Chapter 3

Recommendations for Phase II

Phase II is the period during which RBM must focus urgently on *achieving impact*. The Evaluation Team felt strongly that if reasonable progress cannot be demonstrated in three to five years' time, the global effort to combat malaria will lose critical momentum. The recommendations in this chapter are therefore oriented toward making things happen at country level.

It is therefore perhaps surprising that the majority of the recommendations presented in this chapter involve changes in governance structures and management at the global and regional levels. The reason for this is that the current 'loose ties' arrangements promoted by the partnership, as discussed in Chapter 2, do not appear to be effective in getting projects up and running at the country level. Without an effective governance structure, RBM is not in a position to agree upon and implement a decisive action plan at the country level. Without clear lines of accountability, no single agency can be held responsible for inactivity or slow progress at the country level. Hence, the Evaluation Team recommends a first order 'fix' but does not presume this is the end of the story.

At the country level, the Evaluation Team hopes to see a greater emphasis on 'scaling up' malaria control activities in the context of health sector development and planning, and poverty-reduction strategies. This will require the active engagement or re-engagement of partners with well-defined commitments to specific activities in a small number of focus countries. It will require a renewed sense of ownership of the RBM mission by the World Bank, UNICEF and others, and a lessening of control by WHO. It will also require greater clarity around the programmatic approaches such as IMCI and EPI that can be used to deliver RBM priority interventions to target populations. To achieve greater impact at the country level, malaria control activities will need to be better integrated with the broader developmental planning and budgetary cycles of governments. Also at the country level, RBM can make better use of social marketing strategies and building relationships with local providers of care, nets and drugs. In financing, communications, research and capacity building, modifications of strategy and emphasis are also needed. Vigorous, effective and large-scale action at the country level must be the main focus of RBM in the coming years, but this will not be possible without major reforms of the RBM global architecture.

To re-activate the partnership, the Evaluation Team recommends three major reforms of the RBM global architecture (described in Section 3.1). The Team also recommends two strategic changes which will permit RBM to achieve rapid impact within a sub-set of malarious countries (described in Section 3.2).

3.1 A Revitalized RBM

Three major reforms of the global architecture of RBM are described in this section:

- reorganization of the RBM Secretariat;
- creation of a governance board; and
- reconstitution of the Technical Support Networks.

In considering alternative organizational structures for RBM, the Team examined the experience of several of the existing global partnerships, including Stop TB, the Global Alliance for Vaccines and Immunization (GAVI), UNAIDS, and the Global Polio Eradication Initiative. Stop TB and GAVI provided particularly useful reference points. Annexes K and L present overviews of the organization of Stop TB and GAVI respectively, and Table 5 compares the main features of these partnerships with both the current and recommended architecture of RBM.

Table 5
Organizational Features of GAVI, Stop TB, and RBM

Activity	GAVI	Stop TB	RBM (current)	RBM (proposed)
Fundraising, Global Advocacy	Global Vaccine Fund, GAVI Board	Coordinating Board	Secretariat	Secretariat
Decision Making, Policy Setting	GAVI Board (15 members)	Coordinating Board (27 members, max.)	Secretariat	RBM Board (10 members)
Operations and Implementation	Working Group	Working Committee/ Secretariat	Secretariat	Secretariat
Administration	Secretariat	Secretariat	Secretariat	Secretariat
Forging Technical Consensus among Partners/ Info Sharing	Task Forces (4)	Working Groups (6)	Technical Support Networks (?)	TSNs organized around RBM interventions (4)
Technical Support to Countries	Regional Working Groups	DOTS Expansion Working Group	RBM Secretariat/WHO Regional Offices/ TSNs	WHO HQ, WHO Regional Offices
Partners' Involvement	Partners' Meetings (every 2 years)	Stop TB Forum (every 2 years)	Partners' Meetings (every year)	RBM Forum (every 2 years)
Country Level Catalyst	Inter-Agency Coordinating Committees	WHO TB Medical Officer (from WHO or seconded from other Partners)	National Malaria Programme Officers (appointed by WHO country office)	RBM Country Champion (appointed by Secretariat)
Focus Countries	No, although there are eligibility criteria	22 high burden countries	No	8-12 focus countries

3.1.1 Reorganization of the RBM Secretariat

There is a pressing need to distinguish more clearly between the Secretariat, which should represent all RBM partners, and the organizational structure of WHO's malaria control activities. Not only will this help WHO achieve better focus on activities relating to its own role as an RBM partner, but it will motivate other partners to become more actively engaged in guiding the specific activities and focus of the Secretariat.

Concerning the location of the Secretariat, it could be moved out of WHO, but the question then is, 'Where to?' The answer with GAVI was to locate the Secretariat in the small UNICEF office in Geneva, thus giving it a relatively independent position while still having the convenience of the administrative support of an established agency. This is certainly an option for the RBM Secretariat, but is not recommended. On balance, the Secretariat is most appropriately and conveniently housed within WHO. It should, however, be separated from the technical malaria

control activities of WHO. This could be achieved by moving the RBM Secretariat out of the Communicable Diseases cluster (CDS) into another cluster, perhaps one dealing with global public goods, inter-agency collaboration, or similar matters.

An alternative would be to keep the RBM Secretariat in the CDS cluster but clearly separate it from the technical RBM team. A variant of this model has been adopted by the Stop TB Initiative, and the Evaluation Team was assured by some partners that they were satisfied with this arrangement. However, in the Stop TB model both the Secretariat of the Partnership and the technical team report to the Stop TB Project Director, who reports to the Executive Director of the CDS cluster. In practice this gives the appearance that Stop TB is a WHO programme, with others playing a role through the Stop TB Coordinating Board (see Annex K). It is strongly recommended that for RBM a clear separation is made between the Secretariat of the partnership and the WHO technical RBM Team. This will redress past imbalances and re-establish trust among the partners. This can be achieved either by moving the Secretariat to another cluster or by ensuring clear separation between the Secretariat and the RBM technical team within the CDS cluster. In either case, the accountability of the Secretariat to the RBM Board (at least *de facto*) is essential.

Concerning the staffing of the Secretariat, a range of expertise in public health, health systems, finance, communications and advocacy will be required. It is advantageous that the Secretariat have good inside knowledge of the work of the core partners. This can be achieved in practice by secondments from the core partners to the RBM Secretariat. Again there are parallels with the Stop TB Initiative, which has several secondees in its partnership Secretariat. The RBM Secretariat might be mainly composed of such secondees. This arrangement will strengthen the effectiveness of the Secretariat and demonstrate the serious commitment of the core partners. Indeed, a condition for being a core partner might be to provide a secondee to the Secretariat of the Partnership.

Concerning the functions of the Secretariat, these should build on the current focus on global advocacy, partner communications and fund-raising, but be clearly distinguishable from the activities of the WHO technical team. The functions of the Secretariat should include the following:

- ❑ global advocacy and resource mobilization;
- ❑ standardizing monitoring and evaluation methods, and collecting, analyzing and disseminating information about the global malaria situation;
- ❑ selection of the focus countries and ongoing monitoring of the activities of partners in focus countries (see Section 3.2.1);
- ❑ the appointment, supervision and support of the Country Champions (see Section 3.2.2);
- ❑ coordination of the core partners and ensuring that the core partners fulfill their responsibilities, especially in the focus countries;
- ❑ the facilitation of cross-fertilization of good practice among countries and regions;
- ❑ general oversight and support of the links between RBM and the major malaria research programmes; and
- ❑ liaising with the Global Fund.

At first approximation these functions suggest a Secretariat with perhaps fifteen professionals together with support staff. These professionals should include secondees from UNICEF, the World Bank, DFID, USAID, other bilaterals and, possibly, NGOs.

3.1.2 Creation of an Autonomous Governing Body

There is a need for some form of governing body to advise and oversee the activities of the Secretariat and to make decisions on behalf of the RBM Partnership. The governing body should seek to ensure that the Secretariat's activities fully represent the interests of the entire Partnership. It should also be charged with commissioning periodic evaluations to ensure that RBM activities are having the intended impact, both globally and in the focus countries. This RBM governing body would be the equivalent of the GAVI Board or the Coordinating Board for the Stop TB Initiative.

It is important that the governing body does not become an excessively demanding organization which will distract the Secretariat from its main tasks. The governing body should not meet too frequently (perhaps twice a year) and should allow plenty of space for the Director of the Secretariat to get on and do an effective job.

A possible structure for a governing body with a total of ten members might be:

- WHO, UNICEF, World Bank;
- Bilaterals (rotating);
- NMCP heads (rotating);
- one NGO (rotating);
- one malaria expert from south (rotating); and
- one private sector representative.

Both the GAVI and the Stop TB Boards are larger than this, with 15 and 27 members respectively. A larger Board may be needed to allow for adequate representation of all partners, although this will challenge the Board's efficiency of decision-making and its overall effectiveness. The creation of a sub-group of the Board that will be more actively engaged in day-to-day operations of the Secretariat may be one way to deal with the unwieldy character of a larger Board. Both GAVI and Stop TB have established precedents for this. For example, the GAVI Board has a ten-member Working Group which is responsible for implementation of the Board's decisions.[22] The Working Committee of the Stop TB Coordinating Board is composed of six members who participate in bi-weekly telephone conferences and who agree to dedicate half a day per week to Stop TB activities.

The creation of an RBM Board will not threaten the existence of the broader RBM Partners' meetings, which might be reconstituted as the RBM Forum. The RBM Forum would represent the wider constituency of all those engaged in the fight against malaria. It would not be a decision-making body. It might meet every two years in a large gathering to review progress and strengthen morale and commitment. The equivalent mechanisms for the other global partnerships are the Stop TB Forum and the GAVI Partners' Meetings, both of which are held roughly every two years.

3.1.3 Reconstitution of the Technical Support Networks

The Technical Support Networks (TSNs), originally known as Resource Networks, have been working poorly. Most partners could not even list which TSNs were in existence or give a clear view of their products and impact. There is also confusion concerning whether they should focus on technical standard setting or on country support or on some combination of these. Even the most successful TSN, the one dealing with ITNs, was thought to have fallen short of the desirable level of technical expertise and guidance.

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[22] The GAVI Working Group is composed of mid-level managers who are involved in the day-to-day operations of their respective organizations, while the GAVI Board is comprised of the highest level representation of partners – e.g. Gro Brundtland of WHO and Carol Bellamy of UNICEF.

The Evaluation Team recommends that TSNs should be reconstituted in order to provide an effective mechanism for technical consensus and communication. They should be structured around the four-part RBM strategy, but they may also form in response to critical challenges of the day that cut across issue/area (e.g. human resources and capacity development; malaria and poverty). The is would suggest at least four TSNs:

- rapid diagnosis and treatment;
- intermittent presumptive treatment for pregnant women;
- insecticide-treated nets and materials; and
- detecting and responding to epidemics.

Some of these areas are large and TSNs may wish to create subgroups on an *ad hoc* basis to deal with highly specialized issues.

The role of the TSN should be to create and support a technical consensus and to deal with complex strategic issues concerning the implementation of that consensus. TSNs should not directly be in the business of country support. However, the information from TSNs would undoubtedly be used by those giving country support and members of TSNs may be called on individually to play a country support role.

TSNs could be recreated by and report to the RBM Secretariat. They should include a wide representation of partners as well as individual experts from countries. Each needs a strong and independent chair (not a WHO staff caretaker) and financial backing to fund core activities. The precise relationship they would have to the WHO malaria technical team (presuming a separation between the WHO technical team and the RBM Secretariat) must be carefully thought through.[23]

3.2 Heightened Focus and Effectiveness at the Country Level

The Evaluation Team heard the opinion expressed repeatedly that RBM in Phase II may be Africa's 'last chance' at a major effort to combat malaria within the region. Commentators expressed a growing recognition that Africa cannot afford another decade of failure and wasted effort. Progress in a dozen countries will represent a huge step forward for Africa, demonstrating that a major response to malaria is indeed possible.

RBM has previously identified 'spotlight countries' – perhaps on as many as three separate occasions – but focused efforts have not been achieved. The only explanation offered was that, due to its particular constitutional mandate, WHO has not been able to provide selective assistance to countries. It was also felt that WHO is unable to influence countries more proactively to underscore the urgency of malaria control, due to its sensitive political relationships with member States.

These two concerns – that RBM has not been able to be either selective or proactively engaged with countries – once again underscore the importance of separating the Secretariat activities and WHO's role as contributing partner. The Secretariat as an independent entity should be capable

[23] The comparable mechanism in Stop TB is the Working Groups. There are six of these, dealing with DOTS expansion, TB/HIV, DOTS plus and multidrug-resistant tuberculosis (MDR TB), new TB vaccines, new TB diagnostics, and new TB drugs. The first three of these are housed at WHO and the others are housed elsewhere. The Working Groups, with the exception of the one dealing with DOTs expansion, are not involved in technical support at the country level. It is clear from a variety of comments from RBM Partners who are also Stop TB partners, that the RBM Technical Support Networks are not working as well as the Stop TB Working Groups. A careful review of this experience will provide useful information to redesign and re-launch the RBM TSNs.

of working with a selection of countries and creating a focused workplan that is proactively engaged.

From the standpoint of organizational effectiveness, selectivity and proactive engagement with countries are also needed to help guide the Secretariat in its activities. For example, the Secretariat's focus on the development of CSPs in numerous countries may have distracted it from pursuing other fruitful leads more vigorously. A more focused Secretariat can avoid problems such as:

- lack of detailed knowledge about countries that RBM supports;
- wasted effort on activities that are disassociated from country-level processes and planning cycles; and
- lack of follow-up support to countries in a timely manner.

3.2.1 Selection of Eight to Twelve Focus Countries

Many of those interviewed agree that focus is needed, but there is little consensus on *how* to focus. In view of how much must be accomplished, even in countries which have been relatively successful by current RBM standards, it is strongly recommended that the focus countries be selected from a sub-set of countries that show a high degree of commitment and that will be able to demonstrate significant progress over the next three years.

A common objection is that this criterion will drive the selection to the well-established 'darlings' of the development community. An alternative expression of this concern is that selection will lead to the picking of only 'low-hanging fruit'. This assumes that it is relatively easy to achieve malaria control in the best-positioned countries, or even that these countries would be successful on their own, in the absence of substantial external assistance. Neither of these positions is tenable. There are no low-hanging fruit in malaria control in Africa. There are high-hanging fruit and very high-hanging fruit. Even in those countries which have the necessary preconditions to control malaria on a national scale, the task will be extremely difficult. Nowhere in Africa today is malaria being rolled back. The effectiveness of the strategy that RBM has developed and advocated has not been demonstrated on a national scale in Africa. Even countries which are best positioned will not make progress without significant input from a newly reorganized and revitalized RBM.

Another argument against country selectivity is that it may prevent the achievement of the Abuja targets. Even if only the largest countries were chosen, it would still prove impossible to halve malaria mortality by 2010 if success was mainly achieved in only eight to twelve countries in Africa. The response to this is two-fold. Firstly, without focus the Abuja targets will certainly not be achieved. Secondly, the focus on eight to twelve countries is a strategy for the shorter-term, perhaps the next three to five years. While this is occurring useful work can also be done which will lead to some reduction in the burden in other countries. In addition, following demonstrated success in eight to twelve countries, RBM will rapidly expand successful approaches to as large a number of countries as possible, as quickly as possible.

The Evaluation Team also recommends that RBM focus on a small number of other countries, within the set of eight to twelve, whose circumstances are more challenging than the rest. These should be countries which, while not ready to implement effective programmes on the national scale, could nonetheless make solid progress over the next three years. Support to this group of countries should focus on preparing them for subsequent large-scale efforts.

Another approach to the selection of focus countries would be to create blocks of contiguous countries in which malaria is being effectively controlled. This approach was contained in the original 1996 hypothesis put forward by AFRO and the World Bank (Annex A). The advantages of creating multi-country zones of effective control are obvious, and include strong inter-country collaboration and the reduction of cross-border flow of infected mosquitoes or people.

The method of selection of the focus countries is a matter for the partners to resolve. The several previous attempts to identify spotlight countries have arrived at very similar lists. When each partner is asked to nominate potential focus countries, the same names come up over and over again. It is desirable for clear criteria to be established and for the process of selection of focus countries to be transparent. An alternative model is for focus countries to self-select. Countries that are better prepared, that have good applications to the Global Fund, and that are asking for and absorbing financial and technical assistance, will naturally become the countries on which the donor community focuses. As mentioned above (Section 2.4), this is already happening in practice. In Africa ten countries receive over 70 percent of the bilateral and multilateral financial support for malaria.

This discussion of focus countries applies mainly to Africa, but may have some application in other regions. For example, the WRPO region of WHO has three holo-endemic countries: Papua New Guinea, the Solomon Islands and Vanuatu. Of these, only Vanuatu, is well placed to make significant progress in malaria control in the next few years. The other two have seen their NMCPs decimated by chronic civil unrest and lawlessness. Thus Vanuatu is the clear candidate to be a focus country in the Pacific Region of WPRO. Similar arguments may apply in other parts of WPRO (for example, Cambodia is more likely to make rapid progress than Laos) in EMRO (Turkey rather than Afghanistan), SEARO (Andra Pradesh rather than Bihar) and PAHO.

3.2.2 Appointment of Country Champions

In the absence of a clear focal point and dynamic leadership at the country level, there is little prospect of effective progress. A component of this leadership needs to be the NMCP, with full support of the Ministry of Health and other parts of government. A model tried by some programmes, and of which there is considerable experience, is the creation of some kind of a committee or steering group at the country level. Thus immunization programmes have their intra-country coordinating committees (ICC). A similar committee could be established for malaria. In addition, as a condition for applying to the Global Fund, countries must create a Country Coordinating Mechanism (CCM). This CCM will, by definition, be dealing with AIDS, TB and malaria. It is possible for leadership to be provided by the CCM, or a malaria subcommittee of the CCM.

In practice, the Evaluation Team has doubts about these mechanisms. The creation of another ICC for malaria would proliferate committees in a confusing way and will not be popular with governments or donors, for good reasons. The CCM is likely to be a large and cumbersome organization. It is required to represent numerous constituencies, both inside and outside government. It is unlikely to be an effective or dynamic body for dealing with day-to-day issues. A malaria sub-committee of the CCM might operate slightly better, but would still suffer from being too large and too complex to be effective in practice.

In the light of these arguments, the Evaluation Team recommends that each RBM focus country appoint a Country Champion. The Country Champion can be located in the local office of any of the RBM partners that are active in that country. One size does not fit all. The appropriate identity and the location of the Champion in each focus country will be different. The Champion needs to be sufficiently senior and experienced to operate as an effective coordinator and advocate among the agencies, NGOs and relevant sections of government. The Champion must be located in a partner organization which is fully committed both to RBM and to rapid progress on malaria in the country concerned. The Champion could in many cases be an appropriate person located in the WHO country office. This is the model in Cambodia and it is highly successful. However, the placement of the RBM Country Champions within the focus countries should be flexible and reflect the specific circumstances of the country to which they are assigned. Country Programme

Advisors (CPAs) have been deployed by UNAIDS for similar purposes with good results in some countries, and may offer a model from which RBM could draw (Box 17). Similarly, the Stop TB Partnership has assigned TB Medical Officers to approximately half of the 22 high-burden countries of focus. These staff are relatively senior compared to the National Programme Officers, and may be seconded by other Stop TB partners, as well as by WHO.

Box 17
UNAIDS Country Programme Advisors (CPAs)

UNAIDS employs between 50 and 60 CPAs in developing countries. Nearly half of these are assigned to African countries. The CPA works primarily with the UN system in host countries to catalyse action at the country level. They are increasingly supported by inter-country teams which help secure technical support for countries. The CPA is typically *not* a technical expert. This created confusion over the CPA's role when the position was first created. The portfolio of roles and responsibilities of the UNAIDS CPA includes, but is not limited to:

1. Advocacy, and facilitating collaboration between the UN system and national and international partners in support of an expanded national response by:
   - encouraging cooperation between the UN system and national and international partners and stakeholders in strategic planning and resource mobilization;
   - increasing the profile of HIV/AIDS within countries;
   - improving country and regional access to technical support; and
   - supporting national efforts to mobilize additional resources.

2. Documenting and disseminating best practice by:
   - promoting national adaptation and application of relevant and appropriate best practice, including UNAIDS policies; and
   - identifying and documenting best practice for incorporation into UNAIDS best practice material or for national/international dissemination.

3. Advising the UNAIDS Secretariat on collaborating and supporting country-level activities by:
   - monitoring the national HIV/AIDS situation and response;
   - identifying opportunities, obstacles and gaps and advice regarding optimal UNAIDS Secretariat collaboration; and
   - assisting, as relevant, with development, monitoring and evaluation of UNAIDS-supported projects, including those funded through Strategic Planning and Development Funds (SPDF).

3.3 Role of Individual Partners

An essential purpose of the re-engineering of RBM recommended here is to create renewed and vigorous commitment among partners to work closely together to achieve impact at the country level. This requires partners to make clear commitments to their roles and responsibilities and then to stick to them and be held to them by others. The recommendations below are focused on clarifying what the key roles of the core partners should be in practice.

3.3.1 WHO

The strong recommendation regarding the future role of WHO as a partner is that it should concentrate on providing scientific and technical leadership to countries and RBM partners. In doing so, it should capitalize on the skills and talents of outside researchers, policy makers and institutions, recognizing that its authority rests with its convening power to call on the best expertise worldwide. The collation, synthesis and distillation of 'best practice' to inform member States is one of its most important roles as the world's only international agency dedicated to health. In this regard, the Evaluation Team found that WHO has tended to under-utilize expert advice from African institutions and other leading sources of technical support from the developing world.

The uneasy relationship between WHO Headquarters and the Regional Offices (particularly AFRO) is a hindrance to the successful performance of its normative functions. In theory, headquarters' role is to provide normative guidance to the Regional Offices which are then responsible for modifying this to fit the specific contexts of countries within their regions. This does not consistently happen in practice, although the relationship is more 'seamless' for some regions than for others.

The concept of 'One WHO', which is being actively pursued by the Director-General, is of great importance in the context of RBM. A single corporate WHO would find it a straightforward managerial task to decide which functions are best done at the corporate headquarters in Geneva and which functions are best decentralized to the regional or country levels. This kind of decision-making needs to happen. The balance in the location of technical expertise between Geneva, the regions and the countries is not of great concern to the other partners, provided that it works effectively in practice. It is a matter for WHO to decide and implement.

A related issue, which should be straightforward in the 'One WHO' model, is to ensure that different parts of WHO learn quickly and effectively from each other. The Evaluation Team found no evidence that information from WPRO was reaching AFRO or vice-versa. There have been no instances of the exchange of staff between these or other regions. Similarly, an obvious role for corporate headquarters in Geneva is to synthesize best practices and make them widely available throughout the system. This is not occurring. RBM staff in Africa are unaware of the exciting progress and achievements in Cambodia. WHO is a knowledge organization, *par excellence*. Before it can effectively share knowledge with others, it has to learn to share knowledge with itself.

The other major recommendation concerning WHO is the separation of the Secretariat from the WHO's partner functions. This is discussed above in Section 3.1.3.

3.3.2 The World Bank

For the World Bank to become an effective partner in RBM, three things must happen. Firstly, a decision must be taken by senior management that Bank collaboration in RBM is indeed a corporate priority and a small budget must be created (estimated to be around $600,000 per year) to fund the costs of this participation. This budget will allow for the creation and support of an RBM Team at the Bank. The RBM Team might comprise a proportion (say 20 percent) of the senior RBM focal point at the Bank, plus (say) two more junior World Bank staff who would work more or less full-time on RBM. This work would not only be at the level of the global partnership, but would also include country missions and country support work. This country work could, in many cases, be charged to other budgets.

The RBM Team at the Bank should also include a staff member seconded to the RBM Secretariat at WHO. The World Bank had a secondee in the Secretariat between March 1999 and September 2000. This arrangement was of great benefit to WHO and the Bank, and to the functioning of the RBM Partnership. It should be recreated. For preference, the World Bank secondee at the Secretariat should not be a malaria or health expert, but should be expert in Bank operations, finance and poverty-related funding mechanisms.

The best location for this RBM Team in the Bank is probably within the Africa Vice-Presidency, although it is important that it supports malaria work in other regions and is able to represent the World Bank's participation in malaria control globally, not just in Africa. These latter requirements suggest an alternative location in the Health, Nutrition and Population Anchor.

Secondly, the World Bank should be an active participant in the process of selecting focus countries. Having selected the focus countries, the World Bank will then need to consider

internally in which of these it can practically offer a significant contribution across at least several of the key roles outlined in Section 2.3.2. The Bank should be careful not to over-promise. If it can deliver in Tanzania but not in Eritrea, then it is better to say so at the outset and avoid false expectations. The Bank should commit to being a full and active partner, initially in a subset of the focus countries. Obviously, it will be easiest for the Bank to be an effective collaborator in a larger country where the Bank has substantial operations, where the Bank has a health sector staff member in-country or close by, and where there is ongoing health sector lending. Over time, the Bank should be able to gradually expand the list of countries in which it is actively working.

An important element of the Bank's commitment to be an effective partner in named countries is the full support and engagement of the Country Directors. The Country Directors have to be persuaded on good evidence that malaria is indeed a high priority in the context of the numerous other priorities with which they have to deal.

Thirdly, the Bank should make a big effort to educate other partners, both in Bank procedures (especially with regard to IDA lending cycles) and the mysteries of PRSPs, HIPCs and related animals. It is also important that the Bank continue its efforts to be more user-friendly to its borrowers. Borrowers still find procedures cumbersome and demanding. In the case of complicated programmes such as NMCPs, Bank lending can be a difficult instrument to ensure the flow of funds in a timely and appropriate manner.

In this connection, the issues relating to Bank procurement remain to be resolved. In the case of malaria control, apart from the generic issues of the need to act more quickly and to simplify procedures, there is the problem of sole source purchasing. In the case of new first-line drugs for the treatment of malaria in chloroquine-resistant areas, it will frequently be the case that there is in practice only one manufacturer in the world who makes the right drug in the right blister pack. Competitive tendering makes no sense in such situations and can lead to the wrong product being purchased. Since the World Bank's commitment to assist with the financing of more expensive anti-malarial drugs in the long-term is especially important, both in relation to the financing of NMCPs and to giving confidence to countries that if they change drugs they will not be left with an unaffordable bill, the need to find new ways of working is especially great.

The World Bank has now made a major and very visible commitment to increase its work and contribution in the field of HIV/AIDS. It is perfectly feasible for a lesser, but equally strong commitment to be made to the RBM Partnership and to malaria control, initially in selected countries and subsequently in a longer list of countries. The External Evaluation Team believes that the RBM Partnership cannot be effective in practice without commitments of this kind from the World Bank and without the effective delivery of those contributions which the World Bank undertakes to make.

3.3.3 UNICEF

As was pointed out in Section 2.3.3, UNICEF has a newfound and much welcomed enthusiasm for malaria control. The question of most importance going forward is what UNICEF's role should be and what pieces of the malaria control challenge UNICEF should especially concentrate on and contribute to. In making this determination, a guiding principle should be to complement the activities of other partners, rather than to compete with them. UNICEF should build on its comparative advantages, which include:

- leadership, advocacy and mobilization for children;
- global procurement capacity (for drugs, but not necessarily for nets);
- advocacy and social mobilization;
- experience in complex emergencies and difficult countries; and
- a strong field presence with over 6000 staff located in developing countries.

UNICEF's strong country presence and great experience with community-based programmes make it an ideal partner to focus on the community and on ensuring demand for and access to preventive and curative services at the community level. This could, and probably should, take different forms in different countries. Social marketing is likely to be a prominent component, as will be working with both public and private providers to ensure good quality service and high access even for the poorest families. In some countries UNICEF could concentrate on the poorest families and work on the especially difficult challenges of access and quality among this group. An additional focus for UNICEF could be supporting countries with their advocacy and communications programmes Finally, UNICEF could appoint and house the Champion in some countries.

Concerning staffing, the Evaluation Team noted that UNICEF was in the process of strengthening its technical capacity, both in New York and its Regional Offices. This is an essential step towards a more effective role for UNICEF within RBM. It is important, however, not to overlap with or duplicate WHO's technical role. Difficulties in this area have risen in the past in other programmes. UNICEF is arranging inward secondments from CDC, and the Evaluation Team welcomes this development. UNICEF should also consider outward secondments, including most importantly a secondment to the RBM Secretariat.

3.3.4 UNDP

As noted in Section 2.3.4, UNDP has been a silent partner till now. This could continue. Alternatively, UNDP could come back into the partnership with a specific and clearly defined role. The obvious role is working alongside the Bank to elevate malaria in national priority setting and to insert malaria into agreements on poverty-related funding mechanisms. This fits well with UNDP's mandate as convenor of the PRSP process at the country level. The effectiveness of this role in practice will depend greatly on the inclinations of the UNDP Resident Representative in each country. In some cases, for example Cameroon, the UNDP Resident Representative is well prepared for and enthusiastic about this role. It would be unfortunate not to take advantage of this contribution, especially in focus countries.

3.3.5 Bilaterals

The key priority for the role of the bilaterals in RBM is to expand the group of bilaterals that are strongly committed to RBM and which pledge to stay with malaria for the long haul. The continued strong contribution of DFID and USAID is essential, but this must be supplemented by similarly strong commitments from perhaps six other bilaterals. The External Evaluation Team believes that this is possible to achieve in practice, and represents a high priority for RBM on the resource mobilization front.

An especially important commitment to be sought is the commitment of the European Commission. The reasons for the less than complete engagement of the European Commission thus far need to be better understood. Following this, RBM should make every effort to draw the European Commission fully into the partnership and to secure substantial long-term commitments from this source.

At the country level, bilaterals can pick and choose where they focus. The significant partners at the country level will vary among countries. Bilateral partners should indicate to which countries they are willing to commit, and then become an active part of the RBM Partnership in those countries. It is important to make clear to bilaterals that, by making a commitment to RBM, they are not making a commitment to be active in every country where RBM is active, or even to be active in every RBM focus country. This is neither necessary nor desirable. It is in everyone's best interest to encourage bilaterals with limited technical and financial resources to concentrate their efforts on a smaller list of countries.

At the country level, the commitment of bilaterals to long-term support for the costs of malaria control is especially important in the context of new and more expensive first-line drugs. As countries contemplate the change from chloroquine to SP and from SP to more expensive combination therapies (Box 7), they are extremely worried about their ability to sustain the greatly increased costs of these new drug policies. Long-term partnerships with selected bilaterals are essential to give confidence to countries to make the necessary changes in drug policy. Commitments of this kind do not impose an impossible burden on bilaterals. As time passes, the costs of the new combination therapies will fall and the ability of countries to finance these costs from internal sources will rise. The relative contribution of donors to the drug bill will therefore fall through time and may be fazed out entirely within a decade or two in most countries. What frightens countries, and is unacceptable in terms of donor/country relations, is a commitment to short-term funding with no guarantee that future funding will be available, even with demonstrated good performance in malaria control.

Finally, bilaterals can be extremely helpful in strengthening the Secretariat by making appropriate secondments. They can also be helpful in offering to provide the Country Champions and to give them administrative and other support facilities.

3.4 Regional Activity

The Evaluation Team examined only the regional activity of WHO in any detail. While UNICEF also has Regional Offices, they were not visited and no inquiries were made into the particular role that they might play in the context of RBM.

The Evaluation Team considered the suggestion that the RBM Secretariat should relocate to AFRO, placing it close to the frontline of the major challenges in malaria control. It was also felt by some that locating RBM in Africa would give recognition to where the burden of disease mainly occurs and would acknowledge the pioneering efforts of AIM as the precursor of RBM. On balance, the Evaluation Team believes that relocation of RBM of the Secretariat to AFRO would not be advisable at this time in the light of several factors.

- ❑ RBM is a global initiative, notwithstanding the fact that 90 percent of the burden is in Africa. Other countries have serious malaria problems and need support and assistance from RBM.
- ❑ The imminent move of at least part of AFRO to Brazzaville will increase its isolation and its difficulty in working effectively. While it is intended to keep the AFRO RBM function in Harare for the time being, this split between Harare and Brazzaville will generate its own set of difficulties and problems.
- ❑ The absence of strong regional equivalents to AFRO (with the possible exception of UNICEF) among the other RBM partners could make the arrangement bureaucratically difficult for the other partners.

The Evaluation Team does believe that AFRO and the Inter-Country Teams that it has created are extremely important to the success of RBM and need to be further developed and strengthened. AFRO and its Inter-Country Teams could be the main point from which ongoing, intensive technical support to countries is provided. This support would focus on the major biomedical, medical and public health issues concerning malaria control. Where communications, finance and resource mobilization are concerned, it may be preferable to locate this expertise within the RBM Secretariat, with support from other partners, particularly the World Bank. One reason for this is that guidance on finance and resource mobilization at the country level requires frequent and close interaction with the headquarters of those partners who are financing malaria activity.

This kind of liaison and interaction is more easily done from Geneva and Washington than from Harare.[24]

The other relevant regional structures of WHO (EMRO, EURO, PAHO, SEARO and WPRO) must also play their full part in providing adequate, timely and competent technical support to their client countries. PAHO and WPRO already function strongly in this area. EMRO and SEARO may need strengthening. Finally, relations among the WHO Regional Offices, and between them and WHO headquarters, need to be improved. Part of this improvement involves clarifying roles and responsibilities. A second part is ensuring the transfer of information and best practice among regions and to and from headquarters. This latter goal will be facilitated by arranging periodic transfers and secondments, in order that technical staff working in one region can spend time familiarizing themselves with the successes and failures in malaria control in other regions. This cross-fertilization, for example from WPRO to AFRO, could be extremely valuable.

3.5 Prioritizing Country Level Action

The country level is the major focus for Phase II of RBM and success at the country level is the determinant of the success of RBM.

In Africa, intensive working with a selection of focus countries, and the achievement of measurable reductions in the malaria burden in those countries, is the very highest priority. Partners must first come together to agree on the selection of focus countries. As stated in Section 3.2.1, this can either be through a transparent process based on criteria, or through self-selection. In any event, the partners need to know which the focus countries are.

In each focus country, a subset of partners, which will be different in each country, needs to commit to long-term support for the NMCP. Plans need to be finalized; resources need to be made available; and action on a national scale needs to unfold. This action must include a strong emphasis on private sector providers, both of nets and treatment. A monitoring and evaluation system needs to be put in placed (see Section 3.10) which can reliably measure a small number of process and outcome indicators.

For countries outside Africa, most will wish to press ahead and make progress in malaria control. RBM will need to be ready and able to support them. Once again, however, some degree of prioritization among countries is appropriate. In most regions, there are a few countries where civil unrest and lawlessness make progress with malaria control impracticable. Such countries should be helped to maintain as much of the fabric of their NMCPs as possible, but they cannot realistically be targets for major external assistance until their situations stabilize. There are also countries in each region whose circumstances make them well suited for a large effort in malaria control at this time. As with Africa, demonstrating strong progress in a few areas is an extremely important goal and will encourage other countries to also take vigorous and effective action.

In the larger countries of Asia, this selective approach should be applied to parts of countries rather than whole countries. This is particularly true in India and Indonesia. Some Indian states and Indonesian provinces are more ready to make rapid progress in malaria control than others. Concerted action in these states and provinces is fully justified. It is also consistent with the development policies of some of the partners: for example, the World Bank's work in India now

[24] Another alternative would be to organize technical support to countries in the manner of Stop TB. The Secretariat of the Stop TB Partnership organizes technical support for the 22 high-burden countries falling within its mandate. The WHO Regional Offices organize technical support for all other countries that request it.

focuses on selected states where the policy environment is more conducive to rapid economic and social progress.

3.6 A Pro-Poor Health Systems Approach

As stated earlier, one of the major achievements of RBM in the first three years has been the development of a consensus around a set of priority interventions in malaria control and prevention. The strategy has been to target high-risk populations, and reduce overall rates of morbidity and mortality. However, little is actually known about the ability of such a strategy to target effectively the very poor. This is a problem, since a key rationale which justifies stepped up spending on malaria control activities is its ability to have an impact on poverty reduction, and the attainment of the Millennium Development Goals.

In fact, given the unusually tight correlation that exists between malaria and poverty, it is likely that a focus on high-risk groups is at least a viable first approximation of a poverty-oriented strategy. Nonetheless, there is evidence that resources dedicated to malaria control are not always equitably distributed.[25] For example, in parts of rural Tanzania the children from the richest fifth of the population are twice as likely to receive appropriate anti-malarial treatment than those from the poorest fifth of the population. The same situation is likely to be seen elsewhere, and is likely to worsen in countries which are transitioning to more expensive combination therapies. Similarly, a focus on private sector solutions to net distribution may easily result in greater coverage for the general population but not for the very poor. More information is clearly needed, and RBM should be at the forefront of these investigations.

RBM should also be at the forefront of operational research to study optimal ways of designing programmes that disproportionately benefit the poor. For example, in The Gambia a targeted bednet programme benefited poor children more than wealthy children, lowering their rates of parasitaemia from 63 percent to 40 percent, compared to 35 percent to 31 percent. Lessons learned from these and other studies should be shared widely among countries and more broadly within the Partnership.

In the short run, RBM should continue with its strategy of targeting high-risk populations, but it should simultaneously seek to develop innovative programmatic strategies to reach the poor. As new strategies are identified, they must be quickly disseminated and integrated into the malaria control activities of the focus countries. The pro-poor approach can be further reinforced by aggressively seeking to strengthen RBM's ties to the broader health sector planning and reform efforts (for example, the PRSP process may provide a useful framework for pushing this agenda at the country level).

3.7 RBM and the Global Fund

It is fortuitous, but significant, that the recommendations for the strengthening of RBM are being made at exactly the time when the Global Fund is being brought into existence. The challenges faced in general by the Global Fund have been commented on elsewhere and are not the focus of this evaluation. The proper relationship between RBM and the Global Fund is, however, a matter of major concern for this evaluation.

The Global Fund is a financing mechanism. It will not have in-house the capacity to develop programmes, monitor their progress, make technical judgments about complex issues, or in general substitute for the role of RBM. This suggests a natural and productive marriage between

[25] This was addressed at a November 2001 Bellagio meeting sponsored by the Rockefeller Foundation in cooperation with the World Bank and WHO on *Working Toward Greater Equity in the Fight Against HIV/AIDS*, *Malaria and Tuberculosis*.

RBM and the Global Fund. The Evaluation Team is mindful of the fact that a similar marriage may be proposed between the Global Fund and the Stop TB Initiative, and the Global Fund and UNAIDS.

The Evaluation Team was informed of the multiple interactions that have taken place between RBM staff in Geneva and the interim Secretariat of the Global Fund, initially in Brussels and more recently in Geneva. These interactions have been more about technical advice and guidance than about major strategic issues and future relationships. This balance needs to shift.

Box 18
Changing Malaria Treatment Policies

Data relevant to changing policy on malaria treatment include the following.

- Properties of the available alternative drugs:
  - efficacy (side effects, contraindications, cross resistance, useful therapeutic life);
  - cost and cost-effectiveness;
  - availability.
- Treatment-seeking behaviour:
  - acceptance;
  - compliance;
  - affordability.
- Capacity of the health system to implement the treatment policy:
  - public and private providers;
  - drug management (purchasing, distribution, quality assurance, regulation);
  - implications for the health budget;
  - financing options.

These factors are outlined in the framework for developing, implementing and updating national anti-malarial treatment policy prepared by AFRO four years ago, but not yet distributed. Efficacy of alternative drugs has been the main information collected before changing policy. The current interest in malaria combination therapy necessitates the use of a broader framework to choose suitable combinations.

The creation of the Technical Review Panel by the Global Fund, and the requirement that staff working for UN agencies may not be members of the Technical Review Panel, raise some questions. Individuals on the Technical Review Panel may suffer two disadvantages in making judgments about proposals on malaria control from individual countries. Firstly, members of the Technical Review Panel may be insufficiently familiar with programmatic and operational issues, together with the social, economic and political contexts in the countries concerned. Second, even on the narrower technical issues (for example, drug choice or the design of an ITN distribution system) the technical opinions of members of the Review Panel may not be informed by the complex negotiation of technical solutions that goes on in each country. When a particular country decides to move from chloroquine to SP, or from SP to some new combination, this is not based on irrefutable technical evidence indicating one undeniably right decision. It is based on a complex web of negotiations and issues concerning drug resistance, cost, availability, supply, compliance, and so on (see Box 18). Experts sitting in Baltimore, Banjul, Beijing, Birmingham, Bombay or Buenos Aires, are likely to be unaware of these complex technical negotiations in Cambodia, Chad or Columbia, unless they have recently visited that country and

immersed themselves in the complexities of this decision-making. By contrast, a strengthened RBM should be in an excellent position to make technical judgments that are informed by the full range of country-specific context and history.[26]

Another important dimension of the necessary relationship between RBM and the Global Fund concerns the measuring and rewarding of performance. This is clearly appreciated both by the leaders of RBM and by the leaders of the Global Fund. The Global Fund has, quite rightly, set its sights on disbursement against performance. This follows the pioneering work of GAVI in this field. It is however recognized that setting the correct performance targets and measuring them accurately is an extremely difficult task, and more difficult for malaria than for immunization programmes. A recent paper in the *Lancet* states:

> "Performance monitoring and the rewarding of countries for outcomes achieved, a cornerstone of the Global Fund and of many of the recent global initiatives, will also be problematic. Performance indicators for malaria and tuberculosis control exist, but weak country information systems often fail to report them." (Brugha *et al*, 2002)

The slow progress, some would say failure, of RBM in Phase I to establish a firm foundation for monitoring and evaluation hinders the early work of the Global Fund. It is essential that simple measures of progress in malaria control be agreed, and systems be put in place in priority countries to measure these reliably. The 'reliably' part of this also needs a great deal of attention. In the review of the early work of GAVI conducted by Brugha *et al* (2002) the danger of countries artificially inflating their performance in order to receive subsequent funding is clearly spelt out. It appears that some countries are fully intending and preparing to engage in such inflation. The incentives to do so are great.

Lastly, a strategic issue to be worked out between RBM and the Global Fund is the matter of country focus. The Evaluation Team recommends unequivocally that RBM needs to focus on between eight and twelve countries in Africa. Without this there will not be demonstrable progress in rolling back malaria within the next few years. The Global Fund, by contrast, is demand-driven. It receives and considers applications from countries. Some of these applications will come from countries which are also RBM focus countries. Indeed, one of the things that RBM should seek to do in focus countries is to assist in gaining access to increased resources from the Global Fund. However, applications will come from other countries as well. These may include countries where little progress in malaria control is likely in the near future and major investment would be unwise. Notwithstanding this, on paper at least, the applications may seem plausible and well considered. This places the decision-making apparatus of the Global Fund in a quandary.

The recommendation of the Evaluation Team on this matter is that the Global Fund should expect to concentrate most of its funding for malaria in Africa on those countries which have been selected by RBM as the focus or priority countries. The Global Fund should, in addition, look favourably on smaller projects in other countries, where there seems to be an opportunity to create a foundation on which later progress can be built. The political acceptability of this compromise will need to be tested in practice.

3.8 Global Financing Strategies

There is an important distinction between what countries can spend through traditional channels and what they need. It was frequently observed that, although the financial needs for effective malaria control may be great, the availability of funds often exceeds what the public sector can

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[26] Decisions concerning changing drug policy are especially difficult. In Annex C, we reproduce an article from a newsletter of Médecins Sans Frontières which illustrates this in the case of Burundi. This article also illustrates the need for close technical coordination between RBM Partners and governments.

absorb in the foreseeable future. This, once again, emphasizes the need for contracting out and for vigorous use of the private sector for the provision of both preventive and curative services. These opportunities are being taken up very slowly in most African countries, and there is considerable reluctance on the part of governments to go too far down this route.

The first priority at the country level in financing is to fully mobilize and exploit those sources of finance that are already available. It is pointed out elsewhere in this report that SWAp baskets, funds from HIPC, and funds from PRBS Programmes are large, available in many countries, and typically not being used for malaria control. In addition, in many countries, greater use could be made of IDA funds. It is particularly helpful to have IDA funds available through APLs, with their long-term commitment and inbuilt flexibility.

Box 19
Gates Malaria Partnership

The Gates Malaria Programme, now called the Gates Malaria Partnership, was conceived as a collaborative research and capacity development project that could make a significant contribution to international efforts to reduce mortality and morbidity from malaria, especially in Africa. The partnership, funded by a generous award of $40 million from the Bill and Melinda Gates Foundation, is now in its second year. The Partnership has research and training components.

The research component of the initiative, coordinated through the London School of Hygiene & Tropical Medicine (LSHTM), is directed at the evaluation of new tools for malaria control, including the economic and social implications of introducing new methods of treatment or prevention. A research committee and a panel of referees have been established to ensure full peer review of all research proposals. These must have one senior investigator based at LSHTM but LSHTM staff are encouraged to develop links with existing or new collaborators in malaria-endemic countries. So far twelve major awards have been made. These cover epidemic prediction, trials of combination therapy, including in pregnancy, evaluation of new insecticides for use on nets, evaluation of a new malaria vaccine, a study on increasing usage of ITNs, and another on the economic and social aspects of home management. Nearly all studies are based in Africa.

The capacity development component of the initiative is a collaborative one involving LSHTM, the Liverpool School of Tropical Medicine, the University of Copenhagen, the Danish Bilharziasis Laboratory and groups in Ghana (School of Public Health), Malawi (College of Medicine, Blantyre), Tanzania (National Institute of Medical Research and Kilimanjaro Christian Medical College) and The Gambia (Medical Research Council Laboratories). In each of these countries the National Malaria Control Programme (NMCP) is an important partner. Training centres have been established at each of the African sites. Their brief is to develop innovative training programmes that will help to overcome particular constraints holding up national malaria control programmes. A number of ideas, for example courses for journalists, the better implementation of drug revolving funds, and demographic data collection and use in malaria control, are beginning to emerge. Delivery of courses will be assisted by trainers based in the European centres.

The capacity development programme also has a more conventional doctoral programme. The initial submission to the Bill and Melinda Gates Foundation included a budget for twelve fellowships. Over 300 applications for these fellowships have been received from scientists in malaria-endemic countries. Through use of co-funding, the budget has been stretched to 27 students, nearly all from Africa, but many very well-qualified students have had to be turned down. Post-doctoral fellowships for scientists from malaria-endemic countries have been less popular and many fewer applications have been received. However, a number of strong potential candidates have been identified and interviews for these posts will be held in June.

Bringing the various activities of the Gates Malaria Partnership together has not been easy but this is beginning to happen and the partnership is gaining momentum with the help and support of the international Expert Oversight Committee.

The Global Fund tentatively expects to allocate $200 million to malaria in its first year of operation. This will more than double the current estimated external flows to malaria control activities. In future years, as the Global Fund grows and its disbursement mechanisms improve, this impact could be even greater. In light of the above, the establishment of a strong partnership between RBM and the Global Fund is essential. It matters greatly for the success of RBM how the Global Fund selects its projects and allocates its resources.

A related and unresolved issue concerns how the major bilaterals will react through time to the growth of malaria funding by the Global Fund. Will they continue in their bilateral support to malaria (increasingly through SWAp baskets and budgetary support) or will they see the Global Fund as the main channel for these contributions? If the Global Fund becomes the main channel, it will put in jeopardy the progress made over the last few years with more collective funding mechanisms through SWAps and poverty-related programmes. The work of the Fund will move the world back towards the projectization of official development assistance and may undermine sound overall financial planning and government ownership of priorities.

Finally, the financing roles of the foundations and the corporate sector are potentially important but still evolving. The Gates Foundation has made a major contribution to RBM, partly through its sponsorship of MMV and MVI, but, more importantly, through the Gates Malaria Partnership. Box 19 outlines this Partnership. In the future, the Gates Foundation and other foundations may choose to support RBM centrally, to support activities which are congruent with RBM, or to support the Global Fund, and thereby contribute to overall efforts to combat malaria. Which way foundations will choose to go is not clear, although early indications suggest a preference for specific activities rather than pooling funds in the Global Fund.

Box 20
Examples of Potential Databases

Technical

- ❑ Status of trials of new interventions
- ❑ Status of drugs in development

Programmatically useful

- ❑ Drug prices at different vendors
- ❑ Reports of operations research
- ❑ Requests for Proposals (RFPs), Requests for Applications (RFAs)

Country programme and partner activities

- ❑ List of partners present or active in countries
- ❑ Monitoring information, for example:
  - o Country status of taxes and tariffs
  - o Coverage statistics

3.9 Advocacy and Communication

While the key to improved communication among partners and country programmes will be changes in the structure of RBM to enhance interaction and increase accountability, an improved website that truly served the partnership might offer a partial solution. The current web page is not a means to coordination because it does not provide the necessary information and because partners do not access it frequently enough (Table 6). The solution to both of these barriers is to

include content that partners need. This content might include a set of updated, easily accessible databases on technical and programmatically useful information[27] (see Box 20 for examples of potential databases). The responsibility for generating and updating these databases might be distributed among the partners, who have to decide jointly which databases will be most useful. Currently, information about country programmes will most easily be obtained by periodic phone interviews.[28] The Secretariat must take the responsibility of ensuring that the website represents the partnership.

Table 6
Hits on the RBM website

Origins (domain names) of visitors accessing the RBM website during 2001 (top ten)

Domain name	Number of requests
Unknown	163,575
International (.int)	73,251
Commercial (.com)	68,792
Network (.net)	66,796
USA education (.edu)	34,316
UK (.uk)	28,604
Non-profit making (.org)	18,739
France (.fr)	13,467
Netherlands (.nl)	11,520
Australia (.au)	11,175
Canada (.ca)	10,179

Organizations accessing the RBM website during 2001 (top ten)

Organization	Number of requests
Unknown	163,704
Int	73,251
Aol.com	14,958
Ja.net	12,649
Worldbank.org	6,285
Wanadoo.fr	5,447
Novo.dk	5,053
Tg (apparently Togo)	4,492
uu.net	4,455
Lshtm.ac.uk	4,113

RBM must continue advocacy at the global level to consolidate and extend its initial success. At present the most important need is to develop a global advocacy strategy that clearly identifies different potential audiences and the advocacy objective for each (for example, RBM should aim for different reactions from heads of state than from heads of foundations, governments and NGOs), and seeks to address their primary concerns and the factors that constrain or might facilitate the desired result. Beginning this activity will require clarity from the partnership concerning priority advocacy objectives (some possible ones include: reducing taxes and tariffs

[27] For those programmes and partners for whom web access is problematic, periodic CD-rom-based updates could be provided.

[28] While laudable, the CAT's effort to provide access to country programmes by holding web-publishing workshops for a handful of participants will not solve the problem in the short term.

in all countries, developing global consensus regarding the process of changing first-line drugs and improving drug quality, positioning RBM relative to the Global Fund or strengthening malaria objectives within PRSPs). In addition, RBM must be willing to carry out some assessment of different audiences to identify the most persuasive arguments.

The RBM Advocacy Guide, produced by CAT, is a useful document for orienting country programmes about advocacy, but it alone is insufficient to enable inexperienced programme managers to carry out effective advocacy. As with global advocacy, the first step is a decision concerning the advocacy objectives; the next, development of a comprehensive strategy. One possible solution is for RBM to provide technical assistance to countries from WHO or other RBM partners, such as UNICEF, with its long history of successful advocacy and social mobilization. Another possibility, preferable because less time-limited than external assistance, would be to encourage national programmes to engage public relations and advocacy professionals from the local private sector.[29]

RBM can also help national programmes by ensuring that lessons learned in one country are accessible to others (this is a good example of programmatically useful information that could be published on the web). Finally, RBM could develop generic materials that countries could adapt for their own use. Two types of generic material would be useful: interactive models that use local data to help officials understand the implications of different kinds of decisions,[30] and informational materials that countries could adapt. The communications unit has begun to consider developing this second type of generic material.

Good national promotion can increase the rate of adoption of ITNs, IPT and prompt, effective treatment. Even when districts bear the major responsibility for implementation, promotion at the national level will raise awareness of malaria and of RBM interventions. In addition, hearing and seeing promotion of malaria control activities heightens their importance for all those responsible for their provision, both public and private. The Evaluation Team strongly believes in the importance of involvement of the private commercial sector (shopkeepers and drug sellers) as distributors and providers of ITNs, insecticide and treatment. Promotion of commercially available products and services is an important role for the public sector in public-private collaborations. Finally, the process of developing and implementing a comprehensive communications strategy will assist NMCPs in clear and strategic thinking as they evolve their CSPs.

3.10 A Global Research Agenda

For the success of RBM in Phase II, a productive research network needs to be established, focusing on practical operational and clinical questions. Whether RBM should establish and manage such a research network, or rely on TDR or other mechanisms is open to question. In either case, it is important that a focused and prioritized research agenda is drawn up, that the studies get done, and that the results are widely disseminated and put into practice.

Today, some of the bigger and more obvious applied research questions are not receiving the attention that they deserve. For example, there are major unanswered questions concerning the distribution, use and re-treatment of ITNs. A collaborative network of researchers in this area needs to be established. ITNs are hardly used in India at all. Is it possible that India can control

[29] A relationship with a local public relations firm would also be helpful when national programmes are faced with negative media, whether it arises from malicious rumour or concerns actual adverse events such as the apparent low quality of one of the first batches of SP included in the essential drug kits in Tanzania.

[30] USAID, through various subcontractors, developed a series of such models that have been effective advocacy tools for birth spacing/family planning, vaccination and vitamin A programmes.

malaria without them? Probably not. This suggests a major push for research and monitored intervention on this subject in India and similar countries.

As noted in Section 3.7, the Global Fund will more than double the international financial flows for malaria even in its first year of operation. The Global Fund has made a decision not to fund research. Bilateral donors may continue their direct country support for malaria projects, or increasingly channel their support through the Global Fund. If they do the latter, funds for research may decrease. This needs to be avoided. The bilateral agencies should be asked to make a strong commitment to fund operational research on malaria, especially in the focus countries. Similarly, there should be a strong commitment from the World Bank to encourage a proportion of the proceeds of IDA credits to be used for research and research capacity strengthening.

3.11 Monitoring and Evaluation

As made clear in Section 2.8, the progress with M&E in the first few years of RBM has been disappointing. There is an urgent need to get an effective system in place that can track a few selected process and outcome indicators in a selection of countries, and which can construct plausible global estimates of the burden of malaria on an annual or biannual basis.

The existing tension between proponents of strengthening national monitoring and evaluation systems and those favoring the rapid development of a global database of key indicators to track progress of the overall initiative must be reduced. Some data are sorely needed for international comparative purposes. Some data are needed at the country and district levels to inform local decision-making. Sometimes the same data will serve both purposes. Often they will not. Philosophical differences should not be allowed to interfere with RBM's progress in the area of monitoring and evaluation.

The Secretariat's first priority should be to build an effective system for international comparative purposes. This can be done by strengthening countries' capacity in data collection around a standard set of indicators using standardized ways of measuring them. This should be a small set of indicators, perhaps not more than five. Without a reliable set of indicators, RBM cannot credibly describe global trends, and this will limit its ability to conduct a global campaign for additional resources. In this scenario, everyone loses. Thus, the creation of an international M&E system should be seen as supportive to countries' own efforts, and not as undermining them by imposing international requirements. Individual countries will benefit from having a *small number* of reliable measures of progress on malaria, since these measures may improve the country's ability to raise money in support of its national programmes and inform some types of policy decisions.

Only as a secondary priority should RBM provide technical assistance to developing countries' capacity to undertake monitoring and evaluation of programmes at the national and district levels. This is compatible with a highly streamlined view of the Secretariat's responsibilities. When and if RBM does engage in this effort, it should do so with a sophisticated understanding of how the data are to be used *locally* to inform policy and decision-making. The indicators relevant to this effort will likely be greater in number and more variable than indicators selected for international comparative purposes. They will be highly sensitive to local conditions and programmatic requirements, and may be, though not necessarily, strictly comparable even with similar data collected by other countries. In some cases, WHO's Malaria Team, UNICEF and some bilateral agencies may be better positioned than the Secretariat to help countries in this effort.

The recommendations from the separate M&E study are attached at Annex H. The External Evaluation Team endorses these recommendations with the following additional observations:

- The Secretariat's M&E enterprise needs strong and competent leadership from WHO headquarters. This leadership role could be located either in the Secretariat or in the WHO Malaria Team.
- Although the priority is to get standardized measures routinely underway in as many countries as possible, it may be advisable to focus on a selection of countries over the next two to three year period. Obtaining reliable and standardized data from, say, approximately 20 countries by 2005 would in itself would be a huge achievement and step forward from the current situation.
- The Secretariat will not need to conduct a new and separate survey effort to collect mortality data from most countries. Large-scale, internationally funded surveys such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) can provide mortality information more efficiently.

3.12 Human Resources and Capacity Development

As pointed out in Section 2.6, human resources and capacity constraints greatly limit RBM's ability to make progress in many of the most seriously affected countries. There are no easy or short-term solutions to this challenge.

It must be recognized that skills development is less critical to capacity building than low salaries, poor working and housing conditions (particularly in rural areas), and limited opportunities for career growth. Since these problems affect the entire health sector, and indeed the public sector as a whole, they will not be easy for RBM to address in isolation. An awareness of, and sensitivity to, the broader environment will be needed. At the global level, it may make sense for RBM to work in collaboration with other Partnerships and programmes, to coordinate a strategic response to the crisis.

Meanwhile, there is a need for getting activity underway at the country level. The Strategic Plan for Capacity Development rightly proposes to focus on a small number of countries in the initial stages. Countries may choose to prioritize different elements of the Strategic Plan. Some countries will wish to conduct assessments of human resource requirements for the entire health sector. In other countries, programmatic assessments will drive human resource requirements (e.g. home management, operations research). The solutions that are proposed to address the gaps identified should be examined carefully for their compatibility with broader policy efforts to address the human resource constraints within the health care sector as a whole.

The Evaluation Team emphasizes three approaches that are particularly relevant for the Secretariat's work in getting activity underway at the country level. Firstly, where training is concerned, the Evaluation team applauds efforts to broaden training approaches[31] to include non-technical areas such as management, finance, communications, the social sciences and related areas. These efforts should continue, but they should not take place in isolation. All health sector programmes require greater expertise in these areas. It makes little sense for RBM, or Stop TB, or EPI to address these generic areas own its own. It is a combined approach that countries need.

Secondly, the human resources and institutional capacity constraints in many of the most affected countries will remain very severe for the next decade at least. Malaria will not be controlled in practice by relying heavily on over-stretched human resources and institutional capacity that lie in the public sector. As argued repeatedly, the mobilization of private sector responses is essential for the effective control of malaria, and human resources and institutional capacity constraints

[31] To improve quality and relevance, future training programmes should incorporate work performance evaluations of staff, and additional follow up. There need to be effective and reliable ways to determine whether or not existing training modules improve performance.

simply add one further element to this argument. If malaria control is left to governments to plan and execute, malaria will not be controlled.

Thirdly, the Evaluation team recommends heightening the focus on 'best practice.' Best practices, or lessons learned, can be gleaned from other programmes (e.g. ACTMalaria – the Asian Collaborative Training Network for Malaria) or from individual countries. For example, Ghana has completed human resource assessments at regional and district levels. These assessments have been used to strategically identify the human gaps and fill them with qualified staff. In addition, Ghana has developed an incentive scheme for qualified health staff in rural posts. It includes housing, transportation, salary increases based on meeting performance targets, and social recognition within communities for achieving standards of excellence. It is difficult for countries to learn from other countries, without the assistance of a clearinghouse or intermediary. The Secretariat can usefully play such a role.

3.13 Complex Emergencies

RBM-CE differs from the main body of RBM in three important ways: its array of donors, its key implementing partners, and its potential array of technical interventions. Each of these factors contributes to a growing fissure between RBM-CE's organizational culture, priority setting, and day-to-day operations and those of the broader RBM Secretariat. For these reasons and others which will be explored more systematically in the Waldman evaluation report on Complex Emergencies, RBM-CE appears to have more in common with the newly formed Control of Communicable Diseases in Complex Emergencies Unit (CCDCE) within the Communicable Diseases cluster of WHO than it does with the RBM Secretariat. The CCDCE seeks to identify the major causes of communicable disease morbidity and mortality in emergency settings; to garner the technical resources of WHO and its operational partners in emergencies (including NGOs) in order to address these problems; to develop norms, standards and guidelines; and to suggest and sponsor research. The Evaluation Team therefore recommends that RBM-CE be spun off from the main body of RBM and that it be re-located to the CCDCE of the Communicable Diseases cluster of the WHO.

3.14 Achieving the Goals, Modifying the Goals, Rejecting the Goals

There is a need for RBM to revisit the goals and re-specify them in a way that is unambiguous and has the full support of all partners, including the most affected countries. At present, the goals are conflicting (for example, between the Abuja goals and the MDGs), unclear (for example, the MDGs), specified differently on different occasions (for example, the Abuja goal is sometimes stated as halving the malaria burden by 2010 and sometimes as halving malaria mortality by 2010) and over-ambitious (Box 21). On top of this, there is no system in place at present to know when and whether these goals will be achieved. A wider question is, "Does anyone believe in these goals anyway and, if not, should RBM persist in advocating them?" This is a vexed question which is always raised when ambitious international targets are set. The pros and cons of having such targets have been well rehearsed.

What really matters is measurable progress in a significant number of highly affected countries. If, for example, such progress can be achieved in a dozen countries in Africa by 2007, this will be a dramatic and remarkable achievement. It should not matter whether it puts Africa on track for halving mortality by 2010.

On balance, the Evaluation Team recommends setting more realistic and more precisely defined goals. These should be couched mainly in country terms rather than global terms. It might also be useful to have goals for each region. Where EMRO should set its sights and where AFRO should set its sights should be very different, and to specify this could stimulate appropriate

action and commitment region by region. Finally, it is important for RBM not to set itself up to failure by specifying goals that can clearly not be achieved.

Box 21
Unrealistic Targets in Africa

In the year 2000, RBM AFRO set an ambitious sequence of targets for its region. They included the following.

By 2001:
- 50 percent of 42 malaria countries in the region will have introduced RBM and developed plans of action;
- 80 percent of the 42 countries will have increased coverage of ITNs to 25 percent.

By 2005:
- 50 percent of households in targeted districts will have at least one ITN.

By 2010:
- all countries will be fully implementing RBM;
- malaria morbidity and mortality reduced by 50 percent from levels in 2000.

By 2015:
- malaria mortality reduced by a further 50 percent and morbidity by a further 75 percent.

The 2001 targets did not come close to being achieved, and probably will not be until 2005 or later. In addition, most people familiar with malaria in Africa do not believe that the 2010 or the 2015 targets can be achieved. If this is true, these targets should be revised.