Roll Back Malaria Partnership

Partnership profile

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Contents

List of acronyms

ACT	Artemisinin-based Combination Therapy
AMP	GSK African Malaria Partnership
CCM	Country Coordinating Mechanisms
GFATM	Global Fund to Fight AIDS, Malaria and Tuberculosis
GPPI	Global Public-Private Initiative
GSK	GlaxoSmithKline
IPPPH	Initiative on Public-Private Partnerships for Health
MIM	Multilateral Initiative on Malaria
MMSS	Malaria Medicines and Supplies Service (or Medicines and Materials Supply Service)
MMV	Medicines for Malaria Venture
MVI	Malaria Vaccine Initiative
NGO	Non-Governmental Organization
PPP	Public-Private Partnership
RBM	Roll Back Malaria
SWAP	Sector Wide Approach
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WTO	World Trade Organization

Introduction

This report forms part of a broader research project on the role of companies in public-private partnerships (PPPs). Such collaborations have become an increasingly important way to stimulate sustainable development. The research project aims to contribute to a better understanding of the rationale, functioning and effectiveness of these partnerships.

This report describes and analyses the Roll Back Malaria (RBM) Partnership, a Global Public-Private Initiative (GPPIs) for health. GPPIs are a specific type of public-private partnerships. The report focuses on the role of pharmaceutical industry partners in the operations and governance of the RBM Partnership. It does not evaluate outcomes or effectiveness in much detail, nor does it provide an analysis of each company's approach to GPPIs for healthcare in general. These issues are addressed in separate reports by SOMO, including three reports on individual companies (Aventis, GlaxoSmithKline, Merck & Co).[1] These reports relate their involvement with GPPIs to the core-business of the companies and to broader company strategies and policies for corporate social responsibility. Field studies on the implementation of the GPPIs in developing countries, conducted by partner organizations of WEMOS, form part of the broader research project.[2]

[1] See http://www.somo.nl.

[2] At the release of this report, the reports of the field studies were still being edited. When they are finished, they will be placed on the WEMOS website, http://www.wemos.nl.

1 Short description of the RBM Partnership

The Roll Back Malaria (RBM) Partnership was founded in 1998 by the World health Organization (WHO), the World Bank, United Nations Children's Fund (UNICEF) and United Nations Development Programme (UNDP). The partnership has a global coordinating function and provides strategic guidance for malaria programmes, in order to ensure optimal use of available resources. RBM aims to half the global malaria burden by 2010 (compared to 1998).

In Phase I of the RBM, from 1998 to 2002, the partnership raised attention for the problem of malaria, which is now generally considered a priority disease. It also reached agreement on priority interventions and strategies for malaria control and prevention.[3] However, the disease burden has increased over the past years to above the 1998 level.[4] In Phase II, from 2002 to 2007, the partnership is expanding the use of insecticide-treated bed nets and scaling up the use of Artemisinin-based Combination Therapies (ACTs), a new generation of anti-malaria drugs.

For 2005, the Partnership aims at the following targets, adopted at the Africa summit on RBM in Abuja, 25 April 2000:[5]

- at least 60% of those suffering from malaria have prompt access to, and are able to correctly use, affordable and appropriate treatment within 24 hours of the onset of symptoms;
- at least 60% of those at risk of malaria, particularly children under five years of age and pregnant women, benefit from the most suitable combination of personal and community protective measures such as Insecticide Treated Mosquito nets and other interventions which are accessible and affordable to prevent infection and suffering;
- at least 60% of all pregnant women who are at risk of malaria, especially those in their first pregnancies, have access to chemoprophylaxis or Intermittent Preventative Treatment.

However, progress of the RBM Partnership is at community level is currently not sufficient to achieve the Abuja milestones.[6]

A recent initiative of the RBM Partnership is the creation of the Malaria Medicines and Supplies Service (MMSS; also Medicines and Materials Supply Service).[7] The MMSS will facilitate the access to cheaper antimalarial drugs of good quality and other types of

[3] D. Daniels e.a. (2002). *Final report of the external evaluation of RBM*.
[4] A. Attaran (19 August 2004). *Where did it all go wrong?* Nature, vol. 430, p932-3.
[5] *The Abuja Declaration and Plan of Action*. http://www.rbm.who.int/docs/abuja_declaration_final.htm, accessed October 2004.
[6] 5th RBM Partnership Board Meeting, 29-30 March 2004, *Summary of proceedings*.
[7] *What is the MMSS?* http://rbm.who.int/mmss; RBM Press release (22 April 2004). *Celebrities lend their voices to children's fight against malaria*, http://www.who.int/mediacentre/news/releases/2004/pr27/en, both accessed in December 2004.

supplies, such as mosquito nets, diagnostic tests and insecticides. To this end, it selects and prequalifies relevant products, assists in the forecasting of supply needs, and provides procurement support. It will also broker pooling of procurement to reduce the cost of malaria treatments and other supplies.

Currently the WHO and UNICEF offer procurement services for ACTs and artemisinin-based components of ACTs to public and non-profit organizations. The prequalification of the products that can be procured in this way is done by the WHO. So far only two products have been prequalified: Coartem (artemether + lumefantrine), an ACT produced by the pharmaceutical company Novertis, and artesunate, an ACT component produced by the company Sanofi-Aventis (previously Sanofi-Synthélabo). In addition, the two Indian companies Cipla and Ipca were found to be complying with Good Manufacturing Practices (a production quality standard) for the production of the ACT artesunate + amodiaquine, but they were not yet fully prequalified. The selected drugs are available for United Nations organizations, governments, NGOs, and other donor organizations, but not for commercial entities.[8]

[8] WHO (second version, 26 April 2004). *Access to artemisinin-based combination antimalarial drugs of acceptable quality*; WHO (September 2004). *Procuring artsmisinin-based combination therapy at preferential prices*. http://rbm.who.int/docs/mmss/procuringACTpreferentialprices.pdf, accessed in December 2004.

2 Partnership policy

2.1 Partners involved

The RBM states it has more than 90 partners.[9] These include the following.

- **Multilateral founding organizations**: WHO, the World Bank, UNICEF and UNDP. Since the foundation of RBM, the UNDP has had no role in practice.[10]
- **Foundations**: The Global Fund to Fight AIDS, Malaria and Tuberculosis (GFATM), Gates Foundation and Wellcome Trust
- **Donor governments**: the European Commission, the UK, Germany, Italy, Japan, Luxemburg, The Netherlands, Norway and the US
- **Corporate partners**: Novartis, Bayer and several biotechnology companies

GlaxoSmithKline (GSK) also supports the aims of the RBM Partnership and is closely involved with it. However, GSK points out that the RBM Partnership does not have an official partners list and the company would not describe itself as a partner.[11] When requested to provide a list of RBM partners, the RBM Secretariat produced a database file containing over 2000 addresses of RBM contacts, but not a list of partner organizations.

2.2 Partnership policy and expansion

The RBM Partnership has been very open to participation. Generating political support is a primary goal of the RBM. It therefore seeks to bring in as many partners as possible and there has been no such thing as a selection or screening of partners. Any company or organization can join the RBM if it wants to. Because of the aim to mobilize maximum support to fight malaria, the partnership is characterised by inclusiveness and a lack of obligations. Being a RBM partner does not entail any specific duties or responsibilities. In fact, the term 'partnership' was invoked by the WHO to mobilize support for the fight against malaria. Contacts and cooperation with private enterprises existed already before the RBM Partnership.[12]

The RBM Partnership has three levels of participation: the international, regional and country level. The international level deals with issues like overall coordination and resource mobilization, the regional level with issues like water management and migration flows, and the country level includes national anti-malaria programmes. Goals are as much as possible set at each of these three levels. Some partners like donor governments are only involved at the international level, others are only involved at the regional level, etc. This adds to the complexity of partnership status.[13]

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[9] RBM website, http://rbm.who.int/partnership, accessed in September 2004.
[10] D. Daniels e.a. (2002). *Final report of the external evaluation of RBM*.
[11] Correspondence with J. Frain, GSK, 27 April 2004.
[12] Interview with H. Schooten, 27 May 2004.
[13] Interview with H. Schooten, 27 May 2004.

An external evaluation of the partnership in 2003 found that because the number of partners had strongly grown over time, it had become difficult to know who among the partners is in charge and who is responsible for making decisions on behalf of the entire RBM Partnership.[14]

The WHO secretariat adopted a set of internal guidelines in 2000 in order to deal with potential conflicts of interests when working with private sector partners. They recommend that the WHO *'should always consider whether a proposed relationship might involve a real or perceived conflict of interests'* and call for a *'step-by-step evaluation of the commercial enterprise'*.[15] As the guidelines are intended for direct relationships between the WHO and companies, it is not clear whether they apply to the involvement of companies with the RBM Partnership as well. If they do apply, it is not clear how they were used. The application of the guidelines had not been discussed in board meetings.[16] Another study on the government of partnerships indicates that a formal assessment of the background of commercial partners of RBM does take place.[17] However, screening of commercial partners would be of limited value if some relevant companies are not an official partner.

2.3 Contributions of pharmaceutical companies

In general, companies do not make contributions directly to the RBM Partnership, but to separate GPPIs linked to it. Some example are mentioned below.

- Novartis provides its malaria drug Coartem for use in the public sector at reduced cost trough the WHO/Novartis Coartem partnership. It signed an agreement with WHO/UNICEF for these supplies. The WHO develops demand forecasts for the planning of production and a WHO-appointed Technical Advisory Group reviews requests for drug supplies. The drug is distributed through national health infrastructures, government aid agencies and NGOs.[18]

- Various companies, including Novartis, Bayer and GSK, are involved in the Medicines for Malaria Venture (MMV) for the development of new drugs against malaria.

- Bayer supports the expansion of insecticide treated bed nets trough NetMark Plus and coordinates the logistics of bed nets distribution. The chemicals for

[14] D. Daniels e.a. (2002). *Final report of the external evaluation of RBM*.
[15] WHO (30 Novermber 2000). *Guidelines on working with the private sector to achieve health outcomes*, annex.
[16] At least not in board meetings attended by the Dutch government representative. Interview with H. Schooten, 27 May 2004.
[17] K. Buse (2004). *Governing public-private infectuous disease partnerships*. In: Brown Journal of World Affairs, Winter/spring 2004, X(2), 225-42.
[18] IPPPH Website, http://www.ippph.org. Accessed in Septermber 2004.

impregnation are supplied by the company itself. Bayer pursues economies of scale to lower the price of the supplies, but does not make donations.[19]

- GSK provides support for malaria programmes through the GSK African Malaria Partnership (AMP). The AMP aims to reduce malaria infections and improve the management of the illness in seven African countries. National ministries of health and international NGOs are directly involved. GSK provided a £1.5 million grant to fund country programmes for three years.

2.4 Motivation and interests of corporate partners

Ethical considerations are cited as an important motivation for pharmaceutical companies to support the RBM Partnerships as well as the GPPIs linked to it.

At least some of the companies have important business interests in involvement with the partnership too. The RBM Partnership creates a large demand for ACTs. These are relatively new medicines, protected by patents that allow the companies that developed these drugs to recover their R&D costs and to make high profits. Current manufacturers of ACTs and Artemisinin-based components of ACTs (all starting with 'arte-') include:[20]

- Novartis, a Swiss innovative and generic drugs producer (Coartem = artemether + lumefantrine)
- Mepha, another Swiss innovative drugs producer (artesunate, artesunate + amodiaquine, artesunate + mefloquine)
- Sanofi-Aventis, a newly merged French innovative drugs producer (artesunate, injectable artemether)[21]
- Cipla, an Indian generics producer (artesunate, artesunate + amodiaquine, artesunate + mefloquine)
- Ipca Laboratories, another Indian generics producer (artesunate, artesunate + amodiaquine, artemether)

At present there exists a gap between the currently purchased quantity of ACTs and the total quantity of ACTs that would be required to meet the RBM's targets for access to treatment. Recently, the RBM Board concluded that the best way to bridge this gap and increase ACT production to required levels would be a 'promise to buy' the required ACTs from the pharmaceutical companies that produce them for 2005 and beyond.[22]

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[19] Netmark Website, http://www.netmarkafrica.org/whatisnetmark/index.html, accessed in August 2004.
[20] WHO/RBM/UNICEF/PSI/MSH (september 2004). *Sources and prices of selected products for the prevention, diagnosis and treatment of malaria.* http://rbm.who.int/rbm/Attachment/20040921/SP-Malaria2004_1.pdf, accessed in November 2004.
[21] Aventis produces injectable artemether, Sanofi-Synthelabo produces
[22] 5th RBM Partnership Board Meeting, 29-30 March 2004, *Summary of proceedings.*

It is probably access to information, rather than influence on board decisions, that provide opportunities for companies to obtain business benefits. Companies cannot exert a large influence in the Board, because agreement among different Board members is required. Donors have a much larger influence in the Board due to the dependence of the RBM Partnership on donor funds. Malaria endemic countries have also an important voice in the Board.

Yet some sources indicate that involvement provides a company with valuable first-hand information about Partnership decisions and plans. For example, the information that a certain country is selected for direct country support allows a pharmaceutical company to immediately approach this country and try to gain a larger share of the market for malaria treatments. The WHO makes recommendations on antimalarial drug regimes, but (sub)national treatment guidelines are ultimately decided by the endemic countries themselves. Some well-informed sources indicate that pharmaceutical companies have been aggressively lobbying to promote their drugs as a national treatment standard.

Although some countries continue to promote the use of older drugs such as Chloroquine, their number is quickly decreasing. Many countries have now adopted or are switching to treatment policies with ACTs as a fist-line treatment or, less frequently, a second-line treatment. These are mostly African countries. Coartem has been chosen as a first-line treatment in Bangladesh, Bhutan, Benin, Ethiopia, Kenya, Mali, Namibia, Tanzania (mainland), Uganda, and Zambia. Artesunate plus amodiaquine is the preferred first-line treatment in Afghanistan, Iran, Southern Sudan, Burundi, Cameroon, Gabon, Ghana, Liberia, Madagascar, Sierra Leone, and Zanzibar.[23] Several more countries have chosen for combinations of artesunate with another drug, such as sulphadoxine-pyrimethamine or mefloquine. These national treatment guidelines are all in accordance with WHO recommendations. The variety in national treatment policies underlines the associated business interests.

2.5 Conditions of cooperation

As mentioned before, most companies (and especially pharmaceutical companies) that are partners of the RBM or closely involved with it do not directly contribute to the RBM Partnership itself. They do not have a well-defined role in the partnership and membership does not bring any specific obligations. The proposed 'promise to buy' indicates that pharmaceutical companies do not even assume the responsibility to supply sufficient quantities of new drugs. This contrasts with other GPPIs for health, such as the Global Polio Eradication Initiative, in which the supply of sufficient quantities of drugs is a main role of the pharmaceutical industry.

[23] WHO AFRO/SEARO/EMRO/WPRO/AMRO (Update December 2004, WHO different regions). *Global AMDP database*. http://www.mosquito.who.int/amdp/amdp_afro.htm, …/amdp_searo.thm, etc.; accessed in December 2004.

In the case of Bayer, which currently provides the private sector representative in the RBM Partnership Board, there is no written agreement that specifies the conditions of the company's involvement and business with the RBM. The company was engaged because of the contribution it could make to the RBM through its supplies.[24] However, Bayer commented that it has signed a statement that there are no conflicts of interests regarding its involvement with RBM.[25] A copy of this statement was not produced.

In general, companies make their contributions to other GPPIs linked to the RBM Partnership, such as NetMark Plus and the Medicines for Malaria Venture. The agreements for these GPPIs are not publicly disclosed and therefore the conditions of cooperation for these partnerships cannot be analysed here.

Some conditions specified in the agreement between Novertis and WHO/UNICEF for the supply of Coartem are communicated by the WHO, though. Governments procuring the drug have to fulfil, among others, the following conditions.[26]

- The use of the drug shall be justified on the basis of a report on the malaria situation.
- Malaria treatment guidelines shall be revised as appropriate to include Coartem and other anti-malarial drugs according to WHO-recommended drug regimes.
- Coartem shall be introduced as first- or second-line malaria treatment with appropriate training of health professionals.
- Assurances shall be provided that the drugs will not be diverted from their agreed use.
- All possible steps shall be taken to prevent parallel exportation of the product (that is, exportation to another country where Coartem is sold at a higher price).
- The price to the end-user of the drug shall not be unduly increased due to tariffs, duties or taxes.

The production costs of Coartem are audited by the accounting firm KPMG to ensure that Novartis does not make profits on the drug. However, some sources indicate that these audits provide no full guarantee, because the calculated production costs of the drug depend to some extent on the attribution of overhead costs, for which there does not exist a uniform standard.

NGOs, bilateral and multilateral donors must obtain approval from the national Ministry of Health before they can purchase Coartem through WHO/UNICEF at the reduced price. Note that the supply agreement applies only to the public sector and NGOs. A recent study found that a large part of malaria treatments is delivered through the private sector too. If

[24] Interview with H. Schooten, 27 May 2004.
[25] Interview with G. Hesse, Bayer, 25 August 2004.
[26] WHO/RBM/UNICEF/PSI/MSH (september 2004). *Sources and prices of selected products for the prevention, diagnosis and treatment of malaria.* http://rbm.who.int/rbm/Attachment/20040921/SP-Malaria2004_1.pdf, accessed in November 2004.

NGOs are included in the private sector, it accounts for over 70% of all malaria care.[27] The figure for the private sector excluding NGOs could not be found. The Roll Back Malaria strategy stresses the subsidizing of ACTs *'through all current delivery mechanisms, both public and private'*.[28] Although the WHO-Novartis arrangement is supported by the RBM Partnership, it does not cover commercial drug sales, even though this is an important delivery channel as well.

2.6 Added value of the partnership

The RBM itself considers that its strength lies in '*its ability to form effective partnerships both globally and nationally*', working on '*internationally agreed malaria-control objectives*' and coordinating partners' activities '*to avoid duplication and fragmentation and to ensure optimal use of resources*'. Furthermore, a key function of the RBM Partnership is to lead advocacy campaigns to raise awareness of malaria at all levels, '*thus keeping malaria high on the development agenda, mobilizing resources for malaria control, and ensuring that vulnerable individuals are key participants in rolling back malaria*'.[29] In line with this, the independent evaluation of the RBM Partnership in 2002 found that there had been major accomplishments[30]

- in advocacy, indicated by an increase in global awareness of the problem
- in resource mobilization, indicated by a large increase in global spending;
- and in consensus-building, indicated by agreement on priority interventions and common targets.

Yet it should also be reminded that the partnership is not on track for achieving its goals; the burden of malaria has actually increased since 1998.

It can be concluded that a large part of the added value of the RBM Partnership is in the coordination of the activities of all partners. However, the role of the private sector in this coordinating function is not entirely clear. Some companies might have a role in coordination because they are running malaria programmes themselves. Inversely, the RBM Partnership was involved with the selection of programmes for the GSK African Malaria Partnership.[31]

One might think that the RBM needs to engage pharmaceutical companies to coordinate the supply of ACTs and mosquito nets as well. However, for ACTs it turns out that sufficient supplies have to be created through a 'promise to buy'. The Partnership is therefore generating a demand rather than to coordinating the supply.

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[27] Institute of Medicine (2004). *Saving lives, buying time: the economics of malaria drugs in an age of resistance*. http://www.nap.edu/books/0309092183/html, accessed in December 2004.
[28] RBM (June 2004). *The RBM Partnership's global response: a programmatic strategy 2004-2008*.
[29] RBM Website, http://rbm.who.int/docs/rbm_brochure.htm, accessed in October 2004.
[30] D. Daniels e.a. (2002). *Final report of the external evaluation of RBM*.
[31] Interview with J. Frain, Vice President of GSK Global Community Partnerships department, 1 June 2004.

Another source of added value, already mentioned briefly above, is that the mobilization of additional resources for malaria programmes. In contrast to other global partnerships with a coordinating function, a substantial part of these funds is also channelled into malaria programmes through RBM (see section on funding and financial structure later in this report). Hence, the RBM acts as an intermediate between public and private donors on the one hand and governments of malaria endemic countries and development organizations on the other. The added value of this function is again in the coordination of activities.

3 Governance of the RBM Partnership

3.1 Partnership and governance structure

Initially RBM had a loose structure to increase flexibility and avoid a high management burden. After an independent evaluation of the partnership in late 2002, the RBM initiative was restructured to make partners more accountable and to accelerate malaria control programmes. The RBM Partnership Secretariat was separated from the WHO Malaria Control Department.[32] Before this, failures of the RBM were easily attributed to the WHO. The Partnership Board was extended and a seat for a private sector representative was added because of the important role of the industry in scaling up supplies of ACTs and impregnated bed nets.

The RBM Partnership has now three levels of governance:

- The RBM Partnership Board
- The RBM Partnership Secretariat
- Working Groups

The RBM Partnership Board

The Board provides overall guidance to the partnership. It has 17 voting members, including one industry representative, and 2 non-voting members. The Board is composed of the following representatives.[33]

- 6 from malaria endemic countries
- 1 from NGOs
- 1 from the private sector
- 1 from research and academia
- 1 from foundations
- 3 from OECD donor countries
- 4 from multilateral agencies
- 2 non-voting board members

Board members serve as representatives of their constituencies and sit on the Board for two years.[34] Donor governments sometimes represent each other in board meetings. The presence of target countries is considered more important.[35] A major concern at the 5th RBM Partnership Board Meeting in March 2004 was access of the poorest people to anti-malaria programmes. This issue has to be addressed through national strategies. Attention

[32] IPPPH website, http://www.ippph.org, accessed in September 2004.
[33] 5th RBM Partnership Board Meeting, 29-30 March 2004, *Summary of proceedings*.
[34] RBM webtie, http://rbm.who.int/portal.html, accessed in September 2004.
[35] Interview with H. Schooten, 27 May 2004.

for this problem was drawn by the donor and target countries in the Board. Hence, these countries were able to influence the agenda of the partnership.

Currently the private sector member in the board is from Bayer. He represents all industry partners, including bed nets and insecticide manufacturers, pharmaceutical companies and other companies like Exxon-Mobil. The industry board member consults the various companies and provides them with information about the issues that are being addressed by the board.

However, there is a large difference between bed nets and insecticide manufacturers on the one hand and pharmaceutical companies on the other. The representative regularly meets with the first group, to which Bayer itself also belongs. Bed nets and insecticide manufacturers are working closely together in a cooperative way. This applies to the development of new technologies as well. Yet there are no regular meetings with pharmaceutical companies.[36]

These generally prefer to deal with RBM partners directly rather than through the industry representative in the board. The pharmaceutical industry is in a very competitive situation, which prevents companies from working together. Pharmaceutical companies have very large business interests in the development and supply of new malaria drugs. They typically have a large lobbying capacity, which allows them to operate individually. To the experience of the present private sector representative, having both industry groups represented in the board through one seat is sometimes problematic.

The Secretariat

The Secretariat is responsible for supporting the scaling-up of malaria programmes and provides support to the Working Groups of the partnership.[37] It is accountable to the Board. Six working groups were created after the external evaluation to replace the existing Technical Support Networks. The RBM Partnership Secretariat was tasked with making them operational and monitoring their performance.

Working Groups

The six Working Groups deal with the following issues: [38]

- Malaria Case Management
- Communication
- Financing and Resource Mobilization
- Insecticide Treated Netting Materials
- Malaria in Pregnancy

[36] Interview with G. Hesse, Bayer, 25 August 2004.
[37] IPPPH, http://www.ippph.org, accessed in September 2004.
[38] RBM website, http://rbm.who.int/portal.html, accessed in September 2004.

- Monitoring & Evaluation

The MMSS

The Malaria Medicines and Supplies Service (MMSS), which supports the supply of antimalarial drugs and other products, is a collaboration between the technical departments of United Nations organizations, technical agencies and donors.[39] It has been only recently established by the RBM Partnership and therefore more information on the organization and structure of the MMSS could not be found.

3.2 Funding of the partnership and financial structure

Funding for malaria programmes doubled between 1998 and 2002 to $130 million[40] and continues to rise. Of these $130 million, $35 million was provided through the RBM Partnership and $95 million outside it.[41] This contrasts with other global disease-specific coordinating partnerships, such as the Stop TB Partnership, for which only a tiny amount of funds passes through the partnership.

The contribution of the Dutch government for malaria programmes is made through the WHO. The WHO, not the RBM Partnership, is responsible for the use of these funds. Most other donors make their contributions directly to the RBM Partnership, which is preferred by the Partnership Secretariat. A separate system exists for funds from the GFATM. These are disbursed via Country Coordinating Mechanisms (CCMs).[42]

At present, all donors make contributions for specific elements of the Partnership and the RBM Partnership Secretariat has a coordinating function only. The budget of the RBM Partnership Secretariat itself is some $23 million in 2004 and covers personnel and administrative costs only.[43]

The $130 million of global expenditures for malaria programmes do not include the domestic resources contributed by malaria endemic countries.[44] Part of the anti-malaria programme in Tanzania was financed via the country's Sector Wide Approach (SWAP), for example.[45] This is part of the regular government budget and not coming from additional RBM resources. The external contributions did not include an estimated $84 million of annual investment on R&D for malaria either.[46]

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[39] *What is the MMSS?* http://rbm.who.int/mmss, accessed in December 2004.
[40] A. Attaran (19 August 2004). *Where did it all go wrong?* Nature, vol. 430, p932-3.
[41] D. Daniels e.a. (2002). *Final report of the external evaluation of RBM.*
[42] Interview with H. Schooten, 27 May 2004.
[43] *RBM Partnership secretariat workplan and budget summary January-December 2003.* RBM Partnershp 3rb Board Meeting, 27-28 March 2003.
[44] D. Daniels e.a. (2002). *Final report of the external evaluation of RBM.*
[45] Interview with H. Schooten, 27 May 2004.
[46] D. Daniels e.a. (2002). *Final report of the external evaluation of RBM.*

Major funding for RBM activities comes from donor governments, the Gates Foundation, UNICEF, the World Bank and the WHO.[47] More recently, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has become a major donor and committed $895 million over two years, considerably increasing malaria budgets. However, some point out that funds for malaria control are still largely insufficient.[48]

It is difficult to estimate the value of contributions of pharmaceutical companies to the activities coordinated by the RBM Partnership, because these take different forms (R&D, donations, preferential pricing and grants) and are provided trough separate GPPIs.

3.3 Monitoring and evaluation

There has been a thorough external evaluation of the RBM Partnership in 2002, commissioned by its founding partners. This evaluation concluded that there had been important achievements, but also signalled a number of problems in the functioning of the partnership, including a lack of accountability in the partnership and inconsistent technical advise to malaria-endemic countries. The recommendations of the evaluation team lead to organizational changes, such as the separation of the RBM Partnership Secretariat from the WHO's Malaria Department, as described before.[49] However, it seems that little attention has been paid to potential conflicts of interest of commercial partners. This is surprising, given the large business interests at stake for pharmaceutical companies that produce anti-malarial drugs. Perhaps the issue was overlooked because to a large extent the lobbying of pharmaceutical companies takes place outside the formal governance structure of the RBM Partnership.

Regarding the output and impact of the activities coordinated by the RBM Partnership, a monitoring framework for 2000-2005 is available.[50] It provides a broad set of indicators for progress towards the Abuja targets. These include target indicators such as the percentage of children under age 5 sleeping under ITNs, but also intermediate indicators such as the number of countries where education about malaria is integrated into the primary school curriculum. Some of the indicators apply to the national level and others to the global level. Monitoring information clearly indicates that the RBM Partnership is not on track to achieve the Abuja milestones.[51] Furthermore, the total disease burden of malaria is monitored by the WHO and shows an increase over the past years.[52] It can be concluded that the impact of the partnership, and especially its lack of progress, has been monitored well.

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[47] IPPPH website, http://www.ippph.org, accessed in September 2004.
[48] A. Attaran (19 August 2004). *Where did it all go wrong?* Nature, vol. 430, p932-3.
[49] D. Daniels e.a. (2002). *Final report of the external evaluation of RBM.*
[50] *The Abuja Declaration and Plan of Action.* http://www.rbm.who.int/docs/abuja_declaration_final.htm, accessed October 2004.
[51] 5th RBM Partnership Board Meeting, 29-30 March 2004, *Summary of proceedings.*
[52] A. Attaran (19 August 2004). *Where did it all go wrong?* Nature, vol. 430, p932-3.

3.4 Transparency

Minutes and summary reports of recent Board meetings, Board teleconferences, Steering Committee meetings and Working Group meetings are available on the website.[53] This applies to the composition of the RBM Board and Secretariat as well. Furthermore, the report of the 2002 external evaluation of RBM provides large amounts of information on the functioning of the Partnership. Only the Secretariat's Work plan and Budget for 2004-2005, which was adopted at the 5th Board Meeting in March 2004,[54] has not yet been publicly posted. The relatively high transparency about the governance of RBM contrasts with the lack of disclosure of agreements for other GPPIs linked to it, like NetMark Plus and WHO-Novartis Coartem. Hence, for outsiders it is not possible to assess the conditions that have been agreed and the implications of these conditions.

[53] RBM website, http://rbm.who.int/portal.html, accessed in September 2004.
[54] *Summary of Proceedings*. 5th RBM Partnership Board Meeting, 29-30 March 2004, New York.

4 Conclusions

On the positive side, the governance of Roll Back Malaria (RBM) Partnership has been thoroughly evaluated and restructured to make it more accountable and effective. In this respect it compares favourably to many other Global Public-Private Initiatives (GPPIs). However, potential conflicts of interests have not been receiving equal attention. The partnership policy and industry representation in the board are clearly inadequate to deal with the high business interests at stake.

Regarding the partnership policy, it might be somewhat inappropriate to call RBM a 'partnership' at all. Although the RBM Secretariat claims that there are more than 90 partners, it remains unclear who these partners are, and it seems that an official partners' list does not exist at all. Furthermore, although 'partners' may have to sign a statement about conflicts of interests, it is not clear whether or how companies are actually screened on business interests and joining RBM does not entail specific obligations or responsibilities. Hence, RBM is merely an organization that coordinates and supports the activities of many different actors involved in malaria programmes; whether these actors are called 'partners' becomes rather irrelevant.

It may be concluded that the main reasons to present RBM as a partnership are to raise attention for the disease, to put malaria programmes higher on the agenda of relevant organizations and to facilitate resource mobilization. In these areas the initiative has been relatively successful, although funds are still falling short.

The added value of RBM is in coordination, advocacy and resource mobilization. There have been some problems with coordination, though, such as inconsistencies in technical advise to malaria endemic countries, and pharmaceutical companies do not play a significant role in coordination. Apparently, the competitive market environment for malaria drugs prevents them from working together and providing a coordinated input into the RBM. As a consequence, the industry representation in the board can hardly represent the pharmaceutical sector. This limits its function to the representation of other relevant industries, such as mosquito nets and insecticide manufacturers, and of donor companies from unrelated sectors.

Furthermore, the supply of Artemisinin-based Combination Therapies (ACTs), a new and more effective type of malaria drugs, could not be raised to required levels through coordination of production. The proposed 'promise to buy' ACTs indicates that pharmaceutical companies are reluctant to make commitments to RBM and do not even assume the responsibility to supply sufficient quantities of new drugs. This contrasts with other GPPIs, in which the supply of sufficient quantities of drugs is a main role of the pharmaceutical industry.

The contributions of pharmaceutical companies can be mainly found at a lower level, through project-oriented partnerships such as the GlaxoSmithKline African Malaria Partnership (AMP), WHO-Novartis Coartem, the Medicines for Malaria Venture (MMV) and several others. Like other malaria programmes, these partnerships aim to contribute to the goals and strategies set by Roll Back Malaria. However, it is not clear how the role of pharmaceutical companies in these initiatives relates to their role in RBM. An analysis of the involvement of pharmaceutical companies in this type of partnerships goes beyond the scope of this report. Such an analysis would also be rather difficult because of the number of malaria-related partnerships and their diversity, and because the transparency of these partnerships generally tends to be much lower than that of RBM.

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