RISKY REMEDIES FOR THE HEALTH OF THE POOR

GLOBAL PUBLIC-PRIVATE INITIATIVES IN HEALTH

Executive summary

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

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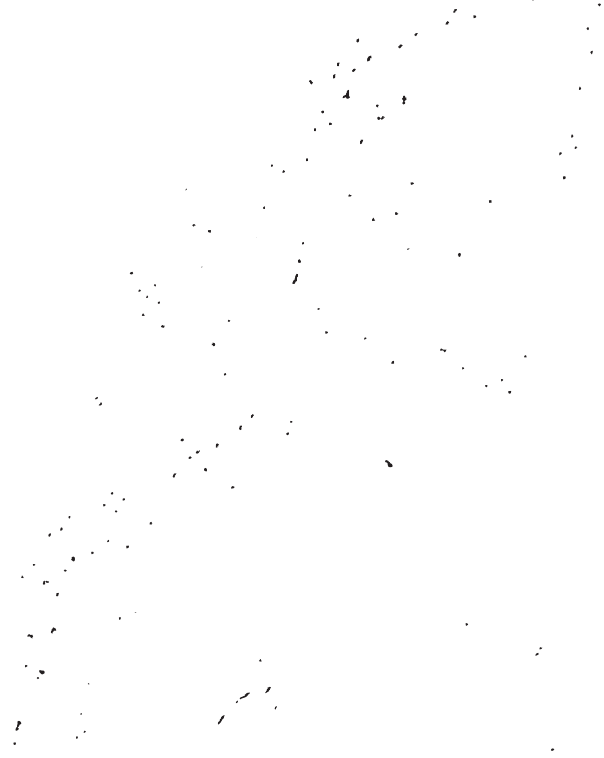

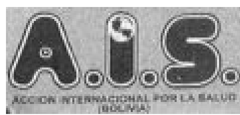

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Abbreviations

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.

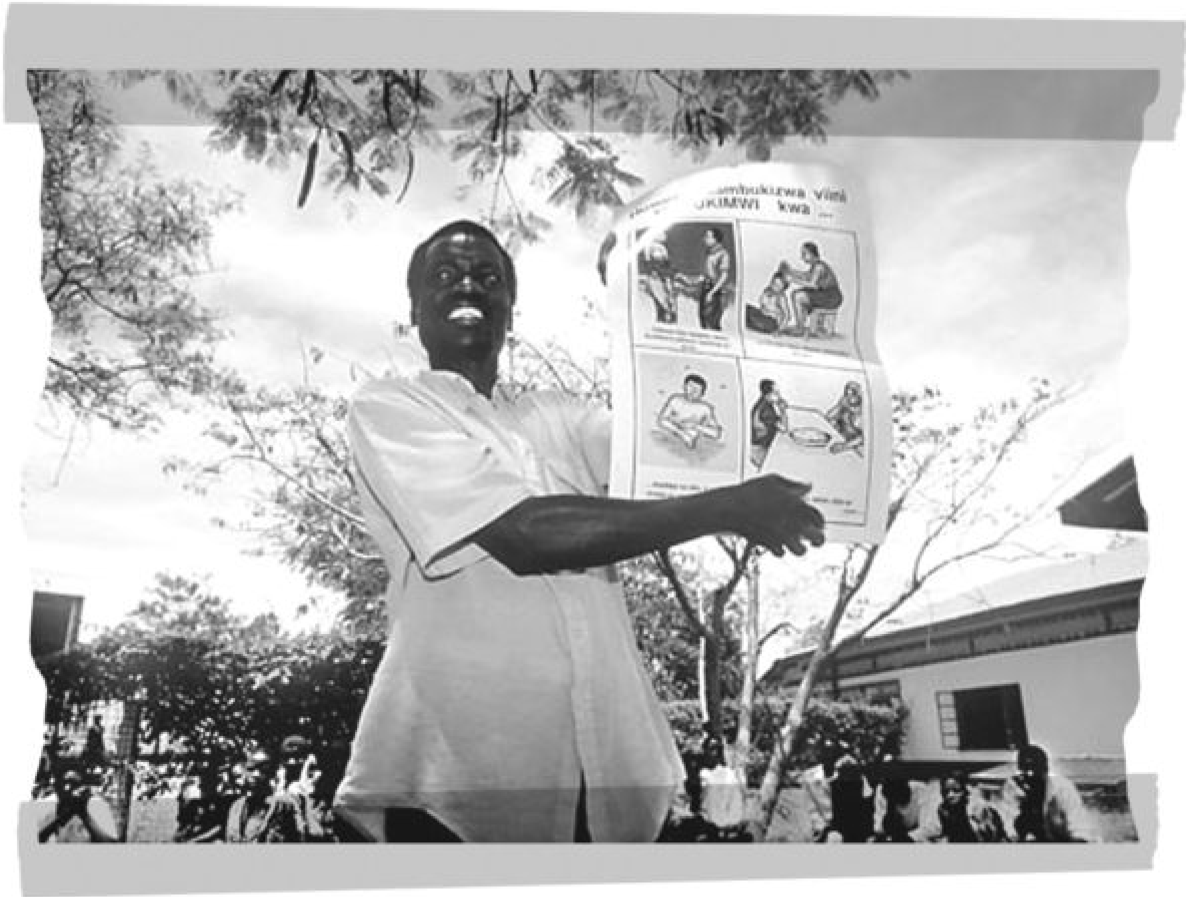
Wemos is an organisation working for a world in which every person can exercise his or her right to health by influencing actors' international policies at different levels. Wemos collaborates closely with organisations in Southern countries with the aim of strengthening their capacities for influencing 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.

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'.

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'.

Recommendations to the WHO[1]

- 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.

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

- 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, 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.

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.

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.

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

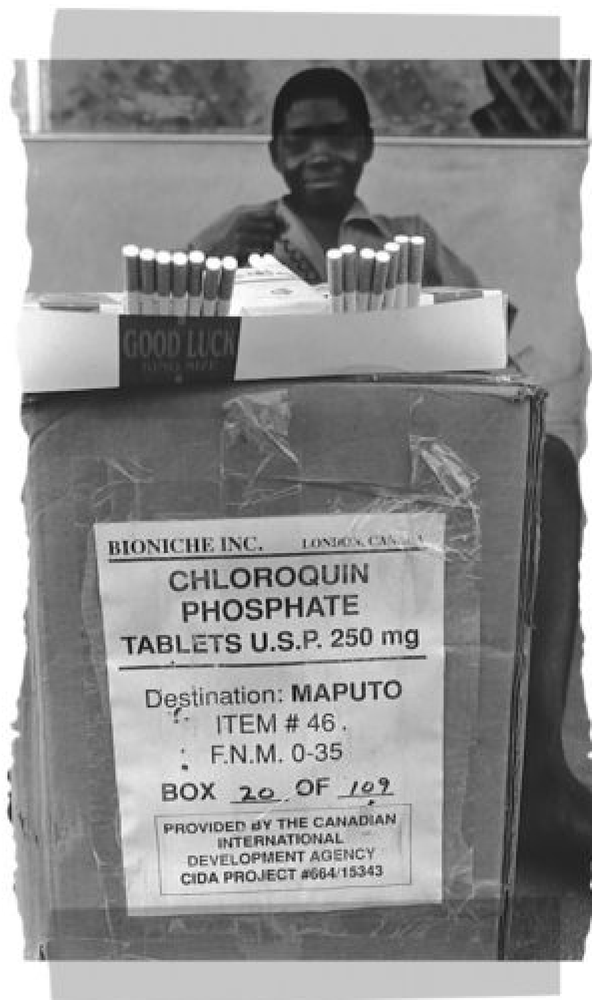
- The interest of philanthropic and other not-for-profit institutions for improving the situation of the poor has played an important role in initiating most of the GPPIs included in this report. We recommend that, in order to make their laudable efforts more effective and sustainable, these entities 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.



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.

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.

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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