External Evaluation of

Roll Back Malaria

Roll Back Malaria in
Complex Emergencies

Ronald Waldman, M.D., M.P.H.

Molly E. Rauch, M.P.H.

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Introduction

This external evaluation of Roll Back Malaria in Complex Emergencies (RBM-CE) commenced in February 2002, and activities associated with the evaluation were conducted through June 2002. The evaluation began a little later than the comprehensive external evaluation of the Roll Back Malaria initiative, of which it never became an integral part. Rather, the evaluation of RBM-CE was conducted in parallel. The findings of the larger evaluation have not influenced those reported on here and the recommendations offered here have not been considered in light of those made by the larger team for RBM as a whole. These considerations are quite important and loomed increasingly larger as this evaluation evolved. In fact, the fundamental question governing this evaluation of RBM-CE became: is malaria control in complex emergencies more like malaria control in other circumstances, or is it more like the control of other public health priorities in complex emergencies? The answers to this question guided the development of the recommendations presented at the end of this document.

Between the time that data collection ended and the time this report was prepared significant events have occurred which leave the future direction of RBM-CE uncertain. At the start of the evaluation there were issues raised regarding the organizational placement of RBM-CE, which had already been moved once (from WHO's Division of Emergency and Humanitarian Action (EHA) to the RBM Secretariat) during its short existence. Disagreement on certain technical issues, especially treatment strategies for malaria, together with other factors mentioned below, threatened the ability of the Technical Support Network for RBM-CE to function effectively.

Notwithstanding these problems, many successes have been registered, most evidently in the provision of technical assistance in countries where the health and livelihoods of large populations were affected by complex emergencies and in the progress of a number of research projects that were commissioned by RBM-CE. Finally, the financial status of RBM-CE seemed sound. This report reviews the findings of the evaluation and makes a number of recommendations for resolving some of the problems that existed at the time.

Methods

The evaluation relied on three principal methods:

1. *Document review*. RBM-CE provided trip reports, meeting reports, progress reports, research results, job descriptions, and various funding proposals for review. The RBM-CE website was also mined for documents. Together, these documents were drawn from extensively in the preparation of this report.
2. *Case studies.* A field visit was conducted to Kinshasa and to eastern Democratic Republic of the Congo, where a wide array of non-governmental organizations (NGOs), UN agencies, and donors were involved in attempts to assist a population affected by the long-term emergency stemming from the unrest that accelerated after the Rwanda genocide (1994) and the fall of the Mobutu regime in Zaire. In the Province of North Kivu, the unstable political situation and its accompanying state of insecurity were compounded by the eruption of a volcano near the town of Goma in January 2002. On the same trip, a visit was made to WHO/AFRO in Harare.
3. *Interviews.* Telephone and face-to-face interviews were conducted with many of the principal members of the RBM-CE Technical Support Network, the RBM-CE Secretariat, participating NGOs, donors and others who had knowledge of the situation.

Technical Support Network

Roll Back Malaria (RBM) was established in 1998 with the goal of reducing malaria morbidity and mortality worldwide by 50% by the year 2010. Based in WHO, RBM has always intended to work through vigorous collaboration with both public and private sector partners to raise the profile of malaria and to develop comprehensive and coordinated malaria control strategies. Claiming that 30% of all malaria deaths occur in countries affected by complex emergencies,[1] the RBM Secretariat established a complex emergencies component (RBM-CE) in December 1998. The working mechanism of RBM-CE, as was the case with eight other ‘specialty sections’, was to establish a network of representatives from different agencies and organizations that would meet regularly and communicate frequently to provide direction to the RBM Secretariat. The network manager, part of the RBM Secretariat, was to coordinate the work of the network internally and with the other networks, and to contribute to RBM’s relationship with the donors to whom RBM is accountable.

The Technical Support Network (TSN) of RBM-CE was created with the following objectives:

1. to raise awareness on the need for appropriate malaria control and stimulate more operational agencies to contribute to malaria control;
2. to provide and broker technical support in the field;
3. to develop, adapt and disseminate technical guidelines;
4. to develop, adapt and disseminate training materials;
5. to identify operational research priorities, and advocate, encourage and technically support operational research; and
6. to coordinate with other RBM Networks, especially epidemic prevention and control, mapping and insecticide-treated materials;

A group of 14 experts formed the initial TSN. Because, in addition to the objectives cited above, the TSN hoped to participate in the field activities of RBM, it was rapidly expanded. At the second Network meeting, in April 1999, the group finalized six areas of activity: training, operational research, information management, fundraising/advocacy, post-emergency, and rapid response teams, and retained two as its top priorities: the development of technical guidelines and the mobilization of a rapid response to the field upon request.

The first year of the TSN’s existence was characterized by attempts to establish the network, to develop projects, and to gather information about malaria control strategies in complex emergencies. During this time, the TSN functioned reasonably well. It was used by the Secretariat as had been intended – in an advisory capacity. Communication was frequent and informal, and the members of the network felt engaged.

During its second year, however, along with a change in leadership within the RBM-CE Secretariat, the role of the TSN diminished considerably. The TSN was no longer consulted on a regular basis, and it was not adequately informed regarding either important activities of RBM-CE or the progress (or lack of it) that was being made toward achieving the objectives. The majority of members of the TSN who were consulted during the course of this evaluation had serious complaints regarding the way they were being used, and particularly about the quasi-total

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[1] A complex emergency is an ill-defined concept that involves some combination of natural and man-made disaster, usually war or civil strife, that frequently results in mass population displacement and excessively high rates of morbidity and preventable mortality. These situations are almost always characterized by an increase in short-term international assistance delivered by what has come to be known as the ‘international humanitarian community’, comprised of private non-governmental organizations with a wide array of principles, experiences and capabilities.

breakdown of the consultative process. Important consequences accompanied this functional disbanding of the TSN. For one thing, the Interagency Handbook on Malaria Control in Complex Emergencies, which had been promised since the inception of the TSN and which had been made one its highest priorities, was repeatedly delayed, to the great frustration of many TSN members, one of whom felt that it was "the one thing that shows the TSN was worthwhile". For another, the centralization of decision-making within the Secretariat and the seemingly arbitrary (to some) circulation of messages or requests for assistance led to a lower level of transparency and a lack of accountability on the part of the Secretariat. RBM-CE came to be seen as primarily a WHO activity, rather than a coordinated one.

Importantly, however, most members of the TSN readily admit that its failure is not entirely due to the neglect of the RBM Secretariat – the TSN itself is partially at fault. There is a general feeling that the role of the TSN was never adequately defined, even when it had the chance to do so itself. In fact, there was some concern expressed by the Secretariat about the TSN suggestion that it should be involved in the provision of technical assistance, not just in coordination and oversight. As it turned out, there were many times when TSN members were not available when called upon. In these cases, the RBM-CE Secretariat brought in available NGO personnel with suitable skills, although some criticism has been raised regarding the small number of NGOs to which RBM-CE appealed.

In addition, it is generally acknowledged that some of the delay in producing the Handbook resulted from chapters being submitted late. This was partly a problem of the commissioned experts, but some of the delay could have been avoided through more strategic writing assignments, based not only on willingness and expertise, but also on the likelihood of the authors completing the chapters within the defined timeline.

Finally, and importantly, there was strong disagreement within the TSN in regard to an approach to malaria treatment. The chapter of the Handbook dealing with treatment became a source of serious contention and one can imagine how this inability to come to consensus might have frustrated the Secretariat, just as it did the members of the TSN.

In summary, the TSN suffered from a lack of clarity regarding its purpose, an inability to respond to requests for assistance, internal disagreement regarding important policies that should have been included in its long overdue Handbook, and a change in leadership style within the Secretariat. The end result of the sum of the problems arising from both the TSN and RBM-CE is that there is no longer a functional Technical Support Network, although some of the Network's members have continued to contribute to RBM-CE activities on an individual, and sometimes an organizational, basis.

RBM-CE and WHO

Although, as mentioned above, members of the TSN increasingly came to see RBM-CE as a WHO activity, there were significant differences in philosophy, approach and implementation style between the RBM-CE Secretariat and the malaria experts within WHO. WHO is essentially a membership organization, accountable to the Ministries of Health of the States which comprise its General Assembly. Yet, in complex emergencies, many State functions, especially social services including health, have broken down and are beyond the reach of the affected populations. It is for this reason that often the main providers of health services to those populations are either local or, more typically, international non-governmental organizations. Whereas the States, and therefore the majority of WHO, approach policy formulation and programme implementation from the standpoint of incremental development, complex emergencies require a rapid response, one that may require a quite different approach.

The tension between being held accountable to States, as is WHO (and this includes, of course, the Regional Offices), and being held accountable to NGOs, as RBM-CE perceived its role, was mirrored in tension between the malaria experts at WHO and the Secretariat of RBM-CE. It

should be noted that there is a longstanding tension between WHO and NGOs, and these are frequently perceived as different ‘cultures’. The RBM-CE Network Coordinator in the second and third years of operation had a strong NGO background and was sympathetic to their style of operation. He has claimed, justifiably, that much of WHO had to learn about the needs of emergency-affected populations and needed to abandon its ‘business as usual’ attitude. This tension came to the fore over the issue of drug treatment policies in Burundi, a country considered to be in the midst of a complex emergency, but where the government still exercises some degree of authority. Although the specifics of the conflict that arose there are complicated, for the purposes of this evaluation it is enough to state that strong disagreement occurred between the NGO approach to case management and that favored by WHO/Geneva and WHO/AFRO. RBM-CE appropriately assigned field staff to Burundi to try to coordinate the control programme on the ground, but their ability to function was hampered by local governmental authorities, with support from the WHO country office and WHO/AFRO. Although it is admitted by all sides that the conflict might have been handled with less acrimony, this episode serves to highlight the potential conflict between governmental (and WHO) processes and those of the NGO community when responding to complex emergencies. It is also a telling example of how RBM-CE can be caught between the two, unless its role is made explicit and understood by the array of involved organizations.

Training

The RBM-CE Secretariat has regarded the development of training materials and the implementation of training courses as a very high priority. At the time of this evaluation, two types of training programme for health providers in complex emergencies were being developed. One is a day-long module that could be added on to already-established courses on public health in complex emergencies. The other is a week-long module intended to provide detailed technical expertise on malaria control in emergency situations. This week-long course is intended to be held three times per year in regions undergoing emergencies.

Both training modules have been delayed, to a measurable degree because they rely on the Handbook as the basis of their curricula. The delay in producing the Handbook is therefore having a negative impact on other RBM-CE projects. RBM-CE held an informal consultation on training issues in June 2001 (a source of contention for the TSN, which was inadequately informed), establishing an advisory group for the RBM-CE training initiative and getting input and ideas for the training modules. The key activity of the advisory group was to contribute to the content of the training initiative by identifying eight priority training topics: initial assessment and planning; surveillance and monitoring; epidemic preparedness and response; case management; operational research; prevention; community participation and health education; and training staff and the community. These training topics mirror the proposed chapters of the Handbook. Additionally, the advisory group provided advice at the meeting about how to select participants as well as instructors for the training courses. Finally, they discussed strategies for evaluating the success of the training initiative.

There is no question that training in malaria control should be a priority. For many NGOs, the prime implementers of disease control programmes in complex emergencies, malaria remains a mysterious disease, one that is difficult to understand, and one with which they are reluctant to get involved. Clarifying some of the confusion surrounding malaria control issues is essential. But the implementation of training activities was delayed. Recently, under circumstances not entirely known to the evaluation team, the RBM-CE Network Coordinator left RBM to direct an NGO that will concentrate in this area.

Successes

Although the TSN had major problems and is no longer functioning, although the committee authorship and publication of the Handbook for Malaria Control in Complex Emergencies has been fraught with difficulties, and although tensions continue to exist between WHO and the RBM-CE Secretariat, RBM-CE has a substantial record of success. In other words, the processes may not have been ideal, and perhaps one should not have expected them to be under the circumstances, but the outcomes have been, in a number of ways, quite good.

Advocacy

This evaluation did not attempt to quantify an increase in awareness regarding the importance of malaria control in complex emergencies among the NGOs who are the primary responders to these situations. It can be stated, however, that all of the NGO representatives interviewed, and a large number of others as well, agree that awareness of malaria as a priority issue has been heightened since RBM-CE has been on the scene. This impression of success in this area is undoubtedly closely linked to the field-level technical assistance discussed next, although clear attribution is difficult to establish.

Field assistance

RBM-CE has fielded technical support missions in at least nine locations: Angola, Burundi, DRC, East Timor, Guinea, Liberia, Somalia, Sudan and Tanzania. RBM-CE Technical Support Network members have also worked in Pakistan/Afghanistan and in Tajikistan, with support from the Network. The field missions have ranged from relatively brief assessments to the stationing of full-time RBM-CE officers for months at a time or even longer. Field missions began in 1999, with trips to Sudan and East Timor. In 2000 RBM-CE was involved for much of the year with a bednet distribution project in East Timor. In the summer of 2000 RBM-CE sent experts to the Democratic Republic of Congo. The number and range of field missions increased dramatically in 2001. In that year experts worked in Burundi, Guinea, Tanzania, Somalia and Angola, and returned to Sudan. Moreover, in May 2001 two full time support officers were deployed in DRC.

Judged by the number and range of field missions, RBM-CE has shown remarkable growth and improvement since the inception of the project. Field missions have developed from rapid assessments into an increasing ability to provide long-term technical support, to ensure coordination, and even to undertake operational research in the field. In other words, RBM-CE has established itself, in many instances, as a recognized and effective leader in malaria control in emergency settings. NGO partners involved in these missions have expressed enthusiasm for the role of RBM-CE in the field and perceive its presence as highly beneficial to overall relief efforts.

Africa has been a key focus of RBM-CE's field response to complex emergencies. As discussed above, however, tensions with WHO/AFRO have arisen on a number of occasions, despite the fact that the Regional Office is represented on the Technical Support Network. For one thing, WHO/AFRO understandably feels that official support to its Member States should be coordinated through its offices, and there is confusion as to whether or not RBM in general and RBM-CE in particular ought or ought not to follow the usual protocols of WHO. Where hiring and deployment of technical officers has been done directly by RBM-CE and the Regional Office has been bypassed, trouble has ensued.

The role of WHO-CE, and especially of its Technical Support Network, can also easily be misunderstood. Whereas most agree that the role of standard setting rightly rests with WHO, there are times when guidelines regarding malaria control, and especially case management, in

complex emergencies have been seen as emanating from RBM-CE. WHO/AFRO has balked at accepting these guidelines, preferring to be led by the expertise of WHO/HQ – and the tensions between RBM-CE and WHO/HQ are briefly noted above. This situation has led to unpleasant situations in the field, such as that in eastern DRC where a dispute arose over who should take the lead on drug sensitivity testing: RBM-CE working with an NGO was pitted against the Ministry of Health (Kinshasa) which was receiving technical assistance from Centers for Disease Control (CDC), a TSN member, but not working, in this situation, in close coordination with RBM-CE.

The case study conducted in the area of Goma, North Kivu Province, Democratic Republic of Congo, is a useful demonstration of many of the points made above. There, a technical officer had been hired by RBM-CE and assigned without adequate consultation with WHO/AFRO. Nevertheless, the officer was eventually able to take up her post and was based in the WHO local office. By working together with the many NGOs that were present, holding frequent meetings to discuss malaria prevention and treatment strategies, and finding creative ways to combine the respective strengths of different NGOs, a broad approach to malaria control was developed and implemented in the area. Without this field assistance from RBM-CE the importance accorded to malaria would have been much less,[2] provincial control strategies would have been less coordinated and coherent, and it is likely that many NGOs that became engaged in malaria control on behalf of the populations they served would not have. NGO praise for the efforts of RBM-CE in Goma was universal and, in the judgment of this observer, was warranted, bureaucratic failings notwithstanding.

Research

Another area RBM-CE, and particularly its Secretariat during the latter half of the evaluation period, can point to with pride is its stimulation and conduct of appropriate operational research. The tools needed for malaria control in complex emergencies differ significantly from those needed in more stable environments. Accordingly, the RBM-CE Secretariat has developed, funded and implemented research on insecticide-treated plastic sheeting, blankets and tents, and on the development of culturally acceptable bed nets in areas affected by complex emergencies. Much of this research has been done through building effective public-private partnerships with product manufacturers, and with the NGO community for study implementation and evaluation.

RBM has a TSN devoted solely to working on insecticide-treated materials; however, complex emergencies raise unique challenges. Where indoor residual spraying and/or the social marketing of insecticide-treated bednets might make sense in a stable society, they have little relevance for people forced to migrate from their homes, people living in temporary, inadequate shelters. To address this situation, the RBM-CE Secretariat has spearheaded research on treating plastic sheeting, commonly distributed during emergencies by UNHCR and others, with residual insecticides. Such plastic sheeting could do double duty as temporary shelter material and insecticide carrier. If effective, and preliminary results are quite encouraging, this method might prove a useful way of reducing human-vector contact in the acute phase of an emergency.

In Sudan, RBM-CE has been involved in a project to design and pilot locally acceptable bednets. It has worked with four NGOs and with Vestergaard Frandsen, the manufacturer of PermaNets, to pilot several kinds of nets and test them in communities for acceptability. These two examples of the research sponsored by RBM-CE demonstrate a commitment to practical problem-solving,

[2] It is interesting to consider whether, in fact, malaria should receive so much attention; or, rather, why other priority conditions, usually responsible for even higher mortality in complex emergencies, do not. There is no Roll Back Diarrhea, for example, or Roll Back Pneumonia. But a discussion of this issue is clearly beyond the scope of this evaluation.

an ability to think creatively, and a recognition that a partnership of private and public interests can bring about desirable and potentially life-saving benefits for even the most vulnerable populations.

Some have offered mild criticism regarding the ad hoc nature of these research projects. It has been suggested that the development of a carefully structured research agenda would ensure that priority problems receive priority attention and that funding should be sought preferentially for what needs to be done, not for what is more conveniently offered. It has been noted that this would be a reasonable role for the Technical Support Network, should it be re-constituted.

Funding

The RBM-CE Secretariat has proven its ability to persuade donors to contribute to its ability to achieve its objectives. Particularly in the areas of training and research, the compelling arguments and persuasive style of the Secretariat has attracted resources from donors and allowed substantial progress in these areas to be made. It is significant to note that the donors for malaria control in complex emergencies are not the same as those for the majority of RBM activities. The largest of the bilateral donors, USAID and DFID both have emergency divisions that have relatively independent budgeting authority and procedures. The principal sources of funding for RBM would not necessarily be committed to funding RBM-CE, or even have the authority to do so. Fund-raising efforts for RBM-CE have therefore involved initiating a dialogue with non-traditional sources and following up with those sources on a regular basis. The RBM-CE Secretariat has been remarkably successful in this regard.

Conclusion

Overall, this is a favourable evaluation of RBM-CE. Although the Technical Support Network has for all intents and purposes ceased to function as a contributory entity, many of its members remain engaged as individuals in the promotion of training, the conduct of operational research, and the on-going discussion of malaria control strategies, especially those surrounding case management. Furthermore, the clear differences in approach between RBM-CE and the body of WHO malaria experts in headquarters and in the Regional Offices, especially AFRO, have led to perhaps unnecessary conflict and efforts should be made to resolve these differences in order to avoid a negative impact on field operations.

However, the successes of RBM-CE in raising the profile of malaria control in emergency settings and engaging the NGO community in planning and implementation of malaria control are notable. The emphasis on research and the design, funding and implementation of successful research projects aimed at resolving major operational problems, hold out promise for saving many lives that might otherwise be lost unnecessarily.

Guiding the answer to the question posed in the Introduction to this report, and essential to the recommendations presented below, is the finding that RBM-CE differs from the main body of RBM in three important ways: 1) its array of donors, 2) its key implementing partners, and 3) its potential choice of intervention strategies.

Some of the donor partners of Roll Back Malaria, such as the World Bank and the United Nations Development Programme (UNDP), are not traditionally involved in the acute phase of complex emergencies. In addition, although DFID and USAID are major donors to relief efforts in emergencies, the divisions of those organizations that deal with emergencies are not always in close contact with the more development-oriented divisions; in fact, they have separate operating budgets and different mechanisms of disbursement. In some ways, USAID's Office of Foreign Disaster Assistance and the Conflict and Humanitarian Affairs Department of DFID can be considered as different organizational donors from their parent agencies. In addition, other organizations that are principal actors in complex emergencies, such as the Office of the United

Nations High Commissioner for Refugees (UNHCR), the World Food Programme, and the Bureau for Population, Refugees, and Migration (BPRM) of the United States Department of State, as well as a variety of others that are major stakeholders in complex emergencies, are not part of the current management structure of RBM, but have a definite stake in the work of RBM-CE.

Secondly, while RBM implements its ground-level activities primarily through Ministries of Health of WHO Member States, and considerable effort is spent orienting and energizing these government bodies, RBM-CE almost invariably works with NGOs as its field-level partner. The reasons for this are multiple, and they vary considerably from one emergency to the next, but the fact is that governments are frequently part of the cause of complex emergencies and cannot be relied upon to be actively involved in the provision of health care to affected populations. Frequently, conflict-affected populations do not have access to any State services at all.

This aspect of RBM-CE has been a serious problem. It was the view of both WHO and NGO contributors to this report that in addition to differences in style, there are real ‘cultural’ differences between the NGO community and the UN bodies. RBM-CE recognized this from the start – initially it was situated in the WHO’s Division of Emergency and Humanitarian Action (WHO/EHA) and operated distinctly from the main body of RBM. When RBM-CE was moved from WHO/EHA to the RBM Secretariat, a move that was felt, at the time, to be of potential benefit, a number of problems arose.

These included the rapid development of funding proposals by RBM-CE and their submission to some of the emergency-oriented donors mentioned above; according to some, this occurred without adequate consultation and review by WHO staff. Also, as pointed out above, staff were hired for deployment to complex emergencies by RBM-CE without adequate consultation and consent from the Regional Offices, especially WHO/AFRO. Finally, where malaria control activities and/or policies suggested by NGOs working in the field were in conflict with those of Ministries of Health, RBM-CE tended to side with the NGOS while the more traditional (and more developmentally oriented) components of WHO argued the MOH side. The two modes of operation have not been adequately wed and, because of the significant cultural chasm, may never be.

A third area of discordance between RBM and RBM-CE is on the technical level. It is generally accepted that the principal objective of emergency interventions is to reduce the mortality rate of the affected populations to baseline levels as rapidly as possible. Longer-term solutions to disease control problems, while recognized as being extremely important, sometimes have to wait until the situation stabilizes. In emergencies where malaria makes an important contribution to excess levels of preventable mortality, different measures may have to be implemented from those recommended in more stable, and more developmental, situations.

For example, in Goma programmes to disseminate and monitor the use of impregnated bednets were being developed. These programmes require time for their implementation – community participation is essential to their success, and in order to elicit community involvement intense health education activities are required. Yet, in the interim, few prevention activities were being sponsored by the NGOs or by the authorities. However, in order to ‘buy time’, the indoor residual spraying of dwelling units might be an effective way of reducing malaria transmission until other measures can be implemented. Also, as mentioned, the use of insecticide-impregnated plastic sheeting is unique to emergencies and destined for the use of displaced populations with inadequate shelter.

For treatment as well, different policies could be considered for different situations. If urgent reduction of malaria-specific mortality in a relatively small area is the goal, as is most frequently the case in complex emergencies, the most effective available treatment regimen might be recommended, regardless of cost and other considerations, at least for a limited period. On the other hand, the development of a rational national strategy that includes the abandonment of one treatment regimen and the adoption of another, including the designation of first- and second-line

drugs for treatment, their purchase and distribution, and careful monitoring and evaluation of their effects, has proven to take considerable time – years, in most instances. In the interval, adherence to national-level policies that recommend the use of ineffective drugs might preclude the ability of NGOs and others working in emergencies to achieve their short-term goals. This was the essence of the problem in Burundi, where a clearer understanding of the overall objectives of NGOs and RBM-CE on the one hand, and the MOH and WHO on the other, might have contributed to a more constructive solution of the problem. So, RBM-CE has developed a research agenda that is separate from that of RBM, funding for which comes from sources different from those of RBM, and implementation of which is by actors other than those to whom RBM is generally accountable.

This evaluation, therefore, has led to the conclusion that malaria control in complex emergencies has more in common with communicable disease control in general in those settings, than it does with the developmental aspects of malaria control coordinated by RBM.

As can be surmised from this evaluation, the two coordinators of RBM-CE have had distinctly different styles, one more participatory, the other more centrally directive. Neither is still with RBM and, with the departure of its coordinator since the time of this evaluation (but in no relation to it), RBM-CE seems to have ceased functioning. The future of the technical assistance and the research components is unclear at this time. WHO has formed a malaria control unit under which malaria control in complex emergencies will fall, but there is no specific emergency expertise in that unit, and the strong relationships that have been formed with the NGO community and with other emergency-oriented entities may be considerably weakened. On the other hand, there is a relatively new unit, the CDS Complex Emergency Programme in the communicable diseases cluster of WHO, which intends to oversee and coordinate communicable disease control in emergencies, including the recruitment and deployment of field-level personnel, and to provide more general training courses to Ministries of Health and NGO personnel.

Recommendations

1. The RBM Secretariat and its donors should recognize that the control of malaria in complex emergencies resembles more, in a number of important ways, the control of communicable diseases in emergencies than it does malaria control in stable environments. By so doing, RBM should forge the closest possible relationship with the WHO Complex Emergency Programme and the new Malaria Control Unit. In emergency settings, attention should be paid to the control of all communicable diseases and priority accorded on the basis of incidence and disease-specific mortality in the field, not on the basis of political imperatives decided upon from more central levels.

2. The idea of developing a participatory network of experts to advise and guide the RBM Secretariat was a good one. Strong consideration should be given to re-constituting the network. Care must be taken, however, to draft clear and specific terms of reference. The Network should not necessarily be involved in decisions involving recruitment and deployment of field staff, but should concentrate on helping RBM develop policies and strategies for malaria control in complex emergencies. As an aside, it might be mentioned that expert committees, or networks, might be formed around other priority communicable disease problems as well – these include diarrhea and pneumonia control.

3. The Interagency Handbook on the Control of Malaria in Complex Emergencies should be published. This Handbook has the potential to be an essential guide for NGOs and others providing services to populations in need. The Handbook was to have been a major product of RBM-CE and its delayed publication has been a source of embarrassment and concern.

4. On-going research should be completed and the results widely disseminated. In addition, a research agenda specific to complex emergencies should be developed by RBM in conjunction with WHO and outside experts (the Technical Support Network, if is revivified) and RBM and its partners should secure the funding and other resources required to implement priority research projects.

5. Under the current circumstances, given the relative lack of activity occasioned by the departure of the Network Coordinator, the RBM Secretariat, in conjunction with WHO and other operational partners, should meet to decide the way forward. The many problems encountered in attempting to forge common administrative and technical strategies should serve as a lesson from which to move forward, not a cause to abandon the laudable attempts to address the important problem of malaria in complex emergencies.

Overall, the impact of RBM-CE has been a positive one. The current circumstances are such that the RBM Secretariat and its partners, including WHO, will need to pay particular attention to maintaining the momentum that has been established. They should do so.