
- support links between Sub-regional Resource Facilities (SURFs), providing technical referral services to country offices and the RBM resource support networks.

### **Malaria endemic countries**

#### **Interest in network**

These countries form the linchpin for the whole endeavor as the implementation is set up in such a way that the process is client driven. This entails that these countries have to come forward with a plan to strengthen the health care sector on which RBM will build. RBM also is heavily involved in the provision of information to such governments if requested, so that governments can take informed decisions in deciding what the priority of malaria control is in their respective country and how it fits in with other sectors. The World Bank will examine these plans critically and will not automatically reallocate funds to such endeavors.

### **National governments**

#### **Interest in network**

Governments have been active on a bilateral level in supporting various activities. This has often been related to previous colonial ties or as allocations of funds available under development policies of those countries. RBM offers an avenue on the operational side that

was previously not available on this scale. National governments might be interested in diverting funds into RBM related projects.

### **Civil society**

#### **Rotary International**

##### ***Interest in network***

The Rotary against malaria (RAM) was designed on the model of their Rotary against Polio project. It has as its core the bed net-approach ([www.bednet.org/fits](http://www.bednet.org/fits)):

“Seed funding of projects dealing with malaria may have multiple spinoffs:

RAM seed funds a village with nets. They organize and sell the nets into their community. The community uses the funds from the sale of the nets to build a water tank to have pure water. Or they use the money to form a village bank, which provides microenterprise loans to local businesses. Local businesses cultivate the work skills needed to be employable. Work creates income. Income improves nutrition and standard of living.” Related to this is R.A.V.E (Rotaract Adopts a Village Everywhere), a campaign by the Rotaract (an organization for young adults sponsored by Rotary International), which encourages Rotaract Clubs to devise strategies to fight Malaria involving bednets and plans to teach people how to use them. Obviously, this project fits well within RBM.

### **Foundations**

#### **Interest in network**

The two main foundations, the Wellcome Trust (previous administrator of Multilateral Initiative on Malaria) and the Burrough Trust, were already engaged extensively in the financial support of various efforts in malaria research. How these foundations can contribute to RBM needs to be negotiated, but RBM provides new avenues of malaria control on an operational level.

## MIM

### *Interest in network*

The Multilateral Initiative on Malaria is a network of organizations and individuals from the public sector, civil society and industry. Its goal was to “strengthen and sustain, through collaborative research and training, the capability of malaria endemic countries in Africa to carry out research required to develop and improve tools for malaria control”(mm3.htm). Other objectives entail”(mm3.htm):

- to raise public awareness of the problem of malaria in order to mobilize the necessary resources and action;
- promote global communication and cooperation between organizations and individuals concerned with malaria, with the aim of maximizing the impact of resources and avoiding duplication of effort;
- to develop sustainable malaria research capacity in Africa through international scientific partnerships;
- to ensure research findings and applied to malaria treatment and control and to translate practical problems into manageable research questions.

Some Specific priorities include”(mm3.htm):

- promote communication and advocacy on the public health importance of malaria (this task is performed by the Malaria Foundation International);
- enhancing interaction between African scientists and the global research community by improving access to electronic communication facilities and the internet;
- complete genome sequencing of malarial parasites and ensure that knowledge gained is applied to the discovery of vaccines and novel drugs;
- supporting a malaria conference in Africa to bring together research and public health communities from across Africa on a regular basis;
- create an inventory of African research capacity and infrastructure, in order to identify opportunities for development;
- creating a working group to address antimalarial drug resistance.

## **Malaria Foundation International**

### ***Interest in network***

This foundation has been founded by Dr. Galinski in order to "facilitate the development and implementation of solutions to the health, economic and social problems caused by malaria". Its goals are to ([www.malaria.org](http://www.malaria.org)):

- to assist with the development and coordination of networks that enhance communications, maximize exchange of views and expertise among malaria scientists and health workers, and encourage the most cost-effective use of available resources.
- to provide a concerted voice for scientists in issues of public debate concerning malaria.
- to educate individuals and institutions about the enormity of the malaria problem worldwide, and help to secure financial assistance for malaria research and control programs.
- to support the education and training of our next generation of malaria experts.

This Foundation is already cooperating by putting RBM related material on Internet (M. Galinski). It is already handling the public relations for MIM, it could perhaps do so for RBM.

## **Private sector**

### **Interest in network**

Involvement of the private sector in malaria control and prevention has steadily decreased from the sixties onward. Activities are limited to the research for new antimalarials and vaccines. Unfortunately, economic reasoning prejudices against heavy involvement in vaccine research due the peculiarities of this market. Vaccine research for malaria is complex due to the need to best even natural immunity. A common estimate is that it will take a decade before a vaccine is discovered, constituting a very high investment. However, the market in terms of purchasing power is small, in most malaria endemic countries, as these countries tend to be poor, necessitating a low price of the medicines. Making a profit seems to be unobtainable, breaking-even the best possible result and incurring a loss seems the most likely.

For these reasons action needs to be taken to change the outcome of this logic. The idea behind the New Medicines for Malaria (MMV) is to create a not-for-profit private enterprise in which the public and private sector work together, in order to “obtain adequate funding to support and manage a portfolio for drug discovery and development projects that can lead to the registration and commercialization of one new product per year” (R.Ridley/ W.Gutteridge/ L.Currat). Contributors include TDR, Worldbank, Global forum for Health research, Rockefeller Foundation and Wellcome Trust, the UK department for International Development, the International Federation of Pharmaceutical Manufactures Association and the Association of British Pharmaceutical Industries (TDR News No. 58, 1999).

These medicines are developed with mainly public money, whereas pharmaceutical companies will provide expertise and resources, such as access to chemical libraries (TDR News No. 58, 1999). New discoveries are patented, the rights belonging to MMV. Private enterprises can then commercialize products thus patented, creating revenue for MMV as holder of the patents, which will flow back into MMV in order to attain some degree of self-sufficiency.

### **Analysis**

However, not all these “partners” are partners in the true meaning of the word. As mentioned above, the core of RBM are the WHO, the Worldbank, UNICEF and the UNDP. This core forms the operational arm of RBM. The core members are represented on the RBM team by members of their own staff, greatly improving the line of communication and providing the members with a way to provide input and critique.

In their relationships the idea of comparative advantage governs their responsibilities. This means that the organizations have determined on the basis of their capacity an area in which they will be primarily active, in essence creating a niche for themselves. “Agencies commonly act in isolation, and unilaterally respond to requests or perceived needs of client countries. Partnerships which result in added value can be realized if each agency is able to (i) appreciate its institutional comparative advantage; (ii) complement the role of others through contributing its institutional strengths; and (iii) seek the input of partners from their own areas of expertise” (Worldbank 1999: 7). These areas are not made exclusive, so it remains possible to have some organizational overlap (J. McLaughlin). This is in my opinion a good strategy as it recognizes the authority of a particular organization in a particular field, but it avoids hardening of the borders and potential protectionist behavior of the members in the future. This

approach also causes the core members to have a high amount of legitimacy, both in their own perception as in that of non-core actors. The WHO seems to have the respect of core and non-core actors, due to Dr. Brundtland's work, and is generally perceived to be able to sustain RBM (J.McLaughlin/ S.Hrynkow/B. Sina).

These core members all utilize the available machinery within their organizations to receive and allocate funds. The greater emphasis on malaria within a sector wide approach might warrant some institutional changes, but the funding for RBM projects is done mainly through existing mechanisms in the organizations e.g. country programs. Sources of funding are the regular resources available to these organizations or might be bilateral grants, previously allocated directly for malaria control to an endemic country, a practice strongly discouraged by the Worldbank. Such grants can be made available through the RBM machinery in order to avoid supply driven projects (J.McLaughlin).

Non-core actors relate rather different to the network. Although they are euphemistically called partners in the organigram, that seems to imply more involvement in the network than actually occurs. It must be kept in mind that this network is still in the process of evolving and crystallization, making it possible that some of these non-core actors will become heavily involved in the activities of RBM, but at the moment this is not the case. That they will do so is imperative, as these actors have often specialized in providing a particular component of the total malaria care and prevention. After categorizing which organization has a comparative advantage in a particular field, the most efficient and thus hopefully most effective method of implementation can be determined.

The non-core actors were not invited to "join" RBM, and they do not view themselves as components of RBM (S.Hrynkow/B. Sina). They have no say in the workings of RBM, although there are meetings and other forms of contact where thoughts can be voiced (M. Galinski), but within the boundaries of common courtesy as it is not the place of non-core actors to criticize the workings of another organization. It would be a better characterization to view these actors and their activities as a pool of potential alliances for cooperation and collaboration between them and RBM. The relations between RBM and these actors have not been defined yet and the opportunities for cooperation have still to be negotiated, but it seems likely that this will be in the form of projects rather than absorption into the RBM team. This also implies that it is relative easy for new actors to start a cooperation with RBM; the borders of the network are permeable in that sense. Such a practice is reinforced by the usage of the normal procedures of the individual core organizations.

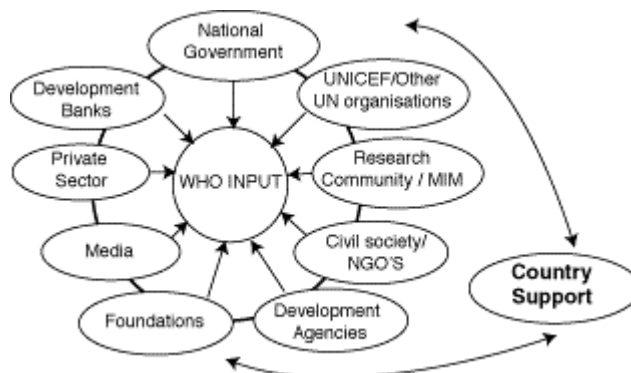
Financing of the activities of these actors is thus done independently, as it was arranged before the launching RBM. It is too early to tell whether some actors will become dependent on the network for financial reasons, yet such a situation would require an actor engaged in an RBM project to redefine its goals in terms of the project goal. As the starting point is that these actors remain separate and independent from the RBM core, the probability of such a development to occur is low.

The presentation of RBM as an “umbrella” or “blanket” is incongruent with the real situation. Whether this actually presents a problem is another question and one that is most likely answered in the negative. A good example is MIM, which, constituting a fully developed network predating RBM, could have resented this presentation of RBM. However, the view of the current coordinator of MIM, the Fogarty International Center, is that this just a confusing situation and that it will be sorted out during future negotiations with the RBM team (S.Hrynkow/B. Sina). Moreover, the naming of RBM as a “blanket” network or as a more select network focussed on the operational side of malaria control has little effect on the de facto working relationships. The relationship between RBM and MIM is characterized by relatively discreet areas of activity with some minor overlap; there is thus no competition.

***Structure of the network***

The complete network is exemplified by this organigram (D.Nabarro, 1998) designed by the RBM team:

*Fig. 2 The network*



Following the observations made above, this organigram obviously doesn't hold. In reality there is the distinction between the inner circle and outer circle. This distinction goes further than mere inclusion in the RBM team, due to the goals of the various actors in both circles. The inner circle has as its aim mainly operational goals; it is the control of malaria that is emphasized. The other actors, most notably MIM and MMV have long term goals in mind: the prevention of the disease. This is a division of labor inherent due to the aims and goals of the organizations. Whereas the RBM network address capacity building in malaria endemic countries through health sector reforms, MIM builds capacity in African countries by increasing research resources. Whereas the RBM network does research aimed at operational uses, MIM (and MMV) researches vaccines and antimalarials. This means that at this moment and in the near future there will be little overlap between the RBM and MIM/MMV, necessitating a change in the organigram in terms of time frames or, in different words, between operational goals and vaccine discovery.

The relations between the inner and the outer circle are yet undefined. Whether these relations, when established, will be structural in nature is questionable; more likely will it entail cooperation in particular projects. The organigram ought to represent this: there are no lines between the inner and outer circle. Moreover, these lines may never come into existence or may so only temporarily. Reality is fluid.

The place of the WHO as the center of the hub is equally misleading. Even within the inner circle the WHO has no longer a predominant position. This reflects the time at which the organigram was made, but a change is warranted. However, RBM is just one of the networks in malaria prevention and control activities, which is not reflected in the diagram. On the contrary, it seems as if RBM is the hub of all the efforts.

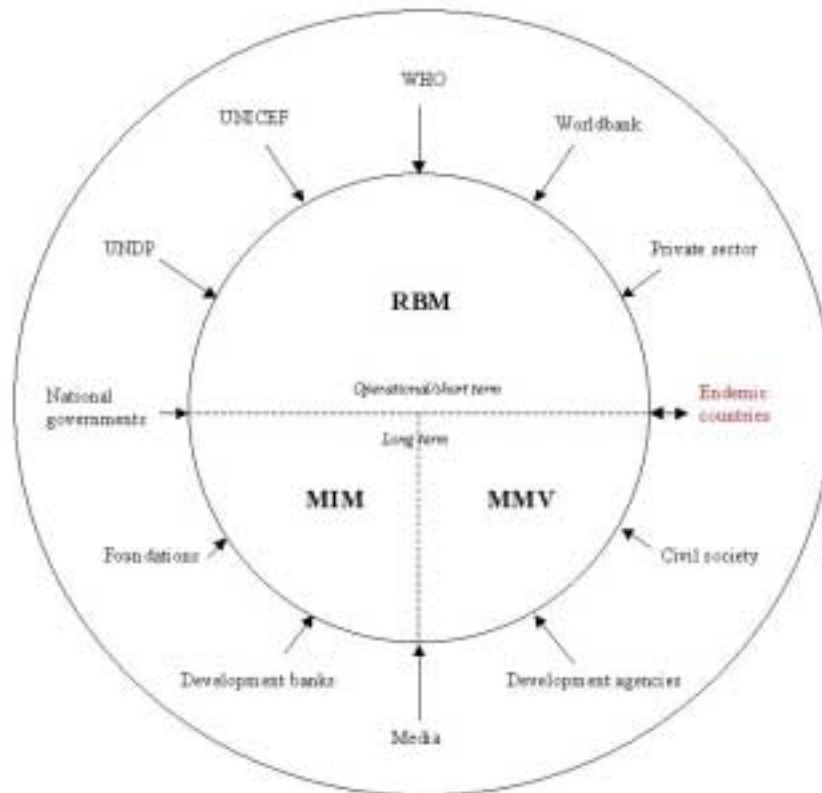
Confusion indeed.

The organigram that seems to fit the situation better is the following<sup>2</sup>:

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<sup>22</sup> That the proposed organigram is larger than previous ones, is not so much a display of misplaced arrogance on my part, but more a result of my ineptness with graphic design programs.

*Fig. 3 Alliances*



The outer circle includes the stakeholders/actors involved in malaria-related activities. The endemic countries themselves are important stakeholders themselves, therefore the inclusion of the endemic states within this circle. The double arrow flowing from the malaria-networks signifies their special status as recipients of malaria control efforts. The inner circle indicates the various networks and efforts currently in place. This list is by no means exhaustive and other initiatives can be placed within the circle on the corresponding hemisphere to indicate their operational or long-term character. As the relationships between the various networks are undefined as of yet, the lines separating them are dotted.

The network circle lies within the stakeholder circle, because most stakeholders are or will participate in most networks. RBM consists of UN specialized agencies and some of the endemic countries, but in the future other actors will be involved as well. MIM is supported by civil society, foundations, UN specialized agencies and national governments. MMV will be supported by UN specialized agencies and the private sector, and others might participate.

In these circumstances it seems more apt to talk of stakeholders forming alliances with each other on particular initiatives. RBM is just one of these networks.

### III. IMPLEMENTATION

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Perhaps the most important feature of the implementation process is the choice to pursue a sector-wide client driven approach. It is up to the governments of the malaria endemic countries to take the initiative in rolling back malaria. It is their task to come forward with a solid plan, which has to be addressed to the Worldbank. The Worldbank says in its report (Worldbank 1999: 9):

“Sector-wide approaches (SWAs) support the view that countries should set their own priorities, and fully appreciate the tradeoffs to be made across the entire health sector. This steers many aid-dependant countries away from the tradition of vertical or parallel programs, and supports the integration of “priority programs” into overall health sector development efforts.”

For this reason the RBM team is primarily committed to provide countries with the information they need to make an informed decision (J.McLaughlin). However, more support than just provision of data (information on malaria epidemiology; inputs required for alternative control) seems necessary in cases where countries are unable to effectively switch from the previously used vertical approach to a sector wide approach. The RBM team can “advise country partners on appropriate malaria indicators/objectives to incorporate into Sector Programs” and “to help countries "prioritize" a leading health problem in a manner which is consistent with aims of a single expenditure program, integration of priority programs, and local priority setting” (Worldbank 1999: 10).

Another consequence of the shift away from vertical programs to sector-wide approaches is that the role of the international community has changed: the emphasis is no longer on the provision of financial support, but rather on the provision of technical support and know-how.

Financial support is a subsidiary goal and defined as follows (Worldbank 1999: 11): “...the Bank Team has proposed that the role of RBM in mobilizing resources at country level is in:

- persuading malaria-affected countries to appropriately prioritize malaria in their own planning, budgeting and use of resources;
- providing information on effective interventions and their costs, and on international experience and lessons learned;

- ensuring that external financiers respond to country requests with sufficient resources;
- enabling countries to identify, mobilize and efficiently and effectively employ existing resources; and
- fostering communications and information exchange that will enable all countries to benefit from each other's experience, research, lessons learned, and to collaborate in areas where effectiveness and efficiency gains are possible (e.g., joint research, shared training institutions or labs, and cross-border collaboration).”

RBM will focus much more on the efficient use of existing financial resources than on the provision of new sources, although this will occur where necessary. The absence of the need for major additional funding is certain to be a beneficial factor to the longevity of the RBM partnership. The shift towards sector-wide initiatives requires organizational learning and restructuring because existing inefficiencies will be first of all more visible due to the increased cooperation between partners, and, secondly, the increased complexity of an integrated effort will exacerbate the ill-effects of such inefficiencies.

“...the lack of financial resources is not the main constraint that impedes countries malaria programs. Although the resource constraint is real (human and financial), it is often precluded and/or compounded by poor use of existing resources, e.g., under-disbursement of external financing, poor coordination of resources, unrecognized opportunities to tap into other sectors and programs, and limited appreciation for expanding the system’s capacity through the private sector (NGOs and for profit).”(Worldbank, 1999: 11).

And:

“...major improvements are now called for to strengthen the capacity for program implementation. The constraints to absorptive capacity need to be better understood, and the Bank is in a position to explore this aspect of Rolling Back Malaria. Weak implementation capacity, poorly understood systems and procedures likely combine with the human resource constraints in the public sector to produce disbursement lags or cancellations of undisbursed financing. This problem is well-known to the Bank, but also plagues other RBM partners. The Malaria Team has proposed two case studies to assess the constraints to resource flow in two or three countries.” (Worldbank 1999: 11).

The malaria control strategy used by the RBM team are those agreed upon in the World Declaration on the Control of Malaria of 1992. This entails six strategy elements (RBM, 1999: 4-6):

- effective management (risk areas are identified, public health authorities design and manage responses);
- Rapid diagnosis and treatment (accessibility of pre-packaged drugs, easy-to-use diagnostic tests);
- Multiple prevention (use of impregnated bednets<sup>3</sup>, chemical and biological control of mosquito population);
- Focused research (operational research, participation by industry)
- Well coordinated action (synchronized effort to roll back malaria);
- Dynamic Global Movement (national actions are backed by partnerships between governments, private sector, NGO's etc.)

The inception process on a country level will commence as follows: First an analysis of the malaria issues is undertaken, providing a good understanding of all concerns after which it is attempted to find examples of sustained success either within the country or outside it. The next step involves considering options for action and an identification of people and organizations most likely to be involved in rolling back malaria. It is attempted to reach consensus about the work plan. Political leaders are needed to support the endeavor. Thirdly, locating human and financial resources for the work plan. Once these are located the effort leaves its tentative phase as partnerships are created, intentions declared and plans are made. A system of monitoring and evaluating the activities completes the framework (RBM, 1999: 7-14).

The preparatory stage of RBM will be completed in December 1999. During this stage the following has been accomplished (RBM, 1999: 6):

- The launch of RBM by UNICEF,WHO, Worldbank and UNDP in October 1998;

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<sup>3</sup> The efficacy of the use of insecticide-treated nets (ITNs) in deterring malaria deaths has been demonstrated, and ITNs are now being widely promoted. Issues surrounding their availability, affordability, retreatment and use are being addressed by numerous projects, many operated by NGOs in collaboration with private manufacturers and distributors. Social marketing is being employed to foster demand for nets and insecticides. Behavior change and education strategies endeavor to ensure that households utilize available prevention measures and appropriately seek care (*Worldbank 1999: 3*). On the 8<sup>th</sup> of October in light of the conference on "Insecticide-Treated Nets in the 21st Century" a bednet program was initiated.

- Consolidation of the global partnership at the global partners meeting held in December 1998;
- Regional meetings with countries in West, East and North, Central and Southern Africa, the Mekong, Central and South Asia;
- Consensus on the RBM concept and principles among all countries in these regions

Moreover, a series of joint consultative missions was undertaken by the World Bank, WHO, and UNICEF between November '98 and March '99. They included six countries: Kenya, Uganda, Tanzania, Ethiopia, Malawi, and Mozambique. The objectives of the missions were to identify the roles of the core partners, and to acquire an overview of the country-specific and cross-country needs and opportunities for supporting a sustainable reduction in malaria.

“Mission teams comprised expertise in malaria control, health systems development, public health, and World Bank operations. Preparations and preliminary work for the missions was performed by local consultants, who also facilitated meetings with key informants, including government officials, health sector staff, researchers, NGOs, and representatives of the private sector. Feedback from country counterparts was extremely positive as regards the joint approach of the agencies involved, and they endorsed efforts to define the mechanisms of partnership within RBM.”(Worldbank, 1999: 7).

The preparatory stage is nearly over and it will be concluded with a final report. The next phase is when the actual implementation take place lasting till 2010. The plan for that period consists of the following (RBM, 1999: 7):

- initiating carefully planned processes to support consensus, establish partnerships and support effective action within malaria-affected countries;
- ensuring that country and regional offices of different partner agencies including the WHO) have the capacity to support these processes;
- arranging for countries to receive technical support, when they want and need it, in order to help develop in-country capacity to build on successes of the past and undertake appropriate action to Roll Back Malaria;
- mobilizing commitment and resources from the global partnership to help countries prepare their RBM strategies and to finance them as they move from conventional malaria control programs to Roll Back Malaria;
- implementing a global advocacy strategy for Roll Back Malaria;

- implementing systems to monitor progress- at country, regional and global level;
- further developing the global partnership at annual meetings and other events;
- making strategic investments in research and other initiatives to develop effective new products for diagnosis, treatment and prevention of malaria.

### **Analysis**

Although actual implementation has not commenced, the biggest problem facing the whole of the network is the transformation of the organizational culture away from vertical (push) initiatives toward sector-wide (pull) approaches. The problem of conducting business as used to, is found not only in organizations like the WHO, but also in the individual donor countries and their organizations and in the malaria-affected countries themselves. The success of RBM will for a great part rely on the success of transforming the WHO from within and to educate others. The question is pushed by RBM, as RBM has no separate machinery beside the secretariat in Geneva, Switzerland. Thus RBM relies very much on the regional offices of WHO that serve as the “catalytic hub” for RBM. All communication is sent to the relevant offices of the regional offices until more efficient mechanisms have been worked out (RBM, 1999: 14). This means, however, that the question of organizational culture can not be avoided.

A second problem will be the forging of effective communication between the core-members. I found the lack of communication and even simple awareness what others are doing or that they are even doing something, quite shocking. The personal ties that are now being created due to all the meetings need to be solidified into a structural format. The impact of such a development on terms of efficiency is enormous relative to the pre-RBM situation.

The choice for a client-driven approach is also a choice for pragmatism over idealism (J.McLaughlin). Sustainability can only be achieved when it has roots in the local level and thus the emphasis is on action taken by the malaria-endemic countries. This entails the possibility of having some countries participating in RBM and others not, which allows safe havens for malaria to proliferate coinciding with a continued high prevalence of malaria and malaria suffering. Whereas a more aggressive approach might reduce the number of such pockets, that will involve imposing measures on malaria-endemic countries top-down. Such initiatives are likely to detract from sustainability. RBM is designed to empower governments with the relevant knowledge allowing them to make their own decisions. The problem of

imposing measures is a matter understood by the RBM and they caution against it (J.McLaughlin).

#### IV. OUTCOME AND FUTURE PROSPECTS OF THE NETWORK

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Since the network is so young and many of the relations haven't been clarified, all predictions on the fate of the network and its potential to fulfil its goals are futile. Nonetheless, it is possible to make some comments on the principles of the network and its general framework, which for our purpose is quite relevant.

The adaptation of the "comparative advantage" doctrine is very sensible. The UN specialized agencies were set up to fulfil specialized tasks thus embodying this principle. It is likely that the lack of communication between agencies has reduced reliance on this principle and caused agencies to take on tasks in which they hold no particular advantage or resulted simply in tasks not being undertaken at all. The question has emerged whether the WHO is the right organization to launch RBM. That comment explains much about the previous practices of the WHO and IGOs in general. The answer is that the WHO is the right actor to do this job, because they have the know-how and mechanisms to do this and secondly, because it is their mandate.

The "comparative advantage" principle will galvanize the system of the UN specialized agencies. It will increase efficiency (provided that institutional links are strengthened and activated) and it will increase the legitimacy of these agencies vis-à-vis non-UN specialized agencies and among each other. The RBM team has been wise not to include hard, discreet divisions of labor. Even though theoretically this might have maximized efficiency, such an approach will easily be perverted into turf battles between organizations.

The application of this principle, the switch to sector-wide approaches and the renewed need for cross-organizational, cross-public/private sector communications will require a lot of organizational learning and a change in organizational cultures. This will not be easy, and it is not something that can be realized within a short period of time. It is a process that will be fueled from the bottom-up, from the operational side. It is at the operational side of the endeavor where people meet each other and creatively solve problems, building an ever-tighter community. RBM presents ample opportunity for this to happen.

This is probably also a reason why the network so far can be characterized as uncontentious. The segments of the scientific community in these various organizations are in constant contact through Internet, meetings and projects, making the probability high that similar norms have developed. It is an empirical matter whether this community fits the

definition of an epistemic community<sup>4</sup>, but there exists a definite consensus on the principles that ought to underlie a malaria control effort. Of course the network is young and undefined, the implementation not yet commenced, so there remains a chance that the network might acquire a more contentious character, but I deem this chance to be low.

One potential obstacle that can undermine all the previous successes will be the question of who gets the credit. It will be essential to give due credit in order to maintain commitment to this cooperation. This is a legitimate need and requirement of organizations as their stakeholders wish to see results of some sort. In the case of the core-actors, the WHO will almost automatically be credited with successes (or mistakes) because it is visible and because preconceptions have been built up (J.McLaughlin). It will be very important for the sustainability that the WHO will not usurp the credit for possible success. Moreover, the interaction with the media will be critical in redefining peoples' perceptions of organizations and their tasks and goals.

Nonetheless, the whole approach of RBM is geared to sustainability. It is quite possible that the partnership might survive long enough for it to raise efficacy sufficient enough to reach its goals by 2010.

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<sup>4</sup> See P. Haas, *Introduction: epistemic communities and international policy coordination* in *International Organization* 46, 1, 1992. pp. 3. Defined as “a network of professionals with recognized expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain or issue-area”.

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