

CASE STUDY

Case studies in public-private-partnership in health with the focus of enhancing the accessibility of health interventions

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Abstract: Various definitions have been framed for public-private partnerships (PPPs) in health depending on the desired relationship and the characteristics of the respective sectors. These relationships span from a continuum of loose relationships with narrow objectives, lack of a legal status and an absence of a formalized membership or governing body to high level institutionalization. The latter includes concrete objectives, the presence of a legal status and permanent multi-sectoral membership. The study used qualitative research methods including case studies, literature review and interview with key informants. The research undertakes an extensive literature review of various PPP models in health in scale and in scope which are aimed at advancing public health goals in developing countries. The major emphasis is on a qualitative description of some of the PPPs in the planning and implementation phases, including the challenges encountered. This background is used to analyse in-depth two case studies which are both health oriented; the first one is a national level NGO consortium with a focus on malaria and the second one is an international advocacy group with an overarching goal of protecting children against malaria through an innovative mechanism. The case study approach is used to analyze why the PPP approach was used to address malaria control and how it was implemented. Both PPPs demonstrated that relationships between the public and private sector may begin from very humble and loose beginnings. However, with perseverance from committed individuals, a vision and trustworthiness may become powerful advocates for meeting prescribed health agendas. In conclusion, three key themes (trust, sacrifice and championship) run vividly through the case studies and are significant for developing countries to emulate.

Keywords: public-private partnership, malaria, insecticide treated nets, champion

Introduction

Public-Private Partnerships (PPPs) can be described as a set of institutional relations between the private and public sectors. The relationships differ in operational mechanisms, management, governance, legal status or lack of it, varying by participants and policy. Depending on the desired relationship and the characteristics of the private and public sectors a number of definitions have been framed for PPPs. The United Nations defines partnerships as voluntary and collaborative relationships between various groups, state and non-state, in which all participants agree to work together to achieve a common purpose or undertake a specific task and to share risks and responsibilities and resources (Martens, 2007).

The Initiative on Public-Private Partnership for Health (IPPPH) points out

that the term *partnership* has been used loosely to include communication, consultation, coordination and collaboration (Widdus, 2003). The study cautions that simply calling a venture a 'partnership' does not mean that there is joint decision making. The terminology is further expounded by Nantulya (2008) who describes PPPs as "a continuum of loose to tight arrangements that combine different skills and resources from institutions in the public and private sectors with the aim of effectively tackling socio-economic problems like education and health that persist in the face of independent actors".

With regards to the field of expertise, the scope or dimension of the activity and its wider context; PPPs are often placed into various categories. In the economies, PPPs involve each party taking a degree in risk based upon a shared desire with the ultimate aim of meeting

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a public policy outcome. In the category from organizational studies the focus of PPPs is on a range of characteristics routinely used to describe inter-organizational working (Field & Peck, 2003). In the latter category, a distinction is lacking between the term *partnership* and other terms which are used to describe cross-organizational relationships such as 'alliance,' 'collaboration,' 'cooperation,' 'networking,' and 'joint working.' De Savigny (2004) has defined some of these terms where examples in each terminology are given as follows; *networks* - complex, interconnected group or system such as the International Network for Demographic Evaluation of Population and Health (INDEPTH, 2002), *alliance* - close, long term associations of groups formed to advance common interests or causes such as the Global Alliance to Eliminate Lymphatic Filariasis (GAELEF, 2009); *collaboration* - working jointly, especially in joint intellectual effort such as the Cochrane collaboration (The Cochrane Collaboration, 2009) and the Mapping Malaria Risk in Africa collaboration (Cox *et al.*, 1999). Other terms described in this category include *consortium*, defined as a cooperative arrangement among groups or institutions of a joint venture.

The present research undertakes an extensive literature review of various PPP models in health in scale and in scope which are aimed at advancing public health goals in developing countries. The major emphasis is on a qualitative description of some of the PPPs in the planning and implementation phases, including the challenges encountered. This background is used to analyse in-depth two case studies which are both health oriented; the first one is a national level NGO consortium with a focus on malaria and the second one is an international advocacy group with an overarching goal of protecting children against malaria through an innovative mechanism.

The national level NGO consortium was able to work hand in hand with the government of Tanzania and influence policy in relation to malaria control. The international advocacy group stemmed from one man's passion to see millions of children saved from one of the most debilitating disease in sub-Saharan Africa, malaria. He left a very prominent position as a Managing Director of Euromoney from 2001–2005 to set up a network to source funds worldwide which would solely be used to buy mosquito nets for protecting children against

malaria. The experience of the two PPPs is used to inform both emerging and existing PPPs in the success and challenges in developing collaborative relationships in policy making.

Methodological approach

The study used qualitative research methods including case studies, literature review and interview with key informants.

Case study

The case study approach is used in the research as it allows in-depth data collection, involving multiple sources of information in a specific period of time (Yin, 1994; Robson, 2002). Case studies reveal, 'a decision or a set of decisions, why they were taken, how they were implemented and with what result' (Yin, 1994). In the present research the case study method was used to analyse why PPPs was used to address malaria control; how the PPP was implemented and the outcome observed in the national level NGO consortium and the international advocacy group. Specifically the case studies elucidated the following: (i) the process of engaging in the PPPs; (ii) the implementation of the PPP; (iii) the values of the partnership in facilitating the individual missions and mandates of the participating agencies; (iv) the limitations and challenges of the PPPs; and (v) lessons learnt from the partnership which can inform developing countries.

Literature review

The literature review involved going through relevant documents related to PPPs in health at different levels; the global level and the national level. The emphasis was on the PPPs which aimed at public health goals and alleviating poverty in the context of developing countries. Published data on PPPs was extensively reviewed. Secondary data included quarterly and annual reports from the NGO consortium and unpublished reports from the international advocacy group. The document review enabled the analyst to gather a historical perspective of the events leading to the development of the PPPs in both case studies. The information was combined with the key informant interviews to identify the key steps in a chronological manner.

Interview with key informants and observations

The lead actors that influenced the PPPs were interviewed. These included the Director of the Tanzania NGO Alliance Against Malaria, the Director of World Swim Against Malaria, the Chief Executive Officer of the largest Net Manufacturing company in Tanzania, civil servants in the Tanzania National Malaria Control Programme and a Public Health Specialist advising the Tanzania Ministry of Health and Social Welfare on strengthening the health system. The questionnaires were structured in a similar manner capturing the key informants' perspectives on PPPs in health, the process of engaging in the PPP and the limitations and challenges of the PPPs and proposed solutions to the problems. In the case study for the international advocacy group, an interview with the key informant was carried out through a tele-conference and hand written notes were taken. Triangulation of the information accrued from the interviews was done through published and grey literature. The interviews were carried out between 2006 and 2008. Observations were also carried out in the field for the national level NGO consortium during data collection.

Data analysis

Grounded theory: Interviews with the key informants were audio taped and transcribed verbatim for the national level NGO consortium (Lacey & Luff, 2001). Observations were also carried out in the field and recorded immediately. These were done covertly to reduce bias. The data was transcribed in MicrosoftWORD® and backed up and stored independently. In both case studies, the recurring themes around the objectives of the study were identified (Lacey & Luff, 2001). The themes that occurred were coded to construct debates around specific issues comparing and contrasting areas which are the same or may have marked differences. The emerging theories from these themes were confirmed at this stage through the in-depth interviews. At this stage the analysis included finer details, giving a rich understanding of specific issues in the implementation and the values of the partnerships in facilitating the individual missions and mandates of the participating agencies (Lacey & Luff, 2001).

Categorization of partnerships

Two case studies namely, the Tanzania NGO Alliance Against Malaria (TaNAAM) and the World Swim Against Malaria (WSAM) are used as examples to describe partnership in health delivery. A review examining the plethora of global partnerships in recent years with a focus on the relationship between the United Nations and the private sector has categorized partnerships according to the desired outcome of the relationship and according to the core function of the institution (Martens, 2007).

Outcome oriented categorization: (a) influencing political and civil discourse – advocacy such as political dialogue, learning forums or collaborative events and campaigns. For example the Roll Back Malaria Partnership (RBM, 1998), (b) adopting international norms, regulations and standards – standard setting – especially in the area of business and industry. For example the International Organization for Standardization (ISO, 2008), (c) mobilising private and public finances such as fund raising campaigns, sponsorship, permanent institution support such as the Global Fund for HIV / AIDS Tuberculosis and Malaria (GFATM 2009), (d) technical cooperation and service delivery such as Management Science for Health (MSH, 2008), (e) coordinating state and non-state activities in a particular sector (coordination) through global networking of public and private institutions. For example the Global Forum for Health Research (GFHR, 2003). Examples of partnerships have been extensively described by Walt (1994).

Categorization according to the core functions of the partnership includes: (a) low level of institutionalization – time limited ad-hoc initiatives with narrowly defined objectives. There is no legal status, no formalized membership or governing body (Martens, 2007; Ellis, 2007), (b) medium level institutionalization – defined membership, secretariat is present, there is no legal status and there is no budget authority, (c) high level institutionalization – permanent multi-stakeholder institutionalization with legal status, formal membership, secretariat and budget authority such as the Global Fund for AIDS, Tuberculosis and Malaria (GFATM, 2009) and the Global Alliance for Vaccines and Immunization [GAVI] (GAVI, 2009).

Under the examples of partnerships defined according to core functions in the low level of institutionalization described above, there are fundamental lessons which can be drawn from these independent settings which clearly show similar features in the way they influence policy (Walt, 1984,1994; Buse *et al.*, 2005; Ellis, 2007). Using some examples in Brazil and UK, it can be observed that, both coalitions (the dam construction project in Northern Brazil and the Asylum and Immigration Act of 1999 in the UK) had clearly defined goals and were united in the perusal of the goal. Both coalitions had 'champions' in the individual NGOs who were central in driving the campaign forward. For example in the coalition between OXFAM GB, the Refugee Council and Trade Union (Ellis, 2007) it was evident that certain individuals in the respective organizations were committed to a common goal and devoted themselves wholeheartedly towards the realization of this goal (Ellis, 2007). While in the Dam construction project in Northern Brazil (Ellis, 2007) the Catholic Church was the champion. The Catholic Church initiated an education campaign to warn the peasants on the negative impact of the contract related to the dam construction (Walt 1994). The separate NGOs and Trade Unions in the coalitions respected and welcomed the expertise and diversity that each brought to bear in the campaign. They realized that they could not succeed independently.

Policy change is lengthy and far from linear (Crosby, 1997). In the two examples cited, the coalitions became stronger with time enabling the partnership to tap into new avenues such as political and international influences. For example in the contract for the dam construction project in Brazil, as the windows of opportunities opened up (Kingdon, 1984), the pressure groups mounted multiple support to the extent of attracting the World Bank to act positively on their behalf. The World Bank laid down some basic conditions regarding satisfactory re-settlement provisions (Walt, 1994). Similarly, in the petition against the voucher scheme which discriminated asylum seekers in the UK, the Trade Union had strong political connections with the Labour Party (the ruling party at the time). This allowed them room to leverage political support against the voucher scheme (Ellis, 2007). In this context, the policy environment surrounding the petition against the voucher scheme was greatly influenced by the Labour Party which allowed the Trade Union room to manoeuvre in favour

of abandoning the voucher scheme (Grindle & Thomas, 1991).

As the debate on the specific examples of PPPs is taken to another level; it is of significance to clarify the different sectors i.e. 'public' and 'private.' The definition of public sector is quite universal referring to all sectors of the government at different levels – state, district, municipal, local government and other inter-governmental agencies which deliver public goods. However in defining the private sector there is a much broader definition. The first definition is quite inclusive stating - 'individual for profit, commercial enterprises or businesses in both the informal and formal sectors, ranging from small business and micro-enterprises, to cooperatives and large national and multinational companies and it also means business associations and coalitions and corporate philanthropic foundations directly funded and/or governed by business (Martens, 2007). Furthermore, the private sector can be divided into two categories; private-for-profit – including commercial enterprises of any size (WHO, 2006) and are outside the direct control of the state (Zwi *et al.* 2001) and the private-for-non-profit include NGOs, philanthropic entities and other not-for profit organizations (Walt, 1994; WHO, 2006b). Non-governmental organizations operate as not-for-profit providers of health care. There are an array of NGOs providing health including health professional associations, HIV/AIDs networks and Faith Based Organizations.

The public health sector is endowed with the responsibility of ensuring that there is adequate coverage of essential health care services and products especially in the public health policy of developing countries. Traditional public health groups however, are confronted by limited financial resources, complex social and behavioural problems, inadequate human resources with the right skill mix, weak delivery systems that limit the availability and accessibility of essential health. Similarly, private for-profit organizations have come to recognize the importance of public health goals for the immediate and long term objectives and to accept a broader responsibility as part of the corporate mandate (Reich, 2000). Hence in recent years both parties have found that there are mutual benefits in engaging in partnerships. There is the potential for the creation of a powerful mechanism for addressing difficult problems by leveraging on the strength of each (Nishtar, 2004).

Private – public partnerships for health at the global level

The low income countries are challenged in reaching the United Nation Millennium Development Goals (MDGs) by 2015 where almost 50% of the targets are directly or indirectly related to health (Widdus, 2001; Widdus & White, 2004; Meredith & Ziemba, 2008). Low income countries and often the poorest populations within these countries do not have access to the medicines, vaccines or other health products, they are faced with weak infrastructures, lack the capital investment and expertise in drug development and health related tools (Widdus, 2001; Widdus & White, 2004). In recent years however, the international community recognized that, in tackling the health problems of low income countries especially those requiring increasing research and development on drugs and vaccines for diseases disproportionately affecting the poor; there is a need for better coordination of the traditional public and private sector roles in order to harness the synergistic combination of the strengths, resources and expertise of the different sectors (Buse & Waxman, 2001; Widdus, 2001).

In one of its reviews the IPPPH observes that in most cases the emergence of the PPPs for health went hand in hand with specific trends which occurred in the late 20th Century including; (a) systematic analysis of the global burden of diseases, and an observation that there were limited tools to tackle them, (b) pharmaceutical companies were challenged with rising research and development costs, (c) the escalating HIV/AIDS pandemic drew global attention and concerted efforts in low and middle income countries and (d) public sector organizations had a greater understanding and knowledge of the private sector/industry goals and product development expertise (Widdus & White, 2004). The review also points out that these trends went concurrently with the emergence of 'champions' to initiate or trigger the PPPs in the right environment.

Consequently in recent years there has been an increase in the number of partnerships in health both at the global and regional levels. The major goal is to improve health in developing countries through the collaboration between different organizations in the private and public sectors. Partnerships for pharmaceutical development for example have led Research

and Development (R&D) efforts to generate more accessible and efficacious products for diseases such as malaria, tuberculosis and HIV/AIDS. Multinationals, venture capitalists and entrepreneurs in the public and philanthropic sectors have argued that costs and risks of products in R&D for endemic diseases in the world must be shared with industry to ensure public health dividend. Such an approach has been termed, '*Social venture capital*' (Wheeler & Berkley, 2001). The characteristic of these new partnerships is that they focus on funding high risk and high cost projects to convert basic scientific discoveries into usable products. Secondly they do not link to a single company but interact competitively with many companies and finally they are driven by a defined goal and mandate and have established themselves as independent legal entities outside existing international and philanthropic organizations (Wheeler & Berkley, 2001). Examples of such public – private partnerships are; the Global Alliance for TB Drug Development (WHO, 2000) and Medicines for Malaria Venture (WHO, 1999). Furthermore, Global Public – Private Partnerships (GPPPs) have been defined as collaborative relationships, which go beyond national boundaries. These include a specific form of governance, a mechanism of mobilizing political resources in situations where those resources are widely disbursed between private and public actors (Walt & Lush, 2001; Buse & Walt, 2000a).

There are three categories of the GPPPs that are described (Walt & Lush, 2001; Buse & Walt, 2000a): (a) product based, (b) product development based and (c) issues and systems based. The first two are of relevance to this study and will be explored further. *Product based* – products of low income countries for public sector programmes which are initiated by the private sector. For example pharmaceutical companies seek partnership with the multilateral sector to lower the cost and increase chances of ensuring the drug reaches those who need it but cannot afford it (Widdus, 2001; Widdus & White, 2004; Buse & Walt, 2000a). *Product development based* – are based not on ineffective demand but on market failure. It is initiated by the public sector and the industry does not see that the potential returns justify the opportunity cost of investment. It involves devising and implementing strategies that ensure accessibility of existing and new products and services in poor countries and populations (Caines *et al.*,

2003; Robert, 2004). Robert (2004) has defined the GPPPs which are product development based as, 'a project or portfolio of projects in which public or philanthropic funds and resources are combined with pharmaceutical company resources in a functional partnership that is co-managed by both parties under an agreement that stipulates the terms of that agreement and defines the product that is to be discovered/developed to meet a public health need.

In addition to the product based and product development categories mentioned above, Widdus (2001) maps out other approaches, which could be used to enable developing countries to access medicines or technology such as creating environments conducive to product quality. One example is from the United Republic of Tanzania where technology was transferred from a developing world to produce Long Lasting Insecticide Treated Nets (LLINs) to a Tanzanian Textile manufacturing company. The Japanese technology from Sumitomo Chemical Company was brought to the country through partnership involving, WHO, UNICEF, the Acumen Fund and private companies. The Acumen Fund is a New York based non-profit organization that invests in philanthropic resources in innovative social entrepreneurs and enterprises with a primary goal of social change. The Acumen Fund provided a loan to the Tanzania-based A to Z Net Manufacturing Company to purchase the required machinery for the manufacture of insecticide treated mosquito nets. The Japanese transferred the technology to the Company on a non-exclusive basis without any license fee. Sumitomo has also agreed to train African technicians and establish quality control procedures for LLNs. ExxonMobil another partner in the venture is providing the resin for the manufacture of LLNs (Anuj Shah, *pers. comm*).

The United Nations and Public – private partnerships

The World Health Organization has encouraged the support of all partners in health development, including institutions in the private sector and non-governmental organizations in the implementation of national health strategies for all (Buse & Walt, 2000b, Buse & Waxman, 2001). This endeavour is in line with the mandate of the United Nations, which aims to promote among other things, corporate responsibility in the areas of labour, human rights and the

environment in response to the unfavourable effects of globalization. The World Health Organization has several aims in encouraging the establishment of partnerships, which include to facilitate universal access to essential drugs and health services and accelerate R&D in the fields of vaccines, diagnostics and drugs for neglected diseases such as Medicines for Malaria Venture (MMV) (WHO, 1999) and Global Alliance for TB Drug Development (WHO, 2000). A recent agreement between a pharmaceutical company and WHO has been in reducing the price of the first co-formulated combination therapy of antimalarial drugs containing an artemisinin derivative; Artemether/Lumefantrine (COARTEM®), which has been made available to the public sector in malaria endemic countries. The company producing Coartem® in the first agreement sold Coartem® to WHO at US\$ 2.4 for a 24 tablet blister pack which is the adult treatment course with the 6 dose regimen. This compares with US\$40 for the price of the same drug sold to industrialised countries (WHO, 2006).

Challenges in public-private partnerships

There are various challenges which have been observed in PPPs. Some of the challenges are outlined in relation to the different categories of PPPs discussed above. In the product development based PPPs (Robert, 2004) stresses that it is important from the onset in the stage of developing a PPP that it operates under legal agreements which may involve different operational cultures. Secondly he notes that often under product development based PPPs numerous projects are involved and therefore there are complex virtual managerial structures to be dealt with for the respective projects.

Challenges have also been observed in PPPs where NGOs are involved and participate in the formulation of policy and implementation of national plans. In the tripartite PPP involving the WHO, Ministry of Health and an NGO which developed a national integrated plan for health and the prevention of non-communicable diseases in India, Nishtar (2008) underscores that, the driving principle promoting PPPs should be the benefit to society and not mutual benefit to partners and centre on equity to health and therefore social responsibility should be enhanced. The author also alludes to the 'Paris Declaration' which should be the driving force in PPPs such that partners recognize the

leadership of the country and the government as the owner of poverty reduction processes and secondly development partners should align their plans so that they fit within the government's plans (Nishtar, 2004). At the same time development partners must harmonise their work in common procedures and joint arrangements (High Level Forum, 2005).

In 2005 the World Economic Forum Global Institute for partnership and Governance and United Nation Department of Economic and Social Affairs brought together a set of multi-stakeholder roundtable discussions to determine where some of the greatest opportunities were in harnessing PPPs to advance the development objectives (World Economic Forum, 2006). Some of the challenges in the planning and implementation of PPPs that were documented include: (a) the establishment of adequate trust among partners; (b) the lack of political will and public support for the PPP concept; (c) the necessity of a well connected 'champion' in a partnership and the challenge of ensuring continuity if the champion leaves the partnership; (d) effective management of high transaction costs and development of governance structures that can sustain the collaboration process over time and (e) lack of programme accountability, weakly defined roles and an absence of advisory committees

Introduction to the case studies

The PPP agenda has been addressed from various angles and at different levels such as the international level where the initiative may be outcome oriented, for example engaging in an advocacy role towards public health gains in developing countries. Some PPPs are addressed at the national level where the public sector for example maybe institutions such as the academia or the state itself (Birungi *et al.*, 2001; Buse & Waxman, 2001; Walt & Lush, 2001; Widdus, 2001). A range of principles have been observed in analyzing the different types of PPPs which could be instrumental to guide initiatives which have already been established or those which will be made in the near future. Some of these principles are described herewith.

Institutional frameworks – in an endeavour to protect the public sector's interest as the central theme, an improved institutional governance system should be in place (Buse & Waxman, 2001). This includes a coherent policy on legislation, regulation and control as well as a

monitoring system to reinforce the policy (Wyss *et al.*, 1996; Birungi *et al.*, 2001; Widdus, 2001). *Defining outputs*–Desired goals and outputs need to be agreed upon by the potential collaborators and the relevant complementary expertise in both sectors need to be acknowledged. The long term interest of each sector should be fulfilled and the contribution of expertise and resources need to be reasonably balanced (Widdus, 2001). *Development of guidelines* – Partnerships in research or the academia should endeavour to develop guidelines which will make clear the principles on which relationships should be based, thus avoiding potential conflicts of interest, protecting academia reputation and integrity of the scientific outputs (Walt & Lush, 2001). However this could also be useful in PPPs established outside the academia.

All NGOs have varied mandates, managerial arrangements, legal status, policies, strategies and target group or focus. They are well articulated to the grassroots niche, an environment they are well acquainted with. Historically NGOs provided essential services in rural settings, however this has now changed (Walt, 1994). NGOs play an 'influencing' role apart from their normative 'doing' role. NGOs influence governments in four categories: (i) working with governments, (ii) introducing innovative approaches, (iii) taking a direct advisory role, and (iv) building networks. The networks that NGOs form build on the legitimacy gained through grassroots work and experience in order to have a greater impact at the national level (Walt, 1994)

Two different PPPs which are different in scale and scope were analysed through a case study approach. The first example is from Tanzania, where a consortium of NGOs was formed with a focus on working on malaria and was able to work closely with the government and to influence government policy. The second example is an alliance called 'Against Malaria Foundation,' which was built from one person's passion to raise funds to protect children in endemic countries against malaria through swimming.

The Tanzania NGO Alliance Against Malaria (TaNAAM)

In 2002, the Ministry of Health through the National Malaria Control Programme (NMCP) called upon stakeholders to develop a proposal on the 'National Insecticide Treated Nets implementation (NATNETS) Plan Support,' to

be submitted for funding to the Global Fund for HIV/AIDS, Tuberculosis and Malaria (GFATM, 2002). The main aim of the project was to provide a discount voucher to enable pregnant mothers to purchase a mosquito net at a highly subsidised cost and an insecticide re-treatment kit at 100% subsidy to infants. The NGOs in the country either working in health or in malaria specifically were among the stakeholders invited. During this meeting the NGOs realised an opportunity of engaging in the proposal write-up where they had a comparative advantage of working at the grassroots level to provide training and promotion to health care providers and target groups in the NATNETS project (URT, 2002). Thereafter, these NGOs held subsequent meetings on the malaria agenda and eventually at the end of 2002 formed a task force with the major goal of facilitating the collaboration and coordination of NGOs working on malaria projects, mobilization of resources, information exchange, liaison and advocacy for health and representation and visibility. The task force selected two NGOs as co-Chairs; World Vision Tanzania (WVT) and CARE. However within the same year under the guidance of The Child Survival Collaboration and Resource Group (CORE), the task force was advised to establish an NGO malaria Secretariat to coordinate malaria strategies and initiatives on behalf of the NGOs.

The rationale for proposing an NGO Malaria Secretariat in Tanzania was clearly spelt out by the task force. In summary the rationale stressed on the creation of a mechanism for NGOs to collectively present RBM advocacy issues which would facilitate a more effective two way relationship with the government and other stakeholders. Thus enabling NGOs to provide added value regarding government priorities and constraints in the implementation of the NMCP strategy 2002–2007. Secondly, there lacked an appropriate forum to effectively engage malaria actors at all levels of information sharing. This was deemed crucial as such a forum would forge synergies for more effective implementation of malaria initiatives. This would also involve documenting stakeholders' activities and a detailed mapping exercise of NGOs working in health in the country (B. Minja, *pers. comm*). It reinforces the thrust that the task force had in partnering with the public sector not only to implement essential health activities but to work in alliance with the government to influence policy (Walt, 1994).

In April 2003, the Ministry of Health selected two districts in the country to pilot the discount voucher scheme before it was launched country wide. Two NGOs from the Tanzania NGO Malaria Secretariat were selected to participate in this activity; WVT and Care International (CARE Tanzania, 2004). It was from this experience that the NGO secretariat managed to develop a competitive application as a component of the training and communication strategies for the roll-out of the discount voucher project in the country, an activity which was awarded to WVT and Care International from the end of 2003.

In May 2003, the NGO secretariat was transformed to 'The Tanzania NGO Alliance Against Malaria (TaNAAM). Its mission, was *'To form a collaborative network of Civil Society Organizations, private sector and other stakeholders committed to effective coordination that maximises collective resources and takes on board advocacy issues to address the challenges of malaria control'* (TaNAAM, 2005). Since May 2005, TaNAAM and two of its' partners – AFRICARE and Plan-Tanzania have been receiving financial support from GFATM Round 4 (GF4) for developing a country-wide advocacy and behavioural change and communication (BCC) strategy towards the change of malaria treatment policy in Tanzania. They were awarded this intervention as part of the overall GF 4 contribution. AFRICARE and Plan International implement their advocacy and BCC strategy through sub-contracting to several Community Based Organizations (CBOs) country wide. These CBOs engage in community mobilization and awareness activities on the change of malaria treatment policy in the country. TaNAAM has mapped and created a database on the CBOs/NGOs working in health and malaria control in the country. In their advocacy role, TaNAAM was also in a position to audit messages that were developed by the media to ensure that they met the public health agenda in relation to malaria control (B. Minja, *pers. comm*).

The strength of TaNAAM is observed from the diverse skills that are available within the individual NGOs that build up the consortium. It is proactively engaging in macro-policies of the ministry of health by developing sound proposals from its knowledgeable network which can compete with other potential bodies at the national scale for financial awards. Indeed there is no room for competition or duplication as the alliance is working towards a common

goal but maximizing scarce resources to bring about a greater impact on health nationwide. As individual NGOs they would be unable to realise such an impact (Nantulya, 2008).

In 2004, TaNAAM conducted their first National Malaria Fresh Air Workshop where 100 participants from 85 NGOs, CBOs, Faith Based Organizations (FBOs), affiliated to health, Ministry of Health and other partner Civil Society Organizations outside health to deliberate on their respective roles in scaling up Roll Back Malaria initiatives in Tanzania (TaNAAM, 2005). At the end of the five-day workshop a *communiqué* was released which highlights the issues TaNAAM was mandated to perform and those which the partners were mandated to do as stipulated. The *communiqué* draws lessons from a firm foundation that TaNAAM had built over the years. It supplemented the mandate of TaNAAM by strengthening its core goal in malaria control through the expansion of networks to district, regional and zonal levels. However it also mandates TaNAAM to coordinate and collaborate with stakeholders across other programmes such as HIV/AIDS and even outside the health sector such as education, agriculture and social welfare.

TaNAAM faced a number of challenges including lack of legal status in establishing their network as described by the Director *'The greatest challenge to networking you start very loose.....we started in 2003 and to date we have not been officially registered.....we came to realise that if we do not register and have a legal status as a network and depend on other members of the organization who are legally registered you lose some opportunities. For example, we cannot mobilize resources without being registered as we cannot open an account. We have to pay a huge administrative fee to members with a legal status who are fund managers of the organization. This amount of money could have been used to deliver more services if we had the legal backing'* (Director, TaNAAM, 17th January 2006).

Through TaNAAM's tenacity and strong leadership of its Director, they were finally registered by the Administrator General of the Government of the United Republic of Tanzania on the 17th April 2008 under a new name as 'The Tanzania National Malaria Movement (TANAM, 2008). This was a long five years of perseverance since its inception in 2003. TANAM's new organization structure has a Board of Trustees who oversees the NGO and a Committee of Experts who avail technical expertise to the network (TANAM, 2008).

Another challenge noted by the network was the delay they experienced in accessing the Global Fund (GF) financial support. The principal recipient of these funds was the Ministry of Finance (MoF); the Ministry of Health would request these funds from the MoF and the funds would then flow to the NMCP who would apportion the funds to the respective contractors including TANAM. In this respect the principal recipient had been selected by the Country Coordinating Mechanism (CCM) to be legally responsible for programme results and financial accountability as stipulated in the GFATM fiduciary arrangements at the time (GFATM 2003). The Director felt that since the network had been officially registered, in future GF proposals they could request for funds directly as a sub-recipient and therefore manage their resources directly without the long delays they experienced which often led to the network delaying in meeting its set targets.

The third challenge was the inadequacy of the financial support received through GF 4 in accordance to the demands experienced at the community level. According to the Director; *'.....this entailed TANAM engaging itself in numerous voluntary activities that demands patience and patriotism'*. In the context of the BCC, the Director articulated this constraint in the perspective of the BCC activities that the network was undertaking; an intervention which yields fruit after a long period, because too often people are resistant to change.

The strengths that mark TANAM are threefold; (i) TANAM is a member of broader international malaria network such as the East African Roll Back Malaria Network (EARN) (RBM, 2009). Through EARN, the network attends annual RBM international meetings in the East African region which enables TANAM to gain experience in malaria control from a diverse community of stakeholders and therefore strengthening its knowledge base. Similarly, using EARN as an entry point, the organization sought potential financiers towards the implementation of its strategic agendas; (ii) TANAM is focused in its goal of building a collaborative network of NGOs and CSOs to effectively coordinate and advocate for malaria control in Tanzania. TANAM has the advantage of the rich experience of its members who are engaged in public health activities at the community level as their corporate mandate and are in a position to influence the implementation of malaria interventions as guided by the NMCP

(iii) TANAM's Director has been the 'champion' and the backbone of the network since its inception in 2003. From very modest beginnings and a very 'loose' structure and no legal status (as described above), she engaged the network in developing credible proposals together with the NMCP in the GF grants and subsequently implementation of the GF grants and was able to influence policy. She also took advantage of any national and international meeting on malaria to lobby support for her organization. TANAM's experience avail fundamental lessons to NGO partnerships which often begin in humble settings and often loose structures.

The Director was asked as to how she managed to get international recognition in the early days of the network. She replied as follows; '.....the way in which you sell your organization really matters a lot. That makes everybody get interested.....We work closely with Executive Directors of International NGOs... they raise our flag high wherever they go (17th January 2006). The visionary character and openness of the Director to TANAM's course have been far reaching. In 2007, she was selected as a Board Member of the GFATM, as one of the members representing the Civil Society in serving a tenure of 2 years (2007/2009) (B. Minja *pers. comm.*). Her role as a malaria activist in the board is to advocate on the best practices for malaria control in various forums, lobbying for more resources for malaria activities and raising the voice of the needs of the vulnerable groups on their behalf. The Director underscores that this position made her a different person, giving her the exposure, knowledge and skills in engaging in international networks. The Director brings these resources to her own country, equipping her with a firmer foundation in articulating better methods for translating policy into action at the community level.

World Swim Against Malaria Advocacy Group (WSAMA)

The 'World Swim Against Malaria (WSAM)' advocacy group operates under the Foundation called 'Against Malaria Foundation (AMF) (The Against Malaria Story, 2008). AMF is a charity registered in the UK, Australia and 11 other countries. It was set up in 2004 with the explicit aim of handling the finances raised through WSAM. WSAM has an overarching goal to educate the communities on the dangers of malaria and to lobby resources to control the disease. The advocacy group is overseen

by nine Trustee Members who have been carefully selected to reflect the specific goal of the initiative; lobbying resources for the control of malaria worldwide. The members include a public health specialist, a Director of Business, a Global Strategy Consultant, an International Investment Banking and Business consultant, a Director of Science at the national History Museum in London, an Executive Director of a UK listed Property Company, a Marketing Career and a Chief Legal Officer and Vice Chairman at Lehman Brothers International Investment Bank. There is also a Malaria Advisory Group which provides technical advice to the advocacy group and scrutinizes all proposals for funding before they are approved. There are eight members from a broad based background from renowned public health specialists in leading universities in public health, the Technical Director of the Malaria Consortium, and leading international researchers in malaria control (The Against Malaria Story 2008).

The history of WSAM goes back to 2003, when Rob Mather, the founder was watching a documentary of a 2-year girl with a degree of burn over 90% of her body. The documentary moved the Director emotionally such that he organized a charity swim towards supporting the medication for the young girl called Terri Calversebert. Within 6 months he raised £200,000.00 for Terri and 100% went to the trust fund that he had set up. He also opened a web site called 'Swim for Terri.' The Director wondered how successful the seemingly small gesture for 'Swim for Terri' had turned out to be. He thought that if this worked so well for one child in need maybe he could do it for a disease where there would be a greater impact. The disease that came to his mind was malaria targeting mosquito net ("*a net saving a life*") as the most the most tangible intervention.

In 2004, the Director decided to take a 2-year unsalaried leave from his position as managing Director of EuroMoney to get 1 million people to swim for malaria. He spent 2004 planning for the philanthropic venture. He launched the programme in December 2004 by making 20 phone calls and asked 20 organizations to arrange for 5,000 of their employees within the receptive organizations to swim and raise funds for malaria. A hundred percent of the funds raised would buy mosquito nets. Apart from the organization from within and outside the UK, prominent figures swam for the noble cause including an Olympic Gold

Medalist, the Managing Director of Citibank Global Group and the Global Head Retail Bank etc. The Director of World Swim Against Malaria has an overarching goal of raising USD 3.5 billion in 10 years, towards malaria control.

The Director identified existing organizations who were already working in malaria control with credible track records in delivering nets to the target groups. Organizations who desired to engage themselves in the WSAM programme required to make a formal application to the WSAM. The applicants were given a questionnaire to outline the plans that the respective organization had in delivering mosquito nets. A legal requirement in the agreement was efficiency in delivering the mosquito nets to the target population and a report including video footage testifying of the delivery of the commodity. One of the duties of 'the Malaria Advisory Committee,' was to scrutinize the proposals and approve them. Once the proposal was approved it took about 3 – 7 days to process the funds including delivery to the recipient organization. The Director also has a post evaluation system in place to follow-up on the implementation of the individual organizations. All the video editing is carried out by Rob personally.

The Director notes that the shortest time that a grant was processed was 21 minutes where he supported one organization with \$100,000.00. In all the agreements, the recipient organization had to ensure \$10,000.00 towards the distribution of the mosquito nets to the end user. Almost all the funding is earmarked for Africa and the Director's motto is *efficiency, accountability and transparency*. The Director expressed the fact that the innovative system that he had set-up is empowering the beneficial organizations to contribute to the alleviation of the suffering caused to millions of children in Africa through the debilitating disease. An innovative way of tracking the distribution of mosquito nets bought through WSAM was the creation of a website hosted free of charge by Microsoft® set-up from the period the Director was supporting Terri. Through this website participants can create their own space to raise money and view the proposals submitted by successful organizations (The Against Malaria Story, 2008).

The Director's observation is that there is insufficient global advocacy towards malaria control. He points out that globally there is more money being used on military arms and to fight

HIV / AIDS than the funding for malaria which is curable and preventable with cost-effective interventions. He urged governments to invest in combating the malaria through recurrent expenditures. The private sector is already doing a lot. The Director of WSAM gave his definition of PPPs as follows; *'these are players or groups with different expertise, which come together, with a common cause working efficiently together as a team. The private sector has expertise in business, financial structures, the drive to do something and commitment (2nd September 2008).'* Rob stressed that commitment and desire in both the public and private sector were not to be underrated. He observed that the public sector NGOs (i.e. NGOs which serve public sector interests) have a track record in delivering mosquito nets in the field as they perform very well. He cited organizations such as the International Red Cross and Population Services International. The Director underscored that one needs good intelligence to work out the best people for the job within the partnership and that the PPPs must be kept simple.

Ingredients for a successful Public-private partnership

According to the WSAM Director, the ingredients of a successful PPPs could be summarised in four areas: (i) people talk about the necessity of doing something such as malaria control but when given the resources they do not deliver – *'things need to be done not just talk'* (ii) one needs a very clear, simple and concise vision; (iii) it is not enough to have the right ideas, one needs to be honest with people for small and large things – *'be trustworthy – but do not over promise,'* (iv) time is your greatest enemy, be efficient (2nd September 2008).

Discussions on PPPs were carried out with the first coordinator of the Tanzania National Voucher scheme (TNVS) in the first year of the implementation of the discount voucher. Her argument in the lack of thrust and dynamism in the public sector in Tanzania was tied to the hierarchical structure that was in place. This caused some insecurity in civil servants lower down the ladder such that they would not express their honest feelings to their peers for fear of losing their employment or being demoted. She had this to say, *'...in the private sector, people are judged on merits, on their outputs, irrespective of where they come from. This is not in the public sector. If you could get a little bit of the private sector push encouraged into the public*

sector, this would be helpful (16th January 2006).

The training and promotion contractor of the TNVS whose role was to train the district Council Health Managements Teams in Tanzania on the discount voucher scheme, felt that one of the reasons partnerships did not reach their expected outcomes was the lack of capacity building in partnerships. This is an angle which many organizations overlook when venturing into partnerships and should be explored further in future PPPs. Preferably individuals who have a long experience in building partnerships would be resourceful in tailor making such training packages for different target groups.

Trust, Sacrifice and Champions

Both the TANAAM and WSAM have a number of key issues in common and most of these have been discussed above. However, three key themes (trust, sacrifice and champions) that are critical for developing countries to emulate in the implementation of PPPs. Trust has been observed by both TaNAM and the WSAM as a key ingredient in PPPs. The Director of WSAM is quoted as saying, ".....many wealthy individuals would contribute to the cause of malaria if they were assured that their money would be used judiciously, with utmost transparency and accountability" (2nd September 2008). He continues,...."it is not enough to have the right ideas, one needs to be honest with people for small and large things – be trustworthy – but do not over promise." While the Director of TANAM mentions, '....mistrust amidst some of the health workers in the Antenatal Clinics of the public health facilities in handling the discount vouchers earmarked for pregnant women attending the clinics" (17th January 2006).

It should be noted that trust involves an element of risk derived from one individual's uncertainty regarding the motives, intentions and future actions of another on whom they depend. It is also observed that in organizational structures, trust can encourage communication and information flow and therefore minimise the varied organizational cultural differences in handling several partners and ultimately reduce transaction costs (Gilson 2003).

An element of sacrifice is observed in both case studies. The Director of TANAM is quoted as follows: "...this is a cost. In fact some lose positions. We have seen one who lost her position as she sacrificed for partnership, and that partnership was TaNAAM (17th January 2006). The Director sacrificed his own extremely influential position,

for a philanthropic venture that would go a long way in saving thousands of children from malaria in endemic countries. Both Directors in the case studies are *champions* of their respective organizations. The motto that the Director of WSAM used for his advocacy groups befits TANAM's Director so well, as they both endeavour to strive to meet their strategic health agendas. The motto is, '*efficiency, accountability and transparency.*' Under the strong leadership of these organizations; unlimited success has been observed where TaNAM's Director for example is serving as a Board member of the GFATM and to date the Director of WSAM has been able to distribute mosquito nets in 28 countries with more than US\$2.5 million raised and more than 500,000 mosquito nets distributed.

In conclusion, both the local international advocacy groups have both demonstrated that PPPs may begin from very humble and loose beginnings but with perseverance, a vision and trustworthiness may become powerful advocates for meeting prescribed health agendas in the developing world.

Competing interests

The authors declare that they have no competing interests.

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