RISKY REMEDIES FOR THE HEALTH OF THE POOR

GLOBAL PUBLIC-PRIVATE INITIATIVES IN HEALTH

Report on the implementation of four GPPIs in five African countries and three Indian states

May 2005

Health wemos for All

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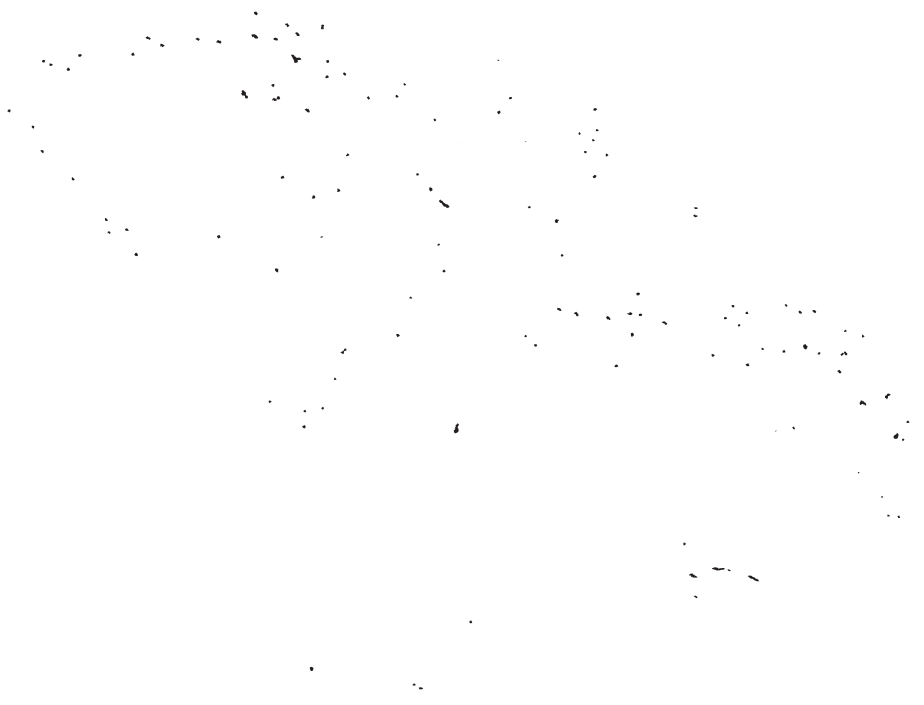




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Abbreviations

CDC	Centers for Disease Control and Prevention
CIS	Commonwealth of Independent States
CMH	Commission on Macroeconomics and Health
CSO	Civil Service Organisation
DALYS	Disability-Affected Life Years
DFID	UK Department for International Development
DHMT	District Health Management Team
DOTS	Directly Observed Therapy Short-Course Strategy
EMEC	Expanded Mectizan Expert Committee
GAELF	Global Alliance to Eliminate Lymphatic Filariasis
GDP	Gross Domestic Product
GNP	Gross National Product
GPEI	Global Polio Eradication Initiative
GPPIH	Global Public-Private Initiative in Health
GPPI	Global Public-Private Initiative
GSK	GlaxoSmithKline
HDI	Human Development Index
HIPC	Highly Indebted Poor Countries
IUATLD	International Union for TB and Lung Diseases
KNCV	Royal Netherlands Tuberculosis Foundation (KNCV Tuberculosis Foundation)
LF	Lymphatic filariasis
MDG	Millennium Development Goal
MDR	Multi-Drug Resistant
MoH	Ministry of Health
NFCP	National Filaria Control Programme
NGO	Non-Governmental Organisation
NIDs	National Immunisation Days
NTF – ELF	National Task Force for Elimination of Lymphatic Filariasis
OECD	Organization for Economic Cooperation and Development
PELF	Program to Eliminate Lymphatic Filariasis
PHC	Primary Health Care
RBM	Roll Back Malaria
SNIDs	Sub-National Immunisation Days
STB	Stop TB
STBPS	Stop TB Partnership Secretariat
TB	Tuberculosis
UN	United Nations
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization

Terms and concepts

The right to health (UN CESCR 2000)

'…an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and drinkable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.'

Key elements of the right to health (UN CESCR 2000)

(a) *Availability.* Functioning public health and health care facilities, goods and services as well as programmes are available in sufficient quantities.

(b) *Accessibility.* Health facilities, goods and services and information are physically, non-discriminatorily and economically accessible.

(c) *Acceptability.* All health facilities, goods and services respect medical ethics and are culturally appropriate as well as being designed to respect confidentiality and improve the health status of those concerned.

(d) *Quality.* As well as being culturally acceptable, health facilities, goods and services are scientifically and medically appropriate and of good quality.

In its Comment No. 14, the Committee on Economical, Social and Cultural Rights (CESCR) states that it 'interprets the right to health, as defined in article 12.1 of the International CESCR, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.'

Definitions of other terms used in the case studies:

Discussions with organisations participating in this study also resulted in the use of additional criteria for assessing the GPPIs' programmes at country level, depending on the availability of data and the possibility of collecting reliable information.

Participation

The opportunities offered by GPPI-specific programmes for participation, promotion and achievement of participation and related mechanisms and the opportunities for target groups to influence decision-making processes. Relevant to this are the content and significance of the decisions in which the recipient countries and target groups are allowed to participate.

Sustainability

The capacity of a health system to function effectively and to continue initiated activities and programmes over time with a minimum of external input.

Equity

The resolution of inequalities that are unnecessary, avoidable and unjust. Equity specifically targets those groups that are socially underprivileged or disadvantaged so they can better achieve their full health potential, as indicated by the health standards among most advantaged groups in society. Equity refers to fairness and social justice in the distribution of health resources among different individuals or groups.

Integral approach
An approach by the health sector to health problems taken in cooperation with other sectors so that proper solutions can be found for those determinants of health problems that lay outside the scope of the health sector.

Health system
All the activities whose primary purpose is to promote, restore or maintain health (WHO, 2000).

Transparency
The following key information is clearly provided, accessible, described, and easy to trace by any party:
- The decision-making mechanisms of a public health programme, both on national and international levels;
- The rationale and motives on which the policy of a health programme is based;
- Complete financial information related to the implementation of public health programmes;
- The organisational and operational structures and the mechanism of implementation of a health programme – mechanisms of financing, planning, implementation, monitoring and evaluation, including updated information about the advances in the implementation of a health programme.

Accountability
In order to be held accountable for their decisions, the responsible institutions, organisational structures and persons in charge of decision-making, planning, implementation and monitoring of health programmes at local, national and international levels are able and willing to make public all information – both operational and financial – about decisions and actions.

Effectiveness
Health programmes achieve the anticipated goals and targets concerning an identified social group or geographical region within a specified period of time. The population for whom these services are intended is satisfied with the activities of the programme.

Governance
The way in which a society or institution 'directs' itself. At the moment no consensus has been reached on how to make this concept operative. As has been suggested by some authors (Buse 2004), in the case of the GPPIs this concept embraces the elements described above: legitimacy, or the extent to which its authority is considered valid by those affected by it; participation, or representation in decision-making; accountability, or the extent to which those with authority can be held responsible for their decisions and actions; and transparency, efficiency and sustainability.

- UN Committee on Economic, Social and Cultural Rights (2000), 'The right to the highest attainable standard of health', CESCR General Comment No. 14.
- World Health Organization (WHO) (2000), World Health Report 2000: Health Systems: Improving Performance, Geneva.
- Buse, K. (2004) 'Governing Public-Private Infectious Disease Partnerships', Brown Journal of World Affairs, Winter/Spring 2004, Vol X, Issue 2.

Executive summary

Enormous changes are taking place in international health. The gap between rich and poor is growing at both national and international levels, resources for health are shrinking in many poor countries and nation states are playing ever smaller roles. The UN, along with other multilateral institutions and major donors, looked for solutions to the problems of a decreasing budget, increasing poverty and a growing perception among donor countries that the UN is ineffective. They began to include private-sector partners, who were experiencing incredible economic growth, increasing influence on policy issues and were willing to demonstrate their commitment to improve their corporate social responsibility (CSR). This is how the public-private partnership paradigm was born at a global level – what are known as Global Public Private Partnerships (GPPIs) – and they began to multiply rapidly. It has been argued that these collaborations will help create more financial and material resources and political support for health care.

Wemos and other civil society organisations (CSOs) have observed the growing importance of GPPIs as instruments for tackling the health problems of immense portions of the world's population. We were concerned about the manner in which they approached health problems, the way programmes were implemented and the role private entities played in these. As a result, Wemos decided to promote carrying out case studies aimed at better understanding the way these initiatives work at field level and their effects on local health systems.

The GPPIs selected for study were Roll Back Malaria (RBM), the Global Alliance to Eliminate Lymphatic Filariasis (GAELF), Stop TB and the Global Polio Eradication Initiative (GPEI). These GPPIs fit into the following categories according to the type of approach they use: improving access to health products, global coordination mechanisms and public advocacy. The WHO acts as secretariat for all these initiatives, and target countries are responsible for their implementation with the assistance of the WHO, UNICEF and non-governmental organisations.

Wemos is an organisation working for a world in which every person can exercise his or her right to health by influencing actors' international policies at different levels. Wemos collaborates closely with organisations in Southern countries with the aim of strengthening their capacities for influencing policies in their own fields of operation. In this instance, the case studies were used as instruments to enhance the capacities of all participating organisations.

The studies on RBM were undertaken by Ifakara Health Research and Development Centre and People's Health Movement in Tanzania, Joint Medical Store in Uganda and Chessore in Zambia. The studies on GAELF were carried out by Consumers Information Network in Kenya, and by Prepare–Test Foundation in Tamil Nadu and Community Health Cell in Karnataka, both in India. Health System Trust performed the study on Stop TB in South Africa and West Bengal Voluntary Health Association carried out the case study on GPEI in West Bengal, India.

Global Public-Private Initiatives in health

GPPIs have experienced incredible growth over the past five years and now number more than 80 worldwide. These GPPIs, which often are focussed on one specific disease or medical product, cover a number of poverty-related and communicable diseases, including blindness, Chagas disease, dengue fever, guinea worm disease, HIV/AIDS, vaccine-preventable diseases, leprosy, lymphatic filariasis, malaria, meningitis, polio, TB, and vitamin A deficiency to name but a few.

Although GPPIs are implemented globally, target countries are mostly low- and medium-income countries. Most target countries are in Africa. However, the concentration of large numbers of GPPIs in certain countries does not necessarily imply that these GPPIs collaborate with each other or harmonise their work at country level. In fact, each GPPI looks for distinct channels for implementing its own activities.

Almost all GPPI secretariats are located in Northern countries. Beneficiary countries have to meet a series of criteria specific to each GPPI regarding epidemiological profiles, geographical aspects, gravity of the health problems focussed on by the GPPIs and economic status. Some GPPIs, especially those donating drugs, apply restrictions for donations according to the economic level of the target countries.

GPPIs are structured and implemented in many ways. At the moment there is no generally accepted definition of this phenomenon, or of the concepts related to organisational and operational elements. Many authors have proposed typologies that can be used to classify GPPIs. The following are descriptions of two of these main categories: a) the type of relationship between the participating organisations and institutional forms in which these relations take place (in particular the private sector in relation to the public sector), and b) the type of approach employed. This refers to the type of delivered service and the sort of objectives pursued.

At the moment there are no standards for monitoring each partner within an overall initiative to ensure that the goals of an individual partner do not supersede the goals and objectives of the GPPI. This point highlights the vulnerability of GPPIs to the agendas of individual partners or group of partners who have the authority to set conditions for providing their resources, whether products, services or finances for the partnership.

A key risk in GPPIs is the governance arrangement. This can potentially have a great impact on decision-making in the public sector. By bringing together corporations, civil societies and government, a GPPI is in effect trying to mesh very different types of ethos, values and principles in the provision of health services. The organisations participating in this report and as well as others are greatly concerned that GPPIs do not have a clear definition as to what constitutes a partner or member. Others authors have reported gross under-representation of Southern stakeholders in the governance arrangements of GPPIs.

Global Alliance to Eliminate Lymphatic Filariasis – GAELF

In 1997, the World Health Assembly adopted a resolution calling for the elimination of lymphatic filariasis as a global public health problem. The Global Alliance to Eliminate Lymphatic Filariasis (GAELF) was officially launched in 2000. GAELF's objective is to eliminate lymphatic filariasis by 2020 by interrupting transmission of infection and alleviating and preventing the suffering and disability caused by the disease. In 1998, the pharmaceutical company GlaxoSmithKline (GSK) agreed to donate as much of its drug albendazole as the WHO's LF programme required. In 1999, Merck & Co. decided to donate its drug Mectizan® free of charge and as long as necessary.

The strategy is to interrupt transmission of LF by mass drug administration (MDA) to the entire population at risk of infection for a period of at least five years. This period corresponds to the reproductive lifespan of the parasite. There are three drugs that can be used to treat LF: albendazole, Mectizan® (ivermectin) and diethylcarbamazine citrate (DEC). They need to be administrated only once a year for this purpose; the combination of two different drugs may enhance the effectiveness of the treatment.

The main partners of GAELF include the WHO, GlaxoSmithKline, Merck (which participates in GAELF through the Mectizan® Donation Programme, a separate GPPI), UNICEF, the Liverpool School for Tropical Medicine, Emory University in Atlanta, the Arab Fund for Economic and Social Development, the Gates Foundation, the World Bank, the ministries of health in endemic countries and donor governments.

Programme costs are expected to rise from nearly US$30 million in 2003 to US$50 million in 2005, and will continue to rise at this pace for several years. Currently available external support is falling far short of the required amounts, leaving a financing gap of US$20 million in 2003, which may increase to US$40 million in 2005.

Conclusions on GAELF based on case studies

Three case studies were carried out: in the two Indian states of Tamil Nadu (where MDA is being implemented in six districts according to the GAELF strategy) and in Karnataka (where MDA is limited to DEC), and in Kenya (in the three districts of Kwale, Malindi and Kilifi, where the GAELF programme is being implemented). The following conclusions were reached:

- GAELF has made it possible for countries to revitalise their programmes for the elimination of the disease and increasing awareness about its incidence and burden. It did so by advocating for action to eliminate the disease, giving technical and financial assistance and supplying drugs for the implementation of programmes.
- The implementation of GAELF activities for tackling lymphatic filariasis using MDA has resulted in increases in the number of people receiving drugs to eliminate this. In the cases of Kenya and the districts taking part in GAELF in Tamil Nadu, India, the studies found that the coverage of persons receiving the drugs is higher than the percentage technically required to eliminate the disease within the given period. Even so, the information available refers only to coverage of people to whom the drugs were handed out, and not to its actual intake.
- Lymphatic filariasis elimination by means of MDA necessitates the employment of a large number of community health workers (CHWs) to distribute and supervise the correct ingestion of drugs and advise the users on adverse reactions. In the cases reported here, these activities were not implemented satisfactorily. For instance, in the case of Tamil Nadu, the actual and correct intake of the distributed drugs cannot be entirely guaranteed due to the lack of follow-up and supervision at household level by community health workers, and this jeopardises the efficacy of the programme. The main reason for this was that these massive operations require skilled staff at the right time and well-organised planning and supervision capacity at district level – critical issues in many rural areas.
- The treatment of disabilities that result from the disease is included in the GAELF programme objectives as an integral part of an intervention for tackling lymphatic filariasis. The case studies in India and Kenya showed that this component of the initiative is not being properly implemented in the areas where the programme is active, and is sometimes not implemented at all. This is an important omission because of the serious economic and social effects of this physical impairment.
- The initiative does not consider actions directed at tackling the underlying causes of the disease, such as lack of safe water, adequate housing and sanitation. The inclusion of preventive actions in inter-sectoral collaboration for dealing with these matters would make GAELF intervention more coherent, seeing that its programme is directed mainly at deprived socioeconomic groups where lack of these basic facilities is very common. This would also contribute to broader development goals such as poverty eradication.
- In the countries where the case studies took place, LF control activities had previously been closely related to the control of other vector–related diseases like malaria. The case studies found that GAELF activities are not collaborating with these important programmes.
- MDA programmes require the concentration of huge numbers of competent health workers for certain periods of time. Most of the places where GAELF initiative activities were implemented were located in deprived areas in poor countries that frequently lacked qualified personnel and sufficient equipment. During an MDA activity these weak health services are overwhelmed with extra activities. This causes disruption of the normal activities in these health services, in any case before and during the MDA campaigns.
- The studies raised the issue of the use of albendazole as a part of the approach to eliminate the disease. At the moment no conclusive evidence has been found that strongly confirms the use of this drug for the elimination of LF. Moreover, the use of albendazole requires the systematic implementation of preventive measures to avoid teratogenic effects of the drug when it is used by women who might be pregnant. The studies in India and Kenya showed that at this moment the local health systems are not able to perform these preventive measures properly due to a structural lack of human and material resources. This leads to unnecessary risks for pregnant women and their unborn children.

- The programme is based heavily on donations from two powerful pharmaceutical corporations that are committed to long-term delivery of the drugs needed. This assures provision of the drugs needed to eliminate the disease but at the same time makes the initiative and the countries very dependent on these companies for completing the initiative.
- In India, where the generic type of albendazole is produced, the donation impairs the local pharmaceutical market in the short and long term, creating a negative effect on the sustainability of the programme.
- At the time of this study, the significant shortage of funds to continue implementing the programme together with the secondary priority given to eliminating the disease (most likely related to major priorities as HIV/AIDS, malaria and tuberculosis) created uncertainty about the future progress of the initiative. In the case of Kenya, the national structure in charge of the initiative's implementation in the country is finding it very difficult to keep up the continuity and progression of the activities because of a shortage of external funding together with limited resources provided for new activities by the national government.

Roll Back Malaria – RBM

The WHO launched the Roll Back Malaria (RBM) Partnership in November 1998. The partnership has a global coordinating function and provides technical guidance for the fight against malaria. By 2010, the partnership aims to reduce the burden of malaria by half.

An independent evaluation of the RBM partnership in 2002 concluded there had been major accomplishments: in advocacy, indicated by an increase in global awareness of the problem; in resource mobilisation, indicated by a large increase in global spending and in consensus-building, indicated by an agreement on priority interventions and common targets. The evaluation also pointed out that RBM had given inconsistent technical advice to malaria-endemic countries.

The RBM campaign consists of six key elements: effective treatment, rapid diagnosis and treatment, multiple prevention, focused research, well-coordinated movement and dynamic global partnership. The RBM principles are usually integrated into national malaria control programmes and it usually supports governments in applying for funds from the Global Fund.

RBM has four founding members: the WHO, UNICEF, UNDP and the World Bank. The WHO plays a central role in the partnership – it is represented on the board and is a voting member.

In general, private companies do not contribute directly to the RBM Partnership, but to separate, associated GPPIs. Novartis provides its antimalarial drug Coartem® for use in the public sector at reduced cost through the WHO-Novartis Coartem® partnership. Various companies, including Novartis, Bayer and GSK are involved in the Medicines for Malaria Venture (MMV) for the development of new antimalarial drugs. Bayer supports the expansion of insecticide-treated bed nets through Netmark Plus, and coordinates the bed net distribution logistics.

The RBM partnership has created a large demand for artemisinin-based combination therapy (ACT). These are relatively new medicines, protected by patents that allow the companies that developed them to recover their Research & Development (R&D) costs and to make high profits. Current manufacturers of ACTs and artemisinin-based components of ACTs include Novartis and Sanofi Aventis. Although the RBM decided that a 'promise to buy' could bridge the gap between the quantity of ACTs required to meet the RBM's targets and the quantity produced by the pharmaceutical companies, at present prices are increasing and the demand has not been met.

Initially, RBM was loosely structured in order to increase flexibility and avoid a high management burden. After an independent evaluation of the partnership in late 2002, the RBM initiative was restructured to make partners more accountable and to accelerate malaria control programmes.

Major funding for RBM activities comes from donor governments, the Gates Foundation, UNICEF, the World Bank and the WHO. More recently, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has become a major donor and committed US$895 million over two years, considerably increasing malaria budgets. However, some point out that funds for malaria control are still largely insufficient. The problem of funding is critical. It is estimated that the total international aid for malaria control in 2000 was just US$100 million, and it has been calculated that US$1 billion per year would only pay for artemisinin-based combination therapies for around 60% of those who need it.

Conclusions on RBM based on case studies

The studies were carried out in three African countries: in Tanzania the study took place in Bagamoyo district, in Uganda in the Kampala and Wakiso districts and in Zambia in Chama, Chingola and Chipata districts and an area in Lusaka. The studies led to the following conclusions:

- The Roll Back Malaria strategy is comprehensive, but what countries are actually doing can be confined to three aspects: improving the availability and use of treatment, improving availability and use of insecticide-treated nets (ITNs), especially for children and women, and providing intermittent presumptive treatment to pregnant women. At the Abuja summit on malaria in 2000, all participating countries agreed 60% of the target groups would be covered by these interventions by 2005. The studies in the three sub-Saharan African countries presented in this document show that the Abuja coverage targets will not be achieved in any of these countries. In two of the three countries, health workers and officials stated that in fact the incidence of malaria has increased over the past few years. This raises questions on the suitability of the strategy and the way it is being implemented within a context of extreme poverty and collapsing health systems. In addition, it is generally recognised that the financial resources currently available for malaria control are insignificant when compared to what is actually needed.
- In the three countries, the general opinion was that the availability of ITNs has increased, particularly in urban areas, but also that many more nets are needed. The three countries are trying different schemes for subsidising the acquisition of nets and promoting the participation of the private sector in their delivery. The main obstacle is that most people cannot afford to buy the nets, subsidised or not. In the case of Tanzania, distribution through private retailers has made the process more difficult, particularly because of the inability of the public authorities to supervise and regulate those sellers. In the three countries, the intention is to create a sustained demand of nets. This will probably take many years, and does not take into account that many people simply cannot afford the nets, which costs thousands of lives. The first question that arises is: why aren't the nets given away free of charge? Although this would not be the entire solution to the problem, it would have a strong preventive effect. Also, it is cheaper to give away nets than to give away drugs using scarce Global Fund resources, and the drugs are also steadily becoming more expensive.
- At the time of the studies, the situation with regard to the availability and delivery of effective treatment was at different stages in the three countries:
  - In Tanzania, treatment with sulfadoxine-pyrimethamine (SP) as a first-line drug was not being implemented effectively. At that moment there were plans to introduce Coartem® with the assistance of the Global Fund.
  - Uganda was waiting to receive funds for the introduction of Coartem®. The drugs used for presumptive treatment were not effective because of a high degree of resistance.
  - Zambia was found to be at a later stage of introducing Coartem® as first-line treatment, again with funding from the Global Fund.

  The introduction of ACT - Coartem® is a matter of concern due to the high price of the drug and the fact that the quantities currently being produced are not sufficient to meet the increasing demand.
- In all three countries, little attention was given to vector control activities, though in Zambia health workers and district officials strongly recommended it as complementary to the use of ITNs.
- In the three countries, although malaria activities were coordinated by the national control programmes, funds from foreign donors were channelled to the district level (in two cases through

basket funds). National coordination mechanisms existed in the countries in which the donors participated. Even so, coordination with the national government and between donors did not always go smoothly. Some donors support only specific components of the programme, creating difficulties for the health officials. In Tanzania it was found that one district had as many as seven different donors funding five different interventions for different diseases – such as the malaria initiative – and each one required different reporting and monitoring procedures. The argument that coordination and integration of different vertical programmes is taking place at local level could not be demonstrated in the areas where the case studies took place – not even in Uganda, where the malaria programme has appointed a focal person in each district.

- In all three countries there was a constant lack of qualified human resources at different levels; invariably there was also found to be a lack of proper health facilities and sufficient equipment. In addition, health workers stated that programmes like the one on malaria bring with them extra activities that come on top of the workload of understaffed health services with inadequate resources. In-service training activities related to malaria were also infrequent, and restricted to instructions for carrying out concrete activities.
- Participation of lower levels in decision-making about matters that concerned them was a bottleneck, and officials at central level complained of a lack of flexibility by donors. This creates a lack of commitment by health workers and sometimes has clear consequences for the implementation of activities. For instance in Zambia, the supplies were not delivered in time to deal with seasonal variations of malaria because the local health workers were not consulted in planning the drug supply to the districts.

Stop Tuberculosis – Stop TB

The WHO established the Stop TB Partnership in November 1998 as a broad-based social movement to fight tuberculosis. This resulted from recognising the toll taken by TB – every year 2 million people die of the disease, even though it is both treatable and preventable.

In 2001, the partnership launched the Global Plan to Stop TB, a strategic plan shared by all partners. It aims to cut the global TB burden in half by 2010 (relative to 2000 levels), and sets targets with required inputs and measurable outcomes. The most important global targets are detecting 70% of people with infectious TB and curing 85% of those detected by 2005. For treating TB, the directly observed treatment, short-course (DOTS) programme is recommended. DOTS expansion and the introduction of DOTS programmes where they are not yet implemented form an important part of the Stop TB strategy. The Stop TB Partnership also provides first-line TB treatments to developing countries through the Global Drug Facility (GDF).

As of the end of 2003 there were over 300 partners involved with the Stop TB Partnership. The main partners are: UN organisations such as the WHO and UNICEF, private organisations such as the Rockefeller foundation, NGOs such as the KNCV Tuberculosis Foundation (KNCV), donor governments and pharmaceutical companies. The WHO provides guidance on global policy, a representative to the Stop TB Coordinating Board, and the management framework for the Stop TB Partnership Secretariat (STBPS). Companies involved with the Stop TB Partnership include Aventis, Novartis and Eli Lilly. In general, companies do not contribute directly to the core operations of the Stop TB Partnership, but provide their support through various working groups of the partnership. As the Stop TB Partnership is not a legal entity, company contributions are formally made to national partnerships, governments, the WHO or other Stop TB partners, not to the global partnership as a whole.

Major donors for the programme are governments, multilateral organisations like the World Bank, the WHO and foundations. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has become a major external donor for TB control. It has approved over US$1 billion in grants for TB and TB/HIV control for a five-year period. For the five-year period 2001-2005, the total estimated costs of the Global Plan to Stop TB are US$9.1 billion. Roughly half of these costs (US$ 4.5 billion) are for DOTS

expansion in high-burden countries. The majority of the costs for DOTS expansion are borne by the countries themselves. Resources for implementing the Global Plan to Stop TB have been falling short and competition for donor funds for public health is increasing.

Conclusions on Stop TB based on the case study

The case study on Stop TB was carried out in South Africa and resulted in the following conclusions:

- In South Africa, TB remains one of the major causes of mortality, particularly among the black and coloured population. The initiative seems to have an indirect influence in the country; at the international level, coordinating the approach of different partners like adoption of the DOTS strategy and in the emergence of public-private partnerships in TB control.
- The South African National Tuberculosis Control Programme (NCTP) has made progress: DOTS coverage has been expanded to almost all districts in the country and policies, guidelines and monitoring tools are in place. However, the programme is far below its cure rate target, which is similar to that for Stop TB. The reasons for this are a lack of skilled and motivated staff at district level, a lack of management capacity and a lack of financial and logistical resources. Nevertheless, the influence of the HIV epidemic has had a strong effect on the programme because of the high incidence of coexistence of both diseases.
- The study in South Africa revealed that both the formal and informal leadership of Stop TB in the country is not strong enough. Many people working in TB don't understand the partnership, and some NGOs listed as partners indicate there is little added value from its participation in the partnership.
- Until inequities, the staffing crisis and the housing and nutritional needs in South Africa are addressed, TB control will continue to take place in an environment that is hostile and antithetical to an integrated approach to the problem.
- An external evaluation carried out in 2003 indicated that much more would have to be done to reach the agreed targets for 2005, and these will probably not be met. For instance, in March 2004 the WHO estimated that only 27% of people with infectious TB were being treated in DOTS programmes and that unless there were a rapid acceleration of DOTS expansion, the global targets for 2005 would not be met until 2013. At the same time Stop TB is dealing with a considerable shortage of financial resources even though the Global Fund supports its plan. This funding problem is exacerbated by an apparent competition with other global initiatives for donor funds.

Global Polio Eradication Initiative – GPEI

The global goal to eradicate polio was approved in a 1988 vote by the World Health Assembly (WHA). The objective of the Global Polio Eradication Initiative (GPEI) is to ensure that wild poliovirus transmission is interrupted globally through coordinated national and international action, that the full humanitarian and economic benefits of eradication are realised, and that the lessons and infrastructure from its implementation are utilised in strengthening health systems and control of other important diseases.

The key to the strategy is MDA – including high infant immunisation coverage with four doses of oral polio vaccine (OPV) in the first year of life – routine immunisation with OPV, National Immunisation Days (NIDs) to provide supplementary doses of OPV to all children under five years of age, surveillance for wild poliovirus and targeted 'mop-up' campaigns once transmission has been limited to a specific area.

The final stage of polio eradication has proved to be extremely difficult and costs have increased much more than initially expected. This has resulted in a substantial funding gap for GPEI, forcing a scaling back of eradication activities in 2003. In January 2005 the WHO reported an escalation of a poliomyelitis outbreak in Sudan, which indicates that the goal of ending polio transmission by 2005 has not been met.

The GPEI has four spearheading partners: the WHO, Rotary International, the Centers for Disease Control and Prevention (CDC) and UNICEF. The WHO is the lead organisation, and provides the overall technical direction and strategic planning for management and coordination. There is no formal agreement concerning the responsibilities of the partners.

The GPEI funding requirements for 2004-2005 have been estimated at US$765 million for two years. As of December 2003, confirmed and projected contributions up to 2005 totalled US$635 million, leaving a funding gap of US$130 million.

Conclusions on GPEI based on the study

The following conclusions were reached based on a case study conducted in India in the state of West Bengal in selected units in Murshidabad district (one of the districts where polio cases were confirmed in 2002 and 2003):

- GPEI was one of first GPPIs launched, and it is generally recognised that the initiative has been highly successful, achieving the eradication of polio in 99.9% of the world in about 16 years of activity. These outstanding results are very important, particularly because polio has long-term consequences for children suffering from the disease. To a great extent, GPEI owes its success to the strong support of Rotary International at all levels: from the community level in carrying out vaccinations to the top level of lobbying and raising funds for the initiative.
- In the case of India, the eradication of polio has been problematic over the last several years, although the number of cases has steadily diminished (with the exception of 2002, when a high upsurge took place). In 2003, the number of cases slowed again, but a few cases were found in states that had been known to be polio-free for many years.
- In Murshidabad, West Bengal, where the case study presented here took place, 30 polio cases were identified in the period from April 2002 to March 2003. Although the reasons are difficult to discern, this upsurge can be brought into perspective by a combination of the following reasons: people's misconceptions about the vaccine, lack of information, boycott of the immunisation activities by different social groups, fatigue of local health workers, people's dissatisfaction with the quality of health services received during the polio immunisation and to some failures in maintaining the cold chain properly. It is important to mention that accessibility to immunisation plays a role in only a few cases.
- With the available figures based only on expected achievement, the study showed that in 2004, polio and DPT had similar coverage rates (above 90%), rates that are significantly higher than other vaccines like measles. The figures also show that in Murshidabad the coverage is higher with all vaccines, probably because of the high priority given to the district after the outbreak of polio in 2002.
- People in communities where the study took place were not well informed about the causes of polio, particularly in relation to drinking water and sanitation. This is an important issue, particularly in an area where more than 70% of the population is living in extreme poverty, there are high levels of illiteracy, people lack access to good-quality drinking water and sanitary facilities are almost nonexistent in many places. When the research team discussed the issue with a health official, he claimed that giving that information could lead to people demanding these facilities, while the administration is not equipped to provide them on a large scale.
- The polio immunisation programme campaigns in Murshidabad have had mixed effects on the local health system. The programme has made coordination with other sectors and local authorities possible in order to achieve the immunisation activities. At the same time, it has affected the delivery of all other health services, particularly while conducting the NIDs (national immunisation days): all personnel and health service resources are concentrated on the immunisation activities for periods of around 15 days, to the detriment of the normal health activities. This last point takes on more importance in areas where public health facilities have poor infrastructure, lack drugs and deliver only a very limited number of services in an irregular manner. This means that many people look for alternative health services when necessary.

General conclusions and recommendations

GPPIs are complex and very diverse entities, acting at different levels and operating within diverse contexts. This makes formulating comparisons between them difficult and irrelevant. This diversity also imposes limits on reaching concrete conclusions valid to them all. However, considering the scope and limitations of this report, some general conclusions can be drawn:

- The Global Public Private Initiatives in health covered in this report are of the following two types: 'improving access to health products' and 'global coordination mechanisms and public advocacy' and are all aimed at poverty-related diseases. The studies found that these initiatives have increased the attention for the health problems they focus on, both at national and international levels, as well as having made improvements to the availability of financial resources, health products and supplies focussed on these diseases.

Contribution to poverty alleviation

- The studies showed that these initiatives do not make significant efforts to approach these poverty-related health problems with a focus on equity and integration. These global initiatives could make valuable contributions to tackling the causal conditions that are at the root of the current serious situation. The way they operate now raises concerns about the suitability of GPPIs to make significant contributions to sustainable improvement of health problems in poor countries and the attainment of the MDGs.

  The organisations participating in the case studies presented here recommend that GPPIs working on poverty-related diseases integrate with and make a clear contribution to global and national strategies and plans for poverty eradication. Donor countries need to thoroughly assess what these initiatives actually contribute to inter-sectoral plans for improving the basic living conditions of the target groups and, if necessary, consider possible alternatives that are more likely to achieve this.

Investing in local health systems

- The GPPIs included in this study contribute too little to strengthening local public health systems, particularly at the lower levels of the systems. Even though the objectives of some initiatives state this, the studies found very little evidence this is happening. Most studies showed that the activities promoted by the GPPIs took place within rather weak, understaffed and under-resourced existing national and local health systems, which are the main source of health services for the poor. There was no evidence that the GPPIs promoted or supported significant investments to improve these institutional settings and structures, and the effect has frequently been that the GPPIs' activities strained precarious local health systems and diverted human and other resources from their normal activities. When participation by private-sector providers was promoted within the framework of a GPPI programme it proved to be problematic, mainly because of the lack of regulation mechanisms. These aspects were considered by national and local actors to be critical reasons why the achievements of the GPPI programmes were low in terms of their own proposed targets.

  Therefore, we recommend that GPPIs like those studied here make significant investments to strengthening national public health systems, particularly in the aspects of training and retention of staff, management and information systems and equipment and infrastructure (especially at district and sub-district levels). Also, careful regulation is needed when private providers are involved in the health care activities within the framework of the GPPIs' programmes.

Harmonisation

- The studies found no concrete examples of ways in which different GPPIs active in the same country attempted to harmonise with each other to a great degree, or even just to integrate some activities. This was not the case even when the programmes of two different GPPIs came under related national structures, like those for vector-control diseases. These studies did not confirm the

argument that the integration of activities from different programmes naturally occurs at district level. Observations by and opinions of local health workers indicate that the activities of different initiatives – promoted through the same mechanisms and structures as other existing vertical programmes – tend to compete with each other, which in turn tends to fragment and overwhelm the local health systems. This impairs the capacity of the local health systems and diminishes the probability that each initiative will achieve sustainable health improvements for the target population.

We recommend that the WHO, which plays a key role in the decision-making mechanisms of the existing initiatives, take active steps to harmonise the programmes of the different GPPIs, first at global and then at country levels. The WHO should call a halt to the creation of and its participation in new GPPIs of the sort covered in this report until an appropriate mechanism has been established to assure harmonisation among different initiatives at global and country levels. This will increase the impact of the existing initiatives and avoid further fragmentation of the already weak health systems in most recipient countries. At country level, the WHO plays a critical role in supporting national governments to take leadership roles in various vertical programmes and bring them into alignment with national priorities.

Sustainability

- As this report was being completed, all four GPPIs considered here were experiencing serious funding shortages for accomplishing their original plans. Two of these initiatives started to rely on the Global Fund for Tuberculosis, Aids and Malaria for financing the action plans of countries participating in its programmes. The studies at national level found that in the case of GAELF and RBM, some activities were experiencing delays and in some cases the action plans were not being funded completely. In the case of GPEI, the global programme reported that in 2003 some activities were not implemented because of the lack of funds.

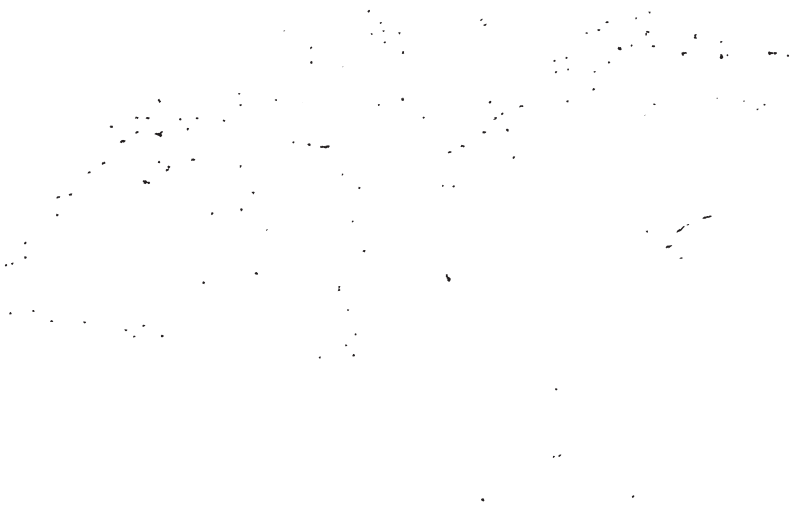
Therefore, we recommend that all parties involved in GPPIs commit themselves to sustaining their contributions to these initiatives for extended periods. They should also invest in the creation of capacities at local and country levels as early as possible in the implementation of their programmes in order to make sure the countries can continue the initiated activities autonomously.

Governance

- Governance has proven to be an issue for GPPIs. At global level, external evaluations have reported deficiencies in transparency and openness, a lack of accountability and a vague definition of partners and their roles and responsibilities. It has also been reported that recipient countries participated only minimally in the global decision-making structures. In three cases (STB, RBM and GAELF), those researching this report found that major changes in the governing mechanisms recently took place, two of which deal with some of the problems mentioned. Most of the initiatives also scored low on transparency, particularly regarding disclosure of information on financial decisions, drug donations and decision-making. At national level the country coordination mechanisms, when they do exist, are not clearly defined, not much is known about them and because they are embedded into government structures there is a lack of transparency. Accountability was a matter of concern, particularly because not much is known about the initiatives, not even among the functionaries and health workers who run their programmes, let alone CSOs and the target population. In addition, the GPPIs studied do not promote approaches, mechanisms or structures that allow different national stakeholders and target groups to participate in decision-making on issues related to the initiative's activities in the countries. Instead, top-down mechanisms are used and when 'participation' is promoted by the initiatives, it tends to be functional and was in some cases described as 'prescriptive'.

The organisations participating in this report consider it necessary for all stakeholders taking part in the GPPIs to have clearly defined roles and responsibilities. GPPIs also need to have well-defined mechanisms to assure the accountability of all stakeholders. These initiatives should have transparent and accountable decision-making mechanisms and information should be made available to the public, especially because public institutions are involved in its structures and as organisations they are taking on a role in the public interest. We also recommended that recipient countries be given a significant amount of influence in the decision-making structures of GPPIs at global level. At country level, GPPIs should promote participative mechanisms for defining priorities, strategies and plans aimed at responding to the needs of the target groups and the structures that work directly with them.

Specific recommendations for each of the actors are included in the final section.



PART I

1 Introduction

1.1 Background

The landscape of international health has changed immensely over the last few years. While health problems related to poverty have increased significantly, other actors and new ways of counteracting these problems have emerged. These changes continue to occur within a context of increasing gaps between rich and poor at international and national levels, shrinking resources available for health in many poor countries and the decreasing role played by nation states. One trend that has rapidly established itself in international health and other sectors is that of Global Public-Private Initiatives (GPPIs). The creation of this form of collaboration or partnership between a UN body and a national government (the public bodies) and corporations, foundations and NGOs (the private parties), is intended to tackle the enormous health problems in poor countries. It has been argued that these collaborations will help to create more financial and material resources and political support for health care. The participation of private companies in global initiatives is at the same time an expression of their increasing influence on the world stage.

Wemos is an organisation working for a world in which every person can exercise his or her right to health by influencing at different levels the international policies of actors. One of Wemos' strategies is to work together with Southern organisations to influence international policies that facilitate or hinder exercising this universal human right. Because of their growing importance as instruments for tackling the health problems of immense portions of the world's population, Wemos decided to launch a project aimed at better understanding the effects of GPPIs and the way they work, seeing these initiatives have concrete characteristics as to how they approach health problems and the way they are implemented. The particular characteristics of these initiatives are due to a change in the roles played by the different partners, especially the central role played by the commercial sector in delivering products and services and their participation in decision-making structures related to the definition and implementation of programmes and policies.

1.2 Participating organisations and scope of the study

Initially, Wemos followed the discussions on GPPIs at the global level, identifying key topics and consulting with some of its Southern partners about the relevant issues arising at country level as a result of the implementation of various GPPIs. With these issues in mind, it was decided to conduct case studies of selected GPPIs in different countries. The factors taken into account when selecting the initiatives were: their approach (particularly for those working on service delivery), the presence of its programmes in the work areas of partner organisations and their links to Dutch international development cooperation. At the same time, Wemos coordinated a study with SOMO (Centre for Research on Multinational Corporations) on some of the pharmaceutical companies participating in the selected GPPIs; the results of this were integrated into this report.

The selected GPPIs and the countries where the case studies took place were: Roll Back Malaria (RBM) in Tanzania, Uganda and Zambia; the Global Alliance to Eliminate Lymphatic Filariasis (GAELF) in Kenya and the Indian states Tamil Nadu and Karnataka; the Global Polio Eradication Initiative (GPEI) in the Indian state West Bengal and Stop TB in South Africa. According to the type of approach employed by these GPPIs, they fit into one or more of the following categories: improving access to health products, global coordination mechanisms and public advocacy.

The WHO acts as secretariat in all these initiatives and the target countries are responsible for implementation with the assistance of the WHO, UNICEF and non-governmental organisations.

The studies on RBM were undertaken by Ifakara Health Research and Development Centre and People's Health Movement in Tanzania, Joint Medical Store in Uganda and Chessore in Zambia. The studies on GAELF were carried out by Consumers Information Network in Kenya, and by Prepare–Test Foundation in Tamil Nadu and Community Health Cell in Karnataka, both in India. West Bengal Voluntary Health Association carried out the case study on GPEI in West Bengal, India, and Health System Trust performed the study on Stop TB in South Africa.

The conclusions that can be drawn about the different GPPIs from the case studies carried out in some countries or regions within countries are limited. The process of implementation was also used as a tool to strengthen the capacity of participating organisations. Attention is given in this report to the opinions of local actors (health workers and communities) and other stakeholders at national level.

This report aims to: First, describe and analyse the ways in which GPPIs are being implemented at country level and to look at the advances and setbacks they are confronted with in trying to achieve their goals. Second, to analyse the effects implementation of the programmes of these initiatives has on local health systems in the recipient countries. In this way, the participating organisations want to contribute to the discussion on the suitability of GPPIs as instruments for achieving sustainable solutions to the health problems faced by poor people around the world. In order to be suitable instruments for this purpose, the participating organisations agreed on four elements with regard to values, approach and governance that should be encompassed by GPPIs (see Annex 1).

1.3 Methodology

The methodology was designed bearing in mind that the case studies would find evidence that should be used by the participating organisations in a subsequent advocacy phase, both at country and international levels. The entire implementation of the case studies was systematically used as an instrument to strengthen the capacity of all participating organisations – those from the South as well as Wemos – in matters such as the analysis of international health issues, research methodology, research for advocacy purposes and analysis of results.

Key moments for joint discussion, training and reflection were planned at various points in the process of implementing the case studies. Initial consultations took place in May and August of 2003 on the following topics: analysis of the problem, reaching agreement on concepts to be used, the issues to be approached, and the focus and methodological aspects for data collection. In April 2004, a second meeting was planned for revising preliminary results, discussion of strategy for analysis and reaching agreement on the key issues for the advocacy phase. A final meeting has been planned for May 2005 to discuss and coordinate the advocacy phase, and to evaluate and draw lessons from the joint working experience.

The desk research on global aspects was carried out by Wemos and was made accessible to the other participating organisations through a digital library installed on Wemos' website.

The field research conducted by the participating organisations included desk research and collection of supplementary information through interviews with representatives of international agencies, health officials, health workers, local health authorities and members of the communities in selected districts.

For a detailed description of the methodology, see Annex 1.

1.4 Structure of the report

The following section of Part I presents a quick review of some global-level contextual facts relevant to a better understanding of the phenomenon of GPPIs in health. Attention is given to growing inequalities within the framework of globalisation.

Drawing on web-based information and a documentation review, section 3 describes the elements of the definition of GPPIs, the factors

that contribute to the tremendous proliferation of these initiatives, where they operate and how they can be classified in order to understand what they do.

In Part II, sections 4 through 7 deal with the case studies of each selected GPPI. Each section begins with a description of the GPPIs, their institutional and organisational features, stakeholders, governance and – based on the study carried out by SOMO – matters related to the pharmaceutical companies involved. Next, the country-level findings of each case study are described. These include a brief description of the health situation, the main features of the health system, the situation of the GPPI-related disease in each country, and a short description of the methodology used. Finally, a description and analysis is given of the particular GPPI in each country, and each of these sections ends with a number of conclusions for each initiative.

In Part III, section 8 includes the general conclusions, the general recommendations and the recommendations for different actors participating in GPPIs.

Annex 1 gives a detailed description of the methodology. Annex 2 includes a more detailed description of each GPPI and Annex 3 gives details of the design and methodology for each case study.

'While a baby girl born in Japan today can expect to live for about 85 years, a girl born at the same time in Sierra Leone has a life expectancy of 36 years.' If the Japanese girl is ill, she can expect to receive on average medications worth about US$550 per year; if the Sierra Leonean girl is ill, she can expect to receive medications worth US$3 per year (WHO 2003: ix).

2 The Global Context

2.1 The globalisation process and the growing inequalities

During the 1980s and 1990s there was an intensification of the process of globalisation – the growing integration of economies and societies around the world. While some countries have benefited from globalisation, including all developed countries and parts of South-East Asia and Latin America, many countries and groups within countries have been bypassed (World Bank 2004). Sub-Saharan Africa, parts of Eastern Europe, the Commonwealth of Independent States (CIS) countries and some Asian and Latin American countries have not reaped the benefits of improved living standards. The economic and social progress has also left out many ethnic and racial minorities as well as vulnerable groups such as women and girls.

Hundreds of millions of people in poor countries have in fact experienced developmental and economic reversals instead of advances. While in the 1980s the Human Development Index (HDI, a summary of a country's human development) showed four countries had experienced reversals; by the 1990s this number had increased to 21 countries. When compared with 1990, 54 countries are now poorer than they were then; 32 of these countries are facing economic crises, and most of these are in sub-Saharan Africa (UNDP 2003: 34). More than 1 billion people still struggle to survive in the face of hunger and poor health on less than US$1 a day (WHO 2003; World Development Indicators 2004).

The global health situation is one of a growing gap between those who have access to health services and healthy conditions and those who do not.

The deterioration of the health of the world's populations is illustrated most dramatically by the drastic reversal of adult mortality rates, particularly related to the HIV/AIDS pandemic. This is especially true in sub-Saharan Africa, where over the last decade life expectancy has been reduced by more than 20 years in Lesotho, Swaziland, Botswana and Zimbabwe. Today 10.5 million children will not survive to their fifth birthdays, dying mainly of preventable diseases. More than 98% of these children are in low-income countries, and half of these are in Africa. Compared with ten years ago, 35% of African children run a higher risk of death.

In high-income countries, communicable diseases contribute to 5% of the total disease burden; in high-mortality poor regions this can reach 40% (WHO 2003: 13). The WHO classifies high-mortality developing regions as those that have high levels of mortality for children under five and for adult males aged 15 to 59 (WHO 2004). The high toll of poverty-related diseases in poor countries is evident from the following figure:

Some facts on poverty-related diseases
Every day 30,000 children die from preventable diseases.
More than 500,000 women die each year during pregnancy and childbirth.
42 million people are living with HIV/AIDS.
Tuberculosis kills 2 million people per year.
Malaria kills 1 million people per year.

Source: World Health Report 2004, WHO

Poor countries face huge challenges in overcoming these inequities. Structural problems including international trade systems and growing external debt burdens with conditions for renegotiation have had a negative impact on economic growth. Poor countries have no control over many of these factors (UNDP 2003: 16). Geographic barriers, commodity dependence, demographic pressures and armed conflicts are compounded with the high burden of diseases, such as HIV/AIDS, malaria and tuberculosis (TB). As a result, poorer countries have less money to spend on essential basic services such as health care (UNDP 2003: 34). Expenditures on weapons and the rampant corruption present in some governments decreases the amount spent on health care even further.

2.2 The response

In the 1970s, the Organization for Economic Cooperation and Development (OECD) countries pledged to contribute 0.7% of their Gross Domestic Product (GDP) to poorer countries as development assistance, but few of them have ever achieved this target. Though overseas aid and development assistance has increased slightly over the past few years, the amount earmarked for health is US$0.01 out of every US$100 of donor countries' GDP – too little to achieve anything.

The differences between rich and poor countries in public expenditures on health are astonishing. While OECD countries spend at least US$1,061 per person per year on health (5% of their GDP), low-development countries spend US$38 (around 2%) (UNDP 2003: 98).

It was in this bleak climate that the United Nations (UN) launched initiatives like the Millennium Development Goals (MDGs)[1], with goal-oriented commitments on development and poverty eradication. Health is at the core of the MDGs – four of the goals are health-related – and they highlight the crucial role of health as a prerequisite for economic growth and social cohesion.

However, the main problem continues to be: Who will pay for the achievement of these goals? Rich countries have not held up their end of the agreement and have not committed the necessary funding to achieve even half of these goals.

The UNDP has indicated that if a full and concerted effort is not made now to achieve the MDGs for reducing poverty by half by 2015, sub-Saharan Africa will not see such a reduction until the year 2147 (WHO 2003: 28).

At the same time, the number and volume of profits of transnational corporations (TNC) increased exponentially during the 1990s. There were then more than 37,000 TNCs with over 206,000 affiliates (such as subsidiaries and branches) around the world, with the top 100 TNCs based in developed countries. In 1992, these companies accounted for around US$2 trillion in investments, and their foreign assets generated approximately US$5.5 trillion in worldwide sales. Between 1982 and 1992, the top 200 TNCs doubled their combined revenue, which went from US$3 trillion to US$5.9 trillion, and their share of global GDP rose from 24.2% to 26.8% (Pha 1995).

The UN, other multilateral institutions and major donors sought answers to the problems of a decreasing budget, increased poverty and a growing perception among donor countries that the UN was ineffective. They began to include private-sector partners, who were experiencing incredible economic growth, increasing influence on policy issues and were willing to demonstrate their commitment to improve their corporate social responsibility (CSR). This is how the public-private partnership paradigm was born at a global level – and it began multiplying at a rapid rate.

[1] 1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

3 Global Public-Private Initiatives in health

3.1 What are GPPIs in health?

There are many definitions for Global Public-Private Initiatives (GPPIs) – which are also frequently referred to as GPPPs (Global Public-Private Partnerships) – none of which are considered definitive. This ambiguity has repercussions for the analysis of the performance and impact of GPPIs in target countries.

Wemos considers *interactions* to better define the nature of the relationships between the public and private sectors. Partnerships tend to imply equality between the stakeholders, and data from the country studies indicate this is not the case. This report therefore uses the word initiatives rather than partnerships. The following adapted definition is used:

GPPI (initiative instead of partnership) in health is a collaborative relationship that transcends national boundaries and brings together at least three parties, among them a corporation (and/or industry association) and an intergovernmental organization, so as to achieve a shared health-creating goal on the basis of a mutually agreed division of labour (Buse and Walt 2000a: 550).

GPPIs have experienced incredible growth in the past five years and now number more than 80 worldwide. These GPPIs, which often focus on one specific disease or medical product, cover a number of poverty-related and communicable diseases, including blindness, Chagas disease, dengue fever, guinea worm disease, HIV/AIDS, vaccine-preventable diseases, leprosy, lymphatic filariasis, malaria, meningitis, polio, TB, and vitamin A deficiency to name but a few.

As observed in Table 1, numerous GPPIs have been created to deal with some of the most frequently occurring infectious diseases that afflict poor countries. In many cases, various GPPIs are involved in activities for the same disease, working on different aspects and at different levels of the fight against it. For instance, in the case of malaria, there are GPPIs that focus on supplying drugs, others on supplying nets and still others on developing medicines and a vaccine. The fact that different GPPIs are working on the same disease does not mean they collaborate with each other or actually attempt synergy of their activities.

Table 1: Top ten diseases targeted by GPPIs

Disease	Number of GPPIs
HIV/Aids	19
Malaria	16
Tuberculosis	11
Sexually transmitted infections	7
Vaccine-preventable diseases of the poor	5
Human African trypanosomiasis	4
Reproductive health	4
Onchocerciasis (river blindness)	4
Trachoma, leishmaniasis, blindness	3

Source: www.ippph.org

3.2 Why GPPIs in health?

Several factors contribute to the proliferation of GPPIs, particularly those in health. According to some authors, three factors caused the shift in private and public relationships at international level. Firstly, there was an ideological shift in the 1990s whereby economists began to think of 'modifying' the market as opposed to 'freeing' the market. This philosophy made it possible to bring together a variety of stakeholders – including private sector representatives – to determine public health policy (Buse and Walt 2000a: 551).

The second shift was the increasing notion that the UN and its agencies were not effective, for example because of inter-agency competition. This resulted in a change in UN funding policy when donors imposed a policy of zero real growth on UN budgets. As a result, the UN shifted toward seeking supplementary funding, especially from the corporate sector (Buse and Walt 2000a: 552).

At the WHO, in 1993 the World Health Assembly (WHA) called to 'mobilize and encourage the support of all partners in health development, including non-governmental organisations and institutions in the private sector, in the implementation of national strategies for health for all' (Buse and Waxman 2001). In 1998, after Dr. Gro Harlem Brundtland became Director-General of the WHO, promotion of partnerships and other interactions with the corporate sector were increasingly pursued. In 2002, there were about 50 WHO partnerships with the corporate sector, which is reflected in the substantial increase in corporate funding for the WHO (Ollila 2003: 46). The WHO's funding comes from two sources: assessed contributions from member states or regular budgetary and voluntary contributions, and the extra-budgetary resources, from different sources such as member states, foundations, the commercial sector, NGOs and others. The assessed contributions declined during the last decade, while the voluntary contributions have increased enormously. Currently, the latter source comprises almost two-thirds of the organisation's total budget. This amounted to around US$1.38 billion in the 2002-03 budget compared with about US$850 million in assessed contributions ('How Stuff Works' 2004). As for the sources of voluntary contributions, the private sector and NGOs saw the largest increases: 119% between 1998 and 2001. Voluntary contributions are less predictable, because they need to be pledged annually or biannually.

In 2000, the WHO launched the Commission on Macroeconomics and Health (CMH) to examine the effects of health on economic growth. It called for a huge increase in health sector resources in low- and middle-income countries to attain improved health, and indicated the need for public-private partnerships to accommodate this increase in resources (Ollila 2003: 45-47). The commission also 'cautioned the governing bodies of (the) WHO not to constrain (the) WHO's work by raising concerns about conflicts of interest' (Ollila 2003: 47).

Within the framework of this policy shift, the UN was under pressure to engage the private sector in order to implement its programmes and provide assistance to people in need around the world. An example of this is the Global Compact: an arrangement between the UN Secretary-General and the International Chamber of Commerce. Here companies are asked to support 'nine principles in the areas of human rights, labour and the environment in their day-to-day practices and operations (Richter 2003: 8). In 2004, a tenth principle against corruption was added.

'The Global Compact is not a regulatory instrument – it does not "police", enforce or measure the behaviour or actions of companies' (Global Compact 2004). Unfortunately, like many other interactions there are no checks to enforce compliance by companies. Many companies use the arrangement to promote their image and do not change their own practices (Richter 2003: 8).

It is difficult to find a UN agency today that does not promote and seek partnerships with private-sector partners. 'The pursuit of PPIs (Public-Private Initiatives, ed.) has become integral to the policy of intergovernmental agencies such as WHO and UNICEF, as indicated by their core policy documents and processes' (Richter 2004).

A third factor in this new policy drive is the realisation that health is an increasingly complex issue and any response will take more than one single sector or organisation to achieve the goals the UN and other organisations have specified in the past. But it is known that poor countries are unable to significantly increase their expenditures in health. It is in this environment that international agencies and countries seek out GPPIs to fill budgetary gaps in order to achieve goals and deliver services. The UN sees GPPIs as a way to get private support for human development in areas where the commercial sector has expertise. This bestows legitimacy and authority to the UN, enabling it to fulfil functions and mandates, and facilitates the UN in obtaining financing and advice from the private sector (Buse and Walt 2000a: 553). For the corporate sector, GPPIs represent opportunities for putting into practice various aspects of CSR and at the same time increasing its influence on global and national policies: achieving direct and indirect benefits such as market penetration, occasional tax breaks, brand and image promotion and increasing corporate legitimacy.

3.3 Where are GPPIs in health active?

Although GPPIs are implemented globally, target countries are mostly low- and medium-income countries. Most target countries are in Africa (see Table 2). However, this does not necessarily imply that the various GPPIs present in certain countries collaborate with each other or harmonise their work. In fact, each GPPI looks for distinct channels to implement its own activities. Almost all GPPI secretariats are located in Northern countries such as Switzerland, the UK and the USA. Beneficiary countries must fulfil a series of criteria specific to each GPPI regarding epidemiological profiles, geographical aspects, gravity of the health problems focussed on by the GPPIs and economic status. Some GPPIs, especially those donating drugs, apply restrictions for donations according to the economic level of the target countries.

Table 2: Top ten sub-Saharan countries with the most GPPIs

Country	Number of GPPIs
Tanzania	28
Ghana	27
Kenya	26
Uganda	25
Mali	24
Nigeria	24
Malawi	24
Zambia	23
Mozambique	23
Senegal	23

Source: www.ippph.org

3.4 How do GPPIs in health work?

GPPIs are structured and implemented in many ways. At the moment there is no generally accepted definition of this phenomenon, or of the concepts related to organisational and operational elements. Many authors have proposed typologies that can be used to classify GPPIs. Following are descriptions of two of these main categories: a) the type of relationship between the participating organisations and institutional forms in which these relations take place (in particular the private sector in relation to the public sector) and b) the type of approach employed. This refers to the type of delivered service and the sorts of objectives pursued.

- Type of relationships (Buse and Walt 200b: 700): useful for clarifying governance and other aspects related to GPPIs.
  - Constituency of membership (donor-recipient or public-private);
  - Organisational form (degree to which private interests 'participate in the strategic-level decision-making in the public interest');
  - Activities between public and private actors taking place in the partnerships (consultation, collaboration or operational).

- Type of approach (IPPPH 2003): refers to broad categories of GPPIs as product-based, product development-based and issues-/systems-based. This is helpful for comparing the various objectives of GPPIs.
  - Product development: Partnerships involved in the discovery and/or development of new drugs, vaccines or other health products that address diseases and conditions neglected in target countries.
  - Improving access to health products: Collaborations focused on improving access and/or increasing the distribution of currently available drugs, vaccines or other health products addressing diseases and conditions neglected in target countries. These can involve long-term donations, discounted, subsidised or negotiated pricing on products. The GPPIs covered in this report fall under this category. They are closely related to the functioning of existing health systems and have considerable potential to influence these systems and country policies.
  - Global coordination mechanisms: Alliances that serve as mechanisms for coordinating multiple efforts to ensure the success of global health goals – often for a particular disease/condition and involving some combination of the other approaches (product development, increasing product access, strengthening health service, advocacy, education, research, regulation and quality assurance).
  - Public advocacy, education and research: Collaborations focused on advocacy, education, or research on health issues predominately affecting poor populations in target countries. This includes fund-raising, social mobilisation and social marketing efforts.

- Regulation and quality assurance: Initiatives working towards improving the regulatory environment and product quality, appropriate use of and access to effective health products that address diseases and conditions neglected in target countries.

- In terms of the role of partners within GPPIs, the following generalisations about the existing GPPIs in health can be made:
  - The WHO and UNICEF generally take an overall leadership and management role and provide some implementation assistance.
  - Target countries are mainly responsible for implementing the initiative through use of their existing resources and structures, with some assistance from the WHO/UNICEF, non-governmental organisations, humanitarian organisations and private organisations such as Rotary International and foundations.
  - Philanthropic organisations such as the Gates Foundations and Rockefeller Foundations are active in initiating GPPIs.
  - Private-sector partners are generally involved in the provision of products and at times donating funds.
  - Donor governments provide financial assistance for the functioning of the initiative.
  - International financial institutions such as the World Bank provide loans and other financial resources for implementing the programmes or acting as a trustee for the administration of donations.

3.5 Governance and GPPIs in health: critical issues

At the moment there are no standards for monitoring each partner within an overall initiative to ensure that the goals of an individual partner do not supersede the goals and objectives of the GPPI. This point highlights the vulnerability of GPPIs to the agendas of individual partners or group of partners who have the authority to set conditions for providing their resources, whether products, services or finances for the partnership.

In addition, the practical implementation of the broad spectrum of GPPIs varies substantially based on the type, objectives and input of the relevant partners. But at the moment there is an absence of standardised frameworks for the initiation, implementation, regulation, monitoring and evaluation of GPPIs and their impact on the fulfilment of the right to health in target countries.

A key risk in GPPIs is the governance arrangement. This can potentially have a great impact on decision-making in the public sector. By bringing together corporations, civil societies and government, a GPPI is in effect trying to mesh very different types of ethos, values and principles in the provision of health services. The organisations participating in this report and others as well are greatly concerned that GPPIs do not have a clear definition of what constitutes a partner or member. This lack of specificity about rights and obligations can lead to problems, especially in conflict resolution. Accountability and transparency are murky when relationships are ambiguous.

A report by Buse on governance of GPPIs found there is gross under-representation of Southern stakeholders in the governance arrangements of GPPIs. This, together with the fact that virtually all the GPPIs' secretariats are located in the North, means there is a crucial need for new approaches to include Southern countries and input by Southern NGOs. Buse found that few of the 'partnerships designed governing arrangements that allowed for public and private partners representation with fiduciary and decision-making autonomy' (Buse 2004). This raises the issues of whether beneficiaries will ever be seen as partners and on the role of developing country governments, as well as how this structure allows for ownership and sustainability.

The study also found that guiding principles for ensuring policies and practices that prevent undue commercial influence in the development of technical norms and standards have been overlooked. The same applies for policies for screening corporate applicants (Buse 2004). This could, for example, result in focusing on curative rather than preventive solutions to health. Some international NGOs were concerned about the WHO's guidelines for interaction with the commercial sector (WHO 2000), pointing out the inherent conflict between commercial goals and public health goals and the prerequisite that the WHO performs its functions independent of commercial influence. They stated that 'industry partnerships and industry sponsorship without

strong, enforceable, accountable and transparent guidelines for these relationships will undermine and destroy the WHO's role and responsibility' (HAI 2004).

The sections in Part II describe and analyse the case studies on the selected GPPIs. Each section refers to a separate GPPI, giving first a description of its institutional, organisational and financial aspects followed by a description of the case studies on that particular initiative in the various countries.

PART II

4 Global Alliance to Eliminate Lymphatic Filariasis – GAELF

4.1 The GPPI

Lymphatic filariasis

More than 1 billion people in over 80 countries are at risk of being affected by lymphatic filariasis (LF), also known as elephantiasis. Currently more than 120 million people are affected, with more than 40 million of these people suffering serious incapacitation and disfigurement as a result of the disease. LF is endemic in 32 of the 38 least-developed countries (WHO 2004a). One-third of those infected with the disease live in India, another one-third lives in Africa, and the final third are found throughout South Asia, the Pacific and the Americas. Lymphatic filariasis is caused by thread-like worms (filariae) that live in the human lymphatic system. The disease is transferred to humans by mosquitoes. Genital damage and lymphoedema are the most recognisable manifestations of the disease.

The incidence of lymphatic filariasis infection continues to increase in areas where the disease is already well established, such as tropical and subtropical areas. This increase has been attributed to 'the rapid and unplanned growth of cities, which creates numerous breeding sites for the mosquitoes that transmit the disease' (WHO, 2004b). The root causes of the disease are related to a lack of safe water, housing and adequate sanitation. Therefore, lymphatic filariasis is principally a disease of the poor. LF is a major cause of disability, acute and chronic infections, social stigmatisation and psychosocial and economic reductions in life opportunities.

The Global Alliance to Eliminate Lymphatic Filariasis – GAELF

In 1997 the World Health Assembly adopted Resolution WHA50.29, which called for the elimination of LF as a global public health problem. The Global Alliance to Eliminate Lymphatic Filariasis (GAELF) was officially formed during a meeting in Santiago de Compostela, Spain, in May 2000. GAELF's objective is to eliminate lymphatic filariasis by 2020 by interrupting transmission of infection and alleviating and preventing the suffering and disability caused by the disease. In 1998 the pharmaceutical company GlaxoSmithKline (GSK) agreed to donate as much of its drug albendazole as the WHO's LF programme required. In 1999 Merck & Co. decided to donate its drug Mectizan® free of charge and as long as necessary. Although linked to GAELF, the donations of Merck& Co are taking place through a separate GPPI, the Mectizan® Donation Programme (MDP) (Weyzig 2004a: 5).

The strategy

The strategy is to interrupt transmission of LF by mass drug administration (MDA) to the entire population at risk of infection, for a period of at least five years. This period corresponds to the reproductive lifespan of the parasite. There are three drugs that can be used to treat LF: albendazole, Mectizan® (ivermectin), and diethylcarbamazine citrate (DEC). They need to be administrated only once a year for this purpose; the combination of two different drugs may enhance the effectiveness of the treatment. The WHO recommends a combination of albendazole and DEC, except for countries where

onchocerciasis (river blindness) is also endemic. In these areas, DEC cannot be used because it causes severe complications, and a combination of albendazole and ivermectin is recommended instead (Filariasis, 2004a).

Occasionally, DEC-fortified salt is also used to prevent LF. In this case the treatment regimen consists of daily intake of DEC-fortified salt over a period of one year. This strategy is only applicable when all salt supplies in a country can be controlled.

There is a lack of reliable, conclusive evidence to confirm or refute the need to add albendazole along with DEC for elimination of LF, as documented in Chichester's 'Review on Albendazole for Lymphatic Filariasis' (David Addiss 2004). The CDC's stance is that although albendazole is approved by the FDA, it is considered investigational for the purpose of eliminating lymphatic filariasis.

Both albendazole and ivermectin are listed as Class C teratogens, and hence there is concern over the inadvertent exposure of pregnant women to these medications in mass therapy campaigns. In addition, the presence of these drugs in breast milk is harmful to babies.

The partners

The main partners of GAELF include the WHO, GlaxoSmithKline, Merck (which participates in GAELF through the Mectizan® Donation Programme, a separate GPPI), UNICEF, the Liverpool School for Tropical Medicine, Emory University in Atlanta, the Arab Fund for Economic and Social Development, the Gates Foundation, the World Bank, the ministries of health in endemic countries and donor governments.

The WHO acts as secretariat and houses four staff, who administer GAELF on a full-time basis. They direct, coordinate, facilitate, provide technical support, monitor and participate in decision-making bodies. It is also the implementing agency for the Global Programme for Elimination of Lymphatic Filariasis.

The role of pharmaceutical companies

The companies provide free drugs for MDA campaigns, promote advocacy, support academic institutions and facilitate programme development. They also participate in coordination and decision-making committees.

Merck & Co., Inc. (Mectizan® Donation Programme) provides medical and technical support for its worldwide donations of Mectizan® for the mass treatment for the elimination of LF. GlaxoSmithKline, UK (GSK) is an active partner, provides millions of albendazole treatments to communities and more than US$1 million in cash grants to other alliance partners each year. Merck and GSK play important roles in the partnership, and without their donations the partnership could not be sustained.

Governance

It is necessary to distinguish between the governance structure of the Global Alliance (GAELF) and the implementation structure for the Global Programme to Eliminate Lymphatic Filariasis (PELF). The Global Programme is ultimately owned by endemic countries. The global PELF and national PELFs are designed with the technical support of the WHO and academic institutions. GAELF, which is not a separate legal entity, supports the implementation of the Global Programme. All members of GAELF are also involved in PELF implementation.

GAELF governance structure

At the third global meeting of the alliance in Cairo, Egypt in March 2004, a new governance structure for GAELF was proposed and adopted by the various partners. There are now three levels of governance:

- **Global Assembly:** The biannual global meeting of all GAELF partners.
- **Representative Contact Group (RCG):** Composed of 30 representatives from various constituencies including the endemic countries. The most important function of the RCG is to appoint the members of the executive group. The RCG also mobilises funds, including funds for the Technical Advisory Group (TAG), Regional Programme Review Groups (RPRGs, see below) and the implementation of the PELFs in endemic countries.
- **Executive Group:** The RCG selected a smaller executive group of six members that is in charge of mobilising support and plays an important role in the governance and functioning of the Global Alliance.

PELF implementation structure

The WHO acts as the secretariat of GAELF. At country level, the drugs are administrated through national programmes. Countries have to submit proposals for a national PELF to the partnership. The WHO supports the national PELFs, and communicates with the following bodies (Filariasis, 2004b):

Regional Programme Review Groups (RPRGs): The tasks of the six regional groups are mainly related to the implementation of the programme. The members are appointed by the regional directors of the WHO.

Technical Advisory Group (TAG): This group meets annually to give non-binding recommendations to the WHO on all aspects of the elimination of LF, provides technical guidance to the global PELF and is made up of a group of specialists.

GSK/WHO Collaborating Coordination Committee (CCC): This committee was set up to support the albendazole donations. Its role is mainly managerial and logistical, and also forecasts drug needs.

Expanded Mectizan® Expert Committee (EMEC): This committee has an important technical function. For instance, the African PRG forwards programme requests to the EMEC for final authorisation from countries where onchocerciasis is co-endemic. Its role is similar to that of a TAG for the concurrence of LF and onchocerciasis. The members of the EMEC are experts appointed by the MDP.

Mectizan® Donation Programme (MDP): This acts as the secretariat of the EMEC. It is not a separate legal entity, but part of Merck. The MDP provides managerial and logistical support for the Mectizan® donations (Weyzig 2004a: 16).

Transparency

Transparency on the governance of GAELF is rather low. The Memorandum of Understanding (MOU) between the WHO and GSK specifying its commitments to GAELF has not been disclosed publicly. The precise composition of the Executive Group, Representative Contact Group and Technical Advisory Group has not been made public. Minutes or reports of the meetings of these bodies are not available to the public, except for very limited information about the TAG meetings. As of October 2004, the report of the third global meeting of the alliance in March 2004 was not yet available to the public, and GAELF did not produce this information when requested. There is no detailed information on the financing of LF programmes in GAELF reports, and only total programme costs are mentioned (Weyzig 2004a: 18).

The pharmaceutical companies participating in GAELF play an important role in implementing the activities of this GPPI. Both Merck and GlaxoSmithKline also have central positions in the governance of the initiative, as they both have a representative in the executive group. Because of the low transparency with regard to GAELF governance, it is difficult to assess how issues related to conflicts of interest are dealt with, if they arise. For instance, because the MOU between GSK and WHO has not been publicly disclosed, it is not known whether integration of Zentel® (the branded version of albendazole) was a condition for donation of albendazole, since GSK has a significant commercial interest in the sales of Zentel®, which is widely used in developing countries for intestinal helminth deworming programmes. The drug is administered at least two times a year for that purpose. Sometimes there is partial integration with the GAELF, which means that once a year the drug is given for LF and it is provided a second time each year independent of the GAELF in order to also be effective for deworming. GSK donations are only provided free of charge when used for LF, not for intestinal helminth.

Funding

Programme costs are expected to rise from nearly US$30 million in 2003 to US$50 million in 2005, and will continue to rise at this pace for several years. Most of these funds are required for implementing LF programmes in Africa and South-East Asia. These programme costs are external funding requirements and exclude drug donations. Domestic resources allocated by ministries of health from the endemic countries, such as health centre staff, transport and management costs, are not included either and are probably higher than external funding (Weyzig

2004a: 10). Currently available external support falls far short of the required amounts, leaving a financing gap of US$20 million in 2003, which may increase to US$40 million in 2005 (Weyzig 2004a: 18).

The first major funding from non-corporate partners came in 2000, when the Bill and Melinda Gates Foundation gave a US$20 million grant for a period of five years to accelerate the implementation of GAELF. The current administration of the Gates Foundation is interested in supporting research and development, but not in providing broad-based country support. Resources for other aspects of PELF implementation have to be mobilised from other sources.

4.2 GAELF in India

The Indian national context

India has a population of 1,049 billion people. Per capita GDP in international dollars was 2,670 in the year 2002. The percentage of households living on less than US$1 a day is 34.7%; the percentage of people living in poverty is rated at 28.6%. The country was ranked 124 on the Human Development Index (HDI) for the year 2002. The Gini coefficient for India was 37.8 in 2002.

A particular area of concern in India is the lack of properly functioning health facilities due mainly to the lack of staff and the overall poor level of sanitation, which has increased the difficulty of controlling infection, soil-related and water-borne diseases. Less than 50% of the urban population and less than 5% of the rural population currently have access to sanitary disposal systems. Poverty-related diseases such as malaria, LF and TB, water-borne diseases like diarrhoea, typhoid, cholera and infectious hepatitis account for 80% of India's health problems. Every fourth person who dies of such diseases is from India.

Acute respiratory infections are responsible for two-thirds of deaths amongst children below five years of age. One-fourth of TB cases worldwide are found in India. Each year, 5,000 new TB infections emerge in India, and 400,000 people die of this each year. Those diseases are strongly related to a lack of proper housing conditions and malnutrition: as an example, 47% of Indian children under five suffer from malnutrition. The infant mortality rate was 67 of 1,000 children in 2002, and is showing a tendency to decrease. There are 4.5 million cases of HIV/AIDS; by 2010 India will have 20 to 55 million cases, the official prevalence rate being 1%.

India's performance has been disappointing on the determinants of health status: healthy environment, adequate nutrition, lifestyle and other interrelated key areas that influence health outcomes such as poverty, literacy, fertility and nutrition (Dharmaraj 2004).

Geographical, social and cost barriers and the inherent systemic and structural weakness of the public health care system impede access of the poor and disadvantaged to health care and health care facilities. Total expenditure on health was 5.1% of GDP in 2001. Of the total health expenditure, only 17% comes from the government, and the rest are out-of-pocket expenditures. The poor spend an average of 12% of their income on health care, as compared with only 2% spent by the state.

The health system does not meet the requirements of the people. Significant factors for its malfunctioning are the critical shortage of key health staff (particularly doctors in public facilities and in rural areas) and a lack of funding.[2] There are 48 doctors available per 100,000 people. As the public health system continues to fail to deliver, the private sector has become the main provider of curative health care, although proper overall regulation is lacking.

The national health policy is focused on the highest-burden diseases: longstanding ones such as TB, malaria, filariasis and blindness, and newly emerging ones like HIV/AIDS. While the national health policy advocates an integrated approach,

[2] Public health investment was 0.9% of GDP in 1999 (Reference: Dharmaraj, Dr. D & Team Global Public Private Initiatives (GPPI) with Specific Reference to Global Alliance in the Elimination of Lymphatic Filariasis (GAELF) in India A Case Study Report Prepare / Test Foundation).

with all previous vertical programmes merged into the general health services, the reality is that existing and new vertical programmes and separate organisations continue to grow. It has become clear that while some successes have been achieved – like the eradication of smallpox – this vertical approach 'is very expensive and difficult to sustain' (p. 25).

Lymphatic filariasis in India

The WHO considers India to be the most LF-endemic country in the world, with an estimated population at risk of 454 million in 261 districts, and with 22.5 million individuals with filarial disease manifestations (14 million with hydrocoele and 8.5 million with lymphoedema/elephantiasis) (WHO 2001: 43). These figures account for more than one-third of the people infected with the disease worldwide. Changes in demographics and associated activities have resulted in the spread of infection and disease to areas other than the traditional endemic foci around river basins and in eastern and western coastal areas. Ninety-five percent of the overall burden is carried by nine states (Andhra Pradesh, Bihar, Gujarat, Kerala, Maharashtra, Orissa, Tamil Nadu, Uttar Pradesh and West Bengal).

In a recent study, people in the 15 to 44 year age group recorded the highest prevalence of infection, while children and young adults below the age of 20 also recorded a high infection prevalence. Lymphoedema affected more women than men, but more men were infected with LF overall (10% to 15% of men versus 10% of women). It has been estimated that the economic loss to India as a result of LF is between US$840 million and US$1.5 billion per annum (p. 38).

National programme for LF

Since 1949, India has implemented a number of programmes using different methods to try to control LF. Unfortunately, the current programme – which is based on selective chemotherapy and larval control – only caters for about 11% of the total at-risk population because it is limited to urban areas. Thus, only 47 million people are protected out of the 420 million exposed to risk of infection countrywide. The core activities of the National Filariasis Control Programme (NFCP) include vector control and density assessment, study of the transmission of the disease in the vector mosquito and people and parasite control. The operational component of the NFCP was merged with the urban malaria scheme in June 1978 to ensure maximum utilisation of available resources. The NFCP's approach to the disease is broad-based and comprehensive. It seems its only drawback is that there is insufficient coverage among the at-risk population.

GAELF in India at national level

India decided to adopt GAELF in light of its commitment as a signatory to the 1997 WHO resolution on the elimination of lymphatic filariasis as a global health problem by 2020. In 2000, the Indian government decided to implement GAELF in the form of a multi-centric study to check the operational feasibility, safety and impact of co-administration of DEC-albendazole with that of DEC alone. This study is going on in nine districts in three states (Kerala,1; Orissa, 2; Tamil Nadu, 6), and is expected to continue until October 2005. Under this programme, a population of 20.5 million will receive both albendazole and DEC, while a population of nine million in four districts of these states will receive DEC alone. The Indian strategy envisages a first phase in which albendazole will be added to the existing single-dose MDA of DEC in 13 districts with a total population of 40 million. A second phase will expand the dual-drug MDA to the 261 endemic districts. The WHO supported India's decision to implement GAELF, and GSK agreed to supply drugs free of charge for five years (2000-2005).

It was decided that the implementation of the programme was to fall under the National Institute of Communicable Diseases, which had successfully implemented previous disease-eradication programmes. The main participants in determining the strategic plan for elimination of LF were the Indian Council of Medical Research (ICMR), the National Anti-Malaria Programme (NAMP) and the National Institute of Communicable Diseases (NICD).

A national task force funded by the WHO was set up for GAELF, with the Director-General of Health Services as its head. The NICD and NAMP are the central agencies for the implementation of GAELF in India, and the NAMP supplies the DEC tablets. The WHO has provided 20 million albendazole tablets.

The Departments of Public Health of the respective state governments implement GAELF organisation on the state level. Deputy directors of health services implement the programme at the district level, primary health centres at a rural level and municipalities and Filarial Control Units implement in urban areas with help of volunteers under the guidance of health and sanitation officers. The key activities of implementation are social mobilisation, advocacy and awareness campaigns, and target groups use them to draw out participation.

4.2.1 GAELF in Tamil Nadu[3]

The health situation in Tamil Nadu

Especially among women and the elderly, the general health situation of the people of Tamil Nadu is far from satisfactory and needs serious attention. The poor suffer disproportionately more from pre-transition diseases like malaria, filaria and TB. Most slums and rural areas do not have sanitation and water facilities, resulting in widespread prevalence of water–borne and vector–borne diseases. The infant mortality rate is 54 per 1,000 live births; the crude birth rate is 19.2 and the crude death rate is 7.8. While this decline has been impressive over the long term, certain serious points of concern have emerged. Compared to the significant declines during the 1970s and 80s, there was near total stagnation in the 1990s in both the birth and death rates, and also in the infant mortality rates. There is an undue focus on immunisation, neglecting the spread of other infectious diseases all over the state (pp. 35-36).

The health system in Tamil Nadu

The Department of Public Health is classified into four different parts: health, Indian medicine, homeopathy and family welfare. Ten directors at state level share the activities and responsibilities of these four divisions. The Department of Public Health is also engaged in directly implementing, at state level, global-level internationally funded programmes like GAELF and other programmes funded by the international agencies (p. 33). Tamil Nadu allocates just 1.5% of its budget to health care. With this present level of allocation, not even a quarter of people's health needs are being met (p. 34).

[3] When no other source is indicated, references in this section refer to the following case study report: Dharmaraj, D. et al (2004), 'Global Public-Private Initiatives (GPPIs) with Specific Reference to Global Alliance to Eliminate of Lymphatic Filariasis (GAELF) in India' (a case study report by the Prepare/Test Foundation). In such cases only the page number(s) is specified, within brackets.

The Directorate of Public Health and Preventive Medicine is directly involved in serving disadvantaged social groups by providing health care services through their primary health centres (PHC) and health sub-centres (HSC) at rural level. The department's field workers also provide health care services by going door to door and visiting the population at their homes. The health posts and family welfare centres serve the urban poor. The major objectives of the Tamil Nadu public health system are maternal and child health, family planning and the control of communicable diseases.

Tamil Nadu's approach to health sector development has not been sufficiently integrated into overall development. This is reflected in the absence of an adequate policy framework that conceives and exploits inter- and intra-sectoral synergies between development processes directed at improving availability of drinking water, sanitation and public hygiene, access to elementary education, nutrition and poverty alleviation on the one hand, and awareness and access to public health and medical services on the other. Moreover, planning is largely done at central government level and hence reduces any initiative that a state government may want to take for reallocating resources in favour of people's demands for health care.

The government of Tamil Nadu is implementing a wide range of health programmes with its own health programme for schoolchildren, specialty camps, health care services to SC/ST population, Integrated Child Development Services (ICDS) programme (with World Bank assistance), micro-nutrient deficiency programmes, MDA in the filariasis control programme (with WHO support) and a malnutrition programme.

Lymphatic filariasis in Tamil Nadu

Of the 58.9 million people living in the state, 36.7 million are at risk, living in 13 of the state's 29 districts. The endemic districts in Tamil Nadu are Chennai, Kancheepuram, Thiruvallur, Vellore, Thiruvannamali, Thiruchirapalli, Villupuram, Cuddalore, Nagapattinam, Thiruvarur, Thanjavur, Pudukottai and Kanyakumari.

The following table shows the official figures on the population at risk and incidence of the disease in the state. Although it is known that the risk of infection is as high in rural as in urban areas, the population at risk lives principally in rural areas.

Population at risk of LF in Tamil Nadu

Urban population at risk	12.08 million
Rural population at risk	24.57 million
Total population at risk	36.65 million
Microfilaria carriers	2.40 million
Microfilaria rate 0.49	
Disease-manifested cases	1.27 million
Disease rate 0.14	

Source: Directorate of Public Health, Government of Tamil Nadu, 1995

National Filariasis Control Programme in Tamil Nadu

The National Filariasis Control Programme (NFCP) has been implemented in the state since 1957. The filaria disease control activities are carried out in 43 urban areas. There are 25 control units, 44 filarial night clinics and 42 filaria and malaria clinics in addition to 1 filaria survey unit for delimitation of endemic areas in non-surveyed districts.

The NFCP units operate under the control of a filaria officer, with unit headquarters in Chengalpattu, Vellore, Chidambaram, Kumbakonam, Nagercoil and Chennai. The centre provides finances to the scheme for 50% of the cost of larvicides, materials and equipment. The entire operational cost is met by the state (Performance Budget 2002-2004, Health and Family Welfare Depart, Government of India). The state has a unique scheme for encouraging local bodies to implement anti-filaria and anti-mosquito schemes with state government grant-in-aid. Out of 726 local bodies in Tamil Nadu, 174 local bodies implement these (pp. 43-44).

The case study

GAELF was investigated in Tamil Nadu by the PREPARE and TEST foundations. These are Indian NGOs that work with indigenous populations and focus their operations in the three states of Orissa, Andhra Pradesh and Tamil Nadu.

The field research was conducted based on stratified random sampling in the endemic

districts where GAELF was being implemented. The samples consisted of urban and rural populations drawn from Kancheepuram Health Unit District (Maraimalai Nagar, Chengalpattu) and Thiruvallur Health Unit District of Tamil Nadu.

The study also included interviews with national and state health officials, functionaries of GAELF programme at national and local level, functionaries of the GAELF implementation units, health workers and community health workers in the study area.

More information on methodology can be found in Annex 3.

4.2.1.1 GAELF implementation in Tamil Nadu

In 2000, the WHO started to provide support to Tamil Nadu for the single-dose MDA programme in the six districts where DEC and albendazole were to be co-administered: Kancheepuram, Thiruvallur, Vellore, Thanjavur, Thirvarur and Nagapattinam. An annual single dose of DEC along with albendazole should be administered to all persons (excluding children below two years of age and pregnant women) for a period of four to six years (p. 44).

As stated in the national plans, the key activities of the MDA programme include: sensitisation of providers and recipients; preparation of the implementation plan at district level; training of district officials who in turn train and orient community health workers (CHWs and volunteers); demographic surveys at community level; preparation of the community through awareness campaigns, using appropriate information, education and communication (IEC) tools; drug distribution through house calls on what is known as Filaria Day; active and passive surveillance of adverse reactions; compliance surveys, and monitoring and evaluation by state health officials (pp. 53-55).

The resources for implementing MDA in Tamil Nadu in 2002 came from various sources:

- Government of India: 31 million DEC tablets, grants for supplies and a grant for advocacy materials (around INR3.1 million[4]);
- Government of Tamil Nadu: grants for training, publicity, material and supplies (around INR9.7 million);
- WHO: 25 million DEC tablets and 13.1 million albendazole tablets, grants for educational materials, community mobilisation, evaluation and documentation (INR8 million, not including the albendazole);
- VCRC: grant for advocacy (INR1 million);
- Corporate sponsors supported the programme by providing 'triggers' (jars of Horlicks and toffees), which encourage communities to take the drugs.

Officially it has been reported that the required coverage (more than 70%) has been successfully achieved in all six participating districts. The following table shows the percentage of the population and the number of persons in households to whom the drugs were handed out during the past few years. This is not necessarily the same percentage or number of persons who actually took the drug.

Percentage of population that received drugs for lymphatic filariasis elimination (LFE) in the years 2001, 2002 and 2003 in Tamil Nadu:

Distribution %	2001	2002	2003
Rural			
DEC alone districts	84.0	86.7	91.8
DEC + ALB districts	85.0	93.4	89.8
Urban			
DEC alone districts	90.0	81.3	87.0
DEC + ALB districts	84.0	88.0	82.2

Source: MDA, Dept. of Public Health & Preventive Medicine, Government of Tamil Nadu, 2003

The field study, however, revealed some critical matters related to the *effect* of the programme *on the local health systems.* It was found that the introduction of the GAELF programme diverts the normal functioning of district-level public health staff for three to four months a year. The programme brings with it a tedious implementation process that includes training activities at different levels, and many administrative, logistic and

[4] Indian rupees (INR50.49 = US$1).

coordination procedures and activities. Thus, to a large extent the PHC's normal health care delivery to the local community is disturbed, which is a major loss to the people (p. 3).

Concerning the *quality* of the programme, the study also found the supervision was not done in a structural manner. As a result there are various shortcomings at different stages of implementation, like the lack of prior visits to households for sensitisation by any of the CHWs. CHWs were only given a one-hour training by the field workers in the implementation units. They were not directed by the trainer to tell about the disease and the purpose and importance of taking the drugs. This meant that information about the disease was not delivered properly to the community. In some instances follow-up visits were never made and the CHWs did not monitor the consumption of the drugs. The Filaria Prevention Assistants (FPAs – community health volunteers) invariably handed over the tablets to anyone in the household, either because the other members were absent or because they had not had breakfast (the tablets should only be taken with food). This suggests that the real coverage of the MDA might be less successful than the figures show.

The field study also revealed that IEC materials were not evenly distributed and in many cases were not distributed at all (p. 59). In addition, some components of the programme were not being carried out according to the programme's outlines. An NGO was entrusted with the morbidity management funds of the programme for India. But even though four years have elapsed, this component still does not exist (p. 4). In the implementation of the GAELF programme in the selected districts, vector control activities, one core element of the NFCP has been practically neglected, probably with critical effects on other vector-transmitted diseases programme.

Regarding the *participation* by target groups, the study found that in the GAELF programme in Tamil Nadu, the involvement of CHWs in drug distribution and the compliance in the use of the drugs distributed are considered to be the main aspects of community participation. Communities do not play any significant role in decisions about the implementation and strategy of the programme.

Finally, concerning *sustainability,* the study mentions the issue of the use of albendazole as an integral part of the GAELF programme. This raises questions about a country's ability to sustain the programme once the free drug donation component has ended. The study also raised a relevant question about the impact of drug donations in cases like albendazole donation as part of GAELF in countries like India. In such cases drug donations can seriously impair the development of long-term solutions like local generic production – because they compete with local products, this has a significant impact on the local market:

'India is self-sufficient in generating the required drugs, as there are many pharmaceutical companies manufacturing DEC and deworming drugs with the generic compound albendazole to meet the local demand. It is presumed that in the next 20 years GSK would completely capture the market for albendazole in India, as albendazole is also used in geo-helminth worm infestation diseases' (p. 3).

4.2.2 GAELF in Karnataka[5]

The health situation in Karnataka

Karnataka State falls in the middle with regard to state HDI rankings. Improvements in its health infrastructure over the years have resulted in a health and demographic scenario that is better than the national average. Crude birth rate (CBR) for the year 2000 was 22 per 1000 live births, crude death rate (CDR) was 7.8 per 1000 population and the infant mortality rate (IMR) was 57 per 1000 population (Narayan 2004).

However, gaps remain even in states like Karnataka that have improved their health infrastructure. These gaps are evident when based on residence, mother's education, religion, caste

[5] When no other source is indicated, references in this section refer to the following case study report: Narayan, Dr. T, Thomas, N.I (2004) 'Understanding Global Public Private Initiatives (GPPIs) based on a case study of the Global Alliance to Eliminate Lymphatic Filariasis (GAELF) in Karnataka State, India' (a case study report by the Community Health Cell). In such cases only the page number(s) is specified, within brackets.

and standard of living (p. 23). North Karnataka is a drought-prone, underdeveloped area, where poverty and migration are perennial problems.

Several advances have been made in health and health care in Karnataka over the past decades. Between 1951 and 2001, life expectancy at birth increased from 37.15 to 61.7 years for males and from 36.15 to 65.4 years for females. The infant mortality rate (IMR) declined from as high as 148 per 1,000 live births in 1951 to 69 in 1981, and even further in 2000, to 57. The crude birth rate fell from 40.8 per 1,000 people in 1951 to 22.0 in 2000, and the total fertility rate went from 6.0 children in 1951 to 2.13 in 1998-1999. Small pox has been eradicated. The state has become free of plague, and more recently of guinea worm infection. Worthy of note is the progress in bringing down the crude death rate by more than two-thirds, from 25.1 in 1951 to 7.8 in 2000. These results were achieved mainly through public health care programmes (p. 22).

The health system in Karnataka

Improvements in the health infrastructure over the years in Karnataka are evident from the increasing number of facilities prevalent in the area. The health system is still weak and fragmented, with several problems like large numbers of staff vacancies especially in critical areas with corruption, political interference, poor supervisory systems, apathy and a poor work ethic (p. 45). Vertical programmes – like malaria eradication and filariasis control among others – function as segregated, stand-alone programmes of the health department. Though they all deal with the same problem of vector-borne diseases, they are dealt with as separate issues, each with their own strategies, health personnel and targets. Each of them draws on the existing health system, thereby fragmenting it further. For example, centrally decided and vertically executed programmes have a tendency to divert resources and attention from people's problems and narrow it down primarily to distribution of drugs.

There is a relatively low level of public confidence in public sector health services, particularly at primary health centre level. The services' lack of credibility adversely affects the functioning of all programmes. As mentioned above, adequate staffing for public sector health services is a huge problem. The health centres, which incidentally are the only centres for follow-up for people in the area, are sometimes not equipped to provide sustained care or treatment – let alone disease control – to people suffering from filariasis (p. 47).

Lymphatic Filariasis in Karnataka

Karnataka is endemic for lymphatic filariasis; the population at risk is more than 15.3 million people. The number of microfilarial cases remained at around 1,500 per year in the 1990s, and decreased to around 1,000 per year in the first years of this century. The number of disease cases varied between 7,200 in 2000 and 6,100 in 2003, but these numbers are higher than at the beginning of the 1990s (p. 31).

The LF programme falls under the centrally sponsored National Filaria Control Programme (NFCP). This programme is operative in only eight districts endemic for the disease, namely, Gulbarga, Bagalkot, Bidar, Koppal, Dakshina Kannada, Udupi and Uttara Kannada (see map). Each district has a filaria control unit, and in selected towns in these districts there are 25 filariasis clinics and a survey cell in Raichur. The filariasis control programme (FCP) infrastructure is largely urban-based, although filariasis is equally prevalent in rural areas. From the total population at risk, only 1.5 million people are protected through the current modality of the intervention of NFCP (p. 35).

The case study

Community Health Cell (CHC) investigated GAELF in Karnataka. CHC is the functional unit of the Society for Community Health Awareness, Research and Action (SOCHARA). It is based in Bangalore. CHC supports community health action through information and advisory services, training and interactive discussions, participatory reflections and reviews, research and evaluation, peer group support, networking and solidarity, policy research and advocacy and action. The field study took place in Gulbarga and Bijapur districts in the North of Karnataka.

The methodology of the case study included:

- Revision of updated secondary sources of information and data on the health and health care situation in India and Karnataka,
- Policy analysis of GAELF and the National Filariasis Elimination Programme through interviews and revision of documents;
- Study of the implementation for the programme through field visits to health institutions in the periphery (sub-centres, primary health centres and community health centres) during which discussions were held with providers, patients and the community. Discussions and/or interviews were also held at the taluk, district, state and national programme unit level, and with other officials at the Directorate of Health Services;
- Document review and interviews were done at national level and with experts from the VCRC, Pondicherry. Health system professionals from academic institutions and NGO resource centres were interviewed. Links were maintained with the ongoing Right to Health Care Campaign of the Jan Swasthya Abhiyan (People's Health Movement in India).

More information on methodology can be found in Annex 3.

4.2.2.1 MDA for Elimination of LF implementation in Karnataka

As indicated, in 1997 the state adopted MDA with only DEC as a strategy for the elimination of LF. In any case, GAELF helped to put the issue of filariasis back on the government of Karnataka's health agenda.

Although information from the central government's regional office in Bangalore was difficult to find, some data about the last MDA that took place between 5 and 7 June 2004 indicated that DEC was administered in the targeted districts as well as in the district of Gulbarga. Gulbarga had not been initially targeted by the NFCP, but was in the end included because of the gravity of the spread of the disease. The field study found that in Gulbarga, with a population of more than 3 million people, about 2.07 million of them received DEC medication. This is a coverage of about 63% of the total population, which is below the 80% recommended as minimal coverage for bringing down the microfilarial load and reducing

transmission of the disease. For the MDA (Filaria Day) in Gulbarga, 90,400 health workers and volunteers were designated to distribute tablets door to door, and 976 supervisors were appointed to monitor this (p. 44).

The study in Gulbarga revealed that the NFCP is experiencing a number of problems. The most critical of these is the lack of personnel. Although the programme has positions for 55 staff in the units and 36 staff in night clinics, by the government's own estimates, only 41 people are working in the units and 26 people in night clinics. However, the real situation is far removed from the official statistics. For instance, in the case of the NFCP unit in Gulbarga, according to official figures the NFCP has 41 staff. All of these staff members are supposedly working, but a visit to the unit revealed that only 12 people are actually working in the unit. The remaining posts were either vacant, or the staff had been assigned to duty in other units. The situation of night clinics is also critical, because the staff who work during the day are also asked to work in the night clinics. Practically, this unit only provides treatment to infected persons and does not have the capacity to carry out vector control activities or provide disability management to infected individuals (p. 38).

The study found that another aspect hindering the work of filariasis control is the lack of trained personnel. In Karnataka there are eight NFCP units, three of which are in Gulbarga district. In the entire Gulbarga district there is only one person trained in filariasis control. The lack of training and growth options demoralises the staff in the NFCP units (p. 38).

The NFCP staff in Gulabarga units claimed that filariasis was not on the government's agenda of priorities. They pointed out that the health communication and promotion team does not cover filariasis when they conduct awareness camps or visits to villages. One of them remarked that, 'The health promotion teams do not even mention 'filariasis' by mistake when they conduct IEC in the community.'

The staff of NFCP interviewed during the field visits expressed the necessity of need-based intervention. They regard the current strategy as an imposed, techno-managerial exercise that is far removed from reality. The immediate need, according to them, is to equip the existing health centres to tackle filariasis, because they have direct contact on a regular basis with the affected population. Hence, all efforts must be made to ensure that rural health infrastructure functions optimally and that staff is trained to treat patients with filariasis and also to conduct preventive and promotive care for vector-transmitted diseases (p. 39).

The views of the staff were corroborated by the researchers' findings during visits to some health centres in the area:

a) At Mudhol Community Health Centre, about 80 kilometres from Gulbarga city, none of the three doctors were present, the pharmacist had been assigned from another centre and there was no staff nurse. It had been announced that the CHC was a 30-bed health centre, but only 10 beds were available.
b) The health centre of Kokonda covers a population of about 25,000 people through five sub-centres. A PHC officer said the PHC had 21 positions available, but only six of which were filled. The medical officer said they were under pressure from the district's deputy commissioner to carry out a pulse polio programme. Regarding filariasis, the officer said they have not been instructed to include it in their services. He said since he took charge of the PHC nine years ago, he has been seeing suspected cases of filariasis. He could not treat them, however, as they did not have drugs for this. He had been prescribing drugs and asked the people to get them from private chemist shops (p. 39).

The researchers also visited the Sedam taluk hospital, which supposedly housed a filariasis clinic and a night clinic. The taluk hospital is the nearest, and in many cases, the only accessible hospital for many of the villages in Northern Karnataka. The failure of filariasis control and treatment at this level points to a complete lack of any care for people affected by filariasis. A senior officer at the hospital said during an interview he had never heard of GAELF. He said the paramedical worker's post was vacant while the lab technician was assigned elsewhere. Commenting on the difficulty of running a night clinic, he said there was no lab technician to perform night sample collection, and he was planning to issue a memo to the staff about this.

He said that since January 2004 they conduct a night clinic every Friday.[6] The taluk health officer was away on pulse polio duty (p. 40).

In Bagalkot, Bijapur and Raichur districts, the researchers found that while many people received the drug, actual compliance with taking them according to instructions was very poor. These facts do not appear on the official reports, since the records only mention how many drugs were distributed (p.40).

The case of Bijapur adequately reveals how mass scale interventions can mask the need to implement stable care and preventive services. Bijapur is a district in the northern part of Karnataka, with a population of 1.8 million people, which falls within the filariasis endemic zone. More than 78% of the population live in rural areas. According to the official figures, 104 cases of filariasis were reported from four primary health centres (Sindgi, Mooratugi, Almel and Balaganoor). However Bijapur has no public facility for treating filariasis. People suffering from the disease have to go to Gulbarga district (Gulbarga or Hungund) or Bagalokot (Khamatagi or Ilkal), and for many patients it is not possible to visit the neighbouring districts because of the gravity of the disease or travel costs (p. 41).

The study raises the issue of side effects of the drug administered (DEC). According to official figures, in Gulbarga about 1% of the people experience adverse reactions after taking the drug. The study found there was insufficient training and support for the army of volunteers, because they were not prepared to handle adverse reactions or to explain why people become ill after taking the drug. The study also mentioned the case of five people, four of them children, who died in North Karnataka after taking anti-filaria drugs provided by the government (p. 36). The government claimed they were all suffering from other ailments when the drug was administered. The study quote that some local researchers that explain the drug could cause severe anaphylactic shock that could be fatal in patients with high levels of microfilaria in the blood stream, allergic reaction occurs on account of the toxins released by the microfilaria killed by the medicine (p. 42).

Regarding the issue of *participation,* the study found that decisions about eliminating diseases (as in the case of LF) and the methodology for accomplishing this are planned in an extremely centralised manner. Staff and lower level officers are not even consulted, and this stands in the way of involvement by the target communities in the programmes (p. 43).

4.3 GAELF in Kenya[7]

The health situation in Kenya

Key health determinants affecting the Kenyan people are extreme poverty and poor sanitation. Vulnerable groups are largely defined by a lack of education, low literacy (estimated at 70.9%) and inequality with regard to employment opportunities. The Gini coefficient for Kenya was 44.9 in 2002. Kenyans face both human and income poverty, with poor and vulnerable people bearing the highest burden of disease. Communicable diseases rank high, with malaria having the highest incidence rate in the country (32.6%). Other highly prevalent illnesses include diseases of the respiratory system, skin diseases, diarrhoea and worms. HIV/AIDS prevalence has decreased over the last few years, but continues to be high. Together these health problems account for over 60% of the country's burden of disease (Nyamor 2004). Lymphatic filariasis is not among the high-burden diseases of Kenya and is not regarded as a life-threatening health problem by the population.

Furthermore, under-five mortality increased from 98.9 per 1000 live births in 1990 to 111.5 in 2000, and a rate of 116 per 1,000 live births in 2003 (p. 23). This was accompanied by an increase of people living in poverty from 43.3% (in 2000) to 51.8% in 2002.[8]

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[6] However, in the five months since the night clinic started, the names of only nine people had been recorded in the register. This was highly improbable in a fully functioning filariasis night clinic, since the area is endemic for filariasis.

[7] When no other source is indicated, references in this section refer to the following case study report: Nyamor G. and C.I.N. Kenya (2004), 'Global Alliance For Elimination Lymphatic Filariasis in Kenya', (a case study report by C.I.N.). In such cases only the page number(s) is specified, within brackets.

[8] These are figures for the year 2002. For more details see Chapter 4 of Nyamor G. and C.I.N. Kenya A Case Study of Global Alliance For Elimination Lymphatic Filariasis in Kenya.

Health indicators are worse in rural areas compared to urban areas, and it takes 60 minutes or more to reach a qualified doctor for more than 60% of the population in rural areas (p. 23). Although significant gains in child health were recorded earlier, these have not been sustained. Contributing factors to this are poor access to health services, especially to essential drugs and referral systems (WHO Country Cooperation Strategy 2002-2005).

The sanitation situation in Kenya is fairly poor. Even though according to the World Bank Development Report 2002 about 84% of the population has good waste management systems, many other reports estimate this to be much lower (between 50% and 70%). Figures from the year 2000 indicate that 51% of the population has access to potable water.

The health system in Kenya

The several levels of the system are operated by public and private providers, with a higher coverage in urban areas. Key actors in the health sector include the MoH, which supervises, coordinates and monitors most health activities in the country; faith-based organisations are in charge of around 40% of health services in the country; national and international NGOs; donor agencies, donor governments; and privately run facilities which are very often out of reach of the poor.

The referral system operates at three levels: national (two hospitals), provincial (eight hospitals) and district (70 hospitals). The health sector is faced with inequalities and disparities due to two major reasons: firstly, it is a result of variations in resource endowment to different people, and second it is a result of inequity in government provision of essential goods and services. Only 30% of the rural population has access to health facilities located within four kilometres, while such access is available to 70% of urban dwellers (WHO Country Cooperation Strategy 2002-2005).

The quality of health services is low due to inadequate supplies and equipment and lack of personnel.

Currently there is a deficit in the number of professional staff, which is compounded by a rise in the number of those leaving for the private sector or to other countries. This has resulted in district health facilities being staffed with fewer and less qualified health personnel. In 2002 there were on average 14 doctors available per 100,000 people.

Aside from the severe lack of resources, Kenyans are also facing a higher and higher burden of total health care financing. Total expenditure on health was 7.8% of GDP in 2001.[9] Recent studies indicated that Kenya's per capita health expenditure is in the range of US$15 to US$21. This is slightly above the average spending level

[9] For more details on the financing and spending flows of the health system, we refer to National Health Accounts (NHA) figures of Kenya, which can be found in the World Health Report 2003, Table 5. A breakdown of data for example on public/private expenditure and external resources for health is also provided.

of US$16 for the countries of sub-Saharan Africa with moderate health sector expenditures (p. 33). Currently, households are contributing over 50% of total health sector expenditure, the bulk of which is out-of-pocket payments for medical care and over-the-counter payment for drugs (p. 29). The introduction of cost-sharing in health provision in the late 1980s[10] has led to a decrease in health-seeking behaviour and an increase in mortality and disease prevalence figures (especially for the communicable diseases).
Equity in health expenditures is still an issue, with only 30% going to the rural areas where 80% of the population live. Government allocation of resources is skewed towards the curative sector rather than to preventive and health promotion interventions.

About 40% of the recurrent budget for health and 90% of the development budget is dependent on donor financing. Due to an inadequate and irregular supply of drugs and non-pharmaceuticals, there is a tendency to rely on private pharmacies, local shops and unlicensed drug vendors, resulting in the misuse of drugs. The over-reliance on donor support for the supply of drugs and vaccines raises serious issues of sustainability (WHO Country Cooperation Strategy 2002-2005).

Lymphatic filariasis in Kenya

Lymphatic filariasis is endemic in six districts along the Indian Ocean coast, with microfilaria prevalence ranging between 9% and 28%, hydrocoele prevalence ranging between 10% and 40% and elephantiasis prevalence ranging from 6% to 10%. Currently, a population of about 2.5 million people are at risk, with some 700,000 believed to be infected (either with microfilaria in the blood or showing signs of disease).

However, LF is ranked very low across most provinces of Kenya and does not even make the 5% of disease prevalence. This is thought to be because the disease has been neglected, and people with no overt signs are not counted as they don't realise they are infected.

An extensive study on LF prevalence was completed in 1973. Following this study, trials on MDA (DEC) in a few coastal communities and Indian Ocean islands indicated that the mf (microfilarial) rate could be reduced by 75% in most communities if DEC was given annually. This was the basis for the LF control strategy as part of the 1999-2004 National Health Strategic Plan, but the government did not have either the capacity or the political will to initiate MDA in endemic districts.

The case study

GAELF in Kenya was investigated by the Tropical Institute of Community Health and Development (TICH), based in Kisumu, and the Consumer Information Network Kenya (CIN), based in Nairobi. The field study was carried out in Kilifi district, with focus on Bahari and Kaloleni divisions.

The study involved mainly qualitative methods, including the following:

- Literature review of documents relevant to the subject.
- Key informant interviews with PELF national, provincial and local programme managers, health service providers and beneficiary community members.
- Key informant interviews were also conducted with institutions that recently collaborated with the PELF in Coast Province. These included NGOs, media companies, civil service organisations (CSOs) and faith-based organisations.

[10] These adjustments are part of the lending policy and criteria set by the World Bank/IMF.

- Testimonies of LF victims and their caregivers in Kilifi district. These included talks with two LF victims from each district.
- Focus group discussions were carried out with different target groups to capture their attitudes, perceptions and beliefs about the disease and the programme.

For more information on methodology, please see Annex 3

4.3.1 GAELF implementation in Kenya

Kenya joined GAELF in August 2001 after the WHO identified it as an LF-endemic country. The Kenyan government then formed the National Task Force for the Elimination of Lymphatic Filariasis (NTF–ELF) to implement the programme, which is integrated into Kenya's disease control programmes and health activities. This task force has strong links with decision-making and policy-making levels of the Kenyan government. It is composed primarily of MoH staff, and is the key decision-making body for the programme.

The national programme manager is the secretary to the NTF–ELF, and is also the adviser to the implementation units of LF-endemic districts known as District Health Management Teams (DHMTs). These district teams mobilise community members and carry out PELF activities through hospitals, health centres, community dispensaries and community health workers. Work plans and corresponding budgets are drawn up by the DHMTs and then sent first to the national programme manager for approval before being sent on to the WHO through the Provincial Medical Officer's (PMO, the head of the province's health services) office for financing. Once the WHO approves the work plans, it issues cheques through the PMO's office for disbursement to the DHMTs. There are no clear criteria to determine who receives what kind of funding (p. 54).

The strategy for the approach to the disease has three components: plans for disability control and prevention, MDA and integration of vector-control measures with the malaria and vector-control programme. In practice, most attention has been placed on the MDA, resulting in its successful implementation in a few districts. Disability control has had very little implementation, and there has been no implementation at all of vector-control measures. Collaboration with Roll Back Malaria is futile because both of them have limited funding (p. 49). At the same time, GAELF has enabled Kenya to undertake LF elimination activities that it would not otherwise have been able to do.

We had an LF control strategic plan that was clearly stipulated in the National Health Strategic Plan 1999 to 2004, but due to financial constraints the programme could not be implemented. When Kenya joined GAELF, funds became available enough for MDA in three districts and we are hoping to receive more funds to complete all the required subsequent MDA and other activities. Before PELF, nobody could allocate funds for LF activities leaving out malaria and other diseases. – an MoH functionary in Mombassa, in appreciation of the programme (p. 43)

The first MDA using DEC and albendazole was successfully effected in September 2002 in Kilifi district. Even though it was the first implementation, it covered a population of 474,773 out of the district population of 586,140, translating to 81% of the target district population.

In October 2003, another round of MDA followed, covering three districts: Kwale, Malindi and Kilifi. This time Kwale district covered 85% of its population, while Malindi district covered 76% and Kilifi district (which was having its second round of MDA), covered 75% of the district population. Drug distribution was house-to-house and was conducted by community drug distributors. The per capita treatment cost of MDA was estimated at US$0.16 (p. 48).

So far, what has been carried out since the onset of the programme includes the following: community mobilisation, training of health personnel, recruitment of community volunteers, MDA in the three districts (namely Kilifi, Kwale and Malindi) and two hydrocoele surgical corrections. The other three endemic districts still have not had MDA because of financial constraints.

PELF has probably had a positive effect on improving the nutritional situation, especially among children, because worms are expelled after taking albendazole. This effect has contributed towards the popularisation of PELF in the areas covered (p. 61).

One of the main problems for the programme's implementation is the financial constraint. It has stood in the way of the simultaneous MDA in bordering districts (some who have had MDA and some who have not) where people regularly interact. This, coupled with delays in subsequent MDAs, may compromise the efforts of the programme, and eliminating LF may take longer than initially planned. Programme functionaries expect delays in programme activities because of limited funding at the global level as well as the processes involved in getting local funding (pp. 52-60)

Training and capacity-building is an important aspect of the programme and is given priority in its implementation. The programme managed to implement the training strategy among MoH staff. There was a good deal of training of the health staff: they had a review of all aspects of LF and were then trained as trainers (TOTs). CHWs and community volunteers, however, were instructed only to carry out the programme's activities.

Both at local and national levels, there is evidence of incompetent planning among the programme management. This was evident when two consecutive mass chemotherapy campaign days were cancelled at the last minute, leaving community members stranded and confused. The delays were attributed to logistical problems. On one occasion, the delay resulted from delayed payment and production of IEC materials. The community and the CHWs condemned the delay and put the blame on the health personnel. The health personnel, on the other hand, were helpless and disgusted by how events unfolded.

Some community participants (volunteers) never received all their allowances as promised, and health personnel who worked overtime are still waiting for payment. Key informant interviews with two public health technicians showed low confidence in the programme (p. 48).

I wish I am not involved in it again, and this is because it was so involving but at the expense of your other plans and activities, and again there is almost nothing to motivate someone. A female public health technician

Concerning the impact of the programme in the national and local health system, GAELF in Kenya is not undertaking any activities to strengthen the national and local health systems. Instead,

… the programme totally depends on existing and available health staff and volunteers, who feel that they are overworked, understaffed and are not remunerated properly. The programme management has been networking with other non-governmental development organisations to support the programme (p. 44).

The study revealed that the GAELF programme in Kenya created distortions in other programmes as a result of being implemented through the existing health system and by the available health personnel.

The already overburdened MoH staff spend time and other resources on PELF activities at the expense of other programmes. This happens particularly with the programme coordinators, since they do have a series of other activities to attend to. The additional commitments include organising workshops, training, field visits, conducting MDA and being on standby for adverse drug reactions of clients, among other things. The programme activities also aggravate the pressure already exerted on health machinery and equipments particularly the vehicles … The entire programme is at the expense of other health programmes, compromising their effectiveness, and this trend weakens the entire health system (p. 60).

The national LF elimination guidelines stipulate that policies and activities should be implemented properly, however, the Kenyan health system is poorly equipped to provide even the most basic health services to meet the main health needs of the population. The policies and strategies therefore end up complicating the health system rather than making it more beneficial and tenable to the population (p. 48).

The issue of the use of albendazole was also raised by the study in Kenya, particularly because albendazole is contraindicated in pregnancy, but during MDAs there is no mention of pregnancy testing for women suspecting to be pregnant, particularly in the villages where women are often uncertain about their pregnancy status in early stages. Demographic data was normally taken,

including asking women whether or not they are pregnant, but this question cannot confirm a woman's pregnancy status. Although no cases have been reported, the implication is that women in early stages of pregnancy could suffer the adverse teratogenic effects of albendazole on pregnancy. The fact is that people have not been informed.

Concerning *participation* at the international level, at the time of the study African countries were not represented on the GAELF board at the WHO in Geneva, but only through the African Regional Programme Review Group. Kenya is not represented in this group and as such cannot fully participate and influence global GAELF directives (p. 54).

At national level, a few stakeholders (including Kenya Medical Research Institute, the Centers for Disease Control, African Medical and Research Foundation (AMREF), the German International Cooperation Agency (GTZ) and University of Nairobi Microbiology Department) have the opportunity to participate in decision-making on issues related to LF, but because meetings are rarely held they cannot participate fully. The study revealed that GAELF did not undertake formal consultations with all relevant parties, and that the programme is not well known; the participation of private-sector organisations is very limited. Most organisations are unaware of the existence and operations of the GPPI (p. 50).

Community leaders are mainly involved in community mobilisation and education to raise awareness, and in any socio-cultural issues that may arise.

We were just told that a programme has been initiated to rid the community of elephantiasis and hydrocoele and that we should mobilise community members. – A community leader from Kilifi district

The community members, therefore, participate mainly as patients during campaigns and MDAs. Their participation is limited to implementation and compliance with medicine. The programme offers limited opportunities if not non-participation in the decision-making related to activities in their own communities.

Although, as mentioned earlier, GAELF has made it possible to start LF elimination activities, the *sustainability* of the programme is a critical matter. PELF in Kenya depends almost entirely on donor funding. The programme often interrupts its programme when funding isn't available and this compromises the effectiveness of the implementation, as districts have to wait extended periods of time for implementation and then repeat dosages of drugs. PELF managers need to seek funding from other development agencies that operate locally, such as the Danish International Development Agency (p. 50). At the moment, because the programme is of limited duration there are no plans to promote ownership of the programme by the national government, the health districts and the communities.

4.4 Conclusions on the Global Alliance to Eliminate Lymphatic Filariasis – GAELF

- This GPPI is aimed at tackling what is a significant public health problem worldwide. A considerable number of persons around the world – particularly those in most poor countries – are at risk or are already suffering from the disease. Lymphatic filariasis is a disease that has serious economic and social consequences for those who suffer from it and their families.

- The case studies found that GAELF made it possible for countries to revitalise their programmes for the elimination of the disease and increase awareness on its incidence and burden. This was done by advocating for action to eliminate it, giving technical and financial assistance and supplying drugs for the implementation of programmes.

- The implementation of GAELF activities for tackling lymphatic filariasis using MDA has resulted in increases in the number of people receiving drugs to eliminate it. In the cases of Kenya and the districts taking part in GAELF in Tamil Nadu, India, the studies found that the coverage of persons receiving the drugs is higher than the percentage technically required for elimination of the disease within the given period. Even so, the information available refers only to coverage of people to whom the drugs were handed out, and not to its actual intake.

- Lymphatic filariasis elimination (LFE) by means of MDA makes it necessary to employ a large number of community health workers (CHWs) to distribute and supervise the correct ingestion of drugs and advise the users about adverse reactions. The case studies segment of this report shows that these activities were not implemented satisfactorily. For instance, in the case of Tamil Nadu, the actual and correct intake of the distributed drugs cannot be entirely guaranteed due to the lack of follow-up and supervision at household level by CHWs, which jeopardises the efficacy of the programme. The main reason for this was that these massive operations require timely availability of skilled staff and other resources and well-organised planning and supervision capacity at district level: a critical issue in many rural areas.

- The treatment of disabilities that result from the disease is included in the GAELF programme objectives as an integral part of an intervention to tackle lymphatic filariasis. The case studies in India and Kenya showed that this component of the initiative is not being properly implemented in the areas where the programme is active, and is sometimes not implemented at all. This is an important omission because of the serious economic and social effects of this physical impairment.

- In its approach, the initiative does not take into account actions aimed at tackling the underlying causes of the disease like accessibility to safe water, adequate housing and sanitation. The inclusion of preventive actions in inter-sectoral collaboration to deal with these matters would make GAELF intervention more coherent, particularly because its programme is directed mainly at deprived socio-economic groups among which lack of these basic facilities is very common. This would also contribute to broader development goals such as poverty eradication.

- In the countries where the case studies took place, LF control activities were previously closely related to the control of other vector–related diseases like malaria. The case studies found that GAELF activities are not attempting synergy or collaboration with these important programmes, although according to the partnership, efforts to control filariasis in populations by reducing the numbers of mosquito vectors have proven largely ineffective.

- The case studies identified another crucial element related to MDA programmes that needs to be examined to consider the prospects for this initiative. These massive actions require the concentration of huge numbers of competent health workers for certain periods of time. Although the case studies described here refer to various contexts, most of the places where GAELF initiative activities were implemented were located in deprived areas in poor countries that frequently lacked qualified personnel and sufficient equipment. During an MDA activity, these already weak health services are overwhelmed with extra activities. This causes disruption of the normal activities in these health services, in any case before and during the MDA campaigns.

- The case studies also raised the issue of the use of albendazole as a part of the approach to eliminate the disease. No conclusive evidence has been found that strongly confirms the use of this drug for the elimination of LF. Moreover, the use of albendazole requires the systematic implementation of preventive measures to avoid teratogenic effects of the drug when it is used by women who might be pregnant. The studies in India and Kenya showed that at this moment the local health systems are not able to perform these preventive measures properly due to a structural lack of human and material resources.

- The programme is based heavily on donations from two powerful pharmaceutical corporations that are committed to long-term delivery of the drugs needed. Although this assures provision of the drugs needed to eliminate the disease, it also makes the initiative and the countries very dependent on these companies for completing the initiative.

- With regard to drug donations, a particular issue was raised by the study in India because the generic type of the donated drug (albendazole) is produced in the country, creating a negative effect on the sustainability

of the programme and impairing the local pharmaceutical market in the short and long term.

- GAELF has a significant shortage of funds, at least at the time this study took place. Such a situation at global level together with the secondary priority given to the elimination of the disease (probably related to major priorities as HIV/AIDS, malaria and tuberculosis) creates some uncertainty about the future progress of the initiative.

- In the case of Kenya, the national structure in charge of the initiative's implementation in the country is finding it very difficult to maintain continuity and progression of the activities because of a shortage of external funding combined with limited resources provided by the national government for new activities.

5 Roll Back Malaria – RBM

5.1 The GPPI

Malaria

'Malaria… is one of the major public health challenges undermining development in the poorest countries in the world.' Today approximately 40% of the world's population is at risk from malaria, mainly those living in the poorest countries throughout the tropical and subtropical regions of the world. Malaria is endemic in 130 countries, ranking eighth among the world's leading causes of ill health and eleventh among the leading causes of death. Malaria causes 300 to 500 million episodes of acute illnesses and 1.2 million deaths annually. 'Ninety percent of deaths due to malaria occur in Africa south of the Sahara, mostly among young children. Malaria kills an African child every 30 seconds, and is the leading cause of death in children under five years' (RBM 2004).

Malaria is a disease of poverty. Of all malarial deaths, 58% are concentrated in the world's poorest 20% of people– the highest association of any disease with poverty. These people lack adequate housing and bed nets and medication are often unaffordable. Malaria parasites are increasingly resistant to current drugs, and the WHO does not foresee the emergence of an effective vaccine for the disease in the near future.

The Roll Back Malaria Partnership

The WHO launched the Roll Back Malaria Partnership in November 1998. The partnership has a global coordinating function and provides technical guidance for the fight against malaria. By 2010, the partnership aims to reduce the burden of malaria by half.

In 2002, an independent evaluation of the RBM partnership found that there had been major accomplishments: in advocacy, indicated by an increase in global awareness of the problem; in resource mobilisation, indicated by a large increase in global spending and in consensus building, indicated by an agreement on priority interventions and common targets. The evaluation also indicated an inconsistent technical advice to malaria-endemic countries by RBM.

The strategy

Roll Back Malaria (RBM) campaign consists of six key elements: effective treatment, rapid diagnosis and treatment, multiple prevention, focused research, well-coordinated movement and dynamic global partnership. During the Abuja Malaria Summit in April 2000, African heads of state committed themselves to an intensive effort to reduce malaria mortality by half for people in Africa by 2010 by implementing the following strategies: prompt access to effective treatment, insecticide-treated nets (ITNs), prevention and control of malaria in pregnant women and children and malaria epidemic and emergency response. Implementation of Roll Back Malaria: the RBM principles are usually integrated in national malaria control programmes. RBM usually supports governments in applying for funds from the Global Fund.

The partners

RBM has four founding members: the WHO, UNICEF, UNDP and the World Bank.
The WHO plays a central role in the partnership – it is represented on the board and is a voting member. The RBM Department within the WHO is responsible for strategic formulation, operations support and capacity development, and coordination of the WHO's global efforts to roll back malaria. It establishes and promotes WHO policies, normative standards and guidelines for malaria prevention and control, including monitoring and evaluation.

Role of pharmaceutical companies

In general, companies do not make contributions directly to the RBM Partnership, but to separate, associated GPPIs. Novartis provides its antimalarial drug Coartem® for use in the public sector at reduced cost through the WHO-Novartis Coartem® partnership. It signed an agreement with WHO/UNICEF for these supplies. Various companies, including Novartis, Bayer and GSK are involved in the Medicines for Malaria Venture (MMV) for the development of new antimalarial drugs. Bayer supports the expansion of insecticide-treated bed nets through Netmark

Plus, and coordinates the bed net distribution logistics (Weyzig 2004b: 8).

At least some of the companies have important business interests in their involvement with the partnership. The RBM partnership creates a large demand for artemisinin based combination therapy. These are relatively new medicines, protected by patents that allow the companies that developed them to recover their Research & Development (R&D) costs and to make high profits. Current manufacturers of ACTs and Artemisinin-based components of ACTs include Novartis and Sanofi Aventis. Recently the RBM board decided that a 'promise to buy' could bridge the gap between the quantity of ACTs that would be required to meet the RBM's targets for access to treatment and the quantity that is being produced by the pharmaceutical companies at present (Weyzig 2004b: 9).

Governance

Initially, RBM was loosely structured in order to increase flexibility and avoid a high management burden. After an independent evaluation of the partnership in late 2002, the RBM initiative was restructured to make partners more accountable and to accelerate malaria control programmes. The RBM partnership secretariat was separated from the WHO Malaria Control Department. Before this, failures of the RBM were easily attributed to the WHO. The partnership board was extended and a seat for a private sector representative was added because of the important role of the industry in scaling up supplies of ACTs and impregnated bed nets. The board has 17 voting members, six of which are from malaria-endemic countries (Weyzig 2004b: 14). In Annex 3, the governance structure is described in more detail.

Transparency

With regard to transparency, minutes and summary reports of recent meetings of decision-making bodies are available on the website, and information about the composition of the board and the secretariat is easily available. This contrasts, however, with 'the lack of disclosure of agreement for other GPPIs linked to it.' The agreements made in the WHO-Novartis Coartem® and the Netmark Plus partnerships are not available to the public. The independent evaluation of 2002 also pointed out a number of problems in the way the partnership functioned, including a lack of accountability (Weyzig 2004b: 17).

Funding

Major funding for RBM activities comes from donor governments, the Gates Foundation, UNICEF, the World Bank and the WHO. More recently, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has become a major donor and committed US$895 million over two years, considerably increasing malaria budgets. However, some point out that funds for malaria control are still largely insufficient (Weyzig 2004b: 16). At present, all donors contribute to specific elements of the partnership and the secretariat only has a coordinating function. The budget of the partnership secretariat itself, around US$23 million in 2004, covers only personnel and administrative costs.

The problem of funding is critical. Harvard researchers estimated that the total international aid for malaria control in 2000 was just US$100 million, and it has been calculated that US$1 billion per year would only pay for artemisinin-based combination therapies for around 60% of those who need it. Hence, although annual spending on malaria has increased since then because of the creation of the Global Fund – as an example, as of 23 October 2003 the fund had disbursed US$37.3 million to malaria programmes (Jon Liden, personal communication 2004) – this is still nowhere near the amount needed (Yamey 2004).

The Dutch contribution is made through the WHO, and the WHO (and not the RBM Partnership) is responsible for the use of these funds. Other donors make their contributions directly to the RBM Partnership, which is preferred by the partnership secretariat. A separate system exists for funds from the GFATM. These are disbursed via Country Coordinating Mechanisms. These CCMs consist of a broad range of stakeholders that coordinate grant proposals and monitor the implementation of approved proposals.

Furthermore, the burden of malaria continues to worsen despite the fact that RBM has been operating for three years. This deterioration is due to both increased illness and death in the endemic areas, and an expansion of these areas.

5.2 RBM in Tanzania[11]

The health situation in Tanzania

Tanzania is one of the poorest countries in the world, with an annual per capita income of approximately US$257 (2002 census). Agriculture contributes 48% of GDP, with the majority of the population living in rural areas. The economy is therefore susceptible to fluctuations in world market prices and to climate changes. Foreign funds account for 41% of the total government budget. Thirty-six percent of Tanzania's 36.6 million people live below the national basic needs poverty line; of these, 51% are women and 46% are under the age of 15. In 2002, Tanzania's Gini coefficient was 38.2. The country was ranked 151 on the Human Development Index (HDI) for the year 2002.

A number of factors impact negatively on the health of the people of Tanzania: poverty, low literacy rate and a lack of basic amenities, in particular clean water and adequate sanitation. Communicable diseases remain a serious public health problem in Tanzania despite continued efforts to prevent and control them (MoH Tanzania 2003: 11).

In Tanzania life expectancy at birth (for the total population) is estimated at 46.5 years. The under-five mortality rate is 165 per 1,000, and the infant mortality rate per 1,000 live births is 104. The leading problems for outpatient treatment in the country are uncomplicated and complicated malaria, acute respiratory infections, pneumonia, diarrhoea, complications of pregnancy, TB and eye infections. The top causes of death are acute febrile illnesses such as malaria, TB, HIV/AIDS, diarrhoea diseases, stillbirths, acute respiratory infections and other undetermined cases.

The health system in Tanzania

In the first period following independence in 1961, there was a rapid expansion of the health infrastructure and free service provision financed through tax revenues and external donor support. However, countrywide coverage was not achieved. In the period from the late 1970s to early 1990s the government encountered increasing difficulties in sustaining the health system due to drastic cuts in public expenditures on health.

As part of its reform process, in 1993 the government introduced cost sharing (user fees) because there were insufficient financial resources to support the expansion of public health services that occurred between 1960 and 1990. Thereafter, other financing options such as Community Health Fund and National Health Insurance were introduced (MoH Tanzania 2003: 18).

An exemption and waiver programme was introduced to ensure that the vulnerable, the poor, children under five and pregnant women received access to medical services. However this programme does not work because among both health workers and community members, awareness of the exemption schemes is very low, this is because the Tanzanian Ministry of Health (MoH) guidelines are confusing and not well understood, and urban health workers sometimes delay the exemption process if there is insufficient information on a patient's financial capacity.

According to the MoH, the government health expenditure per capita is US$5.8 (fiscal year 2002-2003). The government health budget amounted to US$97 million in 1997. The total donor support to the health sector amounted to US$19.8 million and US$20.6 million for 1996 and 1997 respectively, or about 21% of the total budget. The major share of donor financing has gone to preventive programmes of various kinds. According to the *World Health Report 2000,* the total expenditure on health as a percentage of the GDP was 4.8% (WHO Country Cooperation Strategy 2002-2005).
Between 2005 and 2015, Tanzania requires on average US$35 per capita annually to be able to fulfil the health-related Millennium Development Goals (MDGs), compared with US$11 spent on all health issues today. Of the US$11, the government spends US$5 and households pay the remaining US$6 per capita per year.[12]

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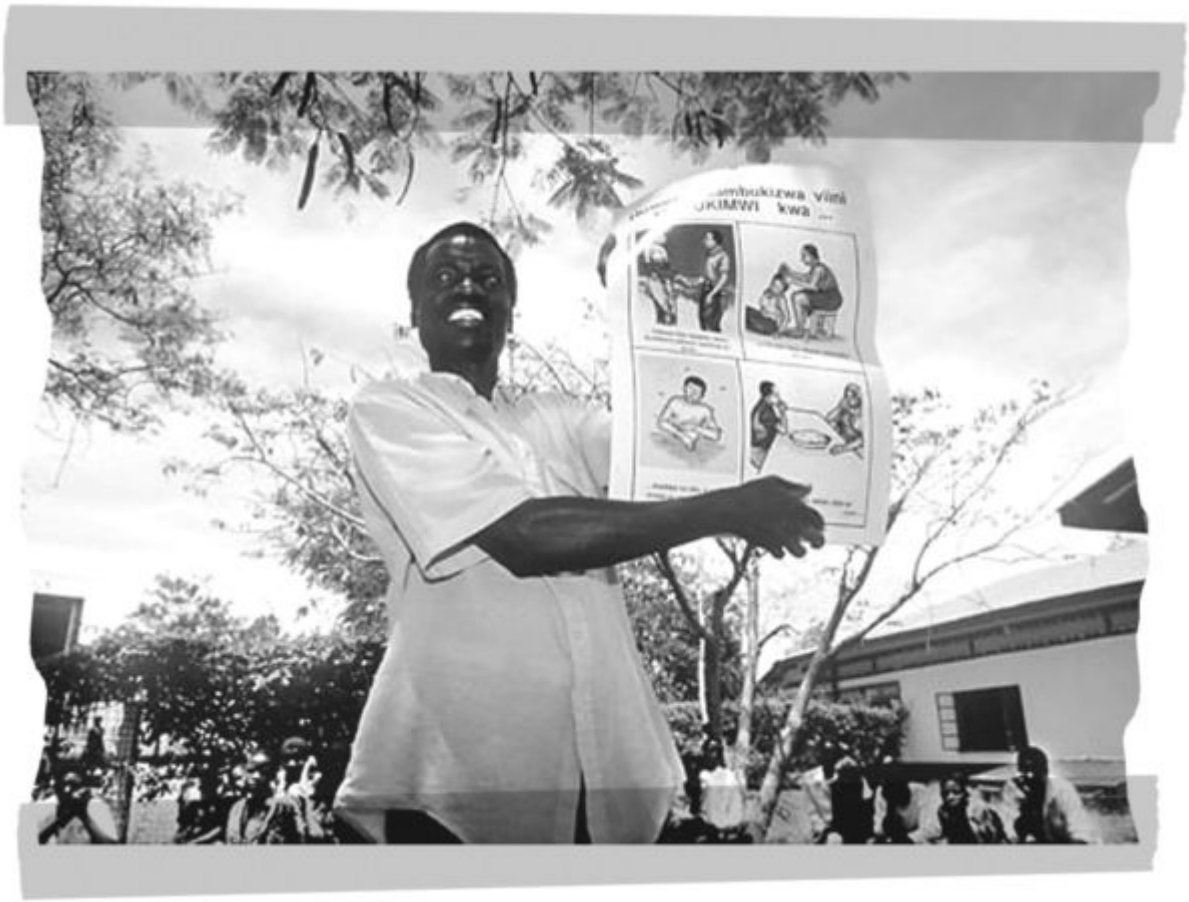
[11] When no other source is indicated, references in this section refer to the following case study report: (2004), 'The Roll Back Malaria Initiative Study Tanzania' (a case study report by the Ifakara Health Research and Development Centre and Peoples Health Movement). In such cases only the page number(s) is specified, within brackets.

[12] There are no figures on the total expenditure on health as a percentage of GDP available.

The main actors in the Tanzanian health sector are:

1. *The Ministry of Health:* sets standards and sector policy for the provision of services.
2. *Private sector:* increasingly recognised as a legitimate actor in service delivery, often receiving public financing for specific populations and/or services. The private-for-profit sector tends to provide relatively low-cost, but also low-quality, care. In 1996, the government suspended the licenses of almost half of all private facilities because of concerns about service quality.

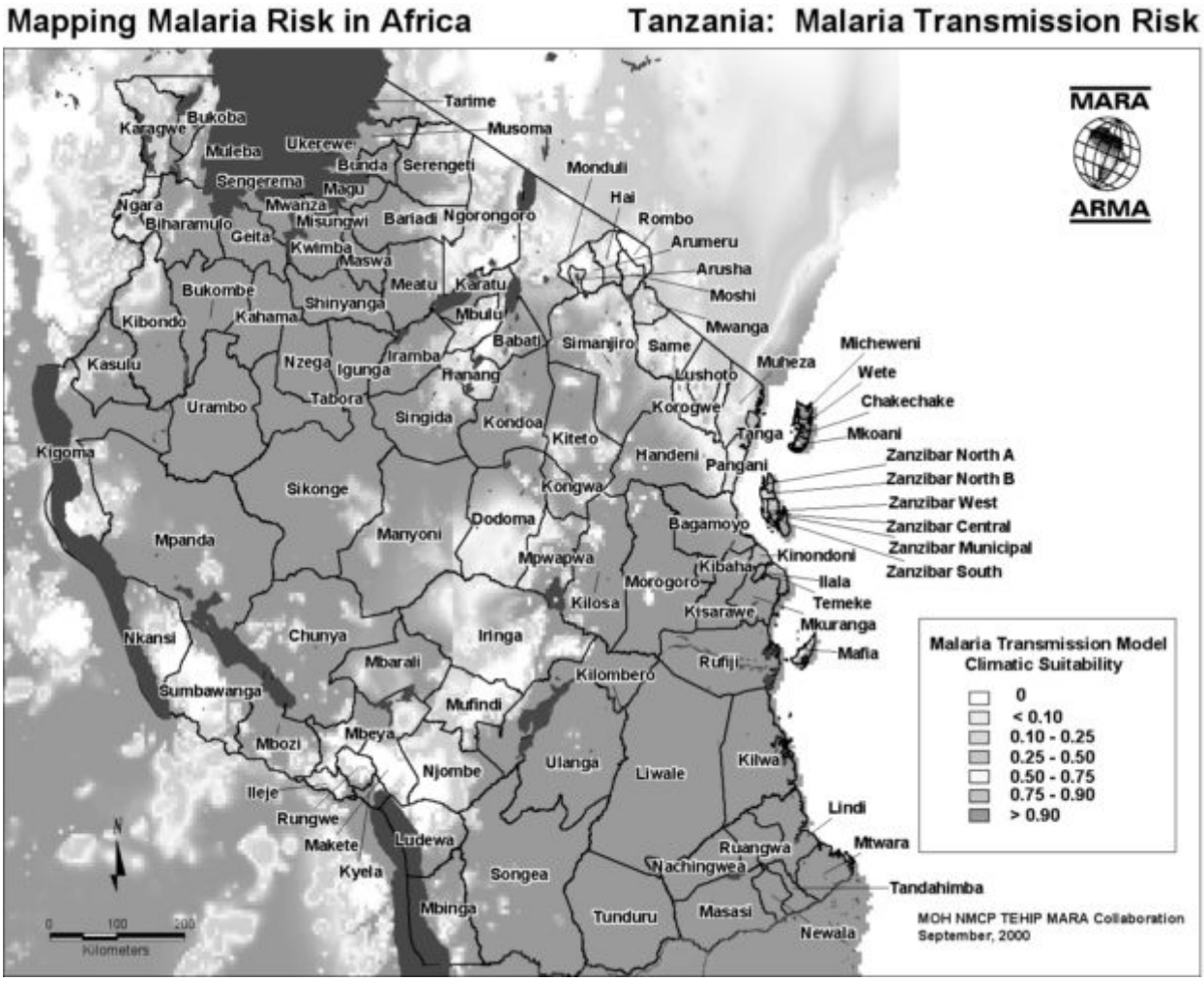


The health services system is a pyramidal referral system, including village/community health services that provide preventive services, staffed by two village health workers who work voluntarily with occasional allowances from the village government, dispensaries, health centre services, district hospitals and regional hospital services. A health centre caters for 50,000 people and supervises all the dispensaries in the division.

Continued expansion of human resources and distribution of basic infrastructure over the past few years led to disparities between salary costs and operating expenditures, resulting in declining service quality and reduced overall performance (MoH Tanzania 2003). Throughout the 1990s, access to health services remained relatively good, while quality and continuity of care remained a problem.

More than 80% of Tanzanians live within 10 kilometres of health facilities, which is considered 'reasonable coverage' in terms of physical accessibility. However, the health facilities are often serving more people than their capacity allows. Most facilities do not provide conducive environments for people with disabilities, under-fives, pregnant women and other underprivileged groups.

Tanzania saw continual reductions in its 67,000 registered health workers in 1994-95 as part of civil service reforms. A rough estimate shows that about 45,000 or about two-thirds of these are directly employed by the government (Møgedal and Stenso 2000). Private medical practice, which had been banned after independence, was permitted again after 1994. In the 1999-2002 MoH work programme the focus was on promoting private-sector involvement in service delivery.



Malaria in Tanzania

Today 31.6 million people are currently at risk from malaria in Tanzania. That number is expected to increase to 40.9 million by the year 2010. Of these people, 75% live in perennial or seasonal transmission areas, resulting in a continued cycle of infection and suffering, and hence poverty and stifled economic performance. The disease is endemic in most regions of the country, especially in the coastal areas and the west of the country. See map for details.

Malaria is the leading reason for health service utilisation, and ranks number one in both inpatient and outpatient statistics in all regions. An estimated 14 to 18 million malaria cases per year result in 100,000 to 125,000 deaths, the majority of which are young children, youths and pregnant women. Of this number, 70,000 to 80,000 are children under the age of five. The disease is the largest single cause of morbidity and mortality in Tanzania, accounting for 34% of deaths of under-fives and 23% of deaths of over-fives in 1996. This accounts for 30% of the total number of Tanzanian life years lost.

Malaria accounts for 30% of Tanzania's total burden of disease, and 39% of all health expenditures directed in curative activities for all diseases (1.1% of GDP). Of this amount, 71% are household expenditures in the formal and informal sectors. An estimated $US 2.14 is spent in Tanzania per person (government and private expenditures) per annum on malaria services.

'Malaria costs the country at least 3.4% of its Gross Domestic Product each year (US$240 million) through the cost of treatment and prevention, the direct costs of deaths that result from infection, reduced productivity in the workforce and absenteeism from education (p. 37).

The case study

The Roll Back Malaria Partnership was investigated in Bagamoyo district, in the coast region of Tanzania by the People's Health Movement East Africa and Ifakara Health Research and Development Centre. The study was conducted at four levels, namely at community, health facility, school and institution/NGO level. A total of 50 key informants were interviewed.

The study applied a range of methods including literature review, individual interviews and focus group discussions (FGDs). Data from the field was manually analysed by the two senior researchers using a grouping system.

More information on the methodology of this case study can be found in Annex 3.

5.2.1 Implementation of RBM in Tanzania

Although the Tanzanian government has long had a system in place to address malaria, because of a lack of resources it was unable to adequately run it. Tanzania adopted the strategy and the action plan agreed in the Abuja Summit in 2000, and established a National Malaria Medium-Term Strategic Plan aimed at reducing morbidity and mortality by 21% by 2007, and by 50% by 2010.

RBM was to rejuvenate the existing Tanzanian National Malaria Control Programme (NMCP). This programme falls under the Epidemiology and Disease Surveillance Unit of the Directorate for Preventive Services in the MoH. This unit is also in charge of other national programmes such as those focussed on AIDS, TB/leprosy and the vector control programme. The NMCP is integrated into six cells: administration, case management, ITNs, information – communication (IEC), operational research and epidemics. RBM is integrated in the overall system of the NMCP with the RBM partners acting as advisors. This programme operates under a heavy bureaucratic structure and therefore has limited autonomy to operate effectively and also little room to coordinate and collaborate with partners. Tanzania decided to implement RBM within the framework of the country's health reforms, giving room for strong participation by the private sector.

The main actors in the implementation of the RBM initiative in Tanzania are the WHO, UNICEF and the Tanzanian MoH, although one key informant said the WHO plays almost no part in the initiative. Many other agencies, such as the Japan International Cooperation (JICA). UK Department for International Development (DfID), the World Bank, the Italian Development Cooperation and the Netherlands Ministry of Foreign Affairs, NGOs and private sector organisations fund and support the implementation of the NMCP. Most but not all of the international agencies support the programme through a 'basket fund' mechanism. For instance, in addition to the fund USAID also supports some elements related to the intermittent treatment of pregnant women. WHO and UNICEF primarily support the MoH in soliciting funding from other donors and the Global Fund. The national programme has many different funding sources to deal with, and the coordination between sponsors is troublesome because of their diverse interests in parts of the programme and their different administrative requirements. Participating NGOs are joined together in a Malaria Forum, but are not involved in the programme's decision-making.

The programme strategies are in line with the RBM global strategy components:

a. Effective malaria case management.
b. Vector control focused on the implementation of the National Insecticide-Treated Net Campaign, aimed at substantially increasing the coverage and use of nets nationwide. NMCP continues to monitor evidence from the vector-control interventions, which is said to provide very little evidence of effectiveness with regard to possible inclusion in subsequent plans.
c. Malaria Prevention in Pregnancy, that is, that all pregnant women are required to attend antenatal clinics and receive a full dose of sulfadoxine-pyrimethamine (SP) at least twice during the course of their pregnancies.

The use of ITNs is a central component of RBM strategy in Tanzania. The availability of these nets has improved: while a decade ago bed nets were available in few shops in big towns at a cost of from US$10 to US$15 each, today nets are available in small stores and are even sold door-to-door at subsidised prices of under US$4 (Ifakara 2004). The private sector has been given a key role in this. With regard to the manufacture of the nets, three local factories are subsidised to produce 3 million nets per year, and in the distribution at local level, shopkeepers use a voucher system called 'Haty Punguzo' in Swahili.[13]

Although reliable figures are not available for Tanzania, in some pilot areas positive results have been reported, for example, that the coverage with nets increased from an initial range of 5% to 10% of households to 30% to 60%. In the Rufiji district, the demographic surveillance system – as part of the Tanzania Essential Health Interventions Project (TEHIP) – reports that the use of ITNs had increased from less that 10% of the households in 2000 to 23% in 2002, and that 13% of the children are sleeping under an ITN. This district also reports that 34% of the ITNs are being re-treated. But at the national level, there is evidence that in rural areas only approximately 5% of the households have bed nets (p. 30).

For years, the NMCP has had a critical shortage in numbers and quality of staff, who lack the necessary skill mix and administrative support (p. 31). The study found that these structural deficiencies plague the NMCP.

The problem is that the system does not yet have quality of service. And there cannot be any quality of service when there are no or not enough qualified staff in place. – NMCP Manager (p.19)

Although Tanzania has received funds from the Global Fund to implement RBM strategy in the country, these funds have been very difficult to expend. For instance, the Swiss Tropical Institute needed to wait several months to channel GFTAM funds to promote ITNs due to a lack of proper arrangements for procurement, distribution and monitoring mechanisms for the distribution of the nets. A functionary stated that 'donor funds cannot change the system'.[14] Besides the bureaucracy of the national government, there are problems caused by lack of coordination among donors and the fragmentation caused by the existence of multiple vertical programmes. This was the case in the Bagamoyo district hospital, where funds from seven different sources including the basket fund were administered along with five different vertical programmes. Each of the programmes and most donors required separate monitoring and reporting systems, which resulted in additional work for the limited existing personnel (p. 51).

With regard to the distribution of ITNs through the voucher mechanism, the vouchers are currently provided to pregnant women when they come to the health facilities for a check-up; they present this to the shopkeepers and get a discount on the bed net price. But many women cannot afford the 500 Tanzanian shillings (TShs.) (less than US$0.50) they need to pay out of their own pockets. Another important problem is that shopkeepers are not supervised, and they add on other costs such as transportation. As a result, the ITNs are being sold at unaffordable prices, ranging from TShs.2,500 to TShs.7,000. The prices differ from area to area depending on the distance and other factors. Improvement in ITN coverage is greater in urban Tanzanian areas, as that is where the programme is concentrated. By the time ITNs reach rural areas, the prices are too high for most villagers, both men and women. Regarding re-treating nets with insecticide, the study in Bagamoyo found that this was hardly ever done.

Concerning case management, in Tanzania about 60% of people with malaria first received treatment from shopkeepers and drug vendors before they reported to health facilities.

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[13] It is aimed at pregnant women in poor areas. The system works as follows: when a woman attends a public health facility for antenatal check-ups she receives a voucher. The pregnant woman gives the voucher (for a complete package that includes a bed net and insecticide for treating the net) to any retailer when she gets the net, and to receive the subsidy the retailer hands over the voucher to the organisations dealing with this in the area of operation. The health districts initially operated the system, but because of cases of fraud it was decided to use NGOs working in the areas.

[14] Personal communication, April 2004.

This practice of self-medication with drugs purchased from medical stores and other shops is attributed to the fact that people cannot afford the cost of health services in health facilities, while shopkeepers are willing to sell drugs in instalments. Pilot surveys found that about half of the drug sellers advise their customers to buy a half-dose of antimalarial drugs. Despite having a good knowledge of the new recommended antimalarial drugs, drug sellers do not conform to the required regulations in the treatment of malaria according to national malaria treatment guidelines (Mohamed 2003).

Prevention and intermittent presumptive treatment in pregnant women is being implemented widely, given that the majority of pregnant women attend maternal and child health clinics, but no reliable data on coverage are available.

With regard to *participation,* the study revealed a consistent lack of participation in the decision-making and implementation at different levels of the malaria programme. It was observed that only those officials at a high programme level were aware of the presence of the RBM initiative in Tanzania, and could therefore exert some influence on its performance.

Almost all health workers and communities felt disenfranchised from the decision-making process and implementation of the malaria programme. Aside from the protocol of consulting elders during the community entry process to get them to agree to the programme, community members who wish to participate are relegated to being volunteers. When opportunities are present, communities are willing to participate actively, as in some villages in Bagamoyo district where health workers promoted the formation of village committees to establish revolving funds for the purchase of ITNs and for price control.

With reference to NGOs, the study found that many of these organisations are not acquainted with the initiative.

For us and other implementers, awareness of RBM is still very low. I have just read about it in newspapers. I see it more as a policy-level decision than a people-centred process. For us it is just a slogan. – Plan International Official, 5 January 2004 (p. 47)

Regarding *sustainability,* foreign donors cover the implementation of most activities promoted by the RBM initiative. Since 2003, many RBM activities in the countries are financed by GFTAM grants, and it seems this will continue to be the case in future. This is in line with the overall situation in the Tanzanian health sector: for instance, in the financial year 2004-2005, 53% of the total MoH

budget was earmarked for recurrent expenditures and 47% for development; of the latter, 96% is financed by foreign donors (p. 31).

During the study it was ascertained from various sources that the commitment of health workers at different levels was also questionable.

There is no financial motivation for the local staff. For us, we are paid well to be efficient. Donor-funded projects cannot make changes; it can facilitate to a certain extent but not make changes. People are not motivated to take this on. – an international agency staff member (p. 55).

5.3 RBM in Uganda[15]

The health situation in Uganda

Uganda is a country in East Africa with a predominantly agricultural economy. The majority of the population is dependent on subsistence farming and light agro-based industries. In the 1970s and 1980s, Uganda faced civil and military unrest that resulted in the destruction of the economic and social infrastructure and which severely harmed Uganda's economy and the country's ability to provide social services. Although the situation has been improving since 1986, the country is still developing.

Uganda ranked 150 in the Human Development Index (2002). Forty-four percent of its people live in poverty. The per capita GDP in international dollars for the year 2002 was US$1,390, which is less than 2001 when it was US$1,490. The Gini coefficient for Uganda was 44.9 in 2002.[16]

The epidemiological profile of the country reflects its high degree of poverty and deficient health services. Uganda has poor health indicators and a heavy burden of disease. Life expectancy at birth is 52. Probability of death before five years of age is 14.3%. Infant mortality rate per 1,000 is 97. Seventy-five percent of life years lost to premature death are due to preventable diseases, including perinatal and maternal related conditions (20.4%), malaria (15.4%), acute lower-respiratory infections (10.5%), AIDS (9.1%) and diarrhoea (8.4%). Together these account for over 60% of the burden of ill health (MoH Uganda p. 10). The burden of disease can be attributed to five groups of preventable conditions such as poor living conditions, poor physical access, low quality of health care and low utilisation of services and a perceived high and unpredictable cost of public services (WHO Country Cooperation Strategy Uganda).

[15] When no other source is indicated, references in this section refer to the following case study report: (2004), 'Case Study Report 2004; Roll Back Malaria [RBM]; Uganda' (a case study report by the Joint Medical Store). In such cases only the page number(s) is specified, within brackets.

[16] The Gini Coefficient ranges from 0 to 100, 0 representing perfect equality and 100 total inequality. The fundamental difference between inequities and inequalities resides in the fact that inequities represent inequalities that are considered and qualified as unjust and avoidable. As a result, measuring health inequalities represents the first step towards the identification of inequities in health.

At the community level, lack of both human and financial resources leads to problems with poor sanitation and drainage and lack of clean water sources, both of which precipitate diseases such as malaria and diarrhoea.

The health system in Uganda

The main actors in the Ugandan health sector are the national government, NGOs (including faith-based organisations managing around a third of the health services in the country), and private for-profit organisations (JMS 2004). There are 11 regional referral hospitals (which also act as district hospitals in the areas where they are located) and two national referral hospitals in Mulagu and Butabika (p. 9).

The health care system is aligned to the administrative structure as described below (p. 9).

Administrative level	Corresponding health structure
Village Local Council I	Health Centre I[17]
Parish	Health Centre II
Sub-county	Health Centre III
County/sub-district	Health Centre IV
District	General Hospital
Regional	Regional Referral Hospital
National	National Referral Hospital

Per capita health expenditure per year is US$12. Government health expenditure was estimated to be 8% of the total government expenditure, which represents about 0.8% of GDP ((MoH Uganda). Household studies have indicated that private household expenditures on health care services represent the largest element of funding (around 60%) for the health care sector (MoH Uganda p. 92).

Although the number of public, non-governmental and private health facilities has increased by 400% since 1978, more than half of the Ugandan population still does not have adequate geographical access to health care services. Access to health care facilities by rural communities is impeded because most health facilities are located in towns and along main roads, a situation further constrained by poor physical infrastructure, hills, rivers and marshes. Even if a health facility can be reached, the severe understaffing of units means that patients have to wait, sometimes for hours, before getting treatment. The population per doctor is 18,700 and the population per nurse is 3,065. Forty-nine percent of the population lives within 5 kilometres or a one–hour walk from a health service facility. There are five doctors for every 100,000 people (p. 8).

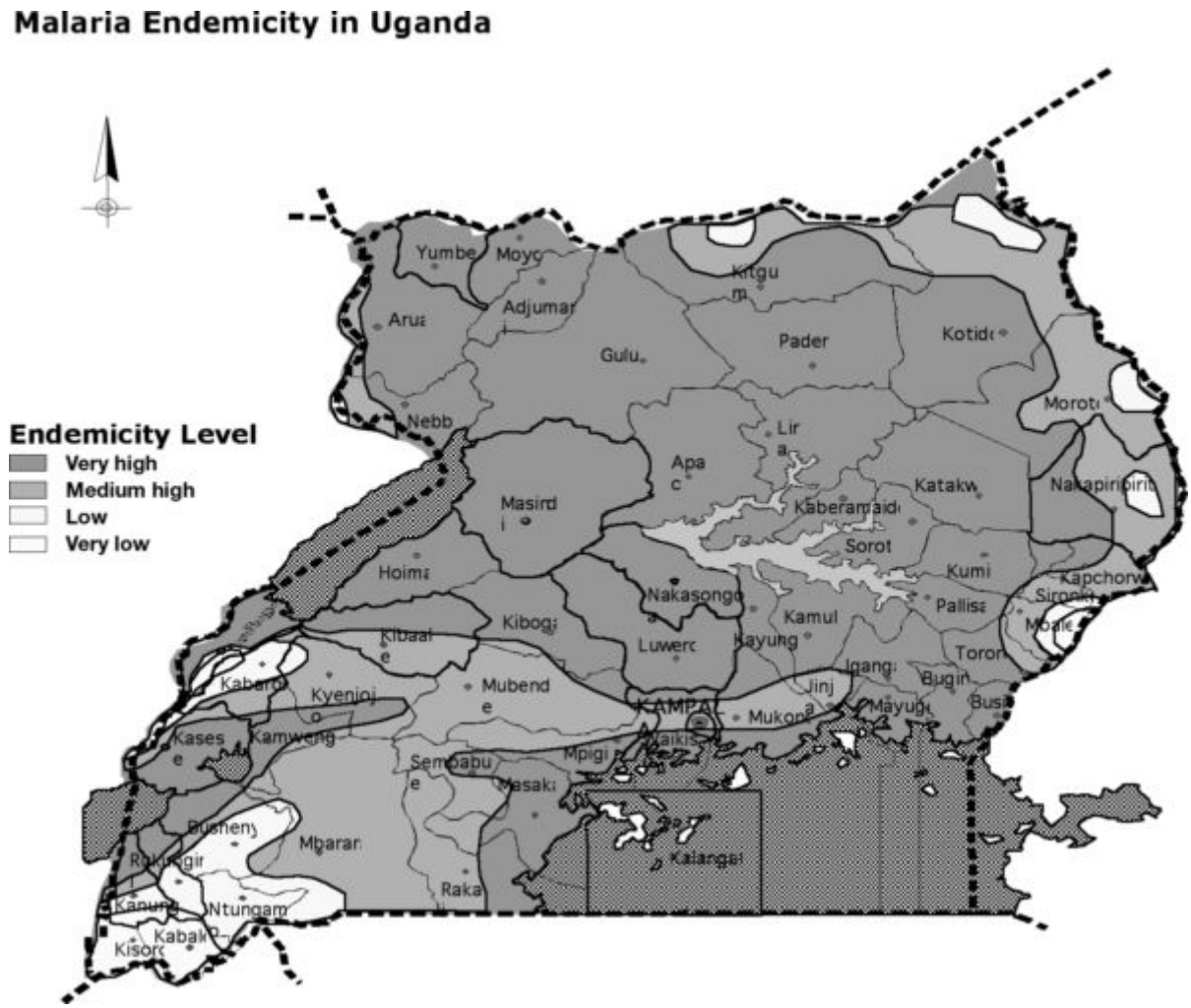
As a result of many years of civil strife and neglect, there is a massive backlog of dilapidated infrastructure, which compromises efficiency and discourages utilisation. In addition, the quality and range of care provided at existing health facilities still requires much improvement (MoH Uganda p. 11).

Human resources for health remain inadequate. Whereas more than 80% of the population is found in the rural areas, the distribution of trained health workers favours the urban areas. An MoH study indicated that only 34% of the established positions were filled by qualified staff. The rest were either filled by untrained nursing aides, or remained vacant (MoH Uganda p. 13).

Malaria in Uganda

Malaria accounts for 80% of morbidity and 45% of mortality among children under the age of five, and is the leading cause of morbidity and mortality in Uganda. On average, a Ugandan child suffers six attacks every year. According to the MoH, malaria accounted for 25% of total outpatient visits, 20% of admissions to health units and 15% of inpatient deaths. An average of 26% to 30% of morbidity of patients was attributed to malaria between 1994 and 1995. Such high rates adversely impact the nation's productivity and resources. 'It is estimated that malaria reduces the GDP by 1.3% per annum and accounts for 23% of the total discounted life years lost. Each bout of malaria causes the loss of about one working week, and many people experience several malaria bouts per year (p. 15).

[17] Health Centre I is virtual, community based and with no physical infrastructure (buildings). It is managed by community health workers.



The disease is endemic in 95% of the country, though some areas are hyper-endemic and the disease is spreading to previously unaffected areas. Only some small areas located in the northeast and the southwest of the country have a low prevalence of the disease. See the map for details.

The case study

In Uganda, Roll Back Malaria was investigated by Joint Medical Store, an NGO based in Kampala. The study covered the central region districts of Kampala and Wakiso, with an area of 2,900 square kilometres. The study had a descriptive cross-sectional design that employed quantitative and quantitative techniques.

Quantitative techniques included interviews with patients during exit interviews using questionnaires that were administered by the research assistants, while qualitative techniques included discussions with key informants at national and district levels. A desk review was conducted at both the national and district level.

The study population included the RBM initiative partners (MoH, WHO, UNICEF and NGOs) and other stakeholders like the districts, health workers and the communities that use the health services. In total, 194 key informants were interviewed.

For more information, see Annex 3.

5.3.1 Implementation of RBM in Uganda

Uganda is a signatory to the Abuja Declaration, and the set targets there have been incorporated in the Health Sector Strategic Plan (HSSP). The Malaria Control Strategic Plan (MCSP) 2001-2005 is part of the HSSP. The RBM partnership supports the implementation of the MCSP. The Malaria Control Coordination (MCC) framework is headed by MoH top management, who formulate policy to support malaria control.

In order to ensure a sustainable malaria control programme, Uganda's MoH has fostered partnerships with other ministries such as the Ministries of Education, Agriculture, Local

Government, Gender and Work, and also with NGOs, CBOs, the private sector, the media and other countries. One such partnership is the RBM, which is integrated within the malaria control programme (MCP). The RBM advise MCP according to the RBM initiative principles. In 2001 and 2002, the RBM also provided funds for implementing activities, but since 2003 the initiative only supports the government in applying for funds from the GFTAM. As a consequence, RBM has less influence on the definition and implementation of the proposed strategy.[18]

The strategy to address malaria has four components: case management, vector control, intermittent presumptive treatment and epidemic preparedness and response. The activities are implemented using existing Ugandan health delivery structures to help Uganda address one of its priority health concerns: malaria. MCP and national partners are responsible for technical support, mobilisation of resources, and quality of services and the level of monitoring implementation.

The execution of activities is guided by the Inter-agency Coordination Committee for Malaria (ICCM), which reports to the MoH head of the MCC, reviews progress quarterly and determines and approves proposed activities for the following period.

Districts undertake planning and management of local malaria control activities in line with national guidelines. Each district has a district malaria focal person who is positioned between the district and the MCP, and is the point of contact with the MCP for technical guidance. Key activities at the district level are supervision and monitoring of the malaria burden in the catchment areas, supporting the health sub-districts in integrating malaria into the primary health care budget so that funds are available to address the disease, and reporting.

Given that the programme is implemented in a decentralised manner, responsibility for consultation with communities and partners on needs and priorities, identification of target groups, mobilisation of communities for malaria control activities, coordination with partners, health programmes and public services, and ensuring equity and accessibility for high-risk groups are district-level responsibilities.

Involvement on a community level is considered central to the programme, and it is expected that communities will identify and make known their needs and priorities, help plan and mobilise resources for malaria control in their areas and conduct community-led malaria control activities.

[18] Personal communication. September 2004.

In Uganda, RBM is integrated within the Malaria Control Coordination Framework, and specifically within the malaria control programme. A MCP functionary indicated that both the advice and technical assistance received from the WHO and the Malaria Consortium (within the framework of RBM) has been valuable and free of charge.[19]

The ICCM – in which the main agencies and NGOs that support the MCP programme participate – is the coordination mechanism created to implement the RBM initiative in Uganda. The ICCM has four working groups, comprising case management, vector control and ITNs, advocacy and information, and education and communication. The case study reports that ICCM has internal coordination problems. For instance, an informant confirmed that the government is sometimes left out of the arrangements agreed between agencies on the national programme.[20] And a representative for the coordination of NGOs in ICCM confirmed that NGOs are only consulted but in fact they have hardly any influence on decisions on how the plans are defined. This person also confirmed that the ICCM group in which NGOs participate has been inactive during the last few months.[21]

Concerning the advances of the malaria programme in Uganda, two different groups of indicators are reported by the government: a) indicators referring to the targets of the Health Sector Strategic Plan (HSSP) and b) indicators on the targets agreed in Abuja. The figures of the two groups are not consistent with each other, probably because every group is based on data concerning only specific geographical areas where some interventions take place.

The table on the indicators for the HSSP targets for the areas covered by home-based management of fever (HBMF), intermittent presumptive treatment of pregnant women (IPT) and insecticide-treated nets (ITNs) shows advances in the coverage of population receiving treatment for malaria and to a lesser degree in the coverage of pregnant women receiving IPT (see table). However, these figures refer to treatment with drugs for which it is known that a high degree of resistance exists in many parts of the country. The positive results achieved with the number of severe malaria cases that were reported to health units within 24 hours of the onset of symptoms is due to increased sensitisation of communities and a decrease in the cost of treatment due to provision of free drugs (pp. 48-49).

Performance compared to HSSP Malaria indicators (p. 27)

Indicator	Baseline value (%)	Target 2002/3 (%)	Achieved 2002/3 (%)	Target 2005 (%)
Proportion of population that received effective treatment for malaria within 24 hours of onset of symptoms	30	35	48	60
Proportion of pregnant women receiving protection against malaria through IPT with SP	0	25	20.3	60
Proportion of children under five years protected by ITNs	5	25	3.8	50
Reduced malaria case fatality at hospital level to below baseline level	5	3	-	3

Source . Ministry of Health. 2003

[19] Personal communication, MCP officer, September 2004.
[20] Personal communication, MCP officer, September 2004.
[21] Personal communication, MCCI officer, September 2004.

The group of indicators referred to in the targets agreed upon in Abuja (see following table) show advances in HBMF coverage and to a lesser extent in IPT coverage. But according to this group of indicators and the HSSP indicators, which only refer to selected areas where the interventions are taking place, it is evident that the Abuja targets will not be met in the country.

Performance compared to Abuja expected targets for 2005

Indicator	2002	2003	2004(1)	2005 Target
HBMF coverage (%)	7	25	40	60
IPT coverage (%)	5	15	25	60
ITN coverage (%)	5	12(2)	30	60

(1) The figures for 2004 are expected results, and have not yet been confirmed.
(2) This figure refers only to selected areas.

Source: Ministry of Health. 2003

Concerning the *availability of antimalarial drugs,* home-based management of fever (HBMF) has been introduced in 43 out of 56 districts in the country, and 30 of the districts were actually implementing it. The WHO donated the drugs, and the MCP is in charge of the distribution. For this purpose, a mechanism for training was implemented. This involved appointing a trainer of trainers, who, in turn, trains the trainers selected by the district and who are then in charge of training what are known as 'distributors', or volunteers who distribute drugs on a community level. However, the study reports that in Wakiso district, distribution is one of the main bottlenecks due to a lack of resources, transport and personnel in the districts. The trainers and distributors are not being supervised and motivated as planned, and consequently the quality of the services provided cannot be guaranteed.

The drugs distributed for HBMF come in packages called Homapak, in two different versions: one for children and one for pregnant women. It means that for the rest of the population, malaria treatment is not available on a community level. The personnel interviewed said they receive many complaints from the communities because drugs are not available to everybody: 'How can we care for our children if we are sick?'

In the health facilities, antimalarial medicines are not always available. One health worker attributed it to the fact that malaria drugs are pooled within the total budget for the drugs that they require every three months. This means that an increased request for malaria drugs has an effect on the availability of other medicines in the health facility.[22]

In addition, it is known that malaria infections in the country are very highly resistant to the drugs being employed in the HBMF and in the health facilities: around 45% to 50% of the cases are resistant to these drugs. Therefore, studies were launched in different regions to look for alternative drug combinations. Some combinations were found to be effective, but the Global Fund has refused to finance drugs other than Coartem® (ACT), an expensive drug even if provided at subsidised prices, which will increase the budget for drugs enormously.

The use of ITNs to prevent malaria is one of the key strategies of the Uganda MCP. Although some progress has been achieved in the availability of bed nets in rural areas, the situation is critical and the coverage is still very low. At least 6 million nets (5 million for children and 1 million for pregnant women) are considered to be needed in the country to achieve the RBM targets, but at present only 2 million are available. According to data published in 2001, the proportion of households with mosquito nets was between 15% and 45% in urban centres, and between 2% and 15% in rural areas. The distribution of bed nets is being promoted through the private providers and a voucher system was recently introduced, especially aimed at children and pregnant women. The re-treatment of nets is subsidised for all of the population, and improvement in rates has been reported in selected areas. The following major problems have to be confronted to increase the use of ITNs: insufficient awareness of the benefits of using them, insufficient networks for distribution and insufficient promotion of net re-treatment. But even if these problems are tackled, the issue of

[22] Personal communication, health worker, Namayumba clinic, September 2004.

affordability – especially for the poor in rural areas – will continue to be a serious limitation.

Concerning the issue of *participation,* while MCP-RBM recognises that community participation is essential, no clear-cut activities and mechanisms have been specified for promoting community participation and ownership of the malaria programme activities. The lack of participation seems to exist at different levels, with officials at the national level calling for a less prescriptive stance from the donors, and district workers asking for more room to participate in the definition of the strategies and the decision-making process at central level and for fewer restrictions for adapting activities according to the local needs.

In relation to *sustainability,* interviews within the framework of the case study revealed it is generally felt that while access to prompt antimalarial treatment has improved, the incidence and prevalence of malaria are still on the rise. This means that drug schemes need to be changed and more expensive drugs will have to be introduced. The availability and accessibility of bed nets and promotion and mobilisation activities will need to be increased. The lack of staff will also need to be solved. This raises the question of sustainability, especially in this programme, which is strongly supported by international donors. Donors are looking for results to justify continued donations, and it is thought that RBM may not achieve its 2010 goal of halving the malarial burden (pp. 6-7). If continued donations are not forthcoming, Uganda will face a huge demand to scale up its malaria programme. The field study found that the districts do not have enough personnel, equipment, materials or necessary resources to carry out these activities properly.[23]

Regarding matters related to the capacity of the *health system,* officials and health workers from different levels affirmed that the targets agreed in Abuja will not be achieved in Uganda. Some of them considered those targets unrealistic for the country. The main constraints confronted are the lack of capacity (technical, financial and operational) and the lack of staff at district level to implement the designed activities and the availability and affordability of drugs and nets.

The fact that MCP is promoting the creation of its own mechanism for the implementation and promotion of the programme at district and local levels can in some way relieve scarce personnel from having to undertake additional activities directed at malaria. However, the study reports that although the malaria activities are integrated into district plans, at the community level these activities are not integrated in the implementation of other programmes.

5.4 RBM in Zambia[24]

The health situation in Zambia

Zambia has a population of 10.3 million people, and of this number over 80% live below the poverty line of less than US$1 per day (p. 2). Despite some progress over the last few years, the Zambian economy continues to grow at a pace that is insufficient to alleviate the immense burden of poverty on the nation's people. In 2003, Zambia's estimated GDP was US$8.596 billion, equating to a per capita GDP of US$800 (CIA 2004). This was significantly less than in 2001, when it was US$906 (WHO, 2004f). The workforce is predominantly engaged in the agricultural sector (85%), though this sector accounts for less than 20% of the country's GDP (CIA 2004).

Zambia's main health indicators are: infant mortality rate is 112, crude mortality rate is 191 for males and 176 for females and the probability of dying between 15 and 49 years of age is 700 for males and 654 for females (per 1,000). Healthy life expectancy at birth is 42 years (WHO, 2004h). In the area of reproductive health the picture is not any different, maternal mortality ratio was estimated to be 649 in 1996, but recent data from the 2001/2002 demographic and health survey (DHS 2001/2002) puts this figure at 729 per 100,000 births (WHO 2004i).

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[23] Personal communication, MCP officer, September 2004.

[24] When no other source is indicated, references in this section refer to the following case study report: Ngulube Dr. T J, Mdhluli L Q, Gondwe K (2004), ' The Performance of the Roll Back Malaria Initiative as a Global Public-Private Initiative (GPPI) to Improve Public Health Services in Zambia'. (a case study report by the Centre for Health, Science and Social Research (CHESSORE)). In such cases only the page number(s) is specified, within brackets.

The Zambian health system

The weakness of Zambia's economy has had a significant impact on the country's ability to provide social services such as education and health care. The country's external debt in 2003 was US$5.281 billion, while in 2000 foreign aid was US$651 million.

The Zambian health care delivery system continues to be characterised by considerable under-funding, resulting in deterioration of physical infrastructure and equipment from both lack of new investments and poor maintenance. The sector has also continued to experience serious human resource incapacity as a result of excess mortality from the HIV/AIDS epidemic – which has drastically changed the disease burden – as well as from brain drain, among them many health professionals, including doctors and nurses (WHO, 2004i).

Health care services are delivered by a number of actors in Zambia, including the public sector and private parties such as employers (primarily the mines before their recent sell-out), mission health facilities and traditional healers. The health sector is predominantly public (IPPHC 2004). However, because the health infrastructure and access to health care are poor, Zambia's health care system does not adequately address the needs of the country's people.

While there has been increased private-sector provision of health care, this remains relatively limited and concentrated in urban areas. There are 1,199 health institutions located in Zambia's nine provinces and 72 districts. These include three central hospitals, nine general hospitals, 36 district hospitals, three specialist hospitals, 30 mission hospitals, 12 industrial hospitals, five unclassified government hospitals, 808 rural health centres and 206 urban health centres. The 30 mission hospitals and 61 health centres are run by different churches, and their activities are coordinated by the Churches Health Association of Zambia (CHAZ). These facilities are an integral part of the government health system, and the Ministry of Health (MoH) supplements their running costs. Private sector companies, the mines in particular, have their own health care systems that provide services to employees and their families at the 12 industrial hospitals and 72 health centres (IPPH 2004).

The total expenditure on health as a percentage of GDP was 5.7% in 2001 (WHO, 2004f) and the National Health Budget was 8% of the total national budget for 2004. This figure is still substantially below the 15% of the national budget to be allocated to health according to the Abuja Declaration of 2000, and has declined substantially since 2001 when the general government expenditure on health was 13.5% of total general government expenditures (WHO, 2004f). This decline has been attributed by health workers in Zambia, as mentioned, to the freezes on health expenditures imposed by the HIPC program. '… newly built health facilities remain without staff because adherence to the HIPC targets dictated that no new health workers were recruited, even for existing facilities where there had been loss of staff' (p. 14).

In the early 1990s, the government introduced cost sharing into public health services. Recognising that poor households faced severe difficulties in paying user fees, the government also introduced the Basic Health Care Package (BHCP) of interventions – based on the main causes of mortality and morbidity in terms of disability-adjusted life years (DALYs) – to be provided at primary, secondary and tertiary levels of the health system (IPPH 2004). However, there is a gap between the cost of providing the BHCP (estimated at US$15 per capita per year) and the public health budget (US$10 per capita per year). Of the US$10 per capita available last year, 60% was spent on district health services. The deficit for delivery of the BHCP is therefore US$9 per capita, which translates into a national resource deficit of US$90 million, based on the population of 10.2 million (IPPH 2004). Of the total health expenditures in 2001, the government accounted for 53.1% of this, while private health expenditure accounted for 46.9% (WHO, 2004f). This private expenditure comes primarily from out-of-pocket expenditures.

Malaria in Zambia

Malaria leads the top ten disease conditions in Zambia, and has done for many years. The disease is hyper-endemic, with 96% of the population at endemic risk and 3% at epidemic risk, and is the major cause of morbidity and mortality in both adults and children, especially those under five years of age. Out of approximately 3 million clinical cases, malaria claims 50,000 lives per year.

The malaria case notification rate (per 1,000) has remained consistently between 40% and 60% over the period 1990-2002, which equals 250 to 400 cases per 1,000 people. Hospital deaths due to malaria have in fact spiked, from around 20% in 1998 to 45% in 2002.

In a country like Zambia, it is easy to identify the vicious circle of poverty and malaria with detrimental for the health and the economic development.

The case study

In Zambia, Roll Back Malaria was investigated by the Centre for Health, Science and Social Research (CHESSORE) in Lusaka. The study was undertaken in four Zambian towns purposely selected to reflect the different regions but representative of the socio-economic profiles of the country: Lusaka, Chama, Chingola and Chipata.

Data was collected at four levels, namely at national, district, health centre and community levels. Discussion guidelines were prepared for each of these levels, and interviews were conducted with key informants. At the health facility level, checklists were used to collect data on malaria and other health parameters. At community level, questionnaires were also used to collect data from randomly selected residents of communities around the sampled health facilities.

For more information, see Annex 3.

5.4.1 Implementation of RBM in Zambia

The Zambian government recognised the growing malaria problem and its detrimental effect on its people and economy, and the need for outside resources to assist in the fight against malaria during tough economic times in Zambia. As Zambia was open to any methods of alleviating its malaria problem, the country was active following the initiation of the RBM, participating in the pre-testing of situation analysis instruments for RBM. In 2000, implementation of the programme was started in the country.

The different aspects of RBM have been integrated into Zambia's basic health services through public health care, and the programme is driven by the National Malaria Control Centre (NMCC), a body of the Ministry of Health (MoH).

The current strategies for malaria control in Zambia are:

1. Integrated vector management.
   a. Provision of ITNs
   b. Indoor residual household spraying
   c. Environmental management
2. Case management.
3. Information, educative and communication (for behaviour change).
4. Malaria in Pregnancy (IPT).
5. Epidemic preparedness and response.
6. Research (largely operational research).

The NMCC serves as secretariat of the Roll Back Malaria programme, and as secretariat to the national RBM task force and the RBM partnership. The RBM task force is made up of deputy ministers (chaired by the deputy minister in the MoH) and reports to the office of the vice president of the country. The national RBM partnership is made up of all individuals and institutions that have expressed a willingness to take part in malaria control.

Although there has been an increment of funding for malaria since the inception of RBM, the NMCC has faced problems in its operations from time to time because of a slow flow of funds. The centre is highly dependent on donors' funds, particularly because the national malaria control programme has being scaled up over the last few years. For instance, in 2001 funding from RBM partners made up approximately 40% of national funds budgeted for malaria control activities in the country. At the same time, donor funding has made it possible for NMCC to work in all 72 districts of Zambia.

Last years the NMCC successfully applied for Global Fund funding, and currently the centre is preparing an application for round five of the Global Fund.

RBM has supported NMCC in recruiting and employing additional staff to expand its activities and to construct additional office accommodation. RBM partnership has also provided incentives as a way to help motivate government civil servants employed at the NMCC.

With funding secured from government, the RBM partnership and the GFATM, the NMCC has also been able to improve its infrastructure in terms of office equipment, laboratory equipment and communication infrastructure. Additional support in the form of motor vehicles and laboratory equipment was received from Japan International Cooperation (JICA).

The NMCC facilitates annual malaria planning and budgeting by district health management teams. The funds for malaria control and prevention activities in Zambia, channelled through the MoH, go to districts through the basket funding mechanism. Other funds for malaria control go to faith-based organisations through the Catholic Health Association of Zambia (CHAZ) directly from donors and to NGOs working at community level through an umbrella NGO organisation (the Zambia Malaria Foundation). Both the CHAZ and the umbrella NGO are members of the RBM partnership. NMCC organises an annual joint consultative meeting with donors and all members of the partnerships.

The team carrying out the study reports that data is scarce on the malaria situation in the country. The only official figures found were those of the MoH (based on a baseline survey carried out in 2001) and a couple of preliminary findings of a follow-up RBM study conducted in 2004 (see table). Although these figures on performance according to RBM-agreed targets are rather incomplete, they indicate it is very unlikely that Zambia will meet the Abuja targets in 2005.

In-depth interviews with health workers at health centre and district level, in the four districts where the field study was carried out, showed that they had some notions about the RBM programme,

Performance compared to Abuja expected targets and MoH targets for 2005

Indicator	Baseline[25] value 2001(%)	Follow-up[26] study 2004(%)	Target 2005 (%)
IPT coverage (%) (policy was introduced later)	0	--	60
ITN coverage (%) (households with at least one ITN)	1.6%	27.4%	60
Proportion of under-five population that received effective treatment for malaria within 24 hours of onset of symptoms	71.8%	--	60
Proportion of children under five protected by ITNs	4.0%	--	50

[25] The Zambia Baseline Survey findings, Ministry of Health, Zambia (2001).
[26] Preliminary findings from the follow-up RBM survey (2004).

but they did not have any idea about public-private partnerships and what it means in terms of the implementation of the programme. For them, RBM was another government programme arising as part of the ongoing national health reforms. The responses of health workers and health officials were mixed concerning the differences observed in resources received at their facilities since the implementation of RBM:

The financial situation here at the Health Centre has remained more or less the same. We haven't seen real change so as to affect our general operations. As I mentioned to you earlier on, when money comes for a particular budgeted programme, our role on the ground is to promote that programme. And worse still, these flows of funds are not consistent. – Lusaka Health Centre (HC)

It is difficult for me to say whether due the RBM initiative, our general finances have improved because it's hard to measure as things seem to have stopped improving for the better. I cannot attribute one programme's success to the general operations of our clinic. – Chingola HC

District health officials were able to tell the research team when RBM resources were disbursed from central level. However, their general view was that the disbursements were not timely enough to enable implementation of planned activities within the financial year. As malaria in Zambia is endemic, with a significant seasonal variation pattern, the activities need to be undertaken in line with expected seasonal variations in malaria prevalence. Health workers said that the untimely disbursement of funds for such activities limited their impact on the malaria control programme.

The strings which donors' funds come with, they are not flexible. That in itself makes it difficult because you are 'glued up' to the guidelines. If you go outside the guidelines then you face a lot of questions and they tell you they will not fund you anymore. So you can not divert these funds according to the need at that moment … – Manager, Planning & Development

Sometimes this money takes too long for it to be released. In some cases we may have planned for

urgent programmes which could not wait, for example let's say to train health workers on the changes in drug policy; we would use funds from other sources but when this (RBM) money comes we are not allowed to take part of it back to where we had taken the initial funds from … – District Director of Health

Concerning the *distribution and availability of drugs,* since RBM started changes have been taking place with regards to the first-line drug used. This has been done in a phased manner as finances and logistical considerations demanded. Although Coartem® is the first-line drug for the case management of uncomplicated malaria, the interim drug Fansidar (SP) is being used pending the full deployment of Coartem®. The use of Coartem® started with an initial six districts, and then scaled up to 28 districts, with the intention to cover all 72 districts by December 2004. Two of the four sampled districts, Chipata and Chingola, were among the first 28 districts. Along with the deployment of the interim and first-line drugs, chloroquine – which was the previous first-line antimalarial drug – was withdrawn from health facilities.

The interviews carried out by the team at the community level revealed that in Chingola and Chipata, 9% of adults and 13% of the children received Coartem® when malaria was diagnosed. In both groups, in all four districts the most prescribed drug was SP (about 55%), followed by chloroquine in 10% of the cases.

The general opinion of the interviewed health workers and officials was that the supply of antimalarial drugs was significantly improved. SP was the most widely available drug at health facilities. Their comments:

The availability of antimalarial drugs has greatly improved. They are always available. We do not experience any stock out. – Chama HC

These days we do not experience any shortages of antimalarial drugs. They are always in stock. – Chama District Health Manager

Mosquito nets are the more commonly visible manifestation of the RBM in Zambia, at health centre and at community level. It is the general opinion that mosquito net coverage in Zambia has significantly increased over the last few years. The study revealed that mosquito nets (treated or untreated) were generally available, with shortages reported in some areas. The cost of buying these nets varied between districts. Although the general policy is to distribute nets through public services at subsidised prices, price variations are considerable in different areas and it is recognised that most people in poor settings cannot afford the nets, especially those in rural areas,

We are being supplied with ITNs by National Malaria Control Centre but the supplies are so erratic. – Manager, Planning & Development

We do receive some ITNs for sale, though the numbers we get are not adequate to cater for every body in the community. The price (Kwacha10,000) also for these nets is quite high for the average community member. – Chipata HC

Here at our clinic we do receive some nets from the district for sale though the price is so high for the average member in the community. We charge K28,000 per net, which is much higher than in other districts. – Chingola HC

In some cases the NMCC has procured and delivered nets through the NGOs. The UNICEF country office, in collaboration with the NMCC, has also procured and distributed nets to the public sector through NGOs and faith-based organisations. In urban areas, the commercial sector is being developed for sustainable distribution efforts, with social marketing being used as a tool to stimulate and generate demand for ITNs.

In addition to receiving drugs and ITNs, the district health services have received additional or new medical equipment to help with the control of malaria in the area. Some health centres have received microscopes to help with laboratory diagnoses of disease, but the research team found that in some facilities the new equipment remains unused due to lack of personnel to operate it.

A consistent finding in the different places where the research took place was that there is still inadequate funding to attain meaningful coverage for impact on malaria. The shortfall in availability and use of medical equipment and supplies was greatest in rural areas and at the smaller health centres.

Health workers also suggested that more progress could be made if multiple approaches were used to control malaria. They suggested the introduction of indoor residual spraying and environmental management. The overall perception among health workers interviewed at health centres and districts was that net (ITN) intervention alone might not be enough to combat the problem of malaria. These are some of the opinions of health workers on the above-mentioned issues:

And as such the RBM programme may fail to achieve the goal. For example, in here in rural areas they only use nets in the rain season. They feel that mosquitoes are only in the rain season. So it would help if there are combination approaches like spraying. Sure! – Chama HC

I think a lot still needs to be done because we are talking about spraying, we do not even have enough funding to purchase the sprayers … – Manager, Planning & Development

Though we receive these ITNs I think we still need to use other preventive measures like residual spraying to reduce the number of mosquitoes. – District Director of Health

The case study found serious shortages in the *health facilities physical infrastructure and equipment* related to the malaria programme. Health workers and officials stated that this situation had consequences for the quality of the activities they are carrying out.

Our clinic is very old as you can see. It was built before independence by the federal government. There have been no rehabilitations. We also have no laboratory facilities hence we just cannot tell the exact number of malaria cases we see. We just treat cases based on clinical diagnosis. – Chama HC

Most of our rural health centres do not have laboratory facilities. As a result it is very difficult to tell if all malaria recorded were actually malaria cases. More than three quarters of malaria recorded in the district are not confirmed cases. – District Health Official

The study also raises the issue of *human resources,* as the shortage of staff and high workloads are chronic problems faced by the health system in Zambia. The government has been unable to solve this long-standing issue. The worsening economic conditions, high poverty level and impact of the debt burden has meant that conditions of service for health workers are not being improved and this will probably not be the case in the foreseeable future. The additional activities required of RBM with greater community involvement has also meant an additional service to be undertaken by health workers. This raised the question as to whether RBM would have any impact on the human resource situation in the Zambian health services. The view from the health staff interviewed was that the situation has not changed since the inception of RBM. If anything the situation has worsened, with high attrition rates from deaths, emigration to greener pastures, retirements and resignations. There appears to be no corresponding recruitment campaigns to reverse or restore the situation. The respondents added that conflicting policy directives have resulted in a situation where newly built health facilities remain without staff because adherence to the HIPC targets dictated that no new health workers were to be recruited, even for existing facilities where there had been a loss of staff.

Staffing levels are going worse with a lot of death among health workers while the government is not recruiting new staff. – Chipata HC

In fact the situation is going worse now. There are a lot of deaths among us health workers. I don't know why. The other thing is that most of our colleagues are leaving the profession to join other organisations or go outside (the country) for greener pastures. – District Director of Health

The issue of ongoing in-service training drew conflicting points of view from health workers on the ground and district health managers who were interviewed. While district health managers talked about ongoing courses for their health workers, the perception of health workers was different, with many of those interviewed reporting receiving no such in-service training.

Yes, here at least we are being updated with the policy issues of drug administration for instance, on the change of drug from chloroquine to Fansidar and Coartem4. Health workers trained in these changes. We have had some training, workshops going on. – Manager, Planning & Development

As far as I can remember I don't think I have been involved in any training to proudly say I have benefited from the RBM apart from maybe one or two day workshops. These were on the implementation of the intermittent presumptive treatment (IPT) that is the giving of Fansidar (SP) in pregnancy; these are some of the minor things that I can remember not courses that I can say have upgraded my CV. – Chipata HC

Concerning the issue of *participation,* the study revealed that at health centre level, health workers are not given any role in the planning of RBM activities. They said that all activities come from their top managers at district or national level, and they are only told what to do at their level. This manner of planning and budgeting, they added, brought with it a number of bottlenecks during implementation, and supplies and requisites, for

example, may be inadequate for full implementation.

Theoretically, planning should be done by us here since the whole system of planning in health now is from the bottom upwards. But certain programmes like the Roll Back Malaria and Global Fund type of programmes, it seems the planning is done up there. We just wait for the results or we are told can you plan for so much, in the end we do not even see these funds being brought downwards. Decisions come from the national level and then, they filter to the clinic level. – Chipata HC (p. 8).

While the overall perception at the health centre level was that planning and budgeting was predominantly carried out at district level, this was not the view expressed by district health managers. Due to shortcomings in the system, when resources were received from the national level, the district health authorities made decisions on how much to allocate to each health centre.

Zambia created community participation structures during recent and ongoing health reforms in the country. These structures are utilised by the RBM GPPI to implement its specific programme activities. However, participation by the community is limited to programme-specific activities such as selling ITNs and conducting health education activities. The study found that the community is not involved in the decision-making processes. As one community member said,

… we just wait to be told what to do in the communities by the health centre in charge. If he doesn't tell us then we just sit. – Community member (p. 6).

According to respondents in surveys carried out at community level in the areas where the study took place, it was found that drugs were available in the health facilities when malaria was diagnosed in 84% of the cases in children and in 77% of the cases in adults.

Community satisfaction with services was also studied using a combination of variables on perception of improved treatment services, the availability of drugs and whether or not clients had noticed any changes since RBM has been in place. This resulted in an average of 55% of respondents declaring that nothing had changed at their health facilities; 37% had noted some improvements and 6% felt that things had become worse. The positive perceptions varied across the four districts; they were highest in Chipata district, followed by Chama. The perception that nothing had changed was greater in the urban and industrialised districts of Chingola and Lusaka.

5.5 Conclusions on Roll Back Malaria

- In all three countries studied – Tanzania, Uganda and Zambia – malaria is the main cause of morbidity and mortality, the latter especially in children. The disease takes a heavy toll on people's health, especially on children and women (particularly pregnant women), the use of health services, the use of scarce economic resources and the loss of productivity. Therefore, malaria is a very high priority in these countries.

- RBM is an initiative directed at tackling one of the major health and development problems worldwide. It is recognised that malaria is closely related to poverty, both as a cause and an effect. In addition, malaria is on the rise as a cause of death and disease in many countries, especially low-income countries. It is maintained that resources for malaria have increased over the last few years, at least in part due to the advocacy done by RBM. In the countries included in this report, RBM assisted to revamp the national programmes for malaria control.

- The Roll Back Malaria strategy is comprehensive, but what countries are actually doing can be confined to three aspects: improving the availability and use of treatment, improving availability and use of insecticide-treated nets (ITNs), especially for children and women, and providing intermittent presumptive treatment to pregnant women. At the Abuja summit on malaria in 2000, it was agreed by all participating countries that by 2005, 60% of the target groups would be covered by these interventions, apparently without taking into account the actual situation at that moment.

The studies in the three sub-Saharan African countries presented in this document show that the Abuja coverage targets will not be achieved in any of these countries, and in two of the three countries health workers and officials stated that in fact the incidence of malaria had increased over the last few years. This could sometimes be explained by the fact that more diagnoses are being made, but it can be argued that according to the findings of the study, the possibilities for correct diagnosis are limited and that diagnoses continue to be made mostly on clinical grounds. In addition, health officials in one country affirmed that the Abuja targets were not realistic for their country. It is generally recognised that these financial resources currently available for malaria control are insignificant when compared to what is actually needed.

- In the three countries the general opinion was that the availability of ITNs has increased, particularly in urban areas, but also that many more nets are needed. Although the three countries are trying different schemes for subsidising the acquisition of nets and promoting the participation of the private sector in their delivery, the main obstacle is that most people, especially poor people (the vast majority of the population) cannot afford to buy the nets, subsidised or not. In the case of Tanzania, the distribution thorough private retailers has made the process more difficult, particularly because of the inability of the public authorities to supervise and regulate those sellers. In the three countries the intention is to create sustained demand of nets. This probably will take many years, not taking into account that many people simply cannot pay for the nets, at the cost of thousands of lives. The first question that arises is, why aren't the nets given free of charge? Although this is not the entire solution to the problem, it has a preventive effect and nets are cheaper than drugs given away free of charge using resources of the Global Fund. It will also have a positive effect on the local production of nets, which will contribute to the national economies.

- The studies found that the situation with regard to the availability and delivery of effective treatment was at different stages in the three countries at the time of the study:
  - In Tanzania, treatment with SP as a first-line drug is not being implemented effectively and drugs were not always available in the health facilities, which forced people to look for medicines in private pharmacies where drug sellers distribute them (often incorrectly); at that moment there were plans to introduce Coartem® with the assistance of the Global Fund.
  - Uganda was waiting to receive funds for the introduction of Coartem®. Before that, studies made in different regions in the country successfully combined different drug regimes, but notice was received that the Global Fund would only finance the ACT-labelled Coartem®. This preoccupied some of the officials interviewed, because the price of the drug will further increase the country's dependence on foreign assistance. The drugs used for presumptive treatment were not effective because of a high degree of resistance.
  - Zambia was found to be at a later stage of introducing Coartem® as first-line treatment, again with funding from the Global Fund.

  Lastly, questions were posed by some informants on the issue of local production of ACT, particularly in Tanzania, where the plant from which the drug is extracted grows.

- In all three countries, little attention was given to vector control activities, though in Zambia health workers and district officials strongly recommended it as complementary to the use of ITNs.

- In the studied countries, although malaria activities coordinated the national control programmes, funds from foreign donors were channelled to the district level, in two cases through basket funds. National coordination mechanisms existed in the countries in which the donors participated. Even so, coordination with the national government and between donors did not always go smoothly. Some donors preferred to support some specific components, which created difficulties for the health officials. In addition to the coordination related to the RBM initiative, in Tanzania it was found that one district had as many as seven different donors funding five different

interventions for different diseases – such as the malaria initiative – and each one required different reporting and monitoring procedures. The argument that coordination and integration of different vertical programmes should take place at local level could not be proved in the areas where the case studies took place – not even in Uganda, where the malaria programme has appointed a focal person in each district.

- In all three countries there was a constant lack of qualified human resources at different levels. Reasons given for this were lack of adequate remuneration, migration and illness and death because of HIV/AIDS, among others. Lack of proper health facilities and sufficient equipment were also invariably found. Related to this, health workers at health centre and village levels said that programmes like the one on malaria bring with them extra activities that come on top of the workload of understaffed health services with inadequate resources. In-service training activities were also scarce, and restricted to instructions for carrying out concrete activities.

- Participation of lower levels in decision-making about matters that concerned them was a bottleneck, and officials at central level complained of a lack of flexibility by donors. District officials asked for more room to participate in decisions at central level, health workers at peripheral level objected to their lack of participation in decision-making at district level, and communities and community health workers said their participation is limited to carrying out activities required by the health workers. These situations sometimes have consequences for the implementation of activities, like in Zambia, where supplies were not delivered on time to face seasonal variations of the disease.

6 Stop Tuberculosis – Stop TB

6.1 The GPPI

Tuberculosis

Tuberculosis (TB) is a contagious disease that spreads through the air. A person with active TB will infect on average 10 to 15 people per year if the disease is left untreated, even though a TB-infected person will not necessarily become ill with the disease. One-third of the world's population is infected with TB, and 5% to 10% of these people become sick or infectious during their life, in people with HIV the proportion is higher.

Geographically speaking, the South-East Asia region accounts for the largest number of cases (33% of the approximately 9 million cases worldwide), but the per capita estimated incidence in sub-Saharan Africa is almost double that of South-East Asia.

In 2002, TB caused an estimated 2 million deaths. 'As with cases of disease, the highest number of estimated deaths is in the South-East Asia Region, but the highest mortality per capita is in the African region, where HIV has led to rapid increases in the incidence of TB and increases the likelihood of dying from TB (WHO, 2004g).

The Stop TB Partnership

The WHO established the Stop TB Partnership in November 1998 as a broad-based social movement to fight tuberculosis. It resulted from recognising the toll taken by TB – 2 million people die of the disease every year – even though it is a treatable and preventable disease.

The strategy

In 2001, the partnership launched the Global Plan to Stop TB, a strategic plan shared by all partners. It aims to cut the global TB burden in half by 2010 (relative to 2000 levels), and sets targets with required inputs and measurable outcomes. The most important global targets are detecting 70% of people with infectious TB and curing 85% of those detected by 2005 (Stop TB 2003). For treating TB, what is known as the directly observed treatment, short-course (DOTS) programme is recommended. This treatment programme has a 95% cure rate and prevents the development of drug resistance (WHO 2004k). DOTS expansion and the introduction of DOTS programmes where they are not yet implemented form an important part of the Stop TB strategy. The partnership provides coordination and strategic guidance to individual partners and separate partnerships. The Stop TB Partnership also provides first-line TB treatments to developing countries through the Global Drug Facility (GDF). The GDF donates these drugs to the poorest countries and has a direct procurement mechanism (Weyzig 2004c: 5).

An external evaluation carried out in 2003 indicated that Stop TB has built a broad network of partners, enhanced political commitment to a global plan to stop TB, and operationalised the Green Light Committee for second-line TB drugs and a Global Drug Facility for procurement and technical assistance for first line drugs.

The partners

As of the end of 2003, there were over 300 partners involved with the Stop TB Partnership. The main partners are: UN organisations such as the WHO and UNICEF, private organisations such as the Rockefeller foundation, NGOs such as the KNCV Tuberculosis Foundation (KNCV), donor governments and pharmaceutical companies.

The WHO provides guidance on global policy, a representative to the Stop TB Coordinating Board, a management framework for the Stop TB Partnership Secretariat (STBPS), housing for the STBPS, and also contributes some staff and pays for the related costs.

The role of pharmaceutical companies

Companies involved with the Stop TB Partnership include Aventis, Novartis and Eli Lilly. In general, companies do not contribute directly to the core operations of the Stop TB Partnership, but provide their support through various working

groups of the partnership.[27] As the Stop TB Partnership is not a legal entity, contributions of companies are formally made to national partnerships, governments, the WHO or other Stop TB partners, not to the global partnership as a whole. Pharmaceutical companies are involved in the partnership in many different ways, and some examples are described below.

- *Aventis:* A plant of this company in Bangladesh is a pre-qualified supplier of TB drugs to the GDF. In this relationship with Stop TB, Aventis is a commercial supplier.
- *Novartis:* A South African plant of Sandoz (the generics division of Novartis) is a pre-qualified supplier of TB drugs to the GDF, and also has a commercial supplier relationship with Stop TB. Novartis also donates drugs to the GDF.
- *Eli Lilly:* The company established a separate GPPI with the WHO and other partners called the Eli Lilly MDR-TB partnership. The partnership aims to train medical staff and to increase availability of drugs to treat MDR–TB (Lilly 2004).

Governance

In 2003 there was a thorough external evaluation of the Stop TB Partnership, which led to improvements in the partnership structure.

The structure of the Stop TB Partnership compromises the following levels: (Stop TB 2004 and 2004a)
(For a more detailed description, see Annex 3.)
Stop TB Partners' Forum is an assembly of Stop TB partners, who met in 2001 and 2004. It is the main coordinating body of the partnership.
Stop TB Coordinating Board decides on the strategies and priorities of Stop TB, taking into account recommendations from the forum and the WHO.
Stop TB Partnership Secretariat supports the work of Stop TB partners and the working groups and is accountable to the board.
Working groups concentrate on different aspects of the work of Stop TB. They have their own independent governance mechanisms, but their work is coordinated and reviewed by the Stop TB Partnership (Weyzig 2004c: 16).
Global Drug Facility (GDF) is a mechanism to expand access to high-quality TB drugs. It procures TB drugs centrally from pre-qualified suppliers and provides technical support on country level to ensure the correct use of the drugs. GDF is hosted by the WHO and managed by the Stop TB Secretariat.
WHO Strategy & Technical Advisory Group (STAG) provides strong policy guidance to the board and secretariat of Stop TB.
Task forces. There are task forces on Advocacy & Communication, Financing, and Resource Mobilisation (Weyzig 2004c: 16). The secretariat oversees the task forces.

Transparency

An independent external evaluation in 2003 reported a lack of sufficient transparency in Stop TB (ISHD 2003). The Stop TB Partnership seems to have improved on the issue of transparency, as many documents concerning meetings of decision-making bodies are available on their website. Information about financial decisions was more difficult to access, however. It was also difficult to get a clear picture of some of the separate agreements and partnerships linked to Stop TB in which pharmaceutical companies are involved, for example, on drug donations (Novartis) and technology transfer (Eli Lilly). As a general rule these agreements are not disclosed, which prevents a full external assessment of the conditions of cooperation (Weyzig 2004c: 24).

Funding

Major donors for the programme:

- Governments: Canadian International Development Agency (CIDA), the Netherlands Ministry of Foreign Affairs, US Agency for International Development (USAID), UK Department for International Development (DFID)
- Multilateral organisations: World Bank, the WHO
- Foundations and others: Harvard University, Open Society Institute (OSI)
- In-kind: Management Sciences for Health (MSH), International Union against Tuberculosis and Lung Disease (IUATLD), University of California

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has become a major external donor for TB control. It has approved over US$1 billion in grants for TB and TB/HIV control for a five-year period.

[27] Interview with J. Broekmans, KNCV, 23 August 2004.

Most Stop TB funds are used for the procurement of first-line TB drugs through the GDF. The Stop TB Partnership itself is only a coordinating body and has a tiny budget compared to the total operations it coordinates. For the five-year period 2001-2005, the total estimated costs of the Global Plan to Stop TB are US$9.1 billion. Roughly half of these costs (US$ 4.5 billion) are for DOTS expansion in high-burden countries. The majority of the costs for DOTS expansion are borne by the countries themselves. The resources for implementing the Global Plan to Stop TB have been falling short and competition for donor funds for public health is increasing.

6.2 Stop TB in South Africa[28]

National health situation

South Africa is a country struggling to correct inequalities and injustices resulting from the policy of apartheid, a policy by which the South African government systematically withheld basic rights from certain racial groups while offering preferential treatment to others. The result of this historic inequity is that today, some 10 years since the first fully democratic election was held in South Africa, the local African population is still heavily disadvantaged in terms of unemployment rates, access to water, sanitation and electricity. The Gini coefficient for South Africa was 59.3 in 2002, which denotes a particularly high degree of inequality across the country.[29]

South Africa is characterised by a quadruple burden of disease. The toll of infectious disease is exacerbated by a high injury burden, conditions related to underdevelopment and chronic diseases. The country's first national burden of disease study indicates that the largest cause of mortality in 2000 was HIV/AIDS followed by homicide, tuberculosis, road traffic accidents and diarrhoea (Barr, Sait & Padarath 2004).

The HIV/AIDS epidemic has resulted in a significant fall in key indicators such as life expectancy at birth (57 years for 1970-1975, to 47 years for 2000-2005). There has also been an alarming rise in infant mortality rates: national number of deaths in one-year-old infants per 1,000 live births rose from 45 to 59 between 1998 and 2002.

Nearly 18% of the population over 20 years of age has no education, which is a matter of concern considering the importance of education in promoting health of individuals. Unemployment rates are high and can be expected to have a serious impact on health, both through negative material impacts as well as negative social factors. The majority of households have access to piped water (84.5%), either in the home, the yard or a public facility. This proportion is lower in the Eastern Cape. Nationally, 13.6% of households have no toilet facility. The Eastern Cape stand out as being particularly vulnerable to diarrhoea and other infectious diseases through inadequate provision of water and sanitation (HTS 2004).

The country's position in the Human Development Index was 107 in the year 2002 (it was rated 94 in 2001). Per capita GDP in international dollars was 10,070 in 2002, though income distribution is very unequal.

The South African health system

The South African health system is based on a primary care philosophy, meaning primary health care facilities provide free services such as immunisation, communicable and endemic disease prevention, maternity care, family planning and oral health services (Barr, Padarath and Sait 2004: 13). There is a severe lack of human resources in the poorer provinces, and an inequitable distribution of human resources across the country.

South Africa spends approximately 8% of its GDP on health care,[30] half of which is accounted for by medical schemes (Barr, Padarath and Sait 2004: 11). South Africa's national government allocates funds to each of the nine provinces, which have

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[28] When no other source is indicated, references in this section refer to the following case study report: Barr D, Padarath A, Sait L (2004), 'The Stop TB Partnership in South Africa A Review' (a case study report by the Health Systems Trust). In such cases only the page number(s) is specified, within brackets.

[29] The Gini Coefficient ranges from 0 to 100, 0 representing perfect equality and 100 total inequality. The fundamental difference between inequities and inequalities resides in the fact that inequities represent inequalities that are considered and qualified as unjust and avoidable. As a result, measuring health inequalities represents the first step towards the identification of inequities in health.

the authority to determine how to allocate the funds. Therefore, the proportion of the provincial budget allocated to health is based on the priorities of each province.

Health care is funded through four main sources in South Africa: government (44%), households (39%), employers (17%) and donors and non-governmental organisations (0.1%) (1999 data) (p. 12).

The varying financial and structural capacities of the provinces heavily impact the quality of care provided. Thus, the socio-economically disadvantaged rural population in rural areas has less chance of fulfilling their right to health.

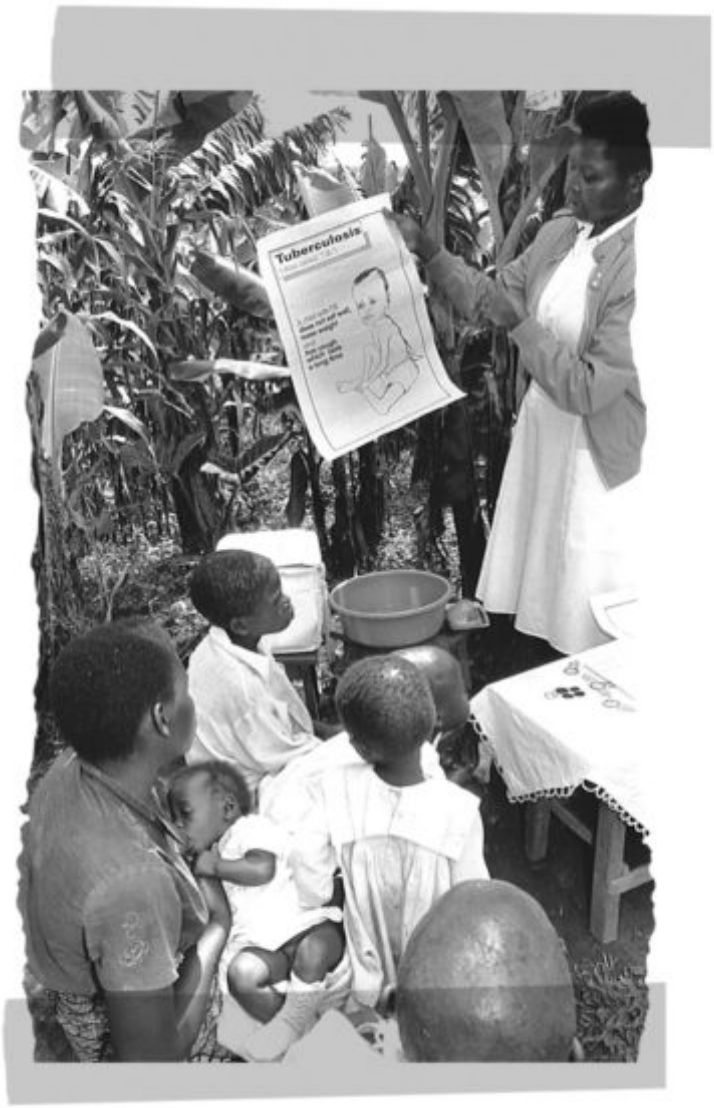
TB in South Africa

According to the South African National Tuberculosis Association, one South African dies from TB every hour. In the Global TB Report 2003, South Africa ranked seventh on the list of top-ten high-burden countries (from ninth in 2001) with an estimated 243,000 cases in 2002 (p. 14).

People discriminated against under apartheid were disproportionately affected by TB in South Africa. This is shown by the wide variance in TB incidence depending on race. Incidence is less than 20 per 100,000 in the white community compared to 400 to 600 per 100,000 in black and coloured communities. KwaZulu-Natal, Eastern Cape and Western Cape have the highest number of cases of TB.

Malnutrition, crowding, poor air circulation and poor sanitation have been linked to an increased probability of becoming infected with TB and of actively developing the disease. Incidence is higher in areas with high unemployment, low household incomes and poor infrastructure.

TB affects mainly the economically active demographic groups in South Africa. In 1999, for example, 61% of the total reported TB cases were between 20 and 39 years of age. During 2002, 224,420 cases of TB were registered. This constituted a 16% increase over the 2001 figures.



A multi-drug resistant (MDR) TB survey undertaken between 2000 and 2002 revealed an increase in the number of MDR-TB cases in the country. The Third Global Report on Anti-Tuberculosis Drug Resistance confirmed the link between poor programme performance or insufficient coverage of a good programme and drug resistance.

The above-mentioned MDR study also found that 55.3% of TB patients were found to be HIV-positive. Each of these epidemics fuels the other, and 'reinforces the need for collaboration and integration of HIV and TB services, as well as the key role of HIV prevention in controlling the TB epidemic (p. 16).

[30] Total expenditure on health was 8.6% of GDP in 2001. For more details on the financing and spending flows of the health system, we refer to National Health Accounts (NHA) figures of Kenya, which can be found in the World Health Report 2003, Table 5. A breakdown of data, for example on public-private expenditure and external resources for health, is also provided.

The case study

Data for this report was gathered from an informal literature review, including 'grey literature' such as unpublished reviews of TB control in South Africa, on topics such as TB control, Global Public-Private Partnerships, the Stop TB Partnership, management of external resources for health, and the human rights approach to health.

Discussion on the Stop TB Partnership in South Africa is largely based on a series of key informant interviews. These were semi-structured to cover a range of specified topics and questions. Interviews were performed by a variety of means: face-to-face interviews with audio recordings and transcription by two researchers, telephone interviews with hand-written note-taking and subsequent review/validation of these notes by the informant or by email questionnaire. Informants were identified by a variety of means: using the web-based Stop TB Partners' Directory, Stop TB documentation review and by the 'snow-ball' technique.

More information on the methodology used in this case study can be found in Annex 3.

6.2.1 Implementation of Stop TB in South Africa

A revised National Tuberculosis Control Programme (NTCP) based on the WHO's DOTS strategy was established in 1995 in South Africa and replaced the non-standardised short-course chemotherapy that had been applied throughout the country for several years. The different interventions are located within the general health services,[31] and medical treatment for people with TB is free (p. 17).

The NTCP short-term objectives to be achieved in 2005 include: to achieve a cure of 80% to 85 % among sputum smear-positive tuberculosis cases detected and to reduce the interrupter rate to less than 10% and the transfer rate les that 5%, to detect 70% of the estimated new smear-positive tuberculosis TB cases, and to achieve DOTS coverage in all districts. These objectives are in line with the Stop TB Partnership targets for the same period.

The NTCP strategies include the integral application of WHO's DOTS strategic framework, which includes: improving diagnostic facilities and improving information systems for control and planning, and establishing partnerships and optimal coordination with the HIV/AIDS & STD Programme to ensure the linkage between the two diseases is appropriately managed.[32]

South African TB control benefits from the technical assistance (TA) and funding of several international agencies that are Stop TB partners. It should be mentioned that some international agencies that are not identifiable as STB partners also make substantial contributions to NCTP.

There is an overall sense that South Africa is relatively independent from international assistance. Support by international agencies and institutions participating in the Stop TB Partnership is primarily in the following areas:

- Contributing to the annual external review of the TB control programme;
- Assisting in developing the Medium-Term Development Plan (MTDP) for TB control and subsequent Provincial Strategic Plans;
- Activities supporting implementation of the MTDP, such as establishment of a standardised reporting system, risk factor studies for treatment defaulting, contribution to MDR-TB and TB/HIV surveillance, training healthcare workers and undertaking prevalence surveys.

The case study found no clear-cut answer to the question about the impact of Stop TB Partnership on international TA in South Africa. Firstly, because all international agencies operating in South African TB control were active in the country prior to the Stop TB Partnership initiation. With regard to the question about the impact Stop

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[31] There are four levels to the NTCP:
- o National – coordinates, facilitates and evaluates TB services for the entire country;
- o Provincial – implements and budgets for TB services;
- o District – key level for the management of primary health care;
- o Health facility level – exists within districts and district hospitals, health centres, dispensaries and clinics within a district.

[32] In fact, the TB and HIV/AIDS units of the National Department of Health were merged in 1999 to address the dual nature of the TB/AIDS epidemic.

TB Partnership had on how international partners operate in the country, the responses were diverse.

At one end of the spectrum, respondents from one technical agency see their work as 'purely bilateral' and that Stop TB has not impacted on [their] role in providing TA (at least not consciously). – Respondent I (his emphasis)

From the perspective of those receiving the support:

[TA] has mainly been bilateral … and not necessarily through the partnership as such … although they [the international technical agencies] are mostly Stop TB Partners … and then, for example, through the TBCTA (TB Coalition for Technical Assistance) we have benefited through the partnership. – Key informant, National TB Control Programme

At the other end of the spectrum is the reported added value that the Stop TB Partnership has brought to the KNCV Tuberculosis Foundation's (KNCV) TA in South Africa.[33] According to a key informant from the KNCV International Unit, the Stop TB Partnership is responsible for 'the coordinated way we are now working, avoiding duplications and making use of the additional competencies of each of the partners'. In addition, this key informant sees Stop TB as 'crucial in identifying and solving new problems such as public private partnership, poverty and TB, TB and children, MDR-TB, HIV-TB, partnerships and social mobilisation', and has also helped reaffirm goals and bring further credibility to the KNCV. In South Africa, this informant perceives a resultant strengthening of the KNCV's work, both qualitatively and quantitatively:

… everything is being discussed at meetings among all stakeholders. This serves as a kind of peer review … Our partners, acknowledging our expertise on assisting in writing MTDP's, invited us to come to SA specifically [to give more TA]. – Key informant, international technical agency

In order to explain these divergent responses, the nature of international partner coordination is important. South Africa is the only high-burden country where no Stop TB Partnership 'National Interagency Coordinating Committee' (NICC) has been established. Similarly, no 'Annual Action Plan' has been produced by or for South Africa, defining roles and responsibilities of different partners (as described in the GPSTB). What does exist, as all informants agreed, is close coordination with the relatively capable NTCP by all partners.

There are regular meetings with provincial TB coordinators attended by NGOs and international technical people. And problem-solving meetings as needed. – Key informant, TB control academic

I don't think [the NICC] is applicable here … it is us [NTCP] coordinating the financial/technical agencies in the country … – Key informant, National TB Control Programme

Some respondents also pointed out that the development of a MTDP, in which all partners are consulted and within which all partners can work, is in itself strong evidence of a degree of extra coordination facilitated by the Stop TB Partnership.

However, to do justice to the Stop TB Partnership's added value in coordination of TB control, one must look beyond the national level. Annual meetings such as that for the DOTS Expansion Working Group allow partners a forum to discuss TB control in South Africa, and in a reportedly valuable global context. Put differently, partly as a result of the Stop TB Partnership, 'the DOTS language is now the universal language of international TB control (key informant, international technical agency). The NTCP recognises that Stop TB 'sets the global guidelines and then the partners who provide TA

[33] The KNCV is identified here because its singular role in South Africa as an 'international focal point' for the Stop TB Partnership may be relevant here. 'For each high-burden country an international focal point has been appointed. Such a focal point is a technical agency with extensive experience and that enjoys the trust and constructive collaboration of the NTP and government.' (key informant)

stick to what is recommended' (key informant, NTCP). Furthermore, some respondents suggested that, because Stop TB has raised TB on the global agenda, some even 'absolutely bilateral' support for TB control may in part be traced back to Stop TB's efforts.

The statement by a key informant (TB control academic) can sum up the role played by Stop TB in South Africa (pp. 35-36):

Stop TB has had a huge influence in South Africa, but indirectly and more at the international level, coordinating the approach of partners globally. Partners that work with TB control are more likely to work within the DOTS/Amsterdam framework. I think the country [South Africa] sees itself more of a 'partner' than before.

South Africa's National TB Directorate has made progress in implementing NCTP. DOTS coverage has increased substantially, and 182 of the country's 183 districts now implement the strategy. Policies and guidelines are also in place, and registers and other monitoring tools have been developed and implemented. However, the lack of management capacity, poor management systems, lack of adequate financial and logistical resources and inadequately trained and motivated staff at district level have often been cited as reasons contributing to the failure of the NTCP (p. 19). In 2003, the programme reported a national TB cure rate of 54%, with four provinces with cure rates below 50%. In fact, the cure rate declined in seven out of nine provinces. The HIV epidemic has certainly had a strong effect on TB programme performance.

There is also confusion about the partnership due to a lack of clarity, transparency and participation. Obtaining information on the Stop TB Partnership in South Africa is difficult, even though the initiative has a website. Few people have knowledge about the partnership, and most documentation is not in the public domain. Many interviewees did not have a clear understanding of the partnership, even though those interviewed should have had a greater understanding of the programme they are implementing. This lack of information results in common misunderstandings, like the assumption that Stop TB is a funding agency like GFATM.

One key informant in South Africa stated:

You know, until you started asking questions about what the impact of the Stop TB Partnership in SA was, I hadn't really thought about it – it was then that I realised that I can't really tell you what they have done in the country. I also started thinking about what is the difference between the WHO and the Stop TB Partnership. Where does one begin and where does the other end? (p. 55).

The study suggests that the Stop TB Partnership has little meaning for national partners in South Africa. Two of the three NGOs listed as partners indicate there has been little added value as a result of being a Stop TB partner. There hasn't been better coordination, identification and solutions for new problems, goal development and implementation of activities or increased utilisation of stakeholder capacity. Neither of the NGOs saw the Stop TB Partnership as a source of formal or informal leadership.

I know we are one of the names on the website as a partner but other than the email newsletter we haven't had any contact with them … We were invited to a conference in Asia, but were advised it was very high-level and might not be any use to us – in any case we couldn't have afforded to go. – Key informant A, director of national partner NGO (p. 37)

It has been our experience that these kinds of partnerships, or the idea of them, remain at an almost 'intangible' level. – Key informant B, executive director of national partner NGO (Barr, Padarath and Sait 2004: 37)

A critical aspect is the vertical implementation of the assistance provided by Stop TB and the possible effect on South Africa's health system, and raises questions about its overall sustainability.

The contract goes to the provinces, we get the reports, but what they do there, we are not consulted, they come with their own ideas, implement, run the project, do not engage the province, management or districts and at the end of the project, they move out and there is no sustainability. A lot of money was spent on

TB – but when you look at these provinces, you don't know the impact and now it's even worse off – because when they pulled out no one was left. – Key informant D, National TB Control Programme (p. 34)

6.3 Conclusions on Stop TB

- Tuberculosis is one of the main public health problems worldwide. Its incidence and virulence has increased over the last several years in certain regions due to the combination of the disease with HIV/AIDS. In 2001, Stop TB was launched to confront the problem, and established a strategic plan with targets, required inputs and outcomes for the detection and cure of people infected with TB. An external evaluation carried out in 2003 pointed out that Stop TB built and organized a broad network of partners to support and enhance political commitment for a Global Plan to Stop TB, and operationalised the Green Light Committee for second-line TB drugs and a Global Drug Facility to assist in procurement and technical assistance regarding first-line drugs.

- The mentioned evaluation also indicated that much more will need to be done to reach the agreed targets for 2005, which will probably not be met. For instance in March 2004 the WHO estimated that only 27% of people with infectious TB were being treated in DOTS programmes and that unless there is a rapid acceleration of DOTS expansion, the global targets for 2005 will not be met until 2013 (Novartis 2004). At the same time Stop TB is currently dealing with a considerable shortage of financial resources even though the Global Fund is supporting its plan. This funding problem is exacerbated by an apparent competition for donor funds with other global initiatives.

- South Africa is a country where tuberculosis remains one of the major causes of mortality, particularly in the black and coloured population. The case of South Africa is peculiar: because of its level of income, the country receives only technical assistance from different Stop TB partners and other international institutions not participating in Stop TB. In addition, South Africa is the only high-burden country where no Stop TB Partnership National Interagency Coordination Committee has been established and no Annual Action Plan has been produced for or by South Africa, although the NTCP coordinates with different Stop TB partners. The influence of the initiative seems to be indirect: at the international level, coordinating the approach of different partners like the adoption of DOTS strategy and the emergence of public-private partnerships in TB control.

- The South African NCTP has made progress, like the expansion of DOTS coverage to almost all districts in the country, with policies, guidelines and monitoring tools in place. However, the programme is far below its cure rate target, which is similar to that of Stop TB. The reasons for this are lack of skilled and motivated human resources at district level, lack of management capacity and lack of financial and logistical resources. These facts need to be taken into account, particularly in the light of the criticism that Stop TB partners' assistance is implemented vertically without enough attention to the sustainability of the initiated activities. Nevertheless, it is clear that the HIV epidemic has had a strong effect on the performance of the programme.

- The study in South Africa revealed that the leadership of Stop TB in the country, both formal and informal, is not strong enough. Many people working in TB don't understand the partnership and some NGOs listed as partners indicate there is little added value from its participation in the partnership. This can be related to the way in which the partnership operates in the country.

- Finally, the country study makes the case of the inequities, the human resource crisis and the housing and nutritional needs in South Africa: until these issues are addressed, TB control will continue to take place in an environment that is hostile and antithetical to an integrated approach to the problem. The study points out that the limitations of taking a purely biomedical, technical approach to disease control are clearly recognised in the Stop TB mission and underlying value statements.

7 Global Polio Eradication Initiative – GPEI

7.1 The GPPI

Polio

Poliomyelitis (polio) is a highly infectious disease caused by a virus that enters the nervous system and can cause total paralysis in a matter of hours. One in 200 infections leads to irreversible paralysis (usually in the legs), and of this number, 5% to 10% die when their breathing muscles become immobilised (WHO, 2004c). Children under five years of age are most at risk of polio. Where hygiene and sanitation are poor, young children are especially at risk. Polio can spread when food or drink is contaminated by faeces. As clean water and sanitation are often not available in the South, one could call polio a poverty-related disease.

Although polio is only preventable and not curable, the polio vaccine can protect a child for life if given multiple times. Polio cases have decreased by over 99% since 1988, from an estimated 350,000 cases to 784 reported cases in 2003 (WHO, 2004d) (as of 8 October 2004). In the same period, the number of polio-infected countries was reduced from 125 to 7: northern India, northern Nigeria, Egypt, Pakistan, Afghanistan, Somalia and Niger (WHO, 2004c).

The Global Polio Eradication Initiative - GPEI

The global goal to eradicate polio was approved in a 1988 vote by the World Health Assembly (WHA). The objective of the Global Polio Eradication Initiative (GPEI) is to ensure that wild poliovirus transmission is interrupted globally through coordinated national and international action, that the full humanitarian and economic benefits of eradication are realised, and that the lessons and infrastructure from its implementation are utilised in strengthening health systems and control of other important diseases.

The strategy

The GPEI strategy includes interruption of the poliovirus transmission by 2005, achieving certification of global polio eradication by 2008, developing products for the Global Oral Polio Vaccine (OPV) Cessation Phase by 2008 and mainstreaming the Global Polio Eradication Initiative after 2009.

The key to the strategy is mass drug administration (MDA) – including high infant immunisation coverage with four doses of oral polio vaccine (OPV) in the first year of life -- routine immunisation with OPV, National Immunisation Days (NIDs) to provide supplementary doses of OPV to all children under five years of age, surveillance for wild poliovirus and targeted ‘mop-up’ campaigns once transmission is limited to a specific area.

Polio was one of the six diseases covered under the Expanded Programme on Immunisation (EPI) while GPEI strategy focuses only on polio. It is stated by some critics that EPI has been negatively affected by the implementation of GPEI, especially in poor countries, because scarce resources for immunisation were drawn away towards polio NIDs (Razum, Liyanage and Nayar 2001). Furthermore, it was found that NIDs, a key tool in the GPEI approach, divert resources and attention away from the development of comprehensive primary health care (PHC). Some authors have reported that at least in the southern African region, the WHO's frequent argument that NIDs are promotive to PHC was not confirmed (Shreuder and Kostermans 2004).

The final stage of polio eradication has proved to be extremely difficult and costs have increased much more than initially expected. This has resulted in a substantial funding gap for GPEI, forcing a scaling back of eradication activities in 2003. This raises significant questions about the sustainability of the GPEI.

In the January 2005 edition of the Weekly Epidemiological Record, the WHO reported an escalation of a poliomyelitis outbreak in Sudan.

This indicates that the goal of ending polio transmission by 2005 has not been met (WHO 2004e).

The partners

The GPEI has four spearheading partners: the WHO, Rotary International, the Centers for Disease Control and Prevention (CDC) and UNICEF. The WHO is the lead organisation, and provides the overall technical direction and strategic planning for the management and coordination. There is no formal agreement concerning the responsibilities of the partners. For a more detailed description of the roles of the partners, see Annex 3.

Vaccine manufacturers

There are five major vaccine corporations worldwide, and the vaccine industry has a critical role in supplying sufficient quantities of OPV. This is especially important because most companies are eager to phase out OPV production, as there will no longer be a demand for OPV after polio is eradicated. Companies generally supply vaccines to UNICEF at preferential prices. Some companies have made OPV donations as well (Weyzig 2004d: 9). Aventis is the major vaccine supplier for GPEI, and the company cooperates closely with UNICEF and WHO in the forecasting and delivery of vaccines. During the peak years of 1999 to 2001, Aventis sold 275 million doses annually to UNICEF at preferential prices in addition to donating 50 million doses for these three years. Aventis has no role in the governance of the GPEI.

Governance

The GPEI has no governing or coordinating board. GPEI is governed informally by the four spearheading partners, which meet on a regular basis. The WHO and UNICEF work together on budget proposals. Various partner organisations indicated that the GPEI is functioning well and that there is no need for a more formal governance structure (Weyzig 2004d: 15). It is perceived that national governments are indirectly involved in the governance of the GPEI through the World Health Assembly. Annex 3 describes the governance structure in more detail.

Transparency

Transparency with regard to the governance of the GPEI is low. This is partly a consequence of the informal nature of the GPEI. There are no reports of the informal biannual meetings of the spearheading partners, for example, and an explanation of the governance structure of the partnership (or the inexistence of a formal structure) is not mentioned

in GPEI documents. However, the informal governance of the GPEI does not provide a full explanation. On the GPEI website, few reports of formal management and advisory bodies are posted. Names and addresses of members of these bodies and additional information on partnership governance could not be disclosed without prior internal discussion in the WHO, and was in the end not provided (Weyzig 2004d: 17).

Together with the WHO and UNICEF, Aventis signed a tripartite Memorandum of Understanding (MOU) for the GPEI for each donation. After an internal discussion in the WHO these were not disclosed. The company does not publicly release the agreements, either, but a representative of Aventis was willing to explain the content of the most recent MOU (Weyzig 2004d: 14).

Implementation

The WHO consults the OPV manufacturers on strategic planning of vaccine production. There are formal consultations once a year (Weyzig 2004d: 8). UNICEF procures and distributes vaccines, and participates in the implementation of the NIDs. Rotary International also provides field support during NIDs.

The WHO indicates that national governments are the 'owners and beneficiaries of the GPEI' (Weyzig 2004d: 9). In principle, a country's ministry of health is charged with the task of implementing the polio programmes at district and village levels (Weyzig 2004d: 9).

Funding

The GPEI funding requirements for 2004-2005 have been estimated at US$765 million for two years. As of December 2003, confirmed and projected contributions up to 2005 totalled US$635 million, leaving a funding gap of US$130 million. In early 2003, some activities for polio eradication could not be carried out due to financing shortfalls (Weyzig 2004d: 10).

Total external financial contributions to the GPEI for the period 1988-2005 amount to approximately US$3 billion. These contributions are in addition to the domestic resources allocated by polio-endemic countries. For the entire 1988-2005 period, the largest donors are the US government and Rotary International, which provided over US$500 million each, followed by the World Bank and governments of the UK, Japan and the Netherlands. Public-sector funding constitutes 65% of total external contributions, with multilateral funding at 15% and private-sector funding at 20% (Weyzig 2004d: 10).

7.2 Global Polio Eradication in India[34]

Polio in India

Over the last several years, the incidence of polio in India has been very variable with a tendency to diminish, except for a rise in 2002 when 1,600 cases were reported. According to the National Polio Surveillance Project (NPSP), the number of confirmed cases was 1,126 in 1999, 265 in 2000, 268 in 2001, 1,600 in 2002 and 223 in 2003. Despite this trend, in 2003 India had the highest number of polio cases in the world in that year (83%) (WHO 2004d). Of those cases, 88 were reported in Uttar Pradesh, 36 in Karnataka, 28 in West Bengal, 21 in Andhra Pradesh and 17 in Bihar. In 2003, for the first time in the polio programme's history in the country there were outbreaks of the disease in the states of Karnataka and Andhra Pradesh, which had been polio-free for many years.

GPEI in India

It is not clear how India started the implementation of the GPEI, particularly because it was clearly related to the existence of the UIP (Universal Immunisation Programme). Initially it was claimed that India already had a record of over 90% coverage of OPV among 13-to-24-month-old children during 1985-1999 under the UIP, but there were doubts about the credibility of the data. Apparently admitting the problem with the UIP data, the authorities launched a mass campaign (also known as Pulse-Polio Immunisation, or PPI) to immunise 75 million children less than three years of age in December 1995 and January 1996. This was repeated on an annual basis for two years. Despite the apprehensions of the health administrators about

[34] When no other source is indicated, references in this section refer to the following case study report: Subhankar, Sanghamitgra, Poddar, Bhadra (2004), 'Case Study on Pulse Polio Initiative in Murshidabad District West Bengal India' (a case study report by the West Bengal Voluntary Health Association). In such cases only the page number(s) is specified, within brackets.

the logistical capacity of the system, the target group was increased to include children up to five years of age (Banerjee 2004: 16). To increase the campaign during 1999-2000, the rounds of the annual PPI were raised to four nationwide, with a further additional two rounds in four high-risk states. Significantly, it was only in October 1997 – two years after the launch of the PPI – that the government of India set up the NPSP in collaboration with the WHO.

Thus far, India has had many problems accomplishing set targets like the `zero goal' for 2002 and the extended goal of 2003. Available data show that the 'Final Push' for making the country polio-free from 2004 onwards has also failed (Government of India 2004). Nonetheless, many efforts have been made to eradicate the polio virus: for example, between 1994 and 2003, as many as 26 NIDs (National Immunisation Days) and 7 Special National Immunisation Days (SNIDs) were observed. Special attention has been paid to the more vulnerable states: the States of Uttar Pradesh, Bihar, West Bengal and Delhi, for example, each received four annual rounds, additional rounds and mop-up rounds. Western Uttar Pradesh was singled out for even more intensive vaccination, and had as many as 21 rounds in 2001, each lasting five to seven days (Banerjee 2004: 16). Also, considerable resources have been devoted to attaining the eradication, with most of this coming from donors. But internal resources were also mobilised, both in-kind (about 30% of the costs) as well as a World Bank loan of US$210 million.

According to some researchers, two fundamental factors affected the launching of mass campaigns such as PPI during the last two decades. First, the health services have reached such an advanced stage of decay that it was impossible to build a massive programme like PPI using the health services as a base. Then, administrators of those programmes had to search for other structures to `take over' from PPI, such as the community health workers of the Integrated Child Development System (ICDS) and heterogeneous groups like NGOs and volunteers. This has been a weak point in the implementation. Secondly, fixed booths or posts were used in conducting mass campaigns in place of the traditional house-to-house campaigns, also adopted by PPI. It has had unfavourable results and it took some time to conclude that the house-to-house approach had to be added to that of using fixed booths. However the question remains: how can house-to-house immunisation be done without a correct census of the target population and a reliable record of the coverage?

The health situation in West Bengal

Infant mortality rate was 51 in 2001 (for India as a whole, IMR was 66) and for the year 2002 it was 49 (the rate was 64 for India as a whole). Drinking water and sanitation facilities are two of the most important health determinants in West Bengal.

The health system of West Bengal

Different types of health facilities are available in the area. Some are government facilities, and others are non-governmental in nature. In the survey area one can distinguish between higher-grade hospitals (3), rural hospitals (11), Block PHC (19), PHC (76) and what are known as sub-centres (91).

The health infrastructure is generally poor. The nearest accessible centre is a health sub-centre. These centres are usually open three times a week, and are staffed by health workers. The main activities of these centres are birth registration, regular immunisation and distribution of some specific medicines. The health workers are supposed to visit the villages once a week, but in many cases, this duty is not performed. Population served per doctor in the year 2002 is 4,733 people for rural areas and 826 people for urban areas.

One of the findings that emerged from this study is the physical inaccessibility of the government health services, and the condition of the roads adds to the problems for people. Although 70% of the respondents report that they have a health centre within four kilometres from home, a majority still opt for non-governmental services when their child falls sick. This implies that the properly equipped health infrastructure is not within the reach of the majority of the population, a substantial portion of which is marginalised.

Moreover, private facilities are much more expensive than what is offered by the government infrastructure and therefore economic accessibility is a problem for the marginalised population. The quality of the services depends on the type of

health centre and in what manner the health centre is equipped to deal with a particular health problem. BPHCs do not have the wherewithal to take care of urgent or critical diseases. The patients are referred to the state general or sub-divisional hospitals. In general, the population prefers the non-governmental facilities to the facilities run by the government for reasons related to distance, availability of medicines, misconduct by staff and long waiting times.

Polio in West Bengal

The state government surveillance figures report 30 cases of polio, including one death in the year 2002-2003. Of these cases, 21 were located in Jangipur sub-division (one of the areas of study) and other cases were found in Samsherganh Block, which was also included in the case study. The government reported no cases in 2001-2002 and 2003-2004, and no cases were reported in 2004.

7.2.1 GPEI in West Bengal

GPEI has been implemented in the same manner as its predecessor UIP. The programme is structured on five levels: grass roots, block, district, state and national. At the local level, grass-roots workers and supervisors (Block Medical Health Officer) are responsible for micro-planning, covering components like preparing area and team maps, enumerating children for coverage and estimation of vaccines, and publicity. Plans are submitted to the district level authorities, who in turn submit district-wide plans to the state-level authorities. State authorities can then requisition vaccines and funds at the national level. These plans determine how much funding and vaccines states will receive from the national government.

The approach taken is MDA through NIDs. From April 2003 to July 2004 there were nine rounds of Pulse-Polio Immunisation, and additional rounds were scheduled for October 2004.

Rotary International is a major partner of the Pulse-Polio Programme, allocating funds to the Indian government through its India National PolioPlus Committee (INPPC), and through the WHO for procurement of vaccines. Rotary International's focal role at the national and local levels is social mobilisation. It also carries out advocacy efforts at ministerial level, and carry out surveillance in some Rotary districts.

The case study

The Global Polio Eradication Initiative was investigated in India by the West Bengal Voluntary Health Association (WBVHA). WBVHA works since in 1974 in health promotion and the implementation of primary health care and community health throughout the state of West Bengal. It has Resource Centres in each of the 18 districts of the state. It operates with the active support and involvement of NGOs, schools and community-based organisations and in cooperation with the State government and corporate sector.

The study was conducted in selected units in Murshidabad district. The district was divided in two zones: a zone with units at high risk and a zone with units at low risk, the degree of risk is according to the perception of the District health administration. In each zone 7 units were selected.

The study was based on cluster sampling as per WHO guidelines. The study has been carried out in 30 clusters in two parts:

- The first part seeks to assess the coverage of the Pulse Polio Immunisation Drive for three National Immunisation Days; 22 February 2004, 4 January 2004 and 9 November 2003. This particular survey is conducted on the basis of randomly selected 7 consecutive children in each cluster.
- The second part of the study concentrated on 7 families, in every cluster, each one having at least 1 eligible child. The household were selected on the basis of two eligibility criteria: the household is required to have a child aged equal to or below 5 years, and the child was to live in the area continuously for at least six months.

For more information about the methodology of this case study, see Annex 3.

7.2.1.1 Implementation of GPEI in West Bengal

The official figures on the number of children immunised in three rounds that took place in 2003 show coverage of around 95% at state level. The coverage was similar in Murshidabad district (see table). This table also indicates the enormous scale of activities carried out during each polio immunisation round, particularly during home visits.

Intensified pulse-polio immunisation programme

Area	Estimated child population (0-5)	Number of booths established	Total no. of houses visited by teams	No. of children immunised			% Immu-nised
				Rural	Urban	Total	
APRIL 2003 ROUND							
Murshidabad	847,849	3,340	1,003,772	752,776	50,876	803,652	94.79
West Bengal	8,427,652	33,654	12,145,296	6,464,351	1,592,680	8,057,031	95.60
JUNE 2003 ROUND							
Murshidabad	847,849	3,340	1,050,095	763,803	48,768	812,571	95.84
West Bengal	8,427,652	33,647	12,588,962	6,520,111	1,579,148	8,099,259	96.10
SEPTEMBER 2003 ROUND							
Murshidabad	847,849	3,340	984,961	749,903	452,03	795,106	93.78
West Bengal	9,444,317	37,806	14,330,016	7,296,288	1,686,921	8,983,209	95.12

Source: Health on the March, West Bengal, 2002-2003

In seeking to analyse the performance of the coverage of polio immunisation compared with other immunisations of the universal immunisation programme in the West Bengal and in Murshidabad, it was not possible to obtain figures for the actual coverage of immunisation. The achievement of immunisation programmes is officially given in terms of Expected Level of Achievement (ELA). Using this parameter, polio immunisation coverage was similar to DPT coverage and markedly higher than that for DT and higher than for TT and measles, where a decrease took place in 2004. In any case, these data do not make it possible to draw conclusions on a possible influence of polio immunisation on the coverage performance of other basic immunisations as has been reported by others.

Achievement rate of PP programme vis-à-vis other UIP

Area	Achievement up to March 2004	ELA submitted by district	% of ELA achieved	Achievement up to March 2003	% + / - over last year
		POLIO			
Murshidabad	130,568	135,000	96.72	116,803	11.78
West Bengal	1,552,253	1,688,025	91.96	1583259	-1.96
		DPT			
Murshidabad	130,956	135,000	97.00	118,621	10.40
West Bengal	1,549,157	1,688,025	91.77	1,572,646	-1.49
		TT (PW)			
Murshidabad	123,124	148,500	82.91	114,799	7.25
West Bengal	1,421,380	1,879,929	75.61	1,557,094	-8.70
		BCG			
Murshidabad	158,752	135,000	117.59	144,289	10.02
West Bengal	1,770,850	1,688,025	104.91	1,781,656	-0.61
		DT			
Murshidabad	91,982	135,000	68.13	71,591	28.48
West Bengal	678,002	1,306,924	51.88	801568	-15.42
		MEASLES			
Murshidabad	110,188	135,000	81.62	115,769	-4.82
West Bengal	1,276,716	1,688,025	75.63	1,545,399	-17.33

Source: State Bureau of Health Intelligence, Dept. of Health & Family Welfare, Govt. of West Bengal

These figures for the State of West Bengal and Mushidabad, the area of study, show that in Mushidabad a significant higher coverage of all UIP and polio was achieved in 2004 and also that the increment in coverage was substantially higher in comparison to the rest of the State West Bengal. The study did not report what are the causes of this phenomenon, but is true that the government has given priority to the district after the outbreak of polio in 2003.

Respecting to the occurrence of polio, it was higher in the period April 2002 – March 2003, and after that period the number of cases has diminished to level of previous periods. Most of the cases in the State occurred in Mushidabad district.

Occurrence of polio in Murshidabad district

Time period	Area	Total AFP cases	Polio (confirmed)	Deaths
April 2003 to March 2004	Murshidabad	45	0	0
	West Bengal	451	5	0
April 2002 to March 2003	Murshidabad	110	30	1
	West Bengal	630	72	3
April 2001 to March 2002	Murshidabad	24	0	0
	West Bengal	392	1	0

Source: State Bureau of Health Intelligence, Dept. of Health & Family Welfare, Govt. of West Bengal

The district of Mushidabad has a population of about 5.8 million people. It is divided into five subdivisions and 26 blocks. The district is adjacent to Jharkhand (another Indian state) and Bangladesh. This proximity to national and international borders means there is a population of migrants with the associated consequences for health. For surveillance purposes, the team in charge of the study use the divisions applied by the District Health Administration of high-risk and low-risk zones. The communities where most cases took place in 2003 are part of the high-risk zone.

With regard to the polio programme, based on the randomised samples, the study revealed a high coverage ratio in the last IPP rounds in both zones, but also significant differences between the high- and low-risk zones (p. 5). The coverage found is in line with the official figures:

Pulse-Polio Coverage – Zone H

22 February 2004		4 January 2004		3 November 2003	
Participated (%)	Did not participate (%)	Participated (%)	Did not participate (%)	Participated (%)	Did not participate (%)
98.09	1.91	92.86	7.14	90.95	9.05

Pulse-Polio Coverage – Zone L

22 February 2004		4 January 2004		3 November 2003	
Participated (%)	Did not participate (%)	Participated (%)	Did not participate (%)	Participated (%)	Did not participate (%)
99.52	0.48	98.57	1.43	97.14	2.86

According to Dr. B.R. Manna, Joint Director of Health Services, Department of Health & Family Welfare, Government of West Bengal, 'The coverage for the Pulse-Polio has touched 98% in the recent NIDs. Still, there exist some loopholes in the system which prevents 100% coverage. Around 150 to 200 thousand children fall outside the Pulse-Polio net for every NID.'

According to the survey portion of the case study, the percentage of households that took part in three consecutive NIDs from November 2003 to February 2004 was 91% in the high-risk zone and 95% in the low-risk zone.

Concerning *access to the place of vaccination,* 70% of the people surveyed in the high-risk zone and 52% of the people in the low risk said the polio booth is within walking distance.

The following were *reasons given for not taking the children for immunisation:* they had never heard about the vaccination, nobody visited them to advise them, the children were travelling at the moment of the NID, the child was sick, nobody could take the child to the booth, and in 15% of the cases in the high-risk area the reason was a community boycott.

With respect to the *perception of the necessity of the polio programme,* 95% of the respondents in the low-risk zone and 85% of the respondents in the high-risk zone said they think the programme is necessary. Nevertheless, only 16% of the respondents in the high-risk zone and 10% in the low-risk zone were *aware of the causes of polio* and also most of the respondents in both zones did not know about polio symptoms (pp. 12-13). The aspect of non-awareness about the causes of the disease was remarked on by the team carrying out the study, because the causes of polio are not mentioned in the publicity before the NIDs, particularly the relation to water and sanitation facilities that is critical in the region is critical (see below). This issue was discussed with a health department official, who stated that if the causes of the disease were made known the problem of safe drinking water and sanitation would come to the fore, and the state administration was not equipped to provide these services on a large scale.

One of the weak aspects identified by the study was cold-chain maintenance. Examination of this aspect revealed that in many centres there are technical problems like wiring deficiencies, which cause interruptions to the operation of the electric refrigerators where vaccines are stored. With regard to the human aspect, the study found that training is needed for the personnel responsible for the cold chain.

The study revealed that *socio-economic conditions* in the district are very difficult: more than 70% of the surveyed people live on incomes below the poverty line. In the high-risk zone, 52% of the mothers are illiterate and in the low-risk zone, 33% of the mothers are in the same situation. The study also found that 56% of the respondents in the high-risk zone failed to give the exact date of birth for their children. Muslims make up 64% of the people in the high-risk zone while this group accounts for 33% in the low-risk zone. One interesting finding is that in the high-risk zone 22% of the people are ‘backward groups’ (‘scheduled caste’, ‘scheduled tribe’ and ‘others’), while in the low-risk areas the ‘backward classes’ make up 48% of the population. Other findings were that almost all participants in the survey have tube-well water as a source of drinking water, and 76% of people in the high-risk zone and 56% in the low-risk zone do not have any sanitation facilities.

Concerning the *accessibility* of health services, 70% of the surveyed group in the high-risk zone and 83% in the low-risk zone have a medical facility within a distance of four kilometres; 16% in the high-risk zone and 6% in low-risk zone live more than eight kilometres from a medical facility. In the high-risk zone, 73% of those surveyed use non-governmental facilities, while in the low-risk zone 47% go to this kind of facility. The reasons given for preferring the non-governmental facilities were easy access, no medicines in government facilities, staff misconduct in public services and the waiting times were too long.

The team carrying out the study visited 13 communities during the NID in February 2004. The main findings: according to a Block Medical Officer, pulse-polio coverage is unsatisfactory in Maheshail BPHC (Block Public Health Centre), which falls under Suti II Block. The main reasons are misconceptions among people and the physical inaccessibility of some areas within the block.

Kanchantala Gram Panchayat (which falls under Shamsherganj Block) was one of the problem areas within the district where a polio boycott and non-compliance took place. It was found that the residents of the area have a high level of dissatisfaction with the public health

infrastructure. The nearest BPHC is at Anupnagar. The approach road to the health centre is inaccessible, and according to the inhabitants of the area, the medical and non-medical personnel are rude. It was also found that the quality of drinking water is very poor, with a high iron content, and there was no awareness of the fact that the water in the area is contaminated with arsenic. The sanitation facilities in the villages are almost non-existent.

Another 11 immunisation locations were visited,[35] and the following are the main findings about factors related to polio: With respect to the *personnel of the Pulse-Polio programme,* the programme is predominantly staffed by ICDS (Integrated Child Development Schemes) workers, volunteers from the community (also called social workers) and community health guides (CHG). In some cases government health workers are also involved. In most of the villages, prior publicity is carried out with amplifiers and door-to-door. The time schedule mentioned in all publicity is generally not adhered to, particularly in remote areas. Common reasons for this are: delay in supplying the vaccines to the venue, delay in arrival of the personnel and coverage of more than one booth by same set of personnel.

During the visits, the team observed that the *response of communities* to the immunisation activity (NID) varied from place to place: in some cases, the enthusiasm is perceptible and on hearing that the booth has started operating, mothers accompany their children to the booth for the vaccination. In some instances, although there is no adverse opinion about the immunisation drive itself, people choose to stay home because they know that after the NID activities, follow-up operations take place over two days, when the health workers visit the households and carry out the immunisation. In some centres (for example, Gopinathpur sub-centre) attendance at the particular NID was only about 75% compared with 90% to 95% for the previous NIDs. In other places, the quality of services in general had an effect on the attendance: for instance, in Kalopur people said it is only the polio vaccine they get for free; however, the facilities available for other ailments and for regular vaccination are grossly inadequate, and they feel these should be given urgent attention. In some areas (including Khuniapukur) people expressed adverse opinions about the PPI, and there was the idea that receiving the PP vaccine curbs reproductive power and that this programme is nothing but a well-planned government ploy to restrict population growth. In all villages the team found cases of families who have boycotted the PP drive, but the health workers claimed they have been able to allay the fears and misconceptions. In some areas (including Ghordaur tribal village) people knew nothing about the PP Drive -- there had been no publicity or visits from health workers to inform people about the PP programme. Here regular immunisation is non-existent, and in the neighbouring tribal village of Kulberia, which is relatively more developed, the regular immunisation programme is virtually non-existent, although there has been participation in the PP programme; cold-chain maintenance was found to be improper.

Regarding the *health infrastructure,* the research team found that this is generally poor. Usually the nearest centre accessible to people is a health sub-centre. These centres are usually open three times a week, and are staffed by health workers. The following are the main activities of these centres: birth registration, regular immunisation and distribution of some specific medicines. There the health workers are supposed to visit the villages once a week, but in many cases they do not perform this duty. The immunisation status is better in places where health workers have taken a pro-active role. It was found that in most cases BPHCs are physically inaccessible and the condition of the roads makes it even more difficult for people. In many urgent or critical cases the BPHCs do not have the means to give the care needed and the patients are referred to hospitals.

Concerning *drinking water,* almost all people visited use tube wells as the sole source of drinking water; in many places the tube wells were not functioning. Although the area is

[35] Gurudaspur Primary School, Beuchitala High School, Chuadanga, Kalopur Primary School, Kalopur Mathapara, Nawdapara, Abhiramhpur, Gopinathpur Health Sub-centre, Khuniapukur, Ghordaur (100% tribal village), Kulberia Adibasi Para (100% tribal village).

generally prone to arsenic poisoning, people had a limited awareness of the issue; iron content in the water also seems to be high.

With respect to *sanitation,* proper sanitation facilities are almost non-existent in the entire area. Although there is a subsidised scheme for installing latrines (non-sanitary type with no water seal), there has been a limited response to this scheme for a number of reasons: people are unwilling to pay the amount and expect a full subsidy, and even when people pay, the *panchayat* (local authority) is sometimes unable to supply the equipment.

Regarding the possible *effects of the Pulse-Polio Programme on the health system,* the case study reports that the programme has had both a positive and negative impact on the local health system. On the positive side, the PPI opened up opportunities for coordination by the health sector with other sectors such as the panchayat, the Electrical Department, the Public Works Department and others during the implementation of the programme. On the other hand, the implementation of the programme has adverse effects on the system: one round of Pulse-Polio can take 15 days from planning to completion. In recent rounds, particularly after the setbacks in 2002-2003, the emphasis has been on total coverage. This means that complete booth coverage and house-to-house immunisation is undertaken, until the local authority is sure not a single child has been left out. This takes around seven to eight days. Before the NID, around seven days are spent on planning and logistics. Since all personnel at the local level are focused on the NID – including medical officers, nurses, and paramedical personnel – all other activities, including the UIP activities, are severely affected.

The study found that in terms of *priority of the programme,* the polio programme is extremely important to officials at the national level due to international image, but for health workers this is not the case. According to them, other programmes that combat prevalent diseases also need attention, particularly because during the NIDs other priorities are relegated. 'For the community, obtaining regular health services will always be greater priority than getting two drops of polio (p. 3). With regard to the question posed by the researchers to health officials about why funds are spent for PPI and not used for other programmes considered more urgent, they responded that those funds are exclusively for polio and that there is no question of utilising those funds for other purposes. The interviewed local authorities perceived the need to allocate resources to other programmes such as malaria and TB, but they have little to say about earmarked funds coming from the national government. According to state functionaries, the cost of organising an NID for the entire state comprising 19 districts is about INR80 million to INR90 million (€160,000 to €180,000), which includes the cost of the vaccine, organisation and publicity and educational activities. Six rounds were organised the last year.

Concerning the matter of *participation,* in the PPI it seems it is understood mainly to be the recruitment of local vaccinators and CHGs in order to facilitate and increase community participation in the NIDs. These workers are also trained to educate the community about myths and misconceptions. The case study reports that in different places 'implementation fatigue' of community health workers was perceived. With respect to participation in decision-making, all-important activities of the programme are centrally planned, without the participation of health workers and local authorities.

7.3 Conclusions on Global Polio Eradication Initiative

The conclusions that can be drawn about a worldwide initiative from a single case study in one health district in a country as immense as India are, of course, limited. However, the case study in Murshidabad, one of the few places in the world where polio has not been eradicated and where in 2003 an outbreak took place, can be a rich source of learning.

- GPEI was one of first GPPIs launched, and it is generally recognised that the initiative has been highly successful, achieving the eradication of polio in 99.9% of the world in about 16 years of activity. These outstanding results are very important, particularly because polio has long-term consequences for children suffering from the disease. To a great extent, GPEI owe its success to the strong support of Rotary

International at all levels, from the community level in carrying out vaccinations to the top level of lobbying and raising funds for the initiative.

- In the case of India, the eradication of polio has been problematic over the last several years, although the number of cases has steadily diminished, except in 2002, when a high upsurge took place. In 2003, the number of cases slowed again, but a few cases were found in states that had been known to be polio-free for many years.

- In the case of Murshidabad, West Bengal where the case study presented here took place, 30 polio cases were identified in the period from April 2002 to March 2003. Although the reasons are difficult to discern, this upsurge can be brought into perspective by a combination of the following reasons: misconceptions of the population about the vaccine, lack of information, boycott of social groups of the immunisation activities, fatigue of local health workers, dissatisfaction of people with the quality of health services received from the polio immunisation and to some failures in maintaining the cold chain properly. It is important to mention that accessibility to immunisation plays a role in only a few cases.

- With the available figures based only on expected achievement, the study showed that in 2004, polio and DPT had similar coverage rates (above 90%), rates that are significantly higher than other vaccines like measles. The figures also show that in Murshidabad the coverage is higher with all vaccines, probably because of the high priority given to the district after the outbreak of polio in 2002.

- One finding of the study is that people in communities were not well informed about the causes of polio, particularly in relation to drinking water and sanitation. According to the team carrying out the study, this is an important issue, particularly in an area where more than 70% of the population is living in extreme poverty, there are high levels of illiteracy, people lack access to good-quality drinking water and sanitary facilities are almost nonexistent in many places. Moreover, when discussing the issue with a health official, he claimed it could lead to people demanding these facilities, which the administration is not equipped to provide on a large scale.

- The PPI programme has had mixed effects on the local health system. On one hand, the programme has made possible coordination with other sectors and local authorities in order to achieve the immunisation activities. On the other hand, it has affected the delivery of all other health services, particularly while conducting the NIDs (immunisation days), when all personnel and resources of the health services are concentrated on the immunisation activities for periods of around 15 days, to the detriment of the normal health activities. This last point takes on more importance in the case study area, where public health facilities have poor infrastructure, lack drugs and deliver only a very limited number of services in an irregular manner, which means that many people look for alternative health services when necessary. This brings us back once again to some of the aspects mentioned as reasons for the outbreaks of polio.

PART III

8 General conclusions

GPPIs are complex and very diverse entities, acting at different levels and operating within diverse contexts. This makes it difficult and irrelevant to formulate comparisons between them. This diversity also imposes limits on reaching concrete conclusions valid to them all. However, considering the scope and limitations of this report, some general conclusions can be drawn:

- The Global Public-Private Initiatives in health covered in this report fit into the following types: 'improving access to health products' and 'global coordination mechanisms and public advocacy' and are all focus on poverty-related diseases. The studies found that these initiatives have increased the attention for the health problems they focus on, both at national and international levels, as well as increasing the availability of financial resources, health products and supplies for these diseases. The studies also showed that these initiatives do not make significant efforts to approach these poverty-related health problems in an integrated and structural manner, in order to adequately contribute to tackling the causal conditions that are at the root of the current serious situation. The way they operate now raises concerns about GPPIs' suitability for making significant contributions to sustainable improvement of health problems in poor countries and attainment of the globally agreed MDGs.

- The GPPIs included in this study contribute very little to strengthening local public health systems. Even though some initiatives state this in their objectives, the studies found almost no evidence this is actually happening, particularly at the lower levels of the systems. Most studies showed that the activities promoted by the GPPIs took place within the rather weak, understaffed and under-resourced existing national and local health systems, which are the main source of health services for the poor. There was no evidence that the GPPIs promoted or supported significant investments to improve these institutional settings and structures, and the effect has frequently been that the GPPIs' activities strained precarious local health systems and diverted human and other resources from their normal activities. When the promotion of participation by private-sector providers took place within the framework of a GPPI programme, it proved to be problematic, mainly because of the lack of regulation mechanisms. GPPI programmes were not harmonised with the national and local health systems. These aspects were considered by national and local actors to be critical reasons why the achievements of the GPPI programmes were low in terms of their own proposed targets.

- The studies found no concrete examples of ways in which different GPPIs active in the same country attempted to harmonise with each other to a great degree, or even just to integrate some activities. This was not the case even when the programmes of two different GPPIs came under related national structures, like those for vector-control diseases. These studies did not confirm the argument that the integration of activities from different programmes naturally occurs at district level. Observation by and the opinions of local health workers indicated that the activities of different initiatives – promoted through the same mechanisms and structures as other existing vertical programmes – tend to compete with each other, which tends to fragment and overwhelm the local health systems. This impairs the capacity of the local health systems and diminishes the probability that each initiative will achieve sustainable health improvements for the target population.

- As this report was being completed, all four GPPIs considered here were experiencing serious funding shortages for accomplishing their original plans. Two of these initiatives started to rely on the Global Fund for Tuberculosis Aids and Malaria (at least in the case of the African countries) for financing the action plans of countries participating in its programmes. The studies at national level found that in the case of GAELF and RBM some activities were experiencing delays and in some cases the action plans were not funded completely. In the case of GPEI, the global programme reported that in 2003 some activities were not implemented because of the lack of funds. These facts raise questions about medium-term sustainability and predictability of these initiatives, particularly because they are competing with each other for resources. This situation could become more complex during times when donors give more attention to plans related to the MDGs – and not all these initiatives are integrated into those plans.

- Governance has proven to be an issue in GPPIs. At the global level, external evaluations have reported deficiencies in transparency and openness, a lack of accountability and a vague definition of partners and their roles and responsibilities. It has also been reported that recipient countries participated only minimally in the global decision-making structures. In three cases (STB, RBM and GAELF), those researching this report found that major changes in the governing mechanisms recently took place, two of which deal with some of the problems mentioned. Most of the initiatives also score low on transparency, particularly when it refers to disclosure of information on financial decisions, drug donations and decision-making. At national level, when they do exist the studies found that the country coordination mechanisms are not clearly defined, not much is known about them and because they are embedded into government structures there is a lack of transparency. Accountability was a matter of concern in many cases, particularly because not much is known about the initiatives, not even by the functionaries and health workers who run their programmes, let alone CSOs and the target population. With regard to other matters of governance, at field level the studies found that GPPIs do not promote approaches, mechanisms or structures that allow different national stakeholders and target groups to participate in decision-making on issues related to the initiative's activities in the countries. Instead, top-down mechanisms are used and when 'participation' is promoted by the initiatives, it tends to be functional and was in some cases described as 'prescriptive'.

8.2 Recommendations

This section presents and elaborates upon our recommendations for the various stakeholders of the GPPIs considered in this report. These are based on the findings of the case studies, and in some cases these recommendations could be applied to other similar GPP initiatives of the categories 'improving access to health products' and 'global coordination mechanisms and public advocacy'.

8.2.1 Recommendations to the WHO[36]

- The WHO must promote an integrated approach with an emphasis on equity in the global strategies and plans of the current GPPIs focused on poverty-related diseases. At country level, the WHO should promote integration of these GPPIs into national plans and provide technical assistance to recipient countries in order to shape the GPPIs' programmes to approach poverty-related health problems in an inter-sectoral manner. To avoid fragmentation of local health systems in recipient countries, the WHO should not embark on new GPPIs focused on poverty-related diseases like those considered in this report until the effects of current GPPIs on poverty reduction have been assessed, their contributions to national poverty-eradication strategies confirmed and harmonisation mechanisms between GPPIs at global and country levels established.

- The WHO must make sure that GPPIs working on 'improving access to health products' and 'global coordination mechanisms and public advocacy' invest sufficient financial and technical resources in strengthening public health systems, particularly in the areas of human resources,

[36] These recommendations can also be applied to other UN agencies such as UNICEF and UNAIDS.

management and information systems and equipment and infrastructure, especially at district and sub-district levels. It is important for the WHO to assist those recipient countries participating in GPPIs already implemented to: a) evaluate major deficiencies and possible solutions in the areas mentioned; b) assess the effects of the implementation of GPPIs on these aspects; and c) define the investment needed in these areas to operate these programmes so they are likely to achieve the expected results in both the short and long term.

- The WHO, as initiator and key factor in most GPPIs in health, should take the initiative and take the lead in the search for harmonisation and synergy between strategies and mechanisms of action of the different GPPIs at global level. The WHO country offices should strongly promote the integration of strategic and operational aspects of the different GPPIs both at local and country levels.

- The WHO should ask its partners in GPPIs and the donors of these initiatives for long-term commitments. At the same time, the WHO needs to support the recipient countries individually to negotiate long-term commitment from donors and other partners contributing to GPPIs. To assure the continuity of the activities initiated by GPPIs, the WHO should look for mechanisms focused on providing countries with the technical and financial capacity to continue these programmes autonomously.

- The WHO should make sure all partners have clearly defined roles and responsibilities in the GPPIs in which it participates, and should demand the creation of mechanisms to assure the accountability of all stakeholders. At the same time, as a global normative institution the WHO must promote transparent mechanisms for decision-making in GPPIs to encourage recipient countries to participate more in the GPPIs' decision-making mechanisms at global level. At country level, the WHO should provide technical support on organisational and governance issues to Country Coordination Mechanisms, and use these mechanisms to promote the leadership of national government.

8.2.2 Recommendations to international financial institutions

- International financial institutions (IFIs) can play an important role in promoting the integration of GPPIs focussed on poverty-related diseases in national plans for poverty eradication and achievement of MDGs. IFIs involved in GPPIs can also promote integration of these initiatives with other programmes and projects aimed at improving basic living conditions such as water, sanitation, nutrition and shelter.

- When taking decisions on financial assistance for implementation of GPPI programmes in countries with weak health care delivery systems, IFIs should consider including resources for strengthening public health delivery systems, particularly at district and sub-district levels.

- IFIs should play an important role promoting and requiring integration of different GPPIs programmes at country level, as well as initiating mechanisms aimed at creating synergy in the output of various GPPIs operating in the same country.

- IFIs should thoroughly assess long-term financial sustainability of GPPI programmes prior to taking decisions to support them financially, either directly or indirectly. Transparency in decision-making, clearly defined responsibilities of the different stakeholders and adequate accountability mechanisms of the GPPI also need to be thoroughly assessed by IFIs before engaging in these initiatives.

8.2.3 Recommendations to donor countries

- Before deciding on further financial support to or becoming involved in other GPPIs working on improving access to health products and global coordination mechanisms and public advocacy, donor countries need to thoroughly assess what the current GPPIs actually contribute to poverty eradication and the achievement of MDGs. Donor countries should consider these to be key criteria for supporting the programmes of GPPIs. The evidence has shown that current GPPIs do not specifically work on the underlying conditions of poverty-related diseases and therefore their contribution

to the achievement of poverty eradication can be considered negligible. Because of this, donor countries need to consider alternative instruments and mechanisms for tackling these diseases.

- Based on the findings of the studies presented in this report, we would like to recommend the following. Before become involved in other GPPIs focussed on improving access to health products (particularly medicines), donor countries should carefully assess the effects these programmes have on the performance of the public health systems in poor countries, particularly at district and sub-district levels. In the cases where donors are already involved in GPPIs of the type presented in this report, they must require these initiatives to make substantial investments in strengthening the public health systems of the recipient countries, particularly in aspects of training and remuneration for staff, management and information systems and equipment and infrastructure. Special attention needs to be given to the community health workers and volunteers, who ultimately perform a large number of services at local level.

- Donor countries must require GPPIs to establish specific mechanisms of integration with each other at strategic and operational levels. At country level, existing funding mechanisms such as SWAP and basket funding can facilitate the harmonisation of the different GPPI programmes.

- Prior to become involved in other GPPIs or continuing to support current GPPIs, donor countries should assess the long-term perspectives and predictability of the sustainability of these initiatives. If they decide to become involved, donor countries should be prepared for long-term commitment to these programmes. To increase the likelihood of the sustainability of the GPPI programmes, donor countries have to consider providing additional support to the recipient countries participating in GPPIs in order to develop capacities aimed at creating self-reliance.

- Donors should require a thorough assessment of organisational and governance aspects of current GPPIs before making new commitments to support GPPI programmes. The clearly defined roles and responsibilities of different stakeholders should be considered when assessing these initiatives. Because of their motivations, attention should be paid to the role played by commercial partners in decision-making – this cannot in principle be the same as those of other development actors. At country level, donors should encourage the establishment of transparent and accountable decision-making mechanisms for these initiatives.

8.2.4 Recommendations to the private sector

a. Commercial entities

- To make their commitment to improve the health problems of the poor more effective and coherent, pharmaceutical companies participating in GPPIs must take other measures that improve in a sustainable way poor people's access to medicines for diseases closely linked to poverty. These measures are: support for a systematic, global approach to guaranteed pricing for vital drugs based on equity, refraining from undermining the production of affordable generic drugs, investing more resources in R&D for these diseases and contributing to programmes for the correct use of drugs.

- To guarantee better and more effective results from their contribution to GPPIs, companies should also allocate resources for strengthening service distribution systems.

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- Companies should acknowledge that eradication of poverty-related diseases is a long-term task, and must therefore make a commitment to support the initiatives for extended periods.

- Pharmaceutical companies should make their contributions to GPPIs sustainable by supporting the production of generic medicines for poverty-related diseases in poor countries. In addition to facilitating sustainable access to medicines against these infectious diseases, this would make such countries less dependent on imports of these products and would contribute to their economic development.

- Companies participating in GPPIs should provide transparent information concerning their

roles in these initiatives and collaborate on establishing transparent and accountable mechanisms for decision-making in GPPIs, bearing in mind that because these initiatives also have a public component they need to be accountable to the public

b. Non-profit entities

- The interest of philanthropic and other not-for-profit institutions for improving the situation of the poor has played an important role in initiating most of the GPPIs included in this report. We recommend that, in order to make their laudable efforts more effective and sustainable, these entities commission studies to assess the contribution of GPPIs with regard to the conditions closely related to the causes – persistence of and increase in poverty-related diseases – before becoming involved in other GPPIs, or further involved with current ones.

- In view of the findings of the case studies presented in this report, not-for-profit institutions participating in GPPIs in health should require these initiatives to provide – in addition to medical products – resources for strengthening service delivery systems in the recipient countries to improve the results of the programmes being implemented.

- Not-for-profit institutions participating in GPPIs should require current initiatives to integrate and attempt synergy with other programmes at country and global levels. This will reduce transaction and opportunity costs.

- Not-for-profit institutions participating in GPPIs need to take into account that eradication of poverty-related diseases requires sustained efforts, and because of this they must make a commitment to support the initiatives for extended periods. At the same time, they should take into consideration that additional resources are necessary to build capacity in poor countries in order to continue on their own the activities initiated by the GPPIs. The case of Rotary Club International is a very good example of this.

- Not-for-profit institutions participating in GPPIs should use their influence to require a thorough assessment of governance and organisational mechanisms in order to create GPPI institutions that are transparent and accountable to the public.

8.2.5 Recommendations to governments of recipient countries

- Governments should demand current GPPIs for service delivery to become integrated into national plans for poverty eradication and require current GPPIs to adjust their programmes in order to come into line with national priorities on health. Governments should insist that GPPI programmes integrate their strategies with national structures at different levels, for example at district, regional and national levels, and need to take the necessary measures to ensure that GPPIs harmonise their activities with both other GPPIs and other programmes supported by foreign donors. It is important that governments create mechanisms and directives to promote such harmonisation and synergy between the various GPPIs working in their countries.

- Governments should request the technical assistance of the WHO to assess current deficiencies and estimate extra investments needed for running the health system at district and sub-district levels so the different GPPIs programmes can be implemented properly. This would be the basis for negotiation or proposal submission for every GPPI. According to the findings of the case studies included in this report, the following areas require attention: human resources, information, monitoring and management systems and basic equipment and infrastructure. Measures need to be taken in order to keep the activities of vertical programmes promoted by GPPIs from interfering with the normal functioning of regular basic health services.

- When possible, governments must negotiate long-term commitments for support of activities from the GPPIs in their countries. At the same time, from the very inception of the GPPI programmes governments should reach agreement with these initiatives on the steps and resources needed to create local capacities in order to be able to continue on their own with the activities they initiated.

- As members of the partnerships, governments should demand equal participation in the decision-making mechanisms of GPPIs at global level, as well as a clear and transparent mechanism for priority definition. At the country level, it is essential that governments of recipient countries facilitate the establishment of a transparent and accountable mechanism for decision-making. Governments should facilitate participation by CSO organisations in the CCMs, including those that take a critical stance towards their policies. In implementing GPPI programmes, governments should promote the establishment of decision-making mechanisms that make possible a significant input by district and sub-district levels in defining priorities and operational plans.

8.2.6 Recommendations to health workers in recipient countries

- Health officials in recipient countries should propose and demand measures for integrating the activities of GPPIs into local plans for an integrated approach to poverty-related diseases.

- Health workers should demand information from health authorities about the scope, resources and decision-making mechanisms of the GPPIs working in their countries. When necessary, health workers should demand evidence that GPPIs' programmes are making significant investments in strengthening local health systems, for instance by training and improving the working conditions of staff, and providing equipment and infrastructure.

- Health workers should inform local authorities and communities about the objectives, activities and potential benefits of a GPPI programme and discuss with them possible adjustments to the current GPPI programmes so that these programmes can respond to a majority of people's needs.

- Health workers can play an important role in integrating different vertical programmes by proposing and asking for shared organisational and logistical procedures, use of shared educational materials, integrated drug distribution systems, shared use of equipment, integration of training activities and remuneration aspects. At the same time, health workers can ask for concrete activities and programmes to create and improve local capacities for proper implementation of the programmes. As experts on the local conditions, health workers can propose incentives and other elements necessary to ensure the collaboration of CHWs and other volunteers participating in the GPPI programmes.

- Health workers should collaborate with and also demand more transparency in decision-making at different levels of the GPPIs' programmes. Health workers must collaborate to assure that participative and bottom-up priority-setting and planning mechanisms are in place in the current programmes of GPPIs.

8.2.7 Recommendations to international and local CSOs

- International and national CSOs must raise awareness and discuss with representatives of the GPPIs the ways in which these programmes can contribute to poverty eradication by adjusting their plans of action to local priorities. They should demand that GPPI programmes working on improving access to health products and global coordination mechanisms and public advocacy complement its actions with activities directed at improving basic living conditions in their efforts to fight poverty-related diseases.

- Local and international CSOs should provide evidence on unexpected damaging effects of GPPI programmes in the way they are currently being implemented, especially with regard to fragmentation of local health systems. From national governments and the WHO they should demand harmonisation of the different GPPIs at national and global levels respectively. Based on their experiences, CSOs can propose concrete forms of integration at local level.

- CSOs in recipient countries should provide evidence on the harmful effects of GPPI programmes to local health systems, particularly with regard to overwhelming and straining already weak structures. According to the findings of the studies included in this report, they should demand that GPPIs' programmes make significant investments to

strengthening these systems, particularly with regard to the aspects of human resources, information, monitoring and management systems and equipment and infrastructure.

- Local and international CSOs must advocate for sustainable solutions to the health problems of the poor, demanding long-term support commitments by GPPIs, concrete sub-programmes to develop capacities at local level in order to assure the continuity of the programmes initiated and a participatory mechanism of priority definition and decision-making in order to promote ownership by local actors. Based on their work experiences, CSOs can propose concrete measures for making the GPPI interventions sustainable.

- CSOs in both recipient and donor countries should demand complete information on strategies, objectives and plans and resources involved in GPPIs. They must advocate for transparent decision-making mechanisms and demand participation by CSOs in coordination mechanisms. At the same time, CSOs need to inform communities about the GPPIs' programmes, objectives and plans and resources involved and support the local communities to make use of resources and services made available by these programmes.

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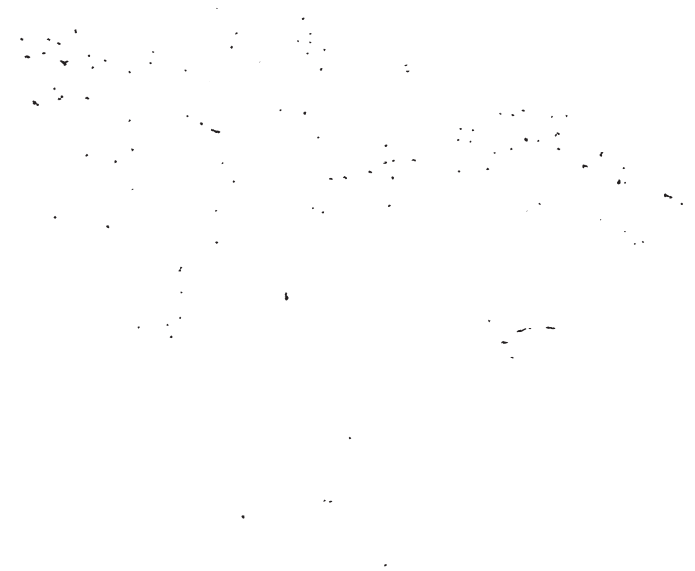


Annex 1: Methodology

A) In the definition of the methodology, two elements were taken into account:

1. The results of the case studies would be used in a later phase as instruments for advocacy activities at national and international levels by the participating organisations.

2. The entire process of implementing the case studies was systematically used as an instrument to strengthen the capacity of all participating organisations – those from Southern countries as well as Wemos – in matters such as the analysis of international health issues, defining research subjects, research methodology, research for advocacy purposes and analysis of results.

B) To enhance this learning process, time for joint discussion and reflection was planned before and during the process of implementation of the case studies:

- Initial consultations with Southern organisations took the form of two workshops, in May and August of 2003. These were held to analyse the problem and to agree on concepts, core assumptions (rather than a hypothesis), the focus and methodological aspects for data collection.
- A workshop was held to revise the preliminary results, discuss a strategy for analysis and agree on key issues for the advocacy phase (April 2004).
- A final meeting has been planned to coordinate the advocacy activities and to evaluate and draw lessons from the joint working experience.

C) Four 'core assumptions' were agreed upon by the participating organisations. These are the guiding principles concerning the approach, the values and governance that programmes as those of the GPPIs should fulfil in order to contribute to a sustainable health improvement of the poor. These are:

1. The approach to health issues must be based on a comprehensive definition of health that takes into account the multi-causality of health including social, political and environmental aspects. The approach must give special attention to health problems of the poor, because it is concerned with existing inequities and social justice. Health programmes should be consistent with fundamentals that permit the achievement of sustainable health improvements for people, particularly the poor.

2. GPPIs in health should contribute to the fulfilment of the right to health. According to the CESCR General Comment No. 14 (2000), 'The right to the highest attainable standard of health' (article 12 of the International Covenant on Economic, Social and Cultural Rights), the right to health includes the following interrelated and essential elements: availability, accessibility, acceptability and quality.

3. In GPPIs in health, the sustained improvement of people's health should prevail over the interests of any of the institutions, companies, organisations or groups participating in the partnership. To guarantee this, it is necessary for the GPPIs to have clear mechanisms of governance as well as transparent decision-making mechanisms at international and country levels. The GPPIs must be accountable to the public.

4. In order to attain sustained improvement of people's health and increase the effectiveness of its interventions, GPPIs must reinforce the national public health system and the institutions in the health sector that work to improve the health of vulnerable groups. At least, GPPI programmes should not undermine the public health systems of the countries where they are implemented.

D) Desk research

- GPPIs at global level: general data collection from official sources and revision of produced literature related to the initiative (including grey bibliography).
- Context in each country: the fulfilment of aspects of the right to health at country level; the health situation and its determinants; national public health system, stakeholders, organisation, functioning and financing, depending on the availability of data.
- Context at local level: the fulfilment of aspects of the right to health, and the health situation and its determinants in the selected areas where field research was to take place.

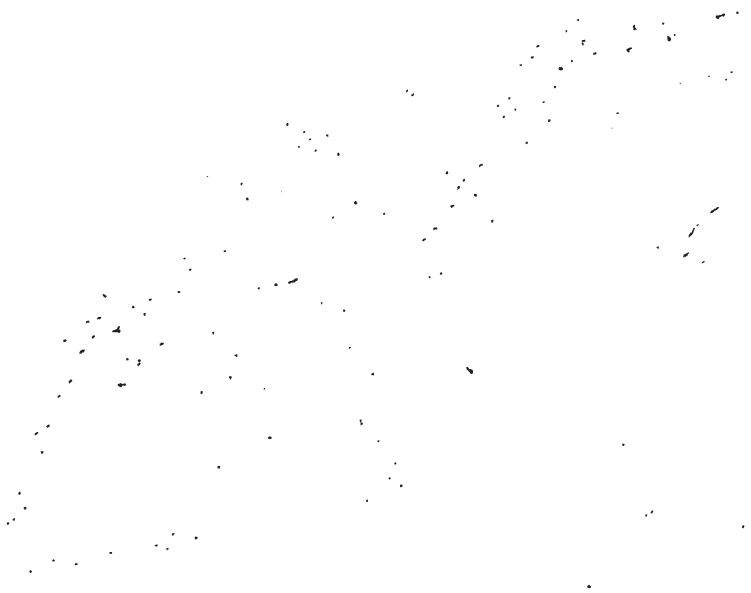
- GPPIs at national level in each country (both official and non-official documents).
- GPPIs at local level in each country: decision-making process at local level, operative plans and organisational structure of the programme, activities and results.

E) Field research

Supplementary information was sourced through interviews with the following key personnel:

- Health functionaries at national and local levels;
- Functionaries of the GPPI programme at national and local levels;
- Health workers at national and local levels;
- The relevant national and local authorities;
- Focal persons from civil society organisations (CSOs) and/or NGOs;
- Focal groups and key informants, at times utilising cluster sampling.

The details of each case study are presented in Annex 3.



Annex 2: Description of the studied GPPPs in health

1. The Global Alliance to Eliminate Lymphatic Filariasis – GAELF

The roles of the partners

- WHO – acts as secretariat and houses four staff who administer GAELF full time, directs, coordinates, facilitates, provides technical support, monitors and is present on decision-making bodies. It is also the implementing agency for the Global Programme to Eliminate Lymphatic Filariasis.

- World Bank - established a trust fund to manage the US$20 million grant given by the Bill & Melinda Gates Foundation to eliminate lymphatic filariasis (LF).

- Private actors
  - Private-sector companies – provide free drugs for mass drug administration (MDA) campaigns, promote advocacy, support academic institutions and facilitate programme development; participate in coordination and decision-making committees.
    - Merck & Co., Inc. – the Mectizan® Donation Programme provides medical and technical support to its worldwide donation of Mectizan® for the mass treatment for the elimination of LF;
    - GlaxoSmithKline, UK – an active partner; provides millions of albendazole treatments to communities and more than US$1 million in cash grants to other alliance partners each year;
    - Binax, Inc. USA – provides a diagnostic tool for LF.

  - NGOs - complement the efforts of the national ministries of health in implementing different components of the programmes; participate in decision-making committees.
    - Amaury Couthino, Brazil - provides financial support to a clinic to assist LF patients, clinical research and development of the infrastructure of the International Training Centre on Lymphatic Filariasis, Recife;
    - Handicap International, Health and Development International (HDI), Norway;
    - Interchurch Medical Assistance (IMA), USA;
    - International Foundation for Dermatology, UK;
    - International Skin Care Nursing Group, UK;
    - International Volunteers in Urology, USA;
    - the Carter Center, Atlanta, USA;
    - the Centres for Partnerships in Health, Australia;
    - the Mectizan® Donation Programme, USA;
    - World Alliance for Community Health, Canada.

  - Academic institutions - strengthen the scientific basis, test new tools and strategies and carry out operational research; provide a presence on decision-making bodies related to clinical aspects of programmes.
    - Ain Shams University, Egypt;
    - Bernhard Nocht Institute for Tropical Medicine, Germany;
    - Chinese Academy of Preventive Medicine, China;
    - Danish Bilharziasis Laboratory (DBL), Denmark;
    - Institute for Medical Research (IMR), Malaysia;
    - James Cook University, Australia;
    - Lymphatic Filariasis Support Centre, Emory University, USA;
    - Lymphatic Filariasis Support Centre, Liverpool School of Tropical Medicine, UK;
    - Michigan State University, USA;
    - Notre Dame University, USA;
    - Universidade Federal de Pernambuco, Brazil;
    - Vector Control Research Centre (VCRC), Indian Council of Medical Research, India;
    - Washington University in St. Louis -- Barnes-Jewish Hospital, USA.

- Donors - pledge funds to support the implementation of national LF elimination programmes (this is further described in 8.1.2.5).
- Recipient countries - countries have to submit proposals for the National PELF (Programme to Eliminate Lymphatic Filariasis) to the partnership. By the end of 2002, a total of 54,689,600 people had received drug co-administration through MDA in 32 countries participating in the PELF.

GAELF governance structure
The main function of the GAELF is to mobilise support for PELF implementation. At the first GAELF meeting in May 2000, it was decided how to organise issues like fund-raising. At the second global meeting in May 2002, it became clear that the partnership needed to be better structured. A temporary partnership structure was designed and set up by September 2002. Two task forces were created, one for advocacy and fund-raising and one for communication; each task force has a chair and four members. A GAELF secretariat was set up.

At the third global meeting of the alliance in Cairo, Egypt in March 2004, a new governance structure for GAELF was proposed and adopted by the various partners. There are now three levels of governance.

1. Global Assembly
   This is the bi-annual global meeting of all GAELF partners.

2. Representative Contact Group (RCG)
   A Representative Contact Group (RCG) was established, composed of 30 representatives from various constituencies:
   - the chairs of the six Regional Programme Review Groups (RPRGs);
   - three country representatives from the African region, and two from each other region;
   - the WHO;
   - the World Bank;
   - non-governmental organisations (NGOs);
   - academic/research institutions;
   - pharmaceutical industry;
   - donors.

The RCG met for the first time after the meeting in March 2004. An endemic country representative was chosen as president of the group. The most important function of the RCG is to appoint the members of the executive group. The RCG also mobilises funds, including for the Technical Advisory Group (TAG), the RPRGs and the implementation of the PELFs in endemic countries.

3. Executive Group
The RCG selected a smaller executive group of six members to carry out the recommendations made at the GAELF meeting in May 2004. The chair of the executive group is Mr. Yankum Dadzie from Ghana. The executive group includes one representative from GlaxoSmithKline (GSK) and one from Merck's Mectizan® Donation Programme (MDP). According to the chair, they do not wield real power. The role of these representatives is mainly supportive, for example by providing the facilities for teleconferences. An important role of the pharmaceutical companies, apart from drug donations and cash contributions, is to use their networks to bring in other donors.

The executive group is in charge of mobilising support and plays an important role in the governance and functioning of the GAELF. The executive group meets at least three times a year and has additional teleconferences. A main task of the executive group is to review and carry out the recommendations made by the two task forces.

PELF implementation structure
The WHO acts as the secretariat of the GAELF. At country level, the drugs are administered through national programmes. Countries have to submit proposals for the National PELF to the partnership. The WHO supports the National PELFs, and communicates with the following bodies:[2]

- The Regional Programme Review Groups (RPRGs). Before the GAELF was launched, a Global Programme Review Group was set up by the WHO and GSK for the donation of albendazole. The task of this group was reviewing applications from the national ministries of health for LF programmes. The global group was later replaced by six RPRGs for each WHO region. Although they are separately represented in the new governance structure of the GAELF, their tasks are mainly related to the implementation of the programme. The members are appointed by the regional directors of the WHO.

- The Technical Advisory Group (TAG). The TAG meets annually to give non-binding recommendations to the WHO on all aspects of the elimination of LF. It provides technical guidance to the Global PELF and is made up of a group of specialists selected for their personal expertise in LF science and programme management. The members are of the group are appointed by the director-general of the WHO.

- The GSK/WHO Collaborating Coordination Committee (CCC). This committee was set up to support the albendazole donations. It has mainly a managerial and logistical role and forecasts drug needs.

- The Expanded Mectizan® Expert Committee (EMEC). The EMEC has an important technical function. The African RPRG forwards programme requests from countries where onchocerciasis is co-endemic to the EMEC for final authorisation. Its role is similar to that of a TAG for the concurrence of LF and onchocerciasis. The members of the EMEC are experts appointed by the MDP.

- The Mectizan® Donation Programme (MDP) acts as the secretariat of the EMEC. It is not a separate legal entity, but part of Merck. The MDP provides managerial and logistical support for the Mectizan® donations and is based within the Task Force for Child Survival & Development, a US-based NGO. Specific Merck staff interact on a regular basis with the secretariat regarding decisions about the operation of the programme and to facilitate the delivery of Mectizan® for both onchocerciasis and lymphatic filariasis.[2]

The Roll Back Malaria Partnership – RBM

Governance

Initially, RBM had a loose structure to increase flexibility and avoid a high management burden. After an independent evaluation of the partnership in late 2002, the RBM initiative was restructured to make partners more accountable and to accelerate malaria control programmes. The RBM partnership secretariat was separated from the WHO Malaria Control Department.[2] Before this, failures of the RBM were easily attributed to the WHO. The partnership board was extended and a seat for a private-sector representative was added because of the important role of the industry in scaling up supplies of ACTs and impregnated bed nets.

The RBM Partnership now has three levels of governance:
- the RBM Partnership Board
- the RBM Partnership Secretariat
- working groups

The board provides overall guidance to the partnership. It has 17 voting members, including one industry representative, and two non-voting members. The board is composed of the following representatives: six from malaria-endemic countries, one from an NGO, one from the private sector, one from an academic institution/research, one from a foundation, three from OECD donor countries, four from multilateral agencies and two non-voting board members.

The secretariat is responsible for supporting the scaling up of malaria programmes and provides support to the working groups of the partnership. It is accountable to the board. Six working groups were created after the external evaluation to replace the existing technical support networks.

The working groups deal with the following issues:
- Malaria Case Management
- Communication
- Financing and Resource Mobilisation
- Insecticide-Treated Netting Materials
- Malaria in Pregnancy
- Monitoring & Evaluation

Currently the private-sector member on the board is from Bayer. He represents all industry partners, including bed net and insecticide manufacturers, pharmaceutical companies and other companies like Exxon-Mobil.

STOP TB Partnership

Governance structure

Stop TB Partners' Forum - an assembly of Stop TB partners, who met in 2001 and 2004. It is the main coordinating body of the partnership.

Stop TB Coordinating Board - decides on the strategies and priorities of Stop TB, taking into account recommendations from the forum and the WHO. It was recently enlarged to 31 members and represents a broad range of partners and the working groups. In addition, an executive committee has recently been established, replacing a working committee. It consists of seven board members and has delegated authority to make decisions that do not require the consideration of the full board.

Stop TB Partnership Secretariat - supports the work of Stop TB partners and the working groups and is accountable to the board.

Working groups - concentrate on different aspects of the work of Stop TB. They have their own independent governance mechanisms, but their work is coordinated and reviewed by the Stop TB Partnership. There are currently six working groups: DOTS Expansion, TB/HIV, DOTS-Plus for multi-drug resistant TB (MDR-TB) (linked to this working group is 'The Green Light Committee', an independent group of experts which approved MDR-TB pilot programmes), New TB Drugs R&D, New TB Diagnostics R&D, TB Vaccine R&D.

Global Drug Facility (GDF) - is a mechanism for expanding access to high-quality TB drugs. It procures TB drugs centrally from pre-qualified suppliers and provides technical support at country level to ensure the correct use of the drugs. GDF is hosted by the WHO and managed by the Stop TB Secretariat.

WHO Strategy & Technical Advisory Group (STAG) - provides strong policy guidance to the board and secretariat of Stop TB.

Task forces - there are task forces on Advocacy & Communication, Financing and Resource Mobilisation. The task forces are overseen by the secretariat.

Global Polio Eradication Initiative - GPEI

The partners

The GPEI has four spearheading partners: the WHO, Rotary International, the Centers for Disease Control and Prevention (CDC) and UNICEF. The WHO is the lead organisation; the WHO and UNICEF are the main implementing partners. There has never been a formal agreement about the tasks and responsibilities of different partners in the GPEI.[2] Nonetheless, a broad consensus seems to exist about the roles of GPEI partners and they are described in the GPEI strategic plan for 2004-2008.[2] These are summarised below.

- WHO - provides the overall technical direction and strategic planning for the management and coordination of the GPEI.

- Rotary International - provides and raises funds and provides field support during National Immunisation Days (NIDs).

- CDC - deploys epidemiologists, public health experts and scientists to the WHO and UNICEF, provides funding for oral polio vaccines (OPVs) and a wide range of technical expertise and laboratory support for disease surveillance and investigating outbreaks of polio.

- UNICEF - procures and distributes polio vaccines for immunisations; participates in the implementation of intensified NIDs and sub-national immunisation days (SNIDs) and mop-up campaigns at a country level along with the WHO; provides technical assistance to national coordinators to develop action plans and secure logistics to access hard-to-reach places; develops materials for training and public information; strengthens social mobilisation efforts; provides cold-chain support.

- Governments - the WHO indicates that national governments are the 'owners and beneficiaries of the GPEI'. In principle, a country's ministry of health is charged with the task of implementing the polio programmes at district and village levels.[2]

- Vaccine manufacturers - There are five major vaccine corporations worldwide, and the vaccine industry has a critical role in supplying sufficient quantities of OPV. This is especially important because most companies are eager to phase out OPV production, as there will be no longer be a demand for OPV once polio is eliminated. Companies generally supply vaccines to UNICEF at preferential prices. There is close cooperation with UNICEF and the WHO in the forecasting and delivery of vaccines. Some companies have made OPV donations as well. Vaccine manufacturers have no role in the governance of GPEI.[2]

Governance

The GPEI does not have a governing or coordinating board, and is instead governed informally by the four spearheading partners. The WHO and UNICEF work together on budget proposals. Various partner organisations indicate that the GPEI is functioning well and that there is no need for a more formal governance structure. The four spearheading partners meet regularly.

The WHO consults the OPV manufacturers about strategic planning of vaccine production. There are formal consultations once a year.

The GPEI does have a number of formal management and advisory bodies. The main ones are:[2]

- Technical Consultative Group (TCG). The TCG provides technical advice to the partnership, including post-eradication polio immunisation options. It supervises research and strategic planning. The TCG meets on an annual basis and consists of six international experts on immunisation, surveillance and disease eradication. In each of the six WHO regions, a similar group exists to review regional progress in polio eradication, routine immunisation and surveillance strengthening. The Global TCG reports to the WHO director of Vaccines and Biologicals and the Strategic Advisory Group of Experts (SAGE)

- Global Commission for the Certification of the Eradication of Poliomyelitis. This commission functions at the global level and supervises country certification. It is an independent body, with representatives of the six regional divisions, the Regional Certification Commissions.

- Interagency Coordinating Committee (ICC). ICC tasks include coordinating the input of partners, advocacy and communications, fund-raising and monitoring progress towards polio eradication. It assists the ministries of health that manage the eradication activities at the local level with plans and budgets. The ICC of the GPEI has been copied by other GPPIs like the Global Alliance for Vaccines and Immunization (GAVI).

There are other formal advisory bodies:
The Steering Committee on Research for the Development of Post-Eradication Immunisation Policy; the Global Laboratory Network; the Task Force for Immunisation (TFI); the Scientific Advisory Group of Experts (SAGE); the Ad Hoc Advisory Committee on Poliomyelitis Eradication (AACPE); the interagency Policy Advocacy Group (PAG) (the PAG coordinates the international advocacy and resource mobilisation efforts of the GPEI).

[2] http://www.filariasis.org/index.pl?iid=2766;
[2] Correspondence with B. Colatrella, Merck Office of Contributions, on May 24 & 26, June 4 & June 25, 2004.
[2] http://www.stoptb.org/Working_Groups/default.asp.
[2] The establishment of a Resource Mobilisation Task Force was approved in March 2004. See Board Meeting 22-23 March 2004: Summary of decisions and actions; and Resource Moblisation efforts of the Stop TB Partnership Secretariat: Update.
[2] F. Weyzig, Global Polio Eradication Initiative, SOMO, 2004, p8
[2] F. Weyzig, Global Polio Eradication Initiative, SOMO, 2004, p8
[2] F. Weyzig, Global Polio Eradication Initiative, SOMO, 2004, p8
[2] F. Weyzig, Global Polio Eradication Initiative, SOMO, 2004, p8
[2] F. Weyzig, Global Polio Eradication Initiative, SOMO, 2004, p9
[2] F. Weyzig, Global Polio Eradication Initiative, SOMO, 2004, p9

Annex 3: Case studies: description of methodology

1) Detailed description of methodology used in the case study on the Global Alliance to Eradicate Lymphatic Filariasis (GAELF) in Tamil Nadu, India.

1. Workshop for discussion and agreement on concepts, core statements (hypothesis) and method to be used and data collection for case studies.
2. Selection of GPPI programme to be studied in each country.
3. Selection of area where the case study will be carried out.
4. Desk research (data collection).
5. Field research.
6. Workshop for discussion of preliminary findings

Research Design

This is a descriptive study based on a case-study approach. The field research was conducted based on stratified random sampling in the endemic districts where GAELF was being implemented. The samples consisted of urban and rural populations drawn from Kancheepuram Health Unit District (Maraimalai Nagar, Chengalpattu) and Thiruvallur Health Unit District of Tamil Nadu.

The relevant data were collected from both primary and secondary sources, keeping in mind the broader objectives of the study. Personal interviews and questionnaires were relied upon to gather the primary data. The reports and data obtained from the government departments also provided substantial first-hand information. The secondary data was derived extensively from the books, journals, articles and websites.

The individuals interviewed for this study include:

Health functionaries at national and local levels:

1. Dr. Bora M.D., National Institute of Communicable Diseases (NICD), Delhi
2. Dr. Rana, Deputy Director, National Malaria and Filaria Control Programme, Delhi
3. Dr. Banerjee M.D., Professor Emeritus, Jawaharlal Nehru University, New Delhi
4. Dr. Jagadeesh Ramaswamy, Additional Director (Malaria and Filaria), Department of Public Health and Preventive Medicine (DPH&PM), Chennai, Government of Tamil Nadu
5. Mr. Mohammed Abdullah, Senior Entomologist, DPH&PM, Chennai, Government of Tamil Nadu
6. Dr. Manjula Datta, Epidemiologist, and Dr. M.G.R. Janaki, Medical University, Chennai, Tamil Nadu
7. Mr. Karuppan, I.A.S., Commissioner, Corporation of Chennai, Tamil Nadu
8. Mr. Chandrasekar Gowth, Additional Director, Department of Public Health, Hyderabad, Government of Andhra Pradesh
9. Mr. Jagan Mohan Rao, Deputy Director, Department of Public Health, Hyderabad, Government of Andhra Pradesh
10. Father Mannu, Chennai

Functionaries of GAELF programme at national and local levels:

1. Dr. Das P.K., Director, Vector Control Research Centre (ICMR), Pondicherry
2. Dr. Kumarasamy, Deputy Director, Indian Council of Medical Research (ICMR), Chennai
3. Dr. Augustin D.J., WHO consultant for GAELF, Chennai, Tamil Nadu

Health functionaries in the GAELF's implementation units (area of study):

1. Mr. Mani, District Malaria Officer, Deputy Director of Health Services, Thiruvallur, Tamil Nadu
2. Mr. Mathiazhagan, Office Superintendent, Filaria Control Unit (FCU), Chengalpattu, Tamil Nadu
3. Ms. Kanniyammal, Entomological Assistant, FCU, Chengalpattu, Tamil Nadu
4. Dr. Sudha J., Medical Officer, Primary Health Centre, Maraimalai Nagar, Kancheepuram, Tamil Nadu

Health workers in the area of study:

1. Health inspectors, pharmacist, lab technician, auxiliary nurse midwives (ANMs), village health nurses (VHN) from Maraimalai Nagar PHC
2. Superior field workers, field workers and MDA volunteers from FCU, Chengalpattu

3. Health inspector, Filaria Control Sub-unit, Sriperumbudur
4. Health inspector, Filaria Control Sub-unit, Adambakkam
5. Filaria prevention assistants (FPAs)/MDA volunteers from Maraimalai Nagar, Chengalpattu and Thiruvallur

Focal persons from CSOs:
Entrepreneur, Albendazole Manufacturing Company, Chennai, Tamil Nadu, Karnataka

Focal groups:
1. Population at risk covered from Thailathoppu and NH-II, MaraiMalai Nagar, Kancheepuram, Villupuram Tamil Nadu
2. LF-infected persons covered from a radial distance of 30 to 50 kilometres from Chengalpattu

Limitations of the study
- It became difficult to obtain first-hand information from the health functionaries at the national and state levels on cost effectiveness and the decision-making process related to GAELF.

- Some of the health functionaries of the GAELF programme were unwilling to discuss their opinions on the need and the efficacy of albendazole in the treatment of lymphatic filariasis.

- Government statistical records were not always accessible, hence the reliability of the data on LF is ambiguous.

Detailed description of methodology used in the case study on the GAELF in Karataka, India.
General objective: To study the influence of the GAELF on the National Filariasis Elimination Programme in India and its implementation in selected sites in Karnataka, with particular reference to the fulfilment of people's right to health and health care, particularly of the poor.

Specific objectives:
1. To study the content, organisational structure, financing and operating mechanisms of the GAELF and the National Filariasis Elimination Programme in India.
2. To study its linkages with the general health services and primary health care in Karnataka state.
3. To study its implementation in selected districts of Karnataka with a focus on access, equity and sustainability, and a special focus on those in need of care.
4. To study all of the above using a framework of the right to health and health care as enshrined in international covenants and in the Indian national constitution and legal/ethical guidelines.
5. To identify conflicts of interests, if any, and to identify how they are mediated/negotiated.

Methodology
1. Participation in two workshops for synchronisation of concepts, methods to be used and discussion on preliminary findings.
2. The health and health care situation in India and Karnataka was outlined through updated secondary sources of information/data.
3. A policy analysis of GAELF and the National Filariasis Elimination Programme was done through interviews and a study of documents.
4. The implementation of the programme at the state level was studied by field visits to health institutions in the periphery (sub-centres, primary health centres and community health centres) when discussions were held with providers, patients and the community. Discussions/interviews were also held at the taluk, district, state and national programme units and with other officials at the Directorate of Health Services.
5. Document review and interviews were done at the national level and with experts from the Vector Control Research Centre, Pondicherry. Health system professionals from academic institutions and NGO resource centres were interviewed. Links were maintained with the ongoing Right to Health Care Campaign of the Jan Swasthya Abhiyan (People's Health Movement in India)
6. The methodological tools, guidelines and framework of analysis used by other participating countries and organisations for the GPPI study were utilised.
7. Principles of research ethics were maintained.

Detailed description of methodology used in the case study on the GAELF in Kenya.
This was a descriptive study and mainly qualitative research methods were used to obtain the findings. A case-study approach was used, with purposive sampling for the health and WHO functionaries in the Nairobi head office and coastal province. Stratified random sampling was used in the endemic coastal province and snowball sampling was also used to identify those with severe clinical symptoms of the disease. The study area was the Coast province in southeastern Kenya.

Overall Objective
The general objective of the study was to obtain insights into the consequences of the implementation of GAELF for the health situation of marginalised groups and into the effects of GAELF on the Kenyan health system at national, provincial and local levels.

Specific objectives of case studies
- Create evidence on and analyse the GAELF's contents, approach, organisation and performance at national and local levels and its consequences for the fulfilment of the right to health of the Kenyan people.

- Analyse and discuss the consequences of GAELF for health policies at national level and get conclusions for the international level.

- Generate evidence on and discuss the effects of GAELF on Kenyan public health systems and the institutions in the health sector working for the improvement of health of vulnerable groups.

- Enhance the CSOs' input and influence in the decision-making processes on GAELF and promote transparency in decision-making and accountability of responsible structures in the countries where these initiatives are implemented.

- Strengthen the CSO's negotiation capacity for influencing health policies and strategies at local and global levels with the goal of fulfilment of the right to health.

Design and methodology
The study involved mainly qualitative methods including:
- Literature review of documents relevant to the subject: medical books, medical journals and research thesis on lymphatic filariasis; newspaper articles and international medical journals. Also reviewed were documents of the Ministry of Health, Ministry of Planning and National Development and Ministry of Finance and Planning.

- Documents of the WHO, United Nations Development Programme (UNDP), World Bank, Kenyan Bureau of Statistics, thesis on filaria, filarial journals, scientific publications and some grey literature were examined, among others.

- Key informant interviews were done with PELF national, provincial and local programme managers, health service providers and beneficiary community members.

  These included:
  - the head of the division of vector-borne diseases;
  - the national programme manager;
  - the disease prevention and control officer, WHO office, Nairobi;
  - the provincial pharmacist, Nyanza Province;
  - the provincial medical officer of health, Coast Province;
  - the chief public health nurse (PELF coordinator), Coast province;
  - the district public health officer (district PELF coordinator), Kilifi;
  - three other public health officers, Kilifi district;
  - five public health technicians, Kilifi district;
  - two nurses at Kilifi district hospital;
  - the chief of Kilifi Township Location, Bahari division, Kilifi district;
  - two community health workers from Bahari and Kaloleni divisions;
  - two victims of elephantiasis and two victims of hydrocoele;
  - four caregivers: two each from Bahari and Kaloleni divisions.

Key informant interviews were also conducted with institutions that recently collaborated with the PELF in Coast province. These included NGOs, media organisations, CSOs and faith-based organisations. These are:

- Family Health International – an NGO providing reproductive health support services;
- Council for Imams – a faith-based organisation;
- Nisha Printers – a local printing company;
- Association of Pastors in the Coast Region – a faith-based organisation;
- Baraka FM – a local media organisation;
- Nation – a national media organisation.

- Testimonies by victims suffering from LF and their caregivers in Kilifi and Mombassa districts. These included talks with two LF victims from each district.

- The '3Ls' (Look, Listen and Learn) method was used to capture additional information from all participants during the study. In addition to focussed group discussions (FGDs) this helped capture the knowledge, perceptions and attitudes of the programme functionaries, health functionaries, CHWs, community volunteers, victims and caregivers.

- FGDs were carried out with different target groups to capture their attitudes, perceptions and beliefs about the disease and the programme. These groups included:
  - Two FGDs with community leaders from Bahari and Kaloleni divisions;
  - Two FGDs with community health workers from Bahari and Kaloleni divisions of Kilifi district;
  - Two FGDs with community volunteers from Bahari and Kaloleni divisions.

Limitation

Difficulty in obtaining information considered sensitive by programme functionaries limited the findings of the study. The study was limited to the coastal belt where the programme has carried out MDA, even though other regions also have incidences of LF. The study should have extended to areas without GAELF so as to present a comparative assessment of the impact of GAELF.

Detailed description of methodology used in the case study on Roll Back Malaria in Tanzania.

Study area

The study was conducted in Bagamoyo district, in the cost region in the eastern zone. The district has a population of 230,164 of which 114,699 are males and 115,465 are females (according to the 2002 census). It is one of the districts in the country that is a malaria endemic-prone area. Three villages were involved, namely Bagamoyo town, Bong'wa and Maji Coast. These villages were selected because of a high prevalence of malaria in the areas.

Sampling

The study was conducted at four levels, namely communities, health facilities, schools and institutions/NGOs. A total of 12 health workers (clinicians and nurses) from government health facilities and three from missionary health centres were involved. The study also involved six students/pupils (three girls and three boys) from secondary and primary schools. Three interviewees from international institutions (UNICEF: 2; WHO: 1), three from national institutions (TFDA: 1; NMCP: 2) and two from NGOs (IHRDC: 1; Plan International: 1) were also involved. At the community level 11 unemployed youths and five village health committee members were interviewed. In addition, five FGDs with community members were conducted.

Methods

The study applied a range of methods including literature review, individual interviews and FGDs. During the interviews the GPPI study guideline was used. Village government and influential leaders were used to identify community members who participated in individual interviews and in FGDs. In some cases a video camera was used to record evidence. Before and during the study, meetings were held to revise the strategy to be used in data collection, and changes were made where necessary.

Data management and analysis
The two senior researchers manually analysed data from the field using a grouping system. Later on, discussions were conducted with the entire research team to clarify some things that were not clear from the analysed data.

Successes and constraints of the process
The research process went smoothly; some respondents responded very well and others were hard to reach. Coordination among the researchers was good, but because of their various tasks it was sometimes hard for them to meet when required. Nevertheless, they managed to communicate, meet, have discussions and continue to work; dialogue and communication was used to sort out issues. The fact that the money allocated for the research was very limited also contributed to a lower degree of attention on the job, because people had to work at other jobs to make ends meet. One of the members of the group dropped out because of job commitments. There was very good collaboration between the researchers and the respondents in different areas. Sometimes it was hard to reach people, especially those in high offices, but with those who agreed to participate, the discussions were excellent.

Detailed description of methodology used in the case study on Roll Back Malaria in Uganda.
1.1 Overall objective
To assess the content, approach, organisation and performance of the RBM Initiative and establish its effect on national health policy and public health systems in Uganda.

2 Specific objectives
i. To describe the goals and objectives of the RBM initiative in Uganda.
ii. To describe the approach and organisational structure of the RBM initiative in Uganda.
iii. To assess the performance of the RBM initiative in Uganda with regard to its objectives.
iv. To assess the impact of the RBM initiative on health infrastructure, human resources, logistics (availability and affordability) and quality of care (technical and perceived).
v. To establish the effect of the RBM initiative on national health policy.
vi. To establish the effect of the RBM on institutions working to improve the health of disadvantaged/vulnerable groups.
vii. To establish the motives and roles of private-sector institutions in GPPI engagement.

2.1.1 Questions addressed by the case study
i. Are GPPIs the most appropriate way to solve health problems in Southern countries in a sustainable and equitable manner?
ii. Do GPPIs strengthen the capacity of national health systems in order to improve the health situation of the social groups in need?
iii. Can GPPIs contribute to the fulfilment of the right to health of people in Southern countries?
    - Availability and accessibility of health services;
    - Acceptability and quality of health services;
    - Participation and sense of ownership, especially by vulnerable groups and communities.

Methodology
The study covered the central region districts of Kampala and Wakiso, with an area of 2,900 square kilometres. The two districts have an estimated population of 3.4 million (Wakiso: 957,280; Kampala: 2.5 million during the day and 1.2 million at night). The two districts have a total of 965 health units (health centres and hospitals), of which 73 are government and 892 private. The study covered the district headquarters and selected government, NGO and private health units in the two districts.

The study was a descriptive cross-sectional design that employed quantitative and quantitative techniques. Quantitative techniques included interviews with patients during exit poll interviews using questionnaires administered by the research assistants, while qualitative techniques included discussions with key informants at national and district levels.

A desk review was conducted at both national and district level. The desk review covered the Ministry of Health (MOH) Malaria Control Programme, national disease surveillance, District Headquarters (Kampala and Wakiso), and WHO, UNICEF and UNDP documentation to gain insights into the organisational structure and implementation of

the RBM partnership in Uganda, its management structure, financing, reporting and accountability and monitoring. The desk review also looked at the RBM initiative goals and objectives, monitoring and evaluation mechanisms, implementation strategy, intended beneficiaries, communication and information flow.

The study population included the RBM partners (MOH, the WHO, UNICEF and NGOs) and other stakeholders such as the districts, health workers and the communities utilising the health services.

Sample size

Group	Number
Key informants	9
Health units	20
Health workers	22
Community members	143

Sampling procedure

The MOH and UNDP libraries were used for the desk review; MOH, UNDP, WHO and RBM publications were selected for review. The key informants were selected in such a way to ensure representation of the different RBM stakeholders, the study area, health units and communities. The health units were selected to ensure representation of the health system structure.

The health workers interviewed were in charge of the selected health units, and the community members interviewed during the exit poll interviews were randomly selected at the health units visited. It was made certain they were 18 years or older; the purpose of the study was explained before they gave their consent, and only those willing to do so were interviewed.

Data collection methods and tools

Both quantitative and qualitative techniques were used. The desk review looked at existing documents, while a key informant guide was used during discussions with the key informants. The exit poll interviews were conducted using structured questionnaires. For quality assurance and control, the tools were pre-tested and a training session was held for the research assistants, who were supervised by the principal investigator. The study used the current monitoring and evaluation RBM indicators. In addition to desk review, the data collection tools were used to assess the existing structures at national, district and community levels.

The tools focussed on knowledge of RBM, common health problems and causes of ill health, factors affecting the health services' delivery, availability, accessibility, acceptability, utilisation and sustainability of RBM services. The data obtained from the interviews was put into a Microsoft Access database and cleaned. Data was then analysed using MS Excel and presented as frequency tables, graphs and text.

Detailed description of methodology used in the case study on Roll Back Malaria in Zambia

2.2 Overall objective

The overall objective of this study was to assess the performance of the RBM GPPI in Zambia with a view to understanding how such a GPPI could provide a solution to improving public health outcomes in the country.

2.3 Specific objectives

In obtaining information to this overall objective, the research applied research tools and techniques to generate data for obtaining information on the following specific objectives:

1. To examine the extent to which the promised global resources to supplement national resources were made available (from the global sources) to plan and implemented RBM programmes in recipient countries.
2. To determine how equitably such global resources were distributed in Zambia.
3. To assess the performance of the health services following the provision of resources from GPPIs at global level.
4. To evaluate the outcomes on morbidity and mortality from malaria with a concerted injection of resources from GPPIs, such as through the ongoing RBM initiative in Zambia.
5. To evaluate the potential role of GPPI approaches as an alternative way of tackling public health problems when countries experience economic stagnation.

3 Methodology

This study was conducted using a number of approaches, tools and techniques so as to obtain a valid picture of the performance of the RBM GPPI in Zambia.

3.1 Sampling and sample size

The study was undertaken in four Zambian towns purposively selected to reflect the different but representative socio-economic profiles of the country. The sampled towns were Lusaka, Chama and Chingola (these being towns with active equity gauge work) and Chipata districts, as justified earlier. Chipata and Chama are towns that were used for monitoring the implementation of the Zambian health reforms. In addition, Chipata district (together with Chingola) also serve as two of the ten sentinel surveillance sites by the national malaria control centre of the MOH.

Tools and techniques used

Data was collected at four levels: national, district, health centre and community levels. Discussion guidelines were prepared for each of these levels and interviews conducted with key informants. At the health facility level, checklists were used to collect data on malaria and other health parameters. At community level, questionnaires were also used to collect data from randomly selected residents of communities around sampled health facilities.

Detailed description of methodology used in the case study on Stop TB in South Africa

Data for this report was gathered from an informal literature review, including 'grey literature' such as unpublished reviews of TB control in South Africa, on topics such as TB control, Global Public-Private Partnerships, the Stop TB Partnership, management of external resources for health, and the human rights approach to health. The Stop TB Partnership website was also used extensively, as was the Independent Evaluation of the Stop TB Partnership produced by the Institute for Health Sector Development, and data bases such as the Initiative on Public-Private Partnerships for Health Partnership Database.

Discussion on the Stop TB Partnership in South Africa is largely based on a series of key informant interviews (n = 13). These were semi-structured to cover a range of specified topics and questions. This range of topics was edited to be relevant to the informants' background and to reflect the developing understanding of the Stop TB Partnership in what was an iterative data gathering process. Interviews were performed by a variety of means: face-to-face interviews with audio recording and transcription by two researchers (n = 2), telephone interviews with handwritten note-taking and subsequent review/validation of these notes by the informant (n = 5) or by email questionnaire (n = 6). Informants were identified by a variety of means: using the web-based Stop TB Partners' Directory, Stop TB documentation review and by the snowball technique.

Key Informant Designation	Position / Background / From
A	Director, national partner, NGO in TB control
B	Executive director, national partner, NGO in TB control
C	Member of Medical Research Council, member DOTS-Plus WG
D	Manager in National TB Control Programme of South Africa
E	Academic, University of Stellenbosch, South Africa
F	Academic, Health Economics Unit, University of Cape Town
G	International partner organisation/technical agency
H	International partner organisation/technical agency
I	International partner organisation/technical agency
J	Stop TB Secretariat
K	Academic, Nelson R. Mandela School of Medicine, South Africa
L	International partner organisation/technical agency
M	Stop TB Secretariat

Detailed description of methodology used in the case study on the Global Polio Eradication Initiative in India

- The study was based on cluster sampling according to WHO guidelines.
- In the context of this study, cluster means village units or wards in urban municipalities.
- Thirty clusters were selected in each zone.
- Clusters were selected purely on a random basis.
- Seven households were selected in each cluster.
- The sample size in each zone is 210.
- The rural-urban mix of the sampling units in two clusters was almost equal.
- The total sample size for two zones combined is 420.

List of cluster sample Zone H

	LEVEL	NAME	
	TOWN	Dhulian (M)	Urban
1	WARD	Dhulian (M) - Ward No.4	Urban
2	WARD	Dhulian (M) - Ward No.15	Urban
	WARD	Dhulian (M) - Ward No.19	Urban
3	WARD	Jangipur(M) – Ward No.8	Urban
4	WARD	Jangipur(M) – Ward No.19	Urban
	C.D.BLOCK	Farakka	
5	VILLAGE	Bewa (P)	Rural
6	VILLAGE	Ballalpur	Rural
7	VILLAGE	Kuli	Rural
8	VILLAGE	Mahadeb Nagar	Rural
9	WARD	Frka Barr. Tnshp (CT) – Wrd No.1	Urban
	C.D.BLOCK	Samserganj	Total
10	VILLAGE	Bhasaipaikar	Rural
11	VILLAGE	Balbalpara	Rural
12	VILLAGE	Jafrabad	Rural
13	WARD	Dhusaripara (CT) - Ward No.1	Urban
14	WARD	Chachanda (CT) - Ward No.1	Urban
	C.D.BLOCK	Suti – I	Total
15	VILLAGE	Panchigachhi	Rural
16	VILLAGE	Ramakantapur	Rural
17	VILLAGE	Ahiron	Rural
	C.D.BLOCK	Suti – II	Total
18	VILLAGE	Bahagalpur	Rural
19	VILLAGE	Amuha	Rural
20	VILLAGE	Ichhlampur	Rural
21	TOWN	Aurangabad (CT)	Urban
22	WARD	Paschim Punropara (CT) - Ward No.1	Urban
	C.D.BLOCK	Raghunathganj – I	Total
23	VILLAGE	Dafarpur	Rural
24	VILLAGE	Kankaria	Rural
25	VILLAGE	Brindabanpur	Rural
26	WARD	Srikantabati (CT) - Ward No.1	Urban
	C.D.BLOCK	Raghunathganj – II	Total
27	VILLAGE	Pananagar (P)	Rural
28	VILLAGE	Bara Jumla	Rural
29	VILLAGE	Kul Gachhi	Rural
30	VILLAGE	Fraser Nagar	Rural

List of cluster sample Zone L

	LEVEL	NAME	
	BLOCK	Murshidabad Jiaganj	
1	VILLAGE	Budhra	Rural
2	VILLAGE	Bali	Rural
3	VILLAGE	Sashidharpur	Rural
4	VILLAGE	Banamalipur	Rural
5	VILLAGE	Beliapukur	Rural
6	VILLAGE	Satlakshmi	Rural
	TOWN	Murshidabad (M)	Urban
7	WARD	Murshidabad (M) - Ward No.15	Urban
	C.D.BLOCK	Berhampore	Total
8	VILLAGE	Bahara	Rural
9	VILLAGE	Andar Manik	Rural
10	VILLAGE	Kodla	Rural
11	VILLAGE	Fate Singdiar	Rural
12	VILLAGE	Kharsadanga	Rural
13	VILLAGE	Chaltia	Rural
14	VILLAGE	Sibpur	Rural
15	VILLAGE	Usta	Rural
16	VILLAGE	Selamatpur	Rural
17	VILLAGE	Baradaha	Rural
18	WARD	Gora Bazar (CT) - Ward No.1	Urban
	C.D.BLOCK	Beldanga – I	Total
19	VILLAGE	Gopinathpur	Rural
20	VILLAGE	Dalua	Rural
21	VILLAGE	Jhunka	Rural
22	VILLAGE	Bishannagar	Rural
23	VILLAGE	Begunbari	Rural
24	VILLAGE	Mirzapur	Rural
25	VILLAGE	Kapasdanga	Rural
	C.D.BLOCK	Beldanga – II	Total
26	VILLAGE	Saktipur	Rural
27	VILLAGE	Mahammadpur	Rural
28	VILLAGE	Rampara Faridpur	Rural
29	VILLAGE	Bikal Nagar	Rural
30	VILLAGE	Kashipur	Rural

The study was carried out in two parts:

- The first part assessed coverage of the Pulse-Polio Immunisation Drive for three National Immunisation Days: 22 February 2004, 4 January 2004 and 9 November 2003.
  This particular survey was conducted on the basis of seven randomly selected consecutive children in each cluster.
- The second part of the study concentrated on seven families, each one having at least one eligible child.

The households were selected on the basis of two eligibility criteria:

- The household was required to include a child age five or below.
- The child had to have lived in the area continuously for at least six months.

The study was carried out for three days on 27, 28 and 29 March 2004. Forty investigators and 10 supervisors were employed for data collection. A one-day training session was organised for the trainers and supervisors by the research team and experts. The total distance covered to reach the villages and town, selected randomly, was approximately 3,500 kilometres.

Two sets of questionnaires were specifically framed to assess in what manner rights to health are protected within the context of the PPI Programme: one was to assess coverage and the other was intended for the household-level study. Therefore, the scope of the study goes beyond a mere case study of Pulse-Polio.

Apart from the questionnaire survey, viewpoints and opinions were solicited from senior officials associated with the Pulse-Polio Programme, and their inputs have been incorporated in the report. The research team also visited the Pulse-Polio Booth during the NID on 22 February 2004, and details of this are also included in this report.

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