

Roll Back Malaria

Internal Review



Final Report

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LIST OF ABBREVIATIONS

AFDB	African Development Bank
AFRO	WHO Regional Office for Africa
AIM	African Initiative on Malaria
AMD	Africa Malaria Day
AMRO / PAHO	WHO Regional Office for the Americas
APW	Agreement for the Performance of Work
ARI	Acute Respiratory Infection
CAH	Child and Adolescent Health, WHO Cluster
CAT	Communications and Advocacy Team
CDC	Centers for Diseases Control
CDS	Communicable Diseases, WHO Cluster
CHD	
CIDA	Canadian International Development Agency
CRD	Research and Product Development for Communicable Diseases, WHO Cluster
COHRED	Council for Health Research and Development
CSR	Communicable Diseases Surveillance, WHO Cluster
DFID	(UK) Department for International Development
DG	Director General
DOMC	
EANMAT	East Africa Network for Monitoring Antimalarial Treatment
EDP	Essential Drugs Programme
EGP	External Relations and Governing Bodies, WHO Cluster
EHA	Emergency Humanitarian Action
EIP	Evidence and Information for Policy, WHO Cluster
EMC	
EMRO	WHO Regional Office for the Eastern Mediterranean
EPI	Expanded Programme on Immunisation
EURO	WHO Regional Office for Europe
FCH	Family and Community Health, WHO Cluster
FIRMA / FIRMAAction	Facility to Intensify Roll Back Malaria Action
FRESH	Focussing Resources on Effective School Health
GFATM	Global Fund to Fight AIDS, TB and Malaria
GMB	General Management, WHO Cluster
HED	
HIPC	Highly Indebted Poor Country
HQ	Headquarters
HRP	
HTP	Health Technology and Pharmaceuticals, WHO Cluster
IEC	Information Education and Communication
IPT	Intermittent Preventive Treatment
IDS	Integrated Disease Surveillance
IMCI	Integrated Management of Childhood Illness, WHO Cluster
IMF	International Monetary Fund
IMPAC	
ITN	Insecticide Treated Nets
JHU	Johns Hopkins University (Bloomberg School of Public Health)
JICA	Japan International Cooperation Agency
LSHTM	London School of Hygiene and Tropical Medicine
M&E	Monitoring and Evaluation

MIM-TDR	Multilateral Initiative on Malaria-Tropical Disease Research
MMV	Medicines for Malaria Venture
MPS	Making Pregnancy Safer
MSN/EXR	
MSN/PER	
MSF	Medecins Sans Frontieres
MTIMBA	Malaria Transmission Intensity & Morbidity and Mortality in Africa
MVI	
MOH	Ministry of Health
MOU	Memorandum's of Understanding
NGO	Non Governmental Organisation
NIH	(US) National Institutes of Health
NMH	Non Communicable Diseases and Mental Health, WHO
Cluster	
NPO	National Program Officer
POPS	Persistent Organic Pollutants
PRSP	Poverty Reduction Strategy Paper
PSAs	Public Service Announcements
RBM	Roll Back Malaria
R&D	Research and Development
RO	Regional Office
SDE	Sustainable Development and Healthy Environments, WHO Cluster
SEARO	WHO Regional Office for South-East Asia
SMT	WHO Social Mobilisation and Training Team
STB	Stop Tuberculosis
TDR	Tropical Disease Research
UN	United Nations
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USAID/OFDA	USAID Office of Foreign Disaster Assistance
USAID/G	USAID Global Bureau
WB	World Bank
WHO	World Health Organisation
WPRO	WHO Regional Office for the Western Pacific
WRs	WHO Representatives

Roll Back Malaria Internal Review Report

EXECUTIVE SUMMARY

Malaria causes 300-500 million cases of acute illness and more than a million deaths each year, placing a high economic and social burden on poor people in tropical and sub-tropical regions throughout the world. However, the burden of malaria is heaviest in Africa south of the Sahara which accounts for 90% of malaria mortality.

Roll Back Malaria (RBM) was launched in November 1998 to catalyse vigorous and innovative collaboration to halve the global burden of malaria by the year 2010. The RBM Partnership was founded by four international agencies¹ to build on the success of regional initiatives, such as the African Initiative on Malaria (AIM), and to respond to an international call for increased action against malaria. The WHO Director General established a Cabinet Project with two distinct but complementary roles: to serve as the RBM Secretariat, and to provide technical leadership within the RBM Partnership and technical support to WHO member states.

In the first thirty months the RBM Partnership grew rapidly and today comprises malaria endemic countries throughout the world and over 90 multilateral, bilateral, non-governmental and private sector organisations. The RBM Partnership has established an evidence-based approach to increase access to high quality cost effective interventions, whilst promoting operational research and the development of new tools to fight malaria.

Although it is too early to demonstrate changes in morbidity, mortality or economic burden, there is evidence that RBM is successfully fostering an environment that promotes the formation of effective partnerships focused on the achievement of common objectives and in which countries can establish policies and action to roll back malaria.

RBM now faces new opportunities and challenges including higher expectations from country partnerships in malaria endemic communities and ensuring smooth transition from advocacy to action against malaria. During this transition period the RBM Partnership undertook the Roll Back Malaria Internal Review (RBMIR) which focussed on the RBM Cabinet Project in WHO; and is the subject of this report. The RBMIR was structured to correspond to the logical framework established for the WHO Cabinet Project in 1999.² The goal, purpose and outputs of the RBM Cabinet Project in WHO are closely linked to the purpose and outputs of the RBM Partnership as a whole. The objectives of the internal review were to assess progress of the Cabinet Project toward achieving its outputs and fulfilling its purpose, to synthesise lessons learnt for the external evaluation of the RBM Partnership and to inform the re-organisation and strategic planning processes of the Cabinet Project.

The principal products of the RBMIR are an Institutional Analysis of the Cabinet Project in relation to its purpose, and a set of Output Studies linked to the outputs of the log-frame. In addition, several special studies, background papers, and meeting reports were generated. This report contains the key observations and findings from these studies and analyses.

¹ WHO, the World Bank, UNICEF and UNDP

² Correspondingly, the external evaluation is structured to address the log-frame for the RBM Partnership established at the same time.

RBM Progress and Status by Output

Communication and Advocacy efforts have succeeded in generating high-level awareness of malaria and successfully placed malaria on the global political agenda which led to the historic Abuja Summit on RBM in 2000, the recent UN General Assembly declaration of 2001–2010 as the Decade of Malaria, increased funding from foundations for vaccine development and malaria research and inclusion of malaria in the Global Fund to Fight AIDS, TB and Malaria (GFFATM). In addition, careful and strategic communications efforts have supported malaria control strategies to achieve success on issues such as DDT controversy and taxes and tariffs removal for net materials and insecticides. An RBM web site has been developed to allow information sharing on a global scale which links other malaria organisations, interested parties and foundations. Communications and advocacy materials have been designed and produced which are circulated widely to malaria workers on a global scale.

The RBM Communications and Advocacy Team (CAT) now needs to consider how it can support country level communications activities and help support a social movement. RBM should also redress inadequate communications capacity at regional and country level, build new working relations to achieve communications and advocacy objectives among RBM partners and enlist communications expertise from the private sector and through outsourcing. The CAT needs to collaborate with other global initiatives and programmes to develop communications materials and activities at country level, maintain existing activities promoting a global image for RBM and become a leader in use of novel and effective approaches for increasing demand at community level for malaria action

RBM Partnership activities have been successful in engaging a wide range of partners at all levels including the private sector. In addition, resource mobilisation has enhanced partners' support from USAID, Asia Development Bank, JICA and World Bank in the regions. RBM Partners with international structures do not, however, appear to be equally committed to rolling back malaria at all levels. Although there is involvement of both voluntary and private sectors in the RBM Partnership, there is a need for more proactive engagement of NGOs and the business community. Examples of partners' involvement include: UNICEF's specialist procurement office for insecticide treated nets; 13 countries have waived taxes and tariffs on raw materials and nets; incorporation of malaria control into decentralisation and Sector Wide Approaches (SWAs), Integrated Management of Childhood Illness (IMCI) and reproductive health programmes and in Heavily Indebted Poor Countries (HIPC) and Poverty Reduction Strategy Paper (PRSP) initiatives.

At regional level the RBM movement is well established, and works through cross border alliances managing common epidemiological problems such as drug resistance. Regional Technical Support Networks, e.g. in Southeast Asia have been established to address operational issues on drug resistance and policies, surveillance and epidemic preparedness and response. There is a need now to define and strengthen the regional role of WHO and partners to adequately support countries in partnership development and maintenance. The regional role of linking partnerships to the global level needs further clarification.

Country Partnerships to roll back malaria have developed and broadened in many countries with structured involvement of multilateral and bilateral partners, other government sectors, non-government organisations, the research community, and increasing involvement of the private sector in the RBM process. These partnerships are being supported by the development of Country Strategic Plans (CSPs). Ten countries have completed their strategic plans, which have been endorsed by all local partners and have received pledges from

government and country health partners covering on average 26% of the required budget. As the focus of RBM moves to country action, further broadening of involvement of partners at country level is needed. RBM Action at country level has been slow in some countries, and a temporary RBM catalyst could facilitate the formation of an effective RBM Partnership by assisting governments in convening and leading RBM partnership.

A key challenge has been how to convert 'loose ties' into commitment and responsibility for country action; it has become important that the original concept of 'loose ties' is reviewed and partnership roles and responsibilities are clearly articulated and agreed where necessary. More regular communication among core partners is required to keep partners adequately informed and meetings of core partners twice a year have been suggested.

Capacity Development: The RBM Cabinet Project has taken a lead in producing a capacity development strategy for RBM, working with a wide range of partners. This strategy covers not only skills development through training, but also improving the enabling environment so that skills can be used. WHO training materials are widely disseminated. There are examples of more innovative approaches to training, more harmonisation with other programmes, and a better recognition of the need for managerial, advocacy, partnership building and other skills alongside technical skills. Many country plans now place a greater emphasis on human resource development as a key to scaling up.

The strategy now needs to be given appropriate priority within WHO. Resources need to be mobilised to cover strengthening of human resource and institutional systems and to broaden out training. The specific roles and responsibilities of WHO and other partners need to be defined. Some more work is needed to identify capacity gaps in individual countries in order to support more comprehensive capacity development planning and implementation at country level. Improvements are needed in the planning and handling of consultancy assignments to better match country needs. There are considerable opportunities to work with new or existing capacity building programmes in order to move all this forward.

Technical Support's two components are appropriate technical strategies and effective means to provide high quality support leading to capacity development. The scaling up of RBM has led to increased demand for technical support by countries and other partners.

WHO has made good progress in prioritising the most effective interventions for malaria control and strategies for delivering these interventions (systems strengthening). In particular drug policy issues have been given prominence, and dialogue has broadened beyond choice of drug to cost and systems considerations. Collaboration with Integrated Management of Childhood Illness in Africa has been successful. There are still technical areas where more evidence is needed to ensure consensus, and RBM needs to ensure access to evidence which will avoid conflicting messages. More work is needed to harmonise support for the newer elements of RBM (partnership, advocacy, resource mobilisation etc.) with traditional technical support.

WHO needs to work more closely with all agencies providing technical advice on malaria to improve co-ordination and ensure technical consensus. The RBM concept of Technical Support Networks was insufficiently communicated and supported, and needs reconsidering, but other networks of support not always led by WHO and often locally based, have proved promising, and could be replicated. Strategies to draw on technical strengths of other partners are needed. It will be important to assure the mix of technical support responds to country needs as they change, and to develop a strategy to source expertise in the newer elements of RBM. A priority is to place stronger emphasis on capacity development in technical support.

Research and Use of Evidence has been given high priority as an essential and integral component of rolling back malaria. RBM has introduced a stronger element of evidence-based culture by linking research and malaria control at the global, regional and country levels through involvement of both communities. High priority research activities, such as combination therapy trials and Medicines for Malaria Venture have been launched with good collaboration with TDR. Global investments for malaria research and development have increased significantly since the launch of RBM.

RBM has been associated with an increased emphasis on research related to field operations and delivery of interventions, and is supporting operational research by malaria programmes. RBM has been a pathfinder in strongly influencing and refocusing the TDR strategy to include implementation research, linking research and control at global and country levels. Health systems, social and economic research has received increased emphasis, but still needs greater support and encouragement from RBM. RBM needs to articulate more clearly its list of high priority operational research areas for malaria control.

The R&D effort mounted so far by the RBM Secretariat needs to be enhanced and sustained. The organisational restructuring of the RBM Secretariat, in which research and development are no longer covered by a 'team', aims to link R&D more closely to the technical strategies and outputs of RBM. There are however, several generic or 'cross cutting' aspects of R&D which need to be nurtured.

Monitoring and Evaluation activities have included the development of the "Global Framework for Monitoring Progress and Evaluating Outcomes and Impact" which was accepted by all the RBM partners and widely disseminated at regional and country levels. A methodological guide is almost complete. Collection and analysis of baseline data have started and sixteen countries from the AFRO region have completed the baseline.

At regional level indicators are being modified to enhance inter-country collaboration and to share the data between countries, efforts are being made to improve the quality of data, operational data such as coverage of vector control are being compiled, and use of Geographical Information System (GIS) is ongoing. Mapping of the global malaria situation is being done through good collaboration with the Health Mapping team at CSR, and the M&E team participates in the development of the Global Atlas.

An institutional framework for M&E is needed that links WHO/Regions, other clusters, partners and RBM Secretariat to avoid duplication of data collection efforts. Further clarification and consensus are needed on case definition, global indicators, means for regularly monitoring process indicators, staffing at regional level and assigning responsibilities for and support to M&E at country level. Rules for notification of malaria epidemics are yet to be designed. Development of an accurate epidemiological baseline is essential to measure progress of RBM. While efforts to tap into various population-based data sources are underway, much more work is needed.

Resource mobilisation and administration: During the implementation stage in countries, RBM is beginning to identify funding sources and develop a workplan for building resource mobilisation and financial management capacity in countries. "Seed-corn" funding provided to countries through the RBM Cabinet Project have proven useful and necessary, but certainly not sufficient. Resource mobilisation would be further facilitated through better coordination with country planning cycles. Focus on malaria within PRSPs has been successful in some countries, newer opportunities through the Global Fund are being fully explored and a channel for private sector resources has been created.

While resource mobilisation efforts have been effective at meeting the immediate resource needs of the secretariat and regions, they have not succeeded in broadening the donor base for the secretariat and convincing funding partners to increase their contribution to the level required. Suggestions for improving the effectiveness and sustainability of the RBM Secretariat include: strengthening the capacity of the secretariat; greater clarity on its role within the broader partnership related to resource mobilisation and management, and improving planning and management procedures at all levels of WHO to reflect RBM priorities. RBM needs to develop a joint resource mobilisation strategy among global partners, using the relative advantages of each, to address five elements: support for country action, support for related health system development and research, RBM partner core functions, WHO core functions and RBM secretariat functions. This strategy needs to be clearly communicated to countries and to use monitoring and evaluation information for reporting, advocacy and resource mobilisation.

At this stage when expectations for country action are growing, some founding partners need to engage in more resource mobilisation for RBM. This should be supported by a full analysis of total resource needs for RBM to achieve its goals. The World Bank/IMF led HIPC initiative has the potential to provide debt relief to many more countries, providing considerable opportunity to address malaria as a poverty issue as seen in Cameroon, Tanzania and Uganda where poverty reduction strategies have brought additional resources for malaria³. Joint missions between global partners will help enable RBM plans.

If the RBM Secretariat is to be successful and sustainable, it needs to aggressively market itself as the best facilitation mechanism available to combat malaria. RBM also needs to focus on mobilising local resources, rather than establishing grants through WHO and examine links with similar partnership programmes (e.g. Stop TB, Polio).

Institutional Issues

The analysis examined how the current institutional arrangements for RBM within WHO fit with WHO's dual roles - as the RBM secretariat and as one partner.

New institutional arrangements for malaria within WHO HQ and the Regional Offices have brought in a wider range of skills. A good start was made on fostering a 'one-WHO' approach to a disease-oriented programme. However the HQ-wide forum originally set up for this no longer meets. Good examples of collaboration on specific issues (e.g. with IMCI) are seen at all levels but they tend to be ad hoc rather than strategic. Reinstatement of the forum is recommended.

A clear achievement in terms of initiating partnerships, the strategy of 'loose ties' has however led to confusion within WHO and among partners about roles and lines of accountability. This has not been helped by changes in leadership and other staff, which have caused some drift in vision and objectives. More formal partnership arrangements are recommended for specific key deliverables in the next stage of RBM with its shifted emphasis towards country action. As part of this, WHO's and other partners' plans for country support should be harmonised with country planning processes and parallel developments in the health sector. As one partner, while its technical role is distinct, WHO's roles in resource mobilisation and funding need to be clear and clearly communicated. This may require a reconsideration of staffing and skills mix at different levels of the WHO, and in particular the Cabinet Project needs to work closely with ongoing work on strengthening country offices. Country Action requires regional support, so all WHO Regional Offices need greater capacity

³ Jane Edmondson (Malaria Consortium) Malaria and Poverty: Opportunities to address malaria through debt relief and poverty reduction strategies. Background Paper for the fourth RBM Global Partners Meeting, 2001

to establish, maintain or reinforce links with regional level RBM partners and effectively address country needs for technical and other support. The specific mix of skills required by the RBM Regional Offices may differ from one region to another.

The RBM Partnership requires a secretariat, and WHO is considered the appropriate host institution. This role needs explicit support of Cabinet and the Director General to sustain the same path-finding spirit of innovation and risk taking which marked the start up phase of RBM. It is recommended that the WHO's secretariat role remain distinct from WHO internal structures and be clearly accountable to the global partnership.

1. INTRODUCTION

Roll Back Malaria (RBM) was launched in November 1998 to catalyse vigorous and innovative collaboration to halve the global burden of malaria by the year 2010. The **RBM Partnership** was founded by four international agencies⁴ to build on the success of regional initiatives, such as the African Initiative on Malaria (AIM), and to respond to an international call for increased action against malaria. The RBM Partnership grew rapidly and today comprises malaria endemic countries throughout the world and over 90 multilateral, bilateral, non-governmental and private sector organisations. It was agreed at the outset that the World Health Organisation (WHO) would serve as the secretariat for the RBM Partnership. The WHO Director General thereby established a **Cabinet Project** with two distinct but complementary roles:

- to serve as the **RBM Secretariat**, and;
- to provide technical leadership within the RBM partnership and technical support to WHO member states. This is sometimes referred to as the **WHO normative role**.

In the first thirty months of the project, the RBM Partnership was setting the stage for a massive scale up of action against malaria. RBM has established an evidence-based approach to malaria control which aims to increase access to high quality cost effective interventions, whilst promoting operational research and the development of new tools to fight malaria. RBM partners have worked hard to raise public awareness about malaria, secure political commitment from the highest levels of government and leverage practical regulatory and policy reforms in order to establish an enabling environment for RBM action. RBM, working closely with economists and research institutions, has also established the causal relationship between malaria, poverty and economic development and the centrality of “the malaria problem” in both the formal and informal health sectors, particularly in Africa.

The stage has now been set and many malaria endemic country governments and their local partners have developed Country Strategic Plans (CSPs) to roll back malaria. RBM country partnerships are poised to depart from “business as usual” and take the first truly innovative steps forward, however most countries are constrained by the lack of adequate resources to support their efforts. Country partners have pledged resources to support CSPs, but to date these do not come close to meeting the estimated resource gaps, which are projected only for the short term and are based on current health system constraints, and an incremental rather than order of magnitude approach to scaling up.

Today RBM is at a transition point and faces a new and urgent set of challenges including high expectations from RBM country partnerships and people living in malaria endemic communities. With malaria high on the international agenda, there is a greater breadth of opportunity available to support RBM and, subsequently to facilitate a smooth transition from advocacy to action against malaria. Therefore, it is both timely and necessary for the RBM Partnership to undertake an assessment of its progress, its successes and failures, and new opportunities and potential risks as part of a forward planning process. The RBM Secretariat in WHO has initiated this process with an internal review. **The Roll Back Malaria Internal Review (RBMIR)** had a special focus on the RBM Cabinet Project in WHO and is the subject of this report. The next phase of the forward planning process will be an external evaluation of RBM with a broader focus on the RBM Partnership. This report is intended to provoke and support dialogue among RBM partners about the way forward as well as facilitate the work of the RBM external evaluation team.

⁴ The RBM founding partners are the WHO, the World Bank, UNICEF and UNDP

2. THE MALARIA SITUATION

Malaria was the major infectious disease problem of the 20th century. During the first half of the century it caused at least one hundred million deaths. Although eradication campaigns had a sustainable impact on malaria in some regions before they were discontinued⁵, there remains a large unresolved burden of the disease at the beginning of the 21st century, particularly in Africa. At present, malaria causes 300-500 million cases of acute illness and probably more than a million deaths each year, in tropical and sub-tropical regions of most continents.

The collective contribution of malaria, through disease and death, to the global disease burden is highly significant. It accounted for 39.3 million Disability Adjusted Life Years lost (in 1998), ranking 8th among the leading causes of ill health and 11th among the leading causes of death, placing a high economic and social burden on poor peoples. Primarily, and very importantly, malaria affects impoverished, disadvantaged communities - 58% of all malarial deaths are concentrated in the world's poorest 20%, the highest association of any disease category with poverty.

A high economic burden is also placed on countries because of malaria, not only in terms of the short term direct and indirect cost to households and societies⁶, but also in terms of countries' potential for economic growth and development. Economists estimate that the "malaria growth penalty" may be as high as 1.3 per cent per annum in African countries south of the Sahara. The cumulative impact of this growth penalty is staggering: malaria keeps poor countries poor and contributes to an ever widening gap in prosperity between the malaria endemic and the malaria free world.

Almost three years after RBM's founding, the global malaria situation continues to deteriorate. As countries have been preparing to roll back malaria, the disease burden has increased. Observed trends of increasing mortality and morbidity from malaria have continued, so far unaffected by RBM advocacy, planning and resource mobilisation. *There are of course examples of real progress being made in communities and districts, but these will remain isolated examples of what RBM might achieve if implementation and scaling up are not adequately supported throughout the Decade to Roll Back Malaria.*

3. THE ROLL BACK MALARIA INTERNAL REVIEW (RBMIR)

The RBMIR was conducted under the authority of the **RBM Project Manager** in order to: inform a proposed re-organisation of the RBM Cabinet Project; provide insight into the need for and direction of "mid-course" corrections in the work of the Cabinet Project and, to prepare for an external evaluation⁷. Management responsibility for the RBMIR was assigned to the Senior Policy Advisor, WHO/RBM/HQ who worked closely with WHO/RBM/HQ output team leaders, Regional Malaria Advisors (RMAs) and designated focal points in the WHO Regional Office for Africa (AFRO). The Terms of Reference (TOR) for the internal

⁵ Malaria eradication campaigns were discontinued when drug and insecticide resistance combined with poor infrastructure and high recurrent costs rendered their objectives untenable and the campaigns unsustainable.

⁶ 0.6-6% of the gross domestic product (GDP) of poor African countries is spent on malaria, while estimated productivity losses through premature mortality and days of work lost to illness amount to at least a further 1% of GDP

⁷ RBM Partners agreed to co-ordinate evaluation requirements within a single exercise. It was agreed that this would be more comprehensive and less time consuming than a series of evaluations linked to specific financial inputs. Both DFID and the World Bank are bound by policy to conduct evaluations of their support to the RBM Cabinet Project in 2001/2002.

review are included in Appendix 1. All aspects of the review was managed by WHO staff with support from the Malaria Consortium, independent consultants, and a temporary advisor from the Johns Hopkins University, Bloomberg School of Public Health.

The RBMIR was structured to correspond to the logical framework (log-frame) established for the WHO Cabinet Project in 1999.⁸ The purpose of the internal review was to assess the progress of the Cabinet Project toward achieving its outputs and fulfilling its purpose. Additionally, the RBMIR was intended to *synthesise* progress and lessons learnt for the external evaluation of the RBM Partnership and to inform the re-organisation and strategic planning processes of the Cabinet Project. It is important to note that the goal, purpose and outputs of the RBM Cabinet Project in WHO are very closely linked to the purpose and outputs of the RBM Partnership as a whole. In fact, the goal of the Cabinet Project and the purpose of the RBM Partnership are identical. A table summarising the RBM Cabinet Project and RBM Partnership log-frames is presented below to illustrate this linkage (Table 1).

Table 1: RBM Partnership and Cabinet Project Goal, Purpose and Outputs (June 1999)

	Partnership logframe	Cabinet Project logframe
Goal	A significant reduction in the global burden of disease associated with malaria	<i>(Same as Purpose statement of Partnership Logframe)</i>
Purpose	To create an environment in which countries can establish policies and action to Roll Back Malaria, which are effective, sustainable and respond well to the local context.	Optimise the impact of the Global Partnership to Roll Back Malaria and ensure the effectiveness of WHO and associated bodies in that partnership
Outputs		
Summary ↓		
A. Strategy within health sector development + advocacy	2. A sustained, effective advocacy campaign that functions on global, regional and country level and services country level needs*	1. WHO-wide RBM strategy – with its emphasis on Roll Back Malaria functioning within, and contributing to, Health Sector Development – is used at all levels within WHO, and is used as the basis for a consistent, effective response.
B. Partnership	4. RBM Global Partnership functioning and effective at country, regional and global levels.	2. Global Partnership functioning at all levels, around agreed strategies, to maximise effectiveness of rolling back malaria in countries.
C. Country action – capacity development/technical support	3. Countries undertake effective intensified action to roll back malaria through intersectoral and health sector development efforts 5. Appropriate technical support accessible to countries through mechanisms that help develop capacity and enable countries to address technical and operational challenges of rolling back malaria.	3. More effective WHO support to country action
D. Research and use of evidence	6. New policies, strategies, methods and tools for rolling back malaria designed through research and development, and deployed in countries	4. Research Agenda that responds to country-level needs
E. Community and societal movements	1. Community action to roll back malaria sustained through societal movements for better health, fostered and supported by the RBM Global Partnerships functioning at country level	5. WHO works with partners and countries to support community action to roll back malaria through societal movements for better health (<i>health sector</i>)

⁸ Correspondingly, the external evaluation is structured to correspond to the log-frame for the RBM Partnership established at the same time.

F. Monitoring and evaluation	7. Information base, monitoring systems and procedures for progress review developed and strengthened	6. Systems for monitoring and tracking global and national-level progress with Rolling Back Malaria operational
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* Output numbers refer to original order. They are re-ordered to link across log-frames

The principle products of the RBMIR include an **Institutional Analysis (IA)** of the Cabinet Project in relationship to its purpose, and a set of **Output Studies (OS)** linked to the outputs of the log-frame. In addition, several **special studies and background papers (BP)**, and **meeting reports (MR)** were generated to inform the IA and OS. This report contains the key observations and findings from these studies and analyses.

Products of the RBM Internal Review

Institutional Analysis (IA)		Output Studies (OS)	
		OS1	Communications and Advocacy
		OS2	RBM Partnerships
		OS3	Capacity Development and Technical Support
		OS4	Research and Use of Evidence
		OS5	Monitoring and Evaluation
		OS6	Resource Mobilisation and Administration.
Special Studies and Background Papers (BP)		Meeting Reports (MR)	
BP1	a. RBM Web Information Network Internal Review Report	MR1	WHO/RBM/AFRO-HQ Joint Planning and Country Progress Review, Harare, July 2001.
	b. Development of the Web Information Network		
BP2	Elements in Country Planning Process of Malaria Control Before and After RBM	MR2	Consultation with WHO Directors and Co-ordinators “one WHO”, Geneva, September 10, 2001.
BP3	Country Case Study: Mali	MR3	RBM/WHO Internal Retreat, Geneva, September 10-12, 2001.
BP4	Technical Support Networks	MR4	RBM-IMCI Task Force Meeting, Harare, September 2001.
BP5	Country Perspectives: Synthesis of Key Informant Interviews from 14 Malaria Endemic Countries in Africa	MR5	Partner Consultation: RBM in a changing environment, Harare, September 2001.
BP6	WHO/RBM/AFRO Analysis of Country Questionnaires	MR6	RBMIR Wrap-up: Review and synthesis of findings, Harare, October 2001.
BP7	WHO/RBM/HQ Staffing and Human Resource Analysis		

3.1 Methods

WHO/RBM/HQ staff formed “output teams” and took primary responsibility for developing the Terms of Reference and conducting the data collection and analysis for each OS. The IA

was developed and undertaken by the internal review core team through support from the Malaria Consortium. A detailed description of the methodology for each OS and the IA can be found in the RBMIR Terms of Reference, Appendix 1, attachments A-H.

Although there were some differences between studies, there was considerable overlap in the proposed methods, questions and data collection opportunities, resulting in a need for a high level of co-ordination and the development of common approaches and tools. Each team used the Cabinet project log-frame to identify the key questions they wished to address through the internal review process. They then established lists of key documents, key informants and potential data collection opportunities during the internal review period (July-September, 2001). Data collection tools such as questionnaires, surveys and interview guidelines were developed, jointly reviewed and harmonised to reduce redundancy and to streamline data collection.

An effort was made to ensure that representatives of all groups of RBM stakeholders were consulted during the RBMIR or had an opportunity to provide comments and suggestions for consideration by the output and internal review core teams through a variety of mechanisms. RBM stakeholder groups included WHO/RBM staff in Geneva, Regional and sub-Regional Offices, other departments and clusters in WHO, RBM founding partners, other RBM partners⁹, and programme implementers from malaria endemic countries. An RBM Internal Review forum was established on the RBM web information network and an invitation was sent to all subscribers to provide comments. In addition targeted surveys were conducted via e-mail by several output teams. Although useful data was collected via the web, the main sources of information to support the OS and IA were document reviews, presentations/discussion at RBMIR events, telephone surveys and structured key informant interviews with individuals or small groups. The key informant interviews, conducted in person whenever possible, were particularly valuable in obtaining information and opinions from a wide array of RBM partners. A list of key informant interviews is included in Appendix 2 of this report.

3.2 Constraints

Although the RBM Secretariat is satisfied with the results of the RBMIR, it is important to note that the review was conducted under several constraints and that a number of planned activities were cancelled.

The timing of the internal review unfortunately coincided with a period during which many WHO and other UN staff traditionally take home and annual leave. As a result, most meetings, consultations and key informant interviews were conducted over a relatively short interval in September, 2001. *For all regions except the African Region (AFRO), consultation with Regional Malaria Advisors and their teams was limited to the Consultation with Directors and Co-ordinators on “one WHO”, the RBM/WHO Internal Retreat and telephone, video and e-mail interactions.* As a result, there is a somewhat greater focus on RBM in the Africa region.

Joint country visits planned for August and September were postponed due to either logistic difficulties or scheduling conflicts among the RBM partners involved. As a result, information from countries is based on document review –particularly Country Strategic Plans (CSPs), surveys, one country case study and key informant interviews conducted in

⁹ “Other” RBM partners included bilateral development agencies such as USAID and DFID, Regional Development Banks (AfDB), research institutions, NGOs and the private corporate sector.

Harare during the Africa Regional RBM-IMCI Task Force near the end of the RBMIR exercise¹⁰. Furthermore, the postponement of country visits limited the RBMIR in its ability to assess country level partnership structures/mechanisms and the opinions of RBM country level partners and stakeholders, including WHO country based staff..

Consultations planned with RBM partners at the international level and the regional level were cancelled or restructured. A one-day consultation with international RBM Partners, scheduled for 13 September, 2001 in Geneva, was cancelled when the event to which it was linked was postponed. Additionally, the agenda of a consultation with RBM regional partners, scheduled for 28 September in Harare to follow the RBM-IMCI Task Force Meeting, was altered due to the limited participation of regionally active partners based in North America and Europe, many of whom could not travel due to temporary travel restrictions. As a result, the RBMIR increased the use and number of telephone surveys and key informant interviews to ensure adequate consultation.

4. RESULTS: RBM PROGRESS AND STATUS BY OUTPUT

In this section, the key findings of each Output Study (OS) are presented in terms of 1) achievements, 2) issues, constraints and missed opportunities, and 3) future priorities and proposed solutions. A detailed presentation of each OS is available in a corresponding annex as follows:

OS1	Communications and Advocacy	Annex A
OS2	RBM Partnerships	Annex B
OS3	Capacity Development and Technical Support	Annex C
OS4	Research and Use of Evidence	Annex D
OS5	Monitoring and Evaluation	Annex E
OS6	Resource Mobilisation and Administration.	Annex F

4.1 Communications and Advocacy

Achievements

The review of activities and responses from a wide range of informants confirm that the Communications and Advocacy Team (CAT) has succeeded in generating high-level awareness of malaria and has successfully placed malaria on the global political agenda. RBM communications and advocacy initiatives drew the attention of African leaders resulting in the historic Abuja Summit on RBM in 2000, the first meeting of Heads of State to focus on a single health issue. The Abuja Summit resulted in a pragmatic list of goals that formed the foundation for real action to address the burden of malaria. The recent UN General Assembly declaration of 2001 –2010 as the Decade of Malaria reinforces the global commitment to reducing the burden in line with RBM goals. This increased awareness also contributed to creating an environment in which donations from foundations, such as Bill and Melinda Gates Foundation, increased funding for vaccine development and malaria research and inclusion of malaria in the Global Fund to Fight AIDS, TB and Malaria (GFFATM). In addition, careful and strategic communications efforts have supported malaria control strategies to achieve success on issues such as DDT controversy, taxes and tariffs removal for net materials and insecticides.

¹⁰ Key informant interviews (KII) were conducted with 14 country delegations to the RBM-IMCI Task Force Meeting. This included 7 anglophone, 6 francophone and 1 luzophone country.

An RBM web site has been developed to allow information sharing on a global scale which links other malaria organisations and interested parties and foundations to a growing information repository. Communications and advocacy materials have been designed and produced which are circulated widely to malaria workers on a global scale.

Issues and Constraints

The RBMIR provided the CAT an opportunity to identify and openly discuss the issues and constraints that it faced during the first thirty months of the RBM Project. These issues and constraints were summarised both in OS1 and during the RBMIR Wrap-up Meeting in Harare on 2-3, October 2001.

Since the establishment of RBM CAT has demonstrated considerable flexibility with activities defined by a rapidly changing set of demands and opportunities. This established an effective working culture within RBM which was primarily reactive and adaptive to a shifting focus. Unfortunately this, and a lack of information sharing within the RBM team, worked perhaps to the detriment of proactive and strategic planning and the establishment of a consistent set of messages.

Team structure, supervision, staff turnover and morale in the Geneva-based CAT have all been effected by institutional and management changes during the first two and a half years of Roll Back Malaria. A staff analysis conducted as a background paper demonstrates a marked lack of consistency in staffing pattern and skills mix over time.

The balance of RBM's two separate mandates under this output (global advocacy vs development of a community level social movement) has favoured the former. Although the focus on global advocacy in the first few years was necessary, more attention to communications support at the local and national level is required. While maintaining the global advocacy effort, the RBM CAT will now redirect its efforts to nurturing and supporting a societal or social movement.

However, RBM CAT also needs to consider how far it can support and/or implement country level communications activities. It also needs to consider how best to work with regions and countries; how to redress the widely acknowledged constraint of inadequate communications capacity at regional and country level; and build new working relations with the communications and advocacy staff of other RBM Partners and enlist communications expertise from the private sector. Given the increasing demands on CAT and the RBM Partnership to support communications at all levels, "outsourcing" support and building strong and effective communications partnerships will be essential to carry out diverse mandates.

Finally, although RBM Web Information Network (WIN) is up and running and houses a comprehensive library of RBM and related documents, it was found to be under-utilised by target audiences and several technical/function and content issues were identified for consideration during the internal review. In addition, the significant costs and human resources associated with the development of the web site were brought under scrutiny and its ongoing maintenance and management reviewed.

Actions and Solutions

In the first years, a key objective of RBM was to secure political commitment and mobilise resources to support a global effort to tackle malaria. CAT has played an intrinsic role in achieving this objective. A review of CAT's activities over the last two years, its successes and its challenges will help determine how CAT can best help sustain the momentum in the

future, while focusing on communications for behaviour change and advocacy for a social movement to roll back malaria.

Already there is evidence that the mandate of CAT has been appropriately expanded within the Cabinet Project. This is reflected in the terms of reference of the new team leader, which require a focus on social mobilisation and the development of messages and mechanisms to effect behavioural change in support of RBM's overall goal.

The RBM internal review suggests the following future functions for RBM Communications & Advocacy Team:

- to focus the communications strategy towards strengthening country level activities to Roll Back Malaria and supporting a societal movement
- to maintain RBM momentum at global level to strengthen and broaden partnerships; and encourage commitment and investment

This requires that the CAT identify communications needs with countries, regions and partners in order to be able to formulate a clear communications strategy for the medium and long-term (next two to eight years) which is collaborative, pro-active, responsive and fully exploits the comparative communications advantage of RBM partners. Improved information sharing within the broader RBM team and the regions will facilitate this.

The communications strategy should:

- Assist in building communications capacity at regional level including web site capacity and usage.
- Collaborate and work with other global initiatives and programmes such as IMCI, FRESH, Safe Motherhood, Reproductive Health ,HIV/AIDS and EPI and other partners to develop communications materials and activities at country level . Within CDS links with other vector borne disease control programmes and TDR should be explored.
- Examine role of strong media outreach.
- Separate two functions of communications team - technical materials development and proactive communications support; and contract out for publication.
- Develop the potential of the web site as a creative tool to enhance advocacy and awareness of malaria at all levels and especially at regional and country level where internet capacity is growing.
- Compile existing proven and effective community mobilisation strategies and share lessons learnt with countries and partners i.e. via guidelines and via web site.
- Maintain existing activities promoting a global image for RBM, focussing on country achievement, trends in disease, new opportunities etc, with an aim to create a northern environment supportive of further investment in RBM.
- Become a leader in use of novel and effective approaches for increasing demand at community level for malaria action and help support a social movement.

CAT also needs to rationalise its functions to implement a comprehensive RBM communications strategy and respond adequately to a demanding role as an information resource on malaria within WHO. CAT will need to strengthen its team by building an appropriate mix of communication skills and improve its planning and response to new developments and changes in the malaria environment. Finally, plans to reform aspects of the web site and RBM WIN are currently underway and a number of issues have already been addressed, notably:

- Rationalisation of RBM WIN technical support: two personnel have new TORs which combine the duties and skills of the previous four person WEB Team.
- The RBM WIN and associated personnel are now part of the Communications and Advocacy Team (RBM WIN formerly under SMT).
- New Advocacy module developed to enhance WIN as advocacy and education tool and broaden user base.
- Plans to develop intranet and extra-net capacity of web site to improve free discussion and debate between country and global partners and encourage information sharing and publication.
- Increasing Regional use of the WIN and making it more technically appropriate for improving Regional and Country communications are prioritised in the 2002-3 Work plans.

4.2 RBM Partnerships

Achievements

RBM has been successful in engaging a wide range of partners at all levels including the private sector. There is strong political, high level commitment to roll back malaria in many countries, particularly in Africa. This has been achieved because of the emphasis that RBM places on 'partnerships'.

Since the start of the Cabinet Project, a series of four global partners meetings have been convened; *with significance for partnership development*. Each of these global partners meetings have furthered the concept of partnerships while at the same time provided it with fresh impetus. The 1st Global Partners Meeting helped to consolidate support for rolling back malaria; the 2nd meeting aimed for consensus between partners.

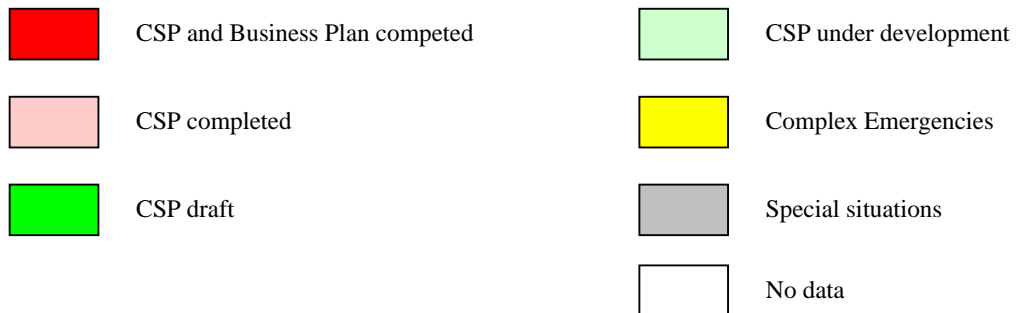
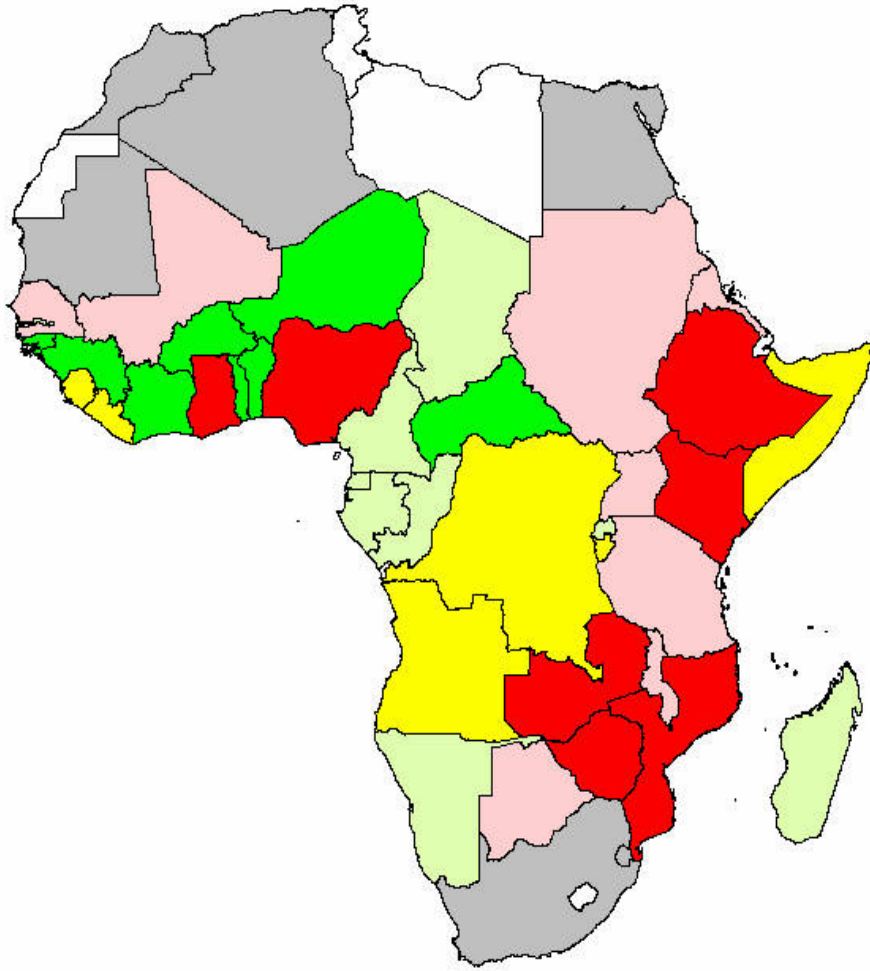
In February 2000, the 3rd Global Partners Meeting reached agreement on implementation arrangements and resolved to develop concerted interagency work plans by building on comparative advantages of different agencies. The meeting also reached consensus that country partnerships are the foundation for implementing RBM action in malaria endemic countries.

Working links have been established with the private sector and other partners. So far, the globally active corporate sector has been mainly engaged. An attempt is also being made to clarify and strengthen the role of private sector retail distribution channels.

RBM has also provided the building blocks for improving utilisation of existing resources; thus increasing efficiency. RBM promotes outcome, rather than input-oriented implementation plans at country level and stimulates the creation of partner and financial management mechanisms. *RBM strengthens health systems by using CSPs to promote IMCI and Reproductive Health Service delivery channels, by promoting CBO such as community nurses.*

Country partnerships are being supported by the development of Country Strategic Plans (CSPs). Fifteen countries have completed their strategic plans (see Map 1). These plans have been endorsed by all local partners and have received pledges from government and country health partners covering on average 26% of the required budget. The partnerships have played an important role in developing more comprehensive plans as part of broader health sector plans.

Map 1: Development of Country Strategic Plans



The current ongoing process of translating CSPs into output oriented work plans and consequent management of partners and financial resources will require a more formal arrangement, similar to ICCs for GAVI or SWAps/HIPC groups, to define partnerships in practice. RBM, therefore, does not just use existing systems.

The involvement of partners in RBM and the success of partnerships is significant for the long-term; this is evidenced through the following examples:

- UNICEF has set-up a specialist procurement office for insecticide treated nets.
- 13 countries have waived taxes and tariffs on raw materials and nets; again contributing to creating an enabling environment.
- In 1998, malaria partners were sceptical about decentralisation and SWAps. In 2001, they often support each other.
- In 1998, IMCI was seen as a “threat” to NMCP; today it is a major RBM delivery channel.
- In 1998, reproductive health services were not part of most NMCP action plans; today malaria in pregnancy is at the forefront.
- In 1998, ITNs were not part of NMCP plans of action in a large number of countries in southern Africa. Today the effectiveness of various ITN delivery channels (public, private, subsidised, free market) is on the agenda.

Examples of partnership building with the regions include working closely with and in support of AFRO:

- Organisation of inter-country meetings - attended by all malaria-affected countries in the period March to April 1999.
- Sponsor of, and TA to, in-country consensus processes (country updates)
- Expanding in-country technical capacity (NPO)
- Initiating a capacity development process to accompany the implementation phase for more effective management performance.
- Sponsored and provided TA to in-country planning processes (country updates)

In other regions, e.g South East Asia and Western Pacific, the RBM movement is well established and works through cross border alliances managing common epidemiological problems such as drug resistance. The RBM movement has facilitated the co-ordination of a wide range of partners towards the common goal of reducing the malaria burden through strengthened health services for the people at highest risk of malaria. In addition to international and bilateral OECD country assistance, the work of partners is complemented by that of many NGOs who support the health sector mainly at province and district levels as well as by training and research activities carried out by inter-country organisations such as ACTMalaria (Asian Collaborative Training Network for Malaria), Southeast Asian Ministers of Education Organisation-Tropical Medicine Programme (SEAMEO-TROPMED) and the Wellcome Trust. In these regions significant public-private distribution partnerships have contributed to enhancing equitable access to interventions.

The Regional Technical Support Networks with national chapters were established in South East Asia to address technical and operational issues on:

- drug resistance and policies,
- surveillance, information management and epidemic preparedness and response,
- transmission risk reduction.

Major progress was made in improving case management and in combating drug resistance by

- helping countries develop and implement informed drug policy,
- deployment of pre-packaged drugs,
- use of rapid diagnostic test in selected areas and situations,

- ensuring good quality of antimalarial drugs,
- improving microscopy services,
- training of health workers and volunteers and
- monitoring drug resistance in sentinel sites using the WHO protocol.

Partnerships to roll back malaria have developed and broadened in many of the countries with structured involvement of multilateral and bilateral partners, other government sectors, non-governmental organisations, the research community, and increasing involvement of the private sector in the RBM process. In addition, resource mobilisation has enhanced partners' support from USAID, Asia Development Bank, JICA and World Bank in the regions.

Issues and Constraints

One of the key challenges for partnerships has been how to convert 'loose ties' into commitment and responsibility for country action. The concept of 'loose ties' during the initial phase of RBM was appropriate as it allowed partners to engage according to opportunity and without binding conditions. 'Loose ties' also aimed to overcome bureaucratic rigidities for participation and involvement. This proved effective during the advocacy phase of RBM's development. Subsequently, efforts had to be directed towards country action where closer co-ordination between partners is anticipated on the ground. This requires a clearer definition of what partners will contribute and assume responsibilities for. At this point of transition from global advocacy to country action it has become important that the original concept of 'loose ties' is reviewed and partnership roles and responsibilities are clearly articulated and agreed where necessary.

The 2nd Global Partnership meeting held in Harare in 1999 focused on country needs. Partners agreed to identify ways to work together, and how to do so better; this process is still not fully worked out. Some global partners are dissatisfied with the level of attention they received from the Secretariat. The Secretariat did not assist global partners in facilitating their own progress, for instance, in enhancing the rate of disbursement of existing financial resources at country level. "Those who influence spending [WHO, UNICEF, UNDP] do not help spend existing resources". There was growing recognition of the need for more regular communication among core partners at the follow-up meeting to GP4. Certain partners have expressed concern about not being adequately informed. Meetings of core partners twice a year are being suggested to address this concern. This would be in addition to Global Partners meetings to be held once every two years.

Up to now, the RBM Secretariat has been mainly responsive to country partnership requests and has only rarely used a proactive approach. This is mainly related to WHO's normal working procedures. This implies that WHO country offices are the primary liaison point for interaction with country partners such as UNICEF, WB and UNDP. A more proactive role in advocating new ways of working, such as outcome-oriented planning and financial management might have catalysed the speed of country partnerships and the development and implementation of CSPs.

Integration of RBM action into social sector support mechanisms, such as debt relief (e.g. HIPC), and into national poverty reduction strategies (PRSP) has occurred only in a few of countries so far. To provide technical support for building effective partnerships at country level, a technical support network on health sector development and SWaps is needed but has not been established. However, with Country Strategic Plans and the need to develop management and administrative procedures which correspond to country partnerships' needs, a rational now exists to set-up and support such a TSN.

Regarding the tracking of progress, the Secretariat produced country updates and has recently published the summaries of the first CSPs from Africa. The tracking of progress at country level is descriptive and not yet based on process and outcome indicators with relevance to the management of CSP implementation.

The attempt to develop a global partners' database, which would assist in identifying resources available/potentially available at country level, has not been successful.

Actions and Solutions

To strengthen the role and involvement of partners it is important that there is agreement on comparative advantages of partners and clarification of roles and responsibilities; including clear arrangements for working together.

There is growing recognition of the need now to define and strengthen the regional role for WHO and partners to adequately support countries in partnership development and for maintaining these partnerships. At the same time the regional role of linking partnerships to the global level needs further clarification.

Focus on country action will require broadening the involvement of partners at country level. There is, therefore, a need to develop a strategy to engage communities, NGOs and private sector at the country level as partners.

As mentioned earlier, to improve the communication between core partners there is a need for core partners to meet regularly - at least twice a year. In addition, to further the achievement of RBM goals it has become important that attempts are made to formalise some partnerships and commitments to ensure accountability and response to countries' needs.

To adequately support the partnership and to maintain adequate communication amongst core partners there is a need to define a focal point for core partners in the Secretariat. This is being addressed through the reorganisation that is being proposed for RBM.

4.3 Capacity Development and Technical Support

A: Capacity Development

Achievements

The RBM Cabinet project has taken a lead in developing a strategy for human resource development in a broader context – it directly addresses not only skills development through training but also improving the enabling environment so that skills can be used. This means strengthening institutional structures and systems. Other achievements in the area of capacity development can be summarised as:

- The capacity development strategy takes an innovative approach to training, broadening the range of training approaches and training providers used. This includes, for example, distance learning, apprenticeships and mentoring, and demonstration projects.
- There are examples of harmonisation (of training materials and approaches and target groups) between RBM and other health programmes such as IMCI, IDS etc.
- There is a shift in focus from training individuals to strengthening training institutions in country, building on existing institutions where possible.
- There is better recognition of the need for managerial, advocacy and other skills alongside technical skills.

- Similarly, the need to develop the consultant pool so as to support countries more effectively with the full range of skills needed has been recognised and institutionalised
- Almost all NMCP managers within the AFRO and EMRO regions, and many other central and district level staff, have been trained on 2-3 month courses on malaria control planning and management.
- Training materials and tools have been developed, are in active use and have been well received; for example guidelines on training on severe malaria are being widely used throughout Africa.
- Many country plans now have a greater emphasis on human resource development which is recognised as a key to scaling up
- Country teams and working groups are bringing a much wider range of skills to bear on malaria control than previously, reflecting the move away from regarding malaria as purely a technical problem
- Regional and global teams also incorporate a wider range of skills than previously.

Issues and Constraints

At the same time, however, the capacity development strategy has not yet been sufficiently prioritised within WHO/HQ despite the priority given to HRD by regions and countries and the clear lack of capacity for scaling up. As a consequence, the strategy is not being followed through and resources have not been mobilised to do more than just training. Some of the other key issues to emerge from capacity development efforts include:

- There is as yet no firm concept of the scale of work required to strengthen the enabling environment and the full range of skills needed
- The recognition of the need to broaden training approaches and to develop HRD planning, managerial and advocacy skills is not yet fully reflected in training provided.
- The balance between pre- and in-service training is not yet right
- Responsibilities and champions within and beyond the immediate RBM staff have not been identified – there is a need to develop the necessary working relationships with health systems strengthening initiatives, and other disease programmes, and to take up opportunities for partnerships with other organisations.
- Improvements are needed in the planning and handling of consultant assignments so that terms of reference and the skills and preparation of consultants better match with country needs and expectations.

Actions and Solutions

Priorities suggested for future action include:

1. To advocate for an adequate share of recognition and resources to capacity development at all levels.
2. To follow up on the consultation about the strategic plan for capacity development and build consensus on the key messages and priorities
3. To examine existing work plans with a view to achieving balance between training and enabling activities in support of that training.
4. To develop strategies and build partnerships for scaling up pre-service training initiatives.
5. To further develop and implement regional and country level consultant professional development.
6. To do further needs assessment on capacity gaps through consultation with country programmes - organised through WHO regional offices with support from HQ - and plan activities based on that
7. To mobilise existing and new partners:
 - to better define the role of WHO and other partners in capacity development in order to develop and implement the necessary working relationships

- to take up opportunities for working with other programmes, e.g. the Bloomberg School, the Gates Malaria Training Programme, and ensure synergy.
- 8. To work with other partners and programmes to ensure that capacity for management (resource mobilisation and financial management), advocacy and partnership is developed.
- 9. *To cost those activities appropriate to WHO based?* and identify and allocate resources to move forward.
- 10. To establish mechanisms to link the SMT better into the day-to-day working of the RBM team at HQ.

B: Technical Support

The provision of effective technical support depends on:

- the existence, awareness, use and communication of technical strategies, which indicate priority approaches to malaria control in different settings.
- appropriate means to provide technical support, which includes technical, organisational and communications competence, consistency of information, use of technical support as an opportunity to develop local capacity and responsiveness to country needs.

Achievements

Through technical support, RBM has prioritised and communicated a clear set of technical strategies and has supported situation analyses, country strategic plans, drug policy development and ITN access strategies.

Appropriate drug policies are a clearly identified priority, and there has been a significant increase in collection and availability of data for drug resistance monitoring.

Strong support has been provided to strengthen capacity for case management. There is strong collaboration with technical support for IMCI particularly in Africa, which avoids conflicting messages, duplication of effort and waste of resources. Guidelines and standards, e.g. on case management, are valued by national programmes.

Technical Support Networks (TSNs) have raised the profile of malaria, and the original concept of a TSN has bred new networks with different functions. Some TSNs are assisting in developing coherent RBM strategies. Networks for technical support (not necessarily developed as RBM TSNs) at the regional and sub-regional levels are particularly effective.

AFRO has developed a pool of inter-country consultants to increase its capacity to provide technical support.

Issues and Constraints

Harmonisation of new elements of RBM (partnership, advocacy, resource mobilisation etc.) with traditional technical elements has proved problematic. As different people have different combinations of skills, there are challenges in ensuring that the new elements are technically sound and conversely that technical support incorporates them.

Some differences of opinion do exist on technical priorities and strategy for scaling up, and controversy on delivery mechanisms may slow down progress, but this may be unavoidable where evidence is inadequate to provide clear direction.

The concept of Technical Support Networks (TSNs) was not well understood, and TSNs were never fully established. . Many do not function, members of others are too busy to give heavy commitment, some are too research oriented, and the relationship of TSNs to WHO in provision of technical support was not fully considered

WHO has not developed a strategy to source expertise adequately in some of the newer elements of RBM such as working with private sector, supporting a social movement or linking to newer funding opportunities. Other founding partners have not sufficiently contributed their expertise in these areas to RBM.

Demand for technical support exceeds supply in Africa and other regions where malaria is reappearing.

The needs of other agency partners for ad hoc technical support has not been met optimally. For instance, the World Bank requested technical support on missions, often with insufficient notice for a response to be achieved. Mechanisms to contract out this work proved difficult to develop.

Technical support for case management has been limited in the NGO and private sector.

Actions and Solutions

Concerted efforts by the Secretariat and among partners will be required to address these issues. The RBM Partnership may need to reconsider the need for TSNs, their purpose, role and structure . In addition, stronger links and enhanced support for inter-country/subregional initiatives and networks for technical support such as EANMAT (East African Network for Monitoring Antimalarial Treatment) and ACTMalaria (Asian Collaborative Training Network for Malaria) needs to be explored and developed. A priority is to place stronger emphasis on capacity development in technical support.

It will be important to assure the mix of technical support responds to country needs as they change, and to develop a strategy to source expertise in the newer elements of RBM. The idea of establishing a consultant pool to provide support to partners and to meet excess demand by countries should be revisited.

The role of RBM in advising countries should be stronger and more decisive, and conflicting messages need to be avoided. WHO needs to work more closely with all agencies providing technical advice on malaria to improve co-ordination and ensure technical consensus. This will require timely establishment of norms.

4.4 Research and Use of Evidence

Achievements

RBM has given high priority to research and development as an essential and integral component of rolling back malaria. RBM has begun to show significant impact on malaria research and development with the result of introducing a stronger element of evidence-based culture into rolling back malaria, linking research and malaria control at the global, regional and country levels, and launching some high priority research activities to support rolling back malaria.

Global investments for malaria research and development have increased significantly since the launch of RBM – for example funding for malaria vaccine research has quadrupled in the past 3 years.

Strengthening the links between research and intervention sectors

Since the inception of RBM, country level activities have increasingly engaged the research community as well as the disease control sector, bringing the necessary evidence to formulate policy and the expertise needed, such as, for situation analyses which preceded the preparation of country plans. RBM also encouraged the national RBM programmes to define their operational research priorities. The internal review consistently reflected closer and effective ties between the research community and the control sector. Key informants reported that one of the principal changes that was detectable in the RBM ‘malaria environment’ was a stronger evidence-based approach with more functional links between researchers and disease control staff than before.

Within WHO, good and improving collaboration between TDR and RBM ensured that research results are changing global policies such as treatment policy including combination therapy, home management of malaria, and rapid diagnostic tests. TDR continues to build public health capacity and leadership for RBM.

Greater emphasis on operational research

RBM has been associated with an increased emphasis on research related to field operations and delivery of interventions. RBM has been a pathfinder in strongly influencing and refocusing the TDR strategy to include implementation research, linking research and control at global and country levels. Funds were provided by the RBM Secretariat to all the WHO Regional Offices to call for, and support proposals from endemic country researchers, some in collaboration with the malaria control programmes, for operational research to support RBM. Many partners, such as bilateral agencies, development banks, UNICEF and NGOs, have begun investing in operational research on malaria at regional and country levels.

A new co-funded programme of research on health systems with a focus on malaria was begun by RBM in collaboration with the Alliance for Health Policy and Systems Research. However, health systems research and research in behavioural and social sciences which have a major role to play in improving the efficiency of delivering existing tools are still under-emphasised, and need greater support and encouragement from RBM.

Increased investment in Research and Development for malaria

Global funds for malaria research and development have increased significantly, from an annual expenditure of about 84 million USD in 1994 (assessment by the Wellcome Trust) to around 200 million USD in 2001. Funding for malaria vaccine research has quadrupled in the past 3 years. Much of this increased financing can be accounted for by investment in malaria by the Bill and Melinda Gates Foundation including: *the Gates MVI and malaria R&D capacity building in Africa to the UK partnership*; donation to John Hopkins University's Bloomberg School of Public Health; and an increase in the NIH malaria budget. This can be attributed, in part, to advocacy by RBM.

High priority research and development launched and supported

Many priority areas of research and development have received enhanced support from RBM working in close collaboration with TDR. Some of these initiatives required supporting new institutional arrangements, e.g. Medicines for Malaria Venture, the venture capital fund for malaria drug development which functions in close linkage with, and patronage of RBM, networking of researchers to address malarial anaemia, Regional Drug Resistance Monitoring Networks, African network for the measurement of malaria morbidity and mortality – MTIMBA, or establishing systems to address priority operational issues, e.g. for quality assurance of rapid diagnostic tests.

Issues and Constraints

A clearer definition of operational research priorities for RBM is needed

Despite the increased activity in research related to operations, some informants interviewed for the internal review felt that RBM needs to articulate more clearly its list of high priority operational research areas for malaria control. The 'Product Development' portfolio of the TDR programme does not reflect RBM's priority needs, and these issues need the attention of RBM.

Actions and Solutions

Sustaining the effort

The R&D effort mounted so far by the RBM Secretariat needs to be enhanced and sustained. The organisational restructuring of the RBM Secretariat, in which research and development are no longer covered by a 'team', aims to link R&D more closely to the technical strategies and outputs of RBM. There are however, several generic or 'cross cutting' aspects of R&D which need to be nurtured, and the most appropriate organisational arrangements to enable this to happen and sustain the ongoing efforts, should be put in place.

4.5 Monitoring and Evaluation

In order to determine whether the RBM approach is working and a major increase in funding is justified, the importance of better data on the malaria burden and on control activities has been strongly emphasised since the start of RBM. Thus, M&E activities were incorporated at the inception of the RBM Cabinet Project and RBM, and constituted one of its main components. RBM established a Monitoring & Evaluation Team (MET) at WHO/HQ to work with WHO regional offices and main partners in order to monitor progress and to evaluate the outcomes and the impact of the RBM initiative.

Four outputs have been identified for M&E within the 2000-2001 Composite Work Plan:

1. Co-ordination of monitoring activities through the established cross-WHO working group
2. Final agreement on framework for monitoring RBM with all partners
3. Technical guidelines on monitoring methodology and specifications of indicators
4. Planning and implementation of data collection/analysis, with countries and partners

Achievements

Co-ordination of monitoring activities through cross-WHO working group

Co-ordinating the efforts of the various partners in terms of M&E is an important role of MET. The creation of a cross-cluster task force dedicated to the epidemiological monitoring of malaria within WHO/HQ, with the participation of various teams involved in that issue, is one of the team's main challenges.

Partners have been identified within the CDS cluster and other clusters as well, namely CAH, Health Mapping and the Massive Effort initiative representatives.

Final agreement on framework for monitoring RBM with all partners

Following consultation with Regional Offices and main partners, the *Global Framework for Monitoring Progress and Evaluating Outcomes and Impact* was accepted by all the RBM partners and was published in September 2000 in English, French, and Portuguese and was widely disseminated at the regional and country levels.

Technical guidelines on monitoring methodology and specifications of indicators

A "*Methodological Guide for monitoring and evaluation of the RBM initiative at country level*" is in final stages of completion and will be submitted to the regional offices and main partners by December 2001. The Regional Bureau for Africa has prepared its own version, *RBM initiative in the African Region: Monitoring and Evaluation Guidelines*, AFRO 2000.

Planning and implementation of data collection/analysis, with countries and partners

Plans and procedures for data collection and analysis, agreed upon with countries and partners, are being implemented. Collection and analysis of baseline data have started and sixteen countries from the AFRO region have completed the baseline. To implement these surveys, various partnerships and collaborations have been formed, these include: UNICEF (End of Decade Survey), Demographic Health Survey, Demographic Sentinel Sites (INDEPTH) and IMCI. National Programme Officers (NPOs) oversee the quality of monitoring methods and systems and it is necessary to improve their capacity.

The Regional Office for Europe has planned a sub-regional meeting involving RBM/HQ and EMRO to modify current indicators, to enhance the inter-countries collaboration and to share the data between countries. Most endemic countries in the Americas region for many years have provided annual reports to the regional office. These progress reports allow for the evaluation of the regional situation of malaria in the Americas.

In SEARO/WPRO, the MEKONG project funded by the European Commission including Myanmar, Thailand, Cambodia, China, Laos and Vietnam, routinely collects impact and monitoring data through the Mekong Malaria Surveillance System. SEARO is also in the process of adapting global indicators to the regional situation. A regional pilot project focusing on the district level is to be implemented in 7 countries and global indicators are to be used to monitor and evaluate this pilot project.

In WPRO, a review of the malaria situation in the region is on going with the objective of compiling epidemiological and operational data such as coverage of vector control, to evaluate the reduction of malaria from 1992 to 2000 and to assess the disease burden.

Evaluation of the global malaria situation

Mapping of the global malaria situation depends on good collaboration with the Health Mapping team at CSR. A joint action plan is being developed and RBM is funding a technical position in that team. The M&E team also participates in the development of the Global Atlas and will contribute in validating data to be integrated.

At regional level, implementation of Geographical Information System (GIS) is on going.

Issues and Constraints

The M&E team participates in the evaluation of the malaria mortality rates and its epidemiological trends in some sentinel sites of the African which also benefits countries. However, funds have not been readily available at sentinel sites level and this has delayed data collection in 2001.

AFRO intends to develop a regional database in collaboration with various partners such as UNICEF and INDEPTH. However, the monitoring and evaluation workload is borne by one single person who is also regularly requested to implement other tasks, both technical and administrative. For this reason, the creation of this database has been delayed.

In EMRO, the regional office receives data from the countries but their quality is variable. Countries with the weakest health infrastructure are only able to provide limited data.

The New Independent States such as Tajikistan, Armenia, Azerbaijan face a resurgence of malaria but existing M&E system is still based on a malaria eradication objective and does not correspond to the current epidemiological situation and therefore needs revision. In EURO countries with weak health information systems, are unable to provide accurate data about malaria control.

Challenges in the Mekong region include the multiplication of indicators and the delay in implementing changes mainly at the district level and ensuring the quality of data especially as it may be collected by the general health system.

An effective M&E system that provides valid assessment of progress and impact is necessary to maintain the commitment and justify resource mobilisation for RBM. Many changes have affected the M&E team and some stability and strengthening is required with more focussed terms of reference to establish and maintain an effective M&E system. *A real institutional framework is needed that the links established with WHO/Regions, other clusters, partners and RBM Secretariat and the delay in establishing a M&E working group hampers the technical credibility of WHO and the role that RBM/HQ is supposed to play vis-à-vis its partners and regions.* Co-ordination between RBM partners also needs to be reinforced both at global and country level to avoid duplication of data collection efforts.

The initial phase of the data collection is ongoing in all the regions. However, it appears that several issues need to be resolved before planning the routine phase of monitoring and evaluation; these include: case definition, consensus on global indicators, means for regularly monitoring process indicators, staffing at regional level and assigning responsibilities for and support to M&E at country level.

Evaluation of the global malaria situation

In the context of evaluating the malaria global situation, there are technical problems which are difficult to solve in the short run. At present, there is no real consensus as regards evaluation of malaria mortality, and the global database on the disease is yet to be designed. Also, rules for notification of malaria epidemics are yet to be designed and their application needs to be homogenised at the global level.

Actions and Solutions

Co-ordination between partners for monitoring and evaluation needs to be reinforced both at global and country level for sharing and comparability of data, and to avoid duplication of data collection efforts.

In situations where infrastructure is too weak to provide reliable and regular data, specific surveys are necessary to collect better data. M&E efforts could be improved by the assignment of a NPO in each of the countries where malaria is an acute problem.

In both EMRO and EURO regions where the indicators for M&E are still based on an eradication objective, they need to be updated.

The analysis of M&E progress and activities has highlighted the following actions:

Institutional issues

- Capacity building should be reinforced at country level.
- Respective roles of HQ, regions and countries should be clarified. Collaboration between the different levels should be reinforced.
- The M&E team would perform better if the institutional framework in the context of RBM/HQ , Secretariat and Regions was clear and formalised.

Technical issues

- A global consensus on case definitions is urgently needed.
- It would be more reasonable for the RBM initiative to monitor the programme and evaluate the results for each region separately, since there is a fundamental disparity between the epidemiological and social context of the regions.
- HQ/Regional/Country staff working on M&E should be strengthened.
- RBM must play a pathfinder role in co-ordination of the various data providers.
- Each region needs to adapt indicators quickly, the *Global Framework for Monitoring Progress and Evaluating Outcomes and Impact* being considered as a reference.
- Since most RBM global indicators need community-based data collection, it is necessary to commit adequate resources (estimation: 20,000 US\$/district. This means 60,000 US\$/country per cycle) and commitment in order to translate data into action in the process of planning/re-planning.
- M&E national capacity should be reinforced. In awaiting this reinforcement, RBM should appeal to other data providers (DHS, INDEPTH)

4.6 Resource Mobilisation and Administration Evaluation

A brief analysis of the resource mobilisation team was undertaken based on the five elements of the RBM composite workplan: planning, resource mobilisation, management of resources, reporting and evaluation.

Achievements

While resource mobilisation efforts have been effective at meeting the immediate resource needs of the secretariat and regions, it has not been successful in broadening the donor base

for the secretariat and convincing funding partners to increase their contribution to the level required. Suggestions for improving the effectiveness and sustainability of the RBM Secretariat include: strengthening the capacity of the secretariat; greater clarity in its role within the broader partnership, perhaps developing a joint resource mobilisation strategy for global partners; and improving planning and management procedures at all levels of WHO to reflect RBM priorities.

Mobilisation of the large amounts of funding necessary to successfully roll back malaria presents an enormous challenge for RBM as a whole and the RBM secretariat has expended a large amount of effort in defining its role in this process. RBM has succeeded in creating a politically enabling environment, and in providing a strategic framework in which resources can be focused. As RBM reaches the implementation stage in countries, RBM is beginning to define a methodology to implement plans, identify specific funding sources, and develop a workplan for building resource mobilisation and financial management capacity in countries. Efforts to include focus on malaria within PRSPs has been successful in some countries and newer opportunities through the Global Fund are being fully explored; a channel for private sector resources has been created. This is a potential source of funding for the countries, and if strategically combined with PRSPs could go very far in moving RBM to scale on the ground.

Traditionally donor proposals have been focused on getting contributions of small amounts based on specific projects which support WHO normative functions. The scope of the RBM project takes a more holistic approach to the burden of malaria, which requires a departure from this method. RBM has been successful in changing the practice of getting contributions against a particular project, into selling the business plan of RBM. This allows much flexibility in the way RBM can apply its resources, and support the process better.

The private sector has become an important partner in RBM through financial, human and technical resources which have been mobilised and allocated to meet specific needs at global or country level.

Issues and Constraints

All partners recognise the importance of increasing resources at the country level, and despite consensus on the enormous opportunities in co-ordinating the relative expertise of the major partners, the partners feel that this has not been adequately addressed. The partnership has yet to develop consensus on the exact role of the RBM Secretariat and WHO in the context of resource mobilisation and management.

There is a need to strengthen the resource mobilisation team as there have been only two people handling all the resource mobilisation, financial and administrative issues, planning and internal reporting, budgeting and evaluation.

A clear resource mobilisation strategy is also needed which is more than the current 'method of working.' In the context of resource mobilisation, regions need to act as an extension of the secretariat rather than a malaria program within a regional office. This has not been clearly defined and as a result each level in the hierarchy experiences the conflicts associated with playing a dual role. This is evident in the workplans which reflect the malaria control activities more than the broader mandate and approach of RBM.

Based on the correlation between product financial implementation rate and product achievement, a delegation of financial responsibility to the team co-ordinators has been implemented. This should improve implementation rate.

Better co-ordination between the activities at WHO/HQ and the Regional, and Country Offices is a critical success factor for RBM. In terms of administrative issues at the WHO Country office, the traditional activity-based funding and accounting has been in place to ensure complete accountability. While there have been minor improvements in the processes, WHO still demands complete accountability. This is problematic because partners have observed that there is a direct correlation between risk and results. This would indicate that WHO's policy of accounting for every dollar will slow implementation at the country level. RBM should be able to track all RBM funding, but should also consider developing a fast track mechanism within the WHO system.

At this stage when expectations for country action are growing it has become important that some founding partners need to engage in more resource mobilisation for RBM. This should be supported by a full analysis of total resource needs for RBM to achieve its goals. Current resources do not match needs either through inadequate quantity or inefficient use of available resources or under-utilised mechanisms to channel funds..

The World Bank has played an important role in putting malaria on the agenda of ministry of finance to ensure that malaria is not just a health issue but a development issue, and in ensuring that malaria is a priority for countries implementing a SWAp. The World Bank has started in RBM with multi-adaptable loans, but the feedback has been that WB loans are complex and very difficult to access. A recurring issue is the lack of clarity in the financing situation to the countries, and the secretariat needs to work with the World Bank to give more clarity to the countries. Many needy countries do not qualify for a WB loan. However, the World Bank/IMF led HIPC initiative has the potential to provide debt relief to many more countries, providing considerable opportunity to address malaria as a poverty issue as seen in Cameroon, Tanzania and Uganda where poverty reduction strategies have brought additional resources for malaria¹¹. There is a disparity in the argument put forward by the World Bank: "money is not the issue" and that put forward by the countries': "money is the issue". Joint missions between global partners will help enable RBM plans.

RBM Secretariat also needs a more diverse funding base for its sustainability and to adequately support RBM at all levels effectively.

Actions and Solutions

Priorities for the future in relationship to resource mobilisation include the establishment of close working relationship with Global Fund and to develop country and partner capacity to ensure malaria control benefits from debt relief and is prioritised appropriately in national health plans.

The Resource Mobilisation team also needs to ensure that the scale of activities being carried out match the role and scale of global RBM movement.

Private sector partnerships offer potentially large amounts of funding, however, this is likely to be specified ('earmarked') to some degree. RBM must strike a balance between the amount of resources available from private sector partners and the degree to which these resources are tied to the specific objectives of each partner.

The need for information on resources by partners must be clearly identified, and if such work is deemed useful, adequate human and time resources must be allocated to the venture which would require management, maintenance and regular updating.

¹¹ Jane Edmondson (Malaria Consortium) Malaria and Poverty: Opportunities to address malaria through debt relief and poverty reduction strategies. Background Paper for the fourth RBM Global Partners Meeting, 2001

In addition, RBM needs to:

- Develop joint global partnership resource mobilisation strategy to address five elements:
 - Support for country action
 - Support for related health system development and research
 - RBM partner core functions
 - WHO core functions
 - RBM secretariat functions

If the RBM Secretariat is to be successful and sustainable, it needs to:

- aggressively market itself as the best facilitation mechanism available to combat malaria. RBM also needs to
 - focus on mobilising local resources, rather than establishing grants through WHO.
 - Examine links with similar partnership programs (i.e. StopTB, Polio)
 - Develop a resource mobilisation strategy jointly with global partners, using the relative advantages of each, and clearly communicate that strategy to countries.
 - Use monitoring and evaluation information for reporting, advocacy and resource mobilisation.

5. RESULTS OF THE INSTITUTIONAL ANALYSIS

The institutional analysis of the RBM Cabinet Project (RBM CP), examined RBM's attempt to find a new way of doing business through institutional arrangements to facilitate the work of RBM within WHO, both its work to co-ordinate WHO's role as a partner and its work as the RBM secretariat. The institutional analysis is presented in detail in Annex G of this report. Specifically, the analysis sought to:

- describe the role, functions and organisation of the Cabinet Project at all levels of WHO and how these operate in practice
- determine whether current institutional arrangements fit with the purpose and outputs of the project, both now and in the future
- propose adjustments and ways to implement them

Six institutional features were analysed to determine the efficacy of the current arrangement to achieve the RBM goals: 'setting', 'strategy, purpose and roles', 'structure', 'systems', 'staffing and skill's, and 'management style'. It is important to note that, although the analysis studied how WHO's institutional arrangements for RBM fit with those of other partners, it did not examine those partners' own institutional arrangements for RBM. This wider analysis is expected to form an important part of the RBM external evaluation.

Achievements

In the last three years the RBM Cabinet Project has developed new institutional arrangements to facilitate its work in the RBM partnership. In accordance with the original philosophy of RBM the Cabinet Project has established 'loose ties' designed to allow flexibility in forming partnerships of different kinds within and outside WHO.

Examples of successful partnering can be seen across bureaucratic boundaries within WHO. Part of the rationale for the Cabinet Project was to find better ways to co-ordinate expertise across divisions and clusters, and overcome existing bureaucratic constraints and inefficient competition for resources – the notion of being a pathfinder for 'one WHO'. RBM did make early progress in working strategically, crossing drawn boundaries within WHO, and there are many examples of collaboration between individuals and groups on specific issues. The successful consensus on DDT, for instance, relied heavily on such collaboration to bring

together different viewpoints and allowed WHO to speak with one voice. Collaboration between RBM and IMCI in AFRO provides a good regional example. In addition, WHO's role as the technical leader, or guide within the RBM partnership has been underlined.

Offices within WHO have reorganised since RBM, in the light of newly acquired roles and functions, and have at the same time broadened their skills base. More recently, the Cabinet Project has demonstrated it can work across the different levels of WHO by engaging in joint planning with AFRO, in July 2001.

Finally, the RBM teams new organisational matrix structures in HQ and AFRO do recognise the dual role as a technical partner and as a secretariat serving the partnership and look likely to be sufficiently flexible to handle changes in roles and responsibilities over time.

Issues and Constraints

In seeking to fulfil its role as an institutional pathfinder, The RBM Cabinet Project has faced a number of challenges that have emerged in the context of institutional arrangements. The RBMIR provided the RBM CP with an opportunity to examine the lessons learned.

Though an achievement in terms of initiating partnerships, 'loose ties' have led to some subsequent confusion about roles and lines of accountability within WHO and among other partners, and made it unnecessarily difficult for some partners to work together. Development and implementation of joint plans will require active attention to working relationships, communications and protocol between the levels of WHO, as well as with other partners. Although the different institutional arrangements of partners were not examined closely in this institutional analysis, it did seem that WHO has gone further in reorganising itself to meet the needs of RBM than have other partners, and that, without some concomitant changes in other partners, the impact of WHO's attempting new ways of working will be limited. However, it was also realised that the RBM CP needs to understand better, and take into account, the respective institutional systems, constraints and comparative advantages of other partners. This includes finding ways to deal with the different lines of accountability that exist for different levels of WHO (for example regional offices being in many respects accountable to member states rather than the WHO Cabinet).

A related issue is that WHO support for malaria planning does not always take sufficient account of parallel processes at country level (e.g. decentralisation, poverty reduction strategies, sector wide approaches) and country planning cycles, nor the planning cycles of other partners. Better co-ordination and understanding of planning arrangements within the partnership is needed.

A multiplication of goals and objectives over time has contributed to the confusion in communicating RBM's purpose to the public health and scientific community, as well as within WHO. Partly as a result of changes in leadership, different aspects of RBM have been emphasised at different times in the project's first two and a half years. Other changes in staffing and skills mix over time have also contributed.¹²

Greater clarity is needed on the Cabinet Project's role as the Secretariat and its support for WHO's role as one partner in the global partnership. There is some disagreement and confusion among partners, unsurprising given the breadth of the partnership and the "pathfinding" nature of the RBM CP. Similarly, the RBM Secretariat's lines of accountability within WHO and to the partnership are unclear. The institutional analysis looked at whether the WHO's role as a partner supplying technical expertise and WHO's provision of secretariat functions were compatible. There is no major reason why not, and

¹² See Communications and Advocacy output study and background paper in Annex A.

why the same team cannot fulfil both roles, though the fulfilment of both roles would benefit from a clearer distinction between them.

The nature and status of RBM as a “Cabinet Project” within WHO, and the implications of a perceived “transfer” to the cluster level (CDS) within WHO HQ, were cited as a major issues here. The RBM CP has less direct communication with the WHO Cabinet and the Director General's Office than it once had, and the nature of the new relationship was unclear. While the role as one partner may be better achieved within the cluster, there is an argument that accountability to the global partnership would be better achieved by the secretariat role remaining distinct from WHO internal structures.

In terms of WHO's role as one partner, its part in technical support is clear. However, there is more vagueness about its role in funding and in implementation, relative to other partners. WHO is not constituted or well equipped to be a provider of major funding for the implementation of country level programmes. Partners seem more comfortable with the idea of the RBM CP having a role as an advocate and facilitator for resource mobilisation, and a more limited role as a funder.¹³ In communicating to partners about how the new organisational structures for RBM within WHO will fulfil the WHO's roles in the partnership, the RBM CP needs to be clear on the resource mobilisation and funding functions.

Although cross-divisional dialogue was prevalent in the early days of RBM, the WHO-wide strategic forum on RBM lapsed. Current collaborations tend to form around specific issues rather than arise from strategic agreements. There were strong sentiments that the earlier discussions were unique in their ability to bring the expertise within WHO together under the RBM umbrella, and that the WHO-wide forum should be reinstated.

Similarly, in RBM's effort to support a “one-WHO” model and new ways of working, there have been tensions over bureaucracy and protocol, with different opinions of what helps and what hinders. There are concerns that new ways of working should not equate with short cuts, for example in terms of providing support to countries, that put at risk good relationships built over time.

Finally, skills mixes for RBM at all levels in WHO, and among consultant pools, need to be improved for the next phase of RBM particularly at country level. These might include, for example, more expertise in partnership building, resource mobilisation, health systems and country planning processes.

Actions and Solutions

This study recommends the following institutional adjustments for the future development of RBM:

- The Cabinet Project needs to tighten some loose ties, but not all. In developing the strategic plan to 2010 some key deliverables should be identified that would benefit from more formal agreements and action taken to negotiate and document agreements. The planning should also recognise areas where looser arrangements will be more productive.
- WHO's role as the Secretariat needs to be distinguished clearly from its role as a partner in the broader partnership. Specifically, we recommend that the Secretariat function be clearly accountable to the global partnership.

¹³ The Resource Mobilisation output study addresses this question in greater depth. The Institutional Analysis examined this issue with regard to appropriateness of resource mobilisation within the current institutional structure at WHO.

- Some simple messages should be agreed on regarding the vision; goals and outputs need to be consistent throughout the partnership and should form the basis for the strategic plan to 2010. Extending the planning horizon will hopefully lead to a clearer message on the balance between short and long-term priorities.
- The WHO-wide RBM malaria strategic forum at HQ level should be revived. In addition, a mechanism to bring together the discussions across the Regional, sub-Regional and Country Offices of WHO would be helpful.
- Recent organisational changes should be finalised and communicated together with information on roles and contacts at each level in WHO – this should be matched by the necessary delegation of authority to assign roles and responsibilities.
- Planning WHO country support should be harmonised with country planning cycles and parallel processes within the health sector.
- WHO staff with malaria responsibilities at all levels should be involved in work already ongoing in WHO on strengthening country offices to ensure that the skill mix needed to fulfil WHO's roles in RBM at country level is taken into account.
- Plans for professional development for WHO malaria staff and for development of a strong consultant base locally and regionally should be devised and implemented in order to develop further the skill mix available. This should be matched by improved contractual arrangements.

As the RBM Cabinet Projects adapts to a changing institutional environment, it must learn from the past in order to better support the objectives of the partnership for the next phase of RBM. This analysis hopes to provide a basis to do that. The external evaluation should provide a basis for other partners similarly to review their own institutional arrangements with the same purpose in mind.

6. PRELIMINARY CONCLUSIONS AND NEXT STEPS

The extensive process of the internal review carried out during the past few months has provided a wealth of information and opinion on the evolution and progress of RBM and the RBM Cabinet Project in WHO, allowing for informed discussion of best practices; problems and their resolution; and, most importantly, forward looking scenarios for scaling up action to roll back malaria. This wealth of information and opinion could not be distilled without losing some of its richness and diversity. Nonetheless, it is necessary to draw some preliminary conclusion that lead to practical and effective next steps. The Institutional Analysis and each of the six Output Studies has done this, however there is a need to synthesise findings –capturing common themes and shared solutions, as well as to prioritise future actions.

The RBMIR exercise in synthesis and prioritisation took place in two stages. First, RBM Cabinet Project staff from WHO/RBM/HQ and WHO/RBM/AFRO met for a two day “wrap-up” session in Harare (2-3 October, 2001) to review the full body of work carried out under the RBMIR and distil the key findings. These findings were then presented to and discussed in two consecutive video-conferences on 15 October, 2001. The first video-conference was internal to WHO and involved RBM staff of other WHO Regional Offices (SEARO, WPRO, EMRO, EURO), the second involved RBM founding partners (World Bank and UNICEF) and development partners (DFID and USAID) involved in planning and supporting the RBM Partnership External Evaluation.

The preliminary conclusions and suggested next steps presented in this section are for consideration by the WHO, RBM Partners and the external evaluation team. The external evaluation team, scheduled to make the external evaluation of RBM early in 2002, will be invited to review and confirm these conclusions and to provide its advice on the prioritisation of the necessary next steps

RBM is making a difference

Among the most basic and frequent questions asked during the course of the RBMIR was: “Is Roll Back Malaria making a difference?”. Although at such an early stage it is impossible to demonstrate changes in morbidity, mortality or the economic burden of the disease, there is clear evidence that RBM is making a difference, particularly by creating an environment in which countries can establish policies and action to roll back malaria¹⁴.

Malaria is definitely “on the map” of international development and health priorities and is on the regional and national political agendas in malaria endemic or epidemic risk areas of the world. Evidence supporting this statement has been cited throughout this report and includes the Declaration of the Abuja Summit on Roll Back Malaria, increasing resources in development budgets and private/foundation funding for malaria control and research and the United Nations General Assembly has designated 2001-2010 as “The Decade to Roll Back Malaria in Developing Countries, particularly in Africa”.

Consensus and ownership have not only been built around the notion that “something must be done” about malaria, but also around the technical strategies (promoted by RBM and backed by credible evidence of efficacy and potential cost effectiveness) through which the malaria burden can effectively be reduced. Prompt access to treatment, promotion of insecticide treated nets and judicious use of other vector control measures, intermittent preventive therapy for pregnant women at risk of malaria infection and prevention and effective response to epidemics have emerged as the “four pillars” of Roll Back Malaria.

¹⁴ This is consistent with the “purpose statement” of the RBM Partnership logframe.

RBM has also made a difference in fostering an environment that promotes the formation of effective partnerships focused on the achievement of common objectives. There are excellent examples of the RBM Partnership at work at all levels and from every region, examples of which have been described throughout the RBMIR Report and annexes.

The RBM Cabinet Project in WHO: Secretariat and RBM Partner

The RBM Partnership in its diversity and numbers requires a secretariat and the WHO is the appropriate host institution for the secretariat. This notion has rarely been challenged, however there has been considerable confusion related to the exact nature of secretariat functions within WHO. Several issues require clarification or redefinition.

The nature and status of RBM as a “Cabinet Project” within WHO needs to be made less ambiguous. There is a perception that the current definition of the term Cabinet Project within WHO is different from that applied when RBM was established, and that the RBM Cabinet Project has been reduced in status and priority following a protracted period of interim management arrangements. It is important for the RBM Partnership that the term Cabinet Project be more than an honorific title and have a functional reality within the institution. The RBM Cabinet Project needs the explicit support of cabinet and the Director General to move forward with the same path-finding spirit of innovation and risk taking which marked the start up phase of RBM. It is essential (not only for assuring the confidence of RBM Partners in WHO’s capacity to provide leadership, but more importantly for scaling-up action against malaria at the country level) that the RBM Cabinet Project be able to work in innovative ways internally and externally with occasional freedom from the endemic institutional, bureaucratic and protocol constraints. It is most essential that the definition of the RBM Cabinet Project and the rights and responsibilities that the term conveys be extended to the WHO Regional Offices and to the Offices of WHO Representatives in malaria endemic countries. Regional and Country Offices must be supported in their efforts to work “outside the box”. Failing this, WHO will have potentially insurmountable difficulty in leading the RBM partnership in scaling-up action against malaria, and its role could be limited to facilitating incremental improvements on a business as usual basis.

The differentiation between RBM Secretariat and WHO’s normative roles has become increasingly difficult. This is in part due to the possibility that the definition of WHO’s normative role is changing over time, with RBM serving, as hoped, as a pathfinder. Under the RBM Cabinet Project, what were formerly thought of as “secretariat functions” such as partnership support, advocacy and resource mobilisation, have become inseparable from more traditional functions such as leadership in technical guidance, establishment of norms and standards for public health and medical practice and providing technical support to member states. Moreover, many of the “secretariat” functions are not and cannot be undertaken by a headquarters-based team alone -as is often perceived both within and outside of WHO. What is needed now is a definition of roles and responsibilities at all levels of the Organisation, with the clarification and acknowledgement that RBM Secretariat and WHO’s expanded normative roles in rolling back malaria are to be taken forward at all levels of the Organisation. This may require a reconsideration of staffing and skills mix at different levels of the WHO.

RBM Partnerships

There is a perceived need, at this juncture, to re-confirm the Commitment of RBM founding partners and to establish some more formal agreements between and among partners for key deliverables. The RBM Secretariat is not suggesting that a formal RBM Partnership agreement be developed and signed by all parties to the partnership. Development of a universal agreement is likely to provide no advantage over the current loose ties which govern RBM founding partners’ collaboration. However, in order to facilitate the differentiation of

roles and responsibilities by comparative advantage for key functions and deliverables, appropriate agreements between one or more partners should be developed and documented. This is likely to provide benefits in terms of accountability and transparency. In the absence of documentation of agreements between and among partners there are several risks: failure to harness the comparative advantage and potential contribution of some partners, duplication of effort, gaps in key functions/deliverables and partners working unnecessarily outside their comparative advantage in an effort to “do it all”. Observations within the RBMIR suggest that these risks are real. The move to more formal agreements suggested by the RBM Secretariat is perhaps little more than an extension of current practices which govern collaboration with specific partners or in specific contexts.

It has been noted repeatedly by key informants that WHO and other RBM Partners with international structures do not appear to be equally committed to rolling back malaria at all levels. This is particularly problematic when there is a high level of commitment from an institution at the Global or Regional level without corresponding country/local level commitment. The solution to this problem will be somewhat unique to each institution, however, since the problem is common to several RBM Partner institutions, those solutions might be sought and implemented in tandem e.g. a global office might have an easier time advocating for country office involvement in RBM if there is also local encouragement from other RBM partners operating at country level.

The RBMIR has also demonstrated that although there is involvement of both the voluntary and private sectors in the RBM Partnership, there is a need for more proactive engagement of NGOs and the business community. The RBM Secretariat developed a framework for promoting partnerships with the voluntary and private sectors which was discussed broadly among RBM Partners at both GP2 and GP3, however only partial use has been made of this framework and relatively little effort has been invested in tapping the potential from these sectors. The effort that has been made has undeniably provided good returns and there are several very noteworthy examples of the contributions of NGOs and businesses to rolling back malaria. In facing the challenge of scaling-up RBM, the RBM Partnership must also scale-up its outreach to and engagement of these partners. Although there are many opinions on the optimal way forward, it is suggested that the RBM Cabinet Project identify a focal person for developing NGO involvement and another to develop private sector involvement in rolling back malaria.

Resources for rolling back malaria: the issue of money

The ability to effectively identify, mobilise and use human and financial resources to roll back malaria is both critical and rare. Going to scale cannot be accomplished without order of magnitude increases in funding as well as innovations in service delivery, project monitoring and evaluation and fiscal management. The dominant challenge facing malaria endemic countries today is not a technical constraint like drug resistance, or the absence of a vaccine, but the effective mobilisation, management and application of resources against the targets and goals of rolling back malaria -whether through strategies to “unblock” disbursement of currently available funds of through new funding opportunities linked to poverty reduction strategies, private foundations or the Global Fund to Fight AIDS, TB and Malaria. This challenge is not unique to malaria, but common to both disease control programmes and health sector development strategies. The RBM Partnership must focus more effort and work more closely with other programmes to increase the efficient use of available resources, and mobilise new resources for rolling back malaria. Moreover, the focus of this effort must be at country level and tightly linked to an agenda of sustainable capacity development.

RBM Action at country level

In some malaria endemic countries RBM has been slow to move forward or there has been a loss in initial momentum or enthusiasm. There may be several reasons for this, however there may be some common solutions. One possible solution is the temporary appointment of an RBM catalyst at country level to facilitate the formation of an effective RBM Partnership. Several possible mechanisms have been proposed for supporting an RBM catalyst, each with its advantages and shortcomings. The desirable characteristics include the following:

- Primary responsibilities are partnership formation and resource identification
- Assists government in convening and leading RBM partnership, but does not replace government in this role
- Has the freedom to communicate with senior level staff across MOH and other government departments and in potential RBM Partner organisations.
- Has an exit strategy: builds capacity for a sustainable effort and becomes inconsequential to its success.

This would suggest the possibility that the catalyst could be an international civil servant at a relatively high level of authority linked to one or more international organisation with a designated counterpart at a high level within government. This is one of several possible solutions which might be assessed and explicitly considered by the external evaluation team.

In countries where RBM has made initial progress, needs may differ. As country level partnerships complete their CSPs, they are poised to take action and truly begin the task of rolling back malaria. As mentioned above, one of the greatest challenges they face is an apparent shortage of “accessible resources”. An important lesson learned is that the country planning process which results in a CSP must be linked both to some new resources for implementation and a resource mobilisation strategy to assure that there is no loss of momentum. To this end, the small amounts of “seed-corn” funding provided to countries through the RBM Cabinet Project have proven useful and necessary, but certainly not sufficient. It is incumbent upon the RBM partnership to assure that country partnerships have the responsibility and the capacity for resource mobilisation and oversight. Further it is important to assure that the resource mobilisation process begins early at the country level, not when the CSP is already complete, and is appropriately backstopped. It has also been suggested that RBM Partners with capacity to supply financial and technical support at country level, would facilitate resource mobilisation and co-ordination, by harmonising their planning cycles for country support to complement country planning cycles.

Country Action requires regional support

The scaling-up of RBM at country level will result in increasing demand for technical support from RBM Partners. This will include both the traditional forms of support provided by WHO and other technical agencies, as well as support for partnership, resource mobilisation and other management functions. Within their role as RBM secretariat, the WHO Regional Offices must have the capacity to meet this demand. All WHO Regional Offices need to be strengthened in order to:

- Establish, maintain or reinforce functional links with regional level RBM partners
- Effectively address country needs for technical and other support through all available and appropriate channels.

The specific mix of skills required by the RBM Regional Offices may differ from one region to another, however the need to reinforce regional capacity is universal.

In the eight years remaining in the Decade to Roll Back Malaria, first the Abuja targets and then the goal of halving the malaria burden are achievable. The RBM Cabinet Project in WHO is capable of and dedicated to serving the RBM partnership in its dual roles as secretariat and lead technical partner. It is dedicated to helping both the WHO and the partnership work more effectively. The RBM Cabinet Project is a learning project and on the basis of careful introspection, provided through this internal review, and the anticipated

recommendations of the external evaluation, is willing and eager to adapt to the changing environment and plan forward in concert with RBM Partners.