

Background Paper

UNDP/World Bank/WHO Special Programme for Research & Training in Tropical Diseases (TDR)



Public-Private Partnerships: Illustrative examples

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(Extracts from a paper presented at a workshop on Public-Private Partnerships in Public Health, Massachusetts, USA, 7-8 April 2000)





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TDR/BP/00.1

This paper was presented at the Workshop on Public-Private Partnerships in Public Health, Endicott House, Dedham, Massachusetts, April 7-8th, 2000.

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PUBLIC-PRIVATE PARTNERSHIPS: ILLUSTRATIVE EXAMPLES

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The World Health Organization, now openly promoting public-private partnerships, has developed a number of innovative collaborative ventures with the private sector. The pioneering work of TDR and some other special programmes have guided WHO's bold new approach. The Global Forum for Health Research, whose major goal is to intensify research effort on problems affecting the poor, is also actively promoting public-private partnerships.

In many countries, there are long established links of the public sector with non-governmental organisations and other non-profit institutions in the private sector for the delivery of health care. (Cross, 1998). On the other hand, until recently, the relationship between the public and the for-profit private sector was often characterised by antagonism, suspicion and confrontation. For example, the World Health Organization's (WHO) promotion of the Essential Drug Programme initially provoked strong reactions from the pharmaceutical industry. Concern about the inappropriate marketing of baby foods in developing countries, prompted some non-governmental organisations and other activists to mount pressure on manufacturers of baby foods; this negative reaction also influenced attitudes to the pharmaceutical industry. However, in recent years, increasing rapprochement between the public and the private sectors, is giving rise to positive encouragement of public-private partnerships in the health.

In this paper, the term "public-private partnership" is used to refer specifically to the collaborative programmes between the public sector and the for-profit section of the private sector. In the rest of the paper, the term "private sector" will be used to refer to the for-profit, commercial private sector, excluding not-for-profit non-governmental organisations and institutions within civil society. The paper describes two illustrative examples of public-private partnerships:

A. UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR)

B. Philanthropic drug donation programmes.

A. TDR - AN EXAMPLE OF PUBLIC-PRIVATE COLLABORATION

TDR was established 25 years ago with two inter-related objectives (Godal et al. 1998):

- **Research & Development:** to develop safe, acceptable and affordable methods of prevention diagnosis, treatment and control of TDR's target diseases.¹
- **Training & Strengthening:** to strengthen the capability of developing disease-endemic countries to undertake the research required to develop new drugs

¹Initially, six groups of diseases were included in the programme: Malaria: Schistosomiasis: The trypanosomiasis - African trypanosomiasis and Chagas disease: The leishmaniases: The filariases - onchocerciasis and lymphatic filariasis: Leprosy. More recently, dengue and tuberculosis were added to the list of diseases in the TDR portfolio.

Co-sponsored by the United Nations Development Programme, the World Bank and WHO, TDR was clearly a public sector initiative but it collaborated with the private sector on aspects of its programme. It was clear that TDR could not achieve some of its specific goals, especially the development of new drugs, without the collaboration of industry. Box I gives an illustrative list of private institutions that were involved with TDR during the first two decades of its operation. Because of the acrimonious controversies between the public and the private sectors, TDR's interactions with the pharmaceutical industry were initially cautious, guarded and closely monitored by the programme's governing bodies. They kept a watchful eye on TDR's links with industry, assuring the sponsors and other interested parties that in all the contracts and joint activities, the public interest was well protected.

TDR interactions with the private sector included:

- Participation of scientists from the pharmaceutical industry in TDR's advisory committees.
- Services to TDR from industry; and
- Joint programmes

Box I

TDR'S COLLABORATIONS WITH THE PHARMACEUTICAL INDUSTRY

1. ACF Beheer, B.V., Maarssen, Netherlands
2. Bayer A.G., Leverkusen, Germany
3. Biobras-Bioquímica do Brasil, Montes Claros, Brazil
4. Burroughs Wellcome Company, Research Triangle Park, North Carolina, USA
5. Ciba Geigy, Ltd., Basle, Switzerland
6. Daiichi Pharmaceutical Co. Ltd., Tokyo, Japan
7. Eli Lilly and Company, Greenfield, Indiana, USA
8. Genetic Institutes, Boston, Maryland, USA Glaxo Group Research Ltd., Greenford, UK
9. IHARABRAS S.A., Industrias Químicas, Sao Paulo, Brazil
10. International Federation of Pharmaceutical Manufacturers Associations, Geneva, Switzerland
11. Janssen Research Foundation, Beerse, Belgium
12. Laboratorios Gador, Buenos Aires, Argentina
13. Merck and Co. Inc., Rahway, New Jersey, USA
14. E. Merck Pharma, Darmstadt, Germany
15. Novo Nordisk A/S, Bagsvaerd, Denmark
16. Pasteur-Mérieux-Connaught, Swiftwater, Pennsylvania, USA
17. Pharmacia Farmitalia Carlo Elba, Milan, Italy
18. Rhône-Poulenc Rorer Doma, Antony, France
19. SmithKline Beecham Pharmaceuticals, London, UK
20. Vestar Inc., San Dimas, California, USA
21. Zeneca Pharmaceuticals, Macclesfield, UK

Source: UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (1994)

Contributions of scientists from pharmaceutical companies to TDR

TDR used a global network of scientists to develop, implement and review its research and development projects. The scientists, drawn from academic and research institutes as well as from industry, were selected strictly on the basis of individual merit and relevance to the needs of the programme. The scientists from drug companies contributed to TDR's task forces, working groups and steering committees in their special areas of expertise, but they were not appointed as representatives of their companies. These outstanding scientists from industry (including two Nobel Prize winners) gave service to TDR on a pro bono basis; they received no fees or honoraria beyond their travel and subsistence expenses.

Specific Services to TDR

TDR requested and obtained a variety of services from pharmaceutical companies including:

- **Special reagents required by research scientists** e.g. radio-labelled chemicals;
- **Good Manufacturing Practice facilities** for biological reagents that will be tested in humans e.g. Armadillo-derived leprosy bacilli, subsequently used for producing test vaccines, were processed and stored by the Wellcome Research Laboratories on behalf of TDR.

Joint activities of TDR with industry

Drug companies participated with TDR in exploring some promising leads and ideas:

- **TDR screening facilities.** TDR made available to industry its drug screening facilities. Over 10,000 compounds passed through the network of biological screens for testing candidate drugs for treatment of onchocerciasis. One compound, ivermectin, proved to be an outstanding product.
- **Clinical evaluation.** TDR worked with industry in the clinical evaluation of new drugs e.g. mefloquine (Hoffmann la Roche); ivermectin (Merck & Co Inc.); efloornithine (Hoechst Marion Roussel Inc.)

TDR's research and development effort has been credited with the successful introduction of effective new technologies. (Box 2).

Box 2 **TDR IN A CAPSULE**

Since its inception in 1975, TDR's inputs and outputs include:

- **8000** projects involving **6500** scientists

Research & Development

5300 projects in 127 countries
totalling US\$300 million

Research Capability Strengthening

2700 projects in 80 countries
totalling US\$117 million

- **1100** scientists from developing countries completed research training
- **67** disease control tools developed of which **38** are in use for disease control
- Using tools and strategies generated with TDR support, there is now the possibility that **onchocerciasis, lymphatic filariasis, leprosy and Chagas' disease** can be eliminated

Source: TDR web site <http://www.who.int/tdr>

Features of TDR's partnerships with the private sector

Characteristic features of TDR's involvement with industry included the following elements:

- **Mutual respect.** In some international multilateral agencies, political considerations influence the selection of technical advisers to a degree that compromises the quality of their expert panels. Distinguished scientists find it difficult to work comfortably in such teams. TDR's working groups included distinguished scientists from all over the world: from developed and developing countries; from both sides of the iron curtain; and from academia, research institutes, health departments as well as from industry. The realisation that they had been selected on the basis of their personal expertise facilitated peer-level relationships among the scientists and generated mutual respect for each other as well as for the programme.
- **Clear goal orientation.** Although TDR supports a wide range of research activities, each group works towards the achievement of clearly defined goals. The strategic work plans include benchmarks for monitoring progress. Scientists from industry are well adapted to this approach but scientists from academia, more used to open-ended type of research plans, also become engaged with the TDR industrial production approach.

● **Sensitivity to each other's requirements.** As a publicly funded programme, TDR's activities had to be transparent for the purpose of accountability to the sponsoring agencies as well as to the public at large. On the other hand, some of the collaborative research involved information and intellectual property of commercial value. TDR was able to accommodate both requirements by providing full disclosure of its operations but arranging for confidentiality on specific matters where indicated. For example, in screening chemical compounds for industry, TDR agreed to handle coded samples without requiring the company to disclose the structure of the molecules.

● **Protecting the public interest.** The essence of partnership is joint investment of effort and fair sharing of rewards. In drawing up contracts with the private sector, TDR pays close attention to the rights of the public sector to intellectual property that is produced through joint efforts. It has been possible to obtain various concessions in the public interest such as tiered pricing for sales to the public sector (e.g. mefloquine) and sub-licensing of patents (e.g. eflornithine). (Box 3)

Box 3

PUBLIC/PRIVATE PARTNERS IN SLEEPING SICKNESS

WHO and Hoechst Marion Roussel Inc. sign a License Agreement allowing WHO to arrange for the production of eflornithine - the 'resurrection drug' for African trypanosomiasis.

The initiative involves the drug eflornithine, on which WHO and Hoechst Marion Roussel have collaborated for a number of years. This drug has been nicknamed the 'resurrection drug' because of its spectacular effect on patients in the late stages of the disease, when the patient is comatose. However, although first registered for use in sleeping sickness in 1990, the drug is not in commercial production, partly because of the limited market, which makes it not at all attractive to the private sector, and partly due to its expense and hence non-affordability by endemic countries. On 6 December 1999, the World Health Organization and Hoechst Marion Roussel Inc. signed a License Agreement, in Geneva, granting WHO reference right to the license to produce eflornithine. The agreement will allow technology for production of the drug to be transferred from Hoechst Marion Roussel to a third party, in the private sector, which will manufacture eflornithine.

Present at the signing was Dr C. Bacchi, who discovered that eflornithine cured trypanosome infection experimentally while working under support from TDR, and drew attention to the parasite's unique polyamine metabolism. The drug was originally developed for use in cancer but did not meet expectations; it is now licensed for use in sleeping sickness in the US, Europe, and 12 African countries. The arrival of eflornithine provided an alternative drug for the treatment of gambiense sleeping sickness, the form of sleeping sickness that occurs in west and central Africa; but for the rhodesiense form of sleeping sickness that occurs in central and eastern Africa, there is no alternative treatment.

The agreement is a response to the challenge of access to drugs to treat diseases of the poor, and illustrates the new determination of WHO to 'make a difference'.

Source: TDR website — <http://www.who.int/tdr>

Comment on the TDR experience

TDR's experience with industry shows what can be achieved by carefully designed public-private partnerships. The relationships have been cordial and productive. TDR's mandate was to discover and develop new and improved technologies for the control of tropical diseases affecting the poor in developing countries. Neither the public sector nor the private sector working alone was able to achieve this goal. Through public-private partnerships, TDR assembled the critical mass that has produced a steady stream of new knowledge and effective technologies. Not only have new products emerged, but there is now evidence that several of the target diseases are now in the process of being eliminated. (TDR 1997; Blanks et al., 1998)

B. SPECIAL DRUG DONATIONS PROGRAMMES

Donation of drugs is a well-established charitable activity of private drug companies. Such gifts provide relief in times of disasters and other emergencies as well as supporting poor countries and their communities. A more recent phenomenon is the donation of specific drugs with explicit major public health goals. Merck and Co. Inc. through their donation of ivermectin (Mectizan), was the pioneer of this new type of giving. The basis of the donation is summarised in Box 4. (Dull & Meredith, 1998; Fettig, 1998)

Box 4 IVERMECTIN COMES FREE

On 20 June 1986, Robert D. Fluss of Merck Co. Inc.'s Division of International Public Affairs telexed the Director of TDR, Adetokunbo Lucas, with this message:

"...Merck and the WHO have collaborated extensively on the development of ivermectin for onchocerciasis. We are very encouraged by the prospects that this drug will be the first new agent available in several decades which will allow for the safe and effective treatment of patients on a mass scale. Merck intends to continue to co-operate with the WHO, the Onchocerciasis Control Programme and endemic country governments, in their efforts to develop and implement programs so that the drug, when approved for use, can be distributed efficiently.

"The special circumstances associated with this disease and the interest of several organizations and governments have caused Merck from the outset to consider ways of accommodating a variety of objectives. First and foremost is ensuring that the drug will be put to optimum use for the benefit of onchocerciasis patients and others who may be at risk of developing this disease. The company concluded that, in this case, the best way to achieve the full potential of ivermectin was to ensure that the economic circumstances of patients and governments in onchocerciasis-endemic areas would not prevent or restrict widespread use of the product once it is approved. Consequently, Merck is undertaking to make appropriate arrangements, if necessary with other interested parties, **to make needed quantities of the drug available to these governments and patients at no cost to them for the treatment of onchocerciasis...**"

Source: UNDP/World Bank/WHO Special Programme for Research and Training in tropical Diseases (1994)

Charity versus Philanthropy

Andrew Carnegie, the well known philanthropist, in speeches and writings, notably his famous essay on "The Gospel of Wealth", made a clear distinction between charity and scientific philanthropy. He presented philanthropy as the mechanism by which "the surplus wealth of the few will become the property of the many, ... **administered for the common good, ... this wealth can be made a more potent force ... than if distributed in small sums to the people themselves.**" He warned that charity could have a "degrading pampering tendency on the recipients" whereas philanthropy was socially significant and beneficial. (Wall, 1970) For the sake of clarity, the first type of donation, consisting of simple random distribution of largesse, can be rightly described as charity. The donation of ivermectin, involving a clearly defined public health goal, can be classed as philanthropy. Several other companies have now followed Merck's example in initiating philanthropic programmes. (Kale, 1999; Wehrwein, 1999) (Table 1) (Box 5; Box 6)

Characteristic features of drug philanthropy

The four programmes listed in Table 1 have three important characteristic features:

- **Purposeful:** In each case, the donation aims at a clearly defined public health goal in terms of a measurable and significant impact on the target disease. The objectives are described in somewhat ambitious terms e.g. "Global elimination of lymphatic filariasis"; "It is possible now that the world can soon end its fight against blinding trachoma, a war that has been waged for at least 200 years." (See Box 5)

Table I
PHILANTHROPIC DRUG DONATION PROGRAMME

Drug Company	Drug Target Diseases	Public Health Goal	Programme Manager	Major Partners*
Merck & Co	Mectizan: Onchocerciasis Lymphatic filariasis**	Elimination of onchocerciasis	Task Force for Child Survival & Development (Carter Center)	<ul style="list-style-type: none"> • Merck & Co • Task Force for Child Survival & Development • WHO • African Programme for Onchocerciasis Control
Pfizer	Zithromax: Trachoma	Elimination of blinding trachoma	International Trachoma Initiative	<ul style="list-style-type: none"> • Pfizer Inc. • Edna McConnell Clark Foundation • WHO
SmithKline Beecham	Albendazole: Lymphatic filariasis	Elimination of Lymphatic filariasis	WHO	<ul style="list-style-type: none"> • SmithKline Beecham • WHO
Glaxo Wellcome	Malarone: Malaria	Control of drug-resistant malaria	Task Force for Child Survival & Development (Carter Center)	<ul style="list-style-type: none"> • Glaxo Wellcome • Task Force for Child Survival & Development- WHO -- Roll Back Malaria

* In each case, many more partners are involved than are shown on these illustrative lists.

** An additional commitment by Merck Co. Inc.

- **Programme:** The drug donation is designed as a component of the strategic plan for dealing with the problem. For example, in the donation of azithromycin for the elimination of trachoma, the control programme includes four elements, the so-called S.A.F.E. strategy: **S**urgery, **A**ntibiotic therapy, **F**ace washing, and **E**nvironmental change (to increase access to clean water and better sanitation, and to increase health education) (Prüss & Mariotti, 2000)
- **Partnership:** Implementation of each programme requires the collaborative effort of several partners. (WHO, 1999a) Apart from the national government, partners usually include the donor company, WHO, institutions responsible for programme management, and non-governmental organisations that may undertake drug distribution and other interventions.

Box 5 **MALARONE DONATION PROGRAMME**

A public-private sector partnership between Glaxo Wellcome and the Task Force for Child Survival & Development, operated in partnership with Ministries of Health.

Objectives

- To reduce suffering and deaths from malaria by appropriate use of donated Malarone in endemic areas with known resistance to standard treatment
- To examine the most effective and responsible method of introducing a new, donated anti-malarial for use in endemic countries
- To explore ways to develop public/private partnerships for improving the health of people at risk from tropical disease

Commitments

- No active commercialisation of Malarone in endemic countries
- Comply with existing malaria control strategies
- Pilot studies to ensure that implementation is practicable and sustainable before expansion

Source: <http://www.malaronedonation.org/>:
See also: Oyediran & Heisler (1999)

Comment on drug philanthropy

The Mectizan Donation Program has accumulated a decade of experience but the other programmes are relatively young and are still largely in their formative period. Even at this early stage, it is valuable to ask critical questions about the concept of drug philanthropy and its implementation. It is relevant to ask some critical questions at this stage:

- **Priorities:** Does the programme address a problem of significant public health importance? Or, will it divert attention and resources away from more important national and regional priorities?
- **Programme:** Is the programme technically sound? Does the drug have an appropriate profile of features to suit the needs of the programme: **efficacy, safety, tolerance, mode of application, etc.?** Does it constitute a significant improvement on the existing package of interventions?
- **Prospects:** Are the stated goals realistic? Can the distribution of the drug together with the other planned inputs deliver the expected outcomes? Is there an appropriate infrastructure in place or can it be developed to support the planned interventions?

These and similar issues need to be addressed in the planning stage of a special donation programme.

Experience gained so far

The Mectizan Donation Program (MDP) has operated long enough for one to undertake a meaningful review of its functioning and its achievements. (Foegen, 1998) Since its inception just over a decade ago, MDP has enabled over 100 million doses of the drug. Most of the endemic areas of onchocerciasis both in Africa and in south America are covered. Each year, the programme approves requests for 30 to 40 million treatments.

Table 2

Number of Mectizan treatments approved through community based, mass treatment and humanitarian donation programmes, by year (1988-1999)

YEAR	Community Based	Humanitarian*	Total
1988	255,000	26,000	281,000
1989	239,200	112,000	351,400
1990	1,321,500	342,500	1,664,000
1991	2,779,800	448,300	3,228,100
1992	4,879,500	509,800	5,389,300
1993	9,050,300	324,600	9,374,900
1994	11,801,800	282,200	12,084,000
1995	15,607,700	269,900	15,877,600
1996	19,141,400	159,700	19,301,100
1997	33,725,000	169,500	33,894,500
1998	30,668,500	73,200	30,741,700
1999	29,740,700	110,400	29,851,100
TOTAL	159,210,400	2,828,300	162,038,700

- The Humanitarian programme responds to random requests from individual practitioners for use in clinics and in other institutions. The programme is managed directly by Merck & Co from their Paris office.

Several factors have contributed to the success that MDP has achieved so far:

- i. An outstanding drug: Mectizan has a profile of good features that make it ideal for mass distribution: efficacy², safety, simple regime (single dose by mouth once a year), well tolerated (improved sense of well being encourages patients to report for repeat doses). Di-ethyl carbamazine (DEC) that was previously used for treatment of onchocerciasis, provoked reactions in infected eyes, often causing further damage; ivermectin did not cause such damaging complications and promotes the healing of early lesions. (Abiose, 1998)
- ii. Unequivocal commitment by Merck Co. Inc.: The donor company's commitment is summarised in the statement: **"Providing Mectizan to as many who need it for as long as necessary"**. Merck & Co., recently announced an expansion of the Mectizan Donation Programme. In response to the finding that Mectizan is also effective against lymphatic filariasis, Merck will expand its donation within Africa for the treatment of lymphatic filariasis.
- iii. Effective Management: The Task Force for Child Survival and Development has set up an efficient mechanism for distributing the drug through the health authorities in the endemic countries and their partners.
- iv. Expert Guidance: The Mectizan Expert Committee, consisting of public health experts, and liaison persons from Merck and WHO, provides technical guidance to the programme. With this arrangement, the donor company keeps in close touch with the programme whilst ensuring that commercial interests do not interfere with operational decisions.

² Mectizan is the most potent anti-infective agent in clinical use; the single adult dose of 12mg once a year compares favourably with antibiotics like penicillin and tetracycline that require doses of 1000mg or more per day! Mectizan does not kill the adult worm and so it must be given annually to eliminate the larvae.

Guidelines for drug philanthropy

Philanthropy from the pharmaceutical industry is not a new phenomenon. The Wellcome Trust, the largest medical philanthropic foundation with assets of the order of £13 billion pounds sterling (over US\$20 billion), was the product of the munificence of the owner of a pharmaceutical company, Sir Henry Wellcome. WHO's guidelines for drug donations deal mainly with response to emergencies and some long term bilateral charitable gifts. (WHO, 1996, 1999b). The first version was issued in May 1996 and represented the consensus of WHO in consultation with a wide range of organisations.³ It would be useful to define guidelines that are appropriate to the philanthropic donations. Such guidelines should include reference to key features of the philanthropic donations: purposefulness, integration into programmes and the mobilisation of partnerships. The guidelines should also address the issue of how to develop such programmes when the donation involves the introduction of a new drug as in the case of ivermectin and malarone.

WHO has drawn up guidelines aimed at reducing inappropriate donations and to guard against abuse. (WHO, 1999). But these guidelines do not apply to the new philanthropic drug donation programmes. At the very least, the new guidelines should address the three characteristic features of drug philanthropy:

- **Purposeful:** defined public health goal; measurable and significant impact;
- **Programme:** strategic plan including chemotherapy as a component; and
- **Partnership:** public-private sector collaboration.

The new guidelines should also address some of the issues that have arisen from the experiences that have been derived from the operation of the four pioneer programmes.

● **Commitment:** the donor company should be willing to make a long-term commitment. (See Box 5) Such commitment may follow an initial pilot phase. (Box 6)

Box 6

GLOBAL ELIMINATION OF LYMPHATIC FILARIASIS

SmithKline Beecham's Commitment

"SmithKline Beecham will provide albendazole free of charge to WHO for use by governments, and those organisations working in association with (or with the permission of) these governments, for such duration as is reasonably designed to achieve the objective of WHO, expressed in resolution WHA50.29 adopted by the 50th World Health Assembly in 1997 and calling for the global elimination of lymphatic filariasis as a public health problem. (Since the strategy calls for treatment of all 'at risk' populations annually for 4-6 years, and since up to 1.1 billion people may be at risk of infection, this donation could comprise as many as 6 billion doses of albendazole over the lifetime of the elimination effort [estimated at 20-25 years])."

Source: The Collaborative Agreement between SmithKline Beecham and the World Health Organization Targeting the Global Elimination of Lymphatic Filariasis
See Also: WHO (1999)

³ Churches' Action for Health of the World Council of Churches, the International Committee of the Red Cross, the International Federation of Red Cross and Red Crescent Societies, Médecins Sans Frontières, the Office of the United Nations High Commissioner for Refugees, OXFAM and the United Nations Children's Fund. In 1999 the number of co-sponsors expanded to include Caritas Internationalis, the International Pharmaceutical Federation, Pharmaciens Sans Frontières, UNAIDS, the United Nations Development Programme, the United Nations Population Fund and the World Bank.

- **Management:** Competent, effective management is required to deal with the various aspects of the programme including mobilisation of and collaboration with partners.
- **Conflict of Interest:** In order to guard against real and apparent conflicts of interest, the system should include an appropriate buffer between the donor company and the operational decisions. Each of the four programmes has endeavoured to achieve this objective by handing over the management to a third party, supported by an independent expert advisory committee. For the Mectizan Donation Program, Merck devolved decision making to the Mectizan Expert Committee, a group of scientists and public health practitioners. Merck provided the supplies of Mectizan as recommended by the expert committee. In order to provide direct charitable contributions, Merck operates a humanitarian programme from its Paris office; it provides gifts of Mectizan in response to requests from individual practitioners unrelated to the main programme. (Table 2)

Comments on Public/Private partnerships

The crisis in the health sector has induced governments in many developing countries to review the relationship between the public and the private sectors. Public-private partnerships will become increasingly more significant in the coming years as policy makers explore options for promoting complementary involvement of the private sector.

WHO now strongly supports the promotion of public/private partnerships with the caveat that such partnerships should be mutually beneficial and must always benefit health. (WHO 1998). This new policy of developing partnerships with the private sector has not gone unchallenged. Some of the activists who have vigorously campaigned against the private sector have expressed their unhappiness with WHO's new policy. (See Box 7) In spite of these criticisms and reservations, WHO under its new leadership has clearly indicated its commitment to work with the private sector. Dr. Gro Brundtland, the Director-General of WHO, has held roundtable consultations with representatives of the pharmaceutical industry. WHO is also engaging industry on research projects aimed at finding new medicines for developing countries, on mechanisms for strengthening the Essential Drug Programme, for combating the illegal traffic in fake medicines, etc. Several of WHO's new initiatives involve partnerships with the private sector:

- Roll Back Malaria
- Medicine for Malaria Venture
- Medicine for African Sleeping Sickness

Box 7 **WHO'S NEW GUIDELINES**

The industry agenda to co-opt the UN and work in partnership with agencies such as WHO continues to cause alarm amongst NGOs working to protect public health. With the stakes so high, WHO's new draft *Guidelines on Interaction with Commercial Enterprises*, could have an important role to play. The guidelines are, however, very disappointing and seem to be more an attempt to seek public approval for partnerships with corporations, than to ensure that WHO stays true to its mandate to improve health. Some good suggestions are made, but the language used is contradictory and confusing, stressing the need for such things as "mutual respect, trust, transparency and shared benefit." These concepts hold very different meaning for transnational corporations who have entirely different aims and values. Commercial enterprises are called on to abide by WHO policies on medicinal drugs, tobacco and chemical and food safety, but no mention is made of WHO's infant feeding policies.

SOURCE: The website of **Baby Milk Action**, "a non-profit organisation which aims to save lives and to end the avoidable suffering caused by inappropriate infant feeding. Baby Milk Action works within a global network to strengthen independent, transparent and effective controls on the marketing of the baby feeding industry".

Conclusion

TDR and the drug donation programmes illustrate successful experiments in public private partnerships. The TDR example was pioneering but not unique in its own time. Another special programme in WHO - research on human reproduction - similarly developed relationships with the pharmaceutical industry. The TDR and donation programmes can be seen as operating at different points in a continuum stretching from discovery, to development and finally to distribution of new drugs and other tools for disease control. The case studies illustrate needs and opportunities that can be met through public-private partnerships. (Etya'ale, 1998)

Promoting public-private partnerships

Only 10% of \$50-60 billion that is spent every year for health research is used for research on the health problems of 90% of the world's people. A new entity, the Global Forum for Health Research (1999) has drawn attention to the "10/90" disequilibrium and it is seeking solutions to the problem in collaboration with the World Health Organization, the World Bank, private foundations, the pharmaceutical industry, NGOs and other stakeholders. The central objective of the Global Forum is to help correct the 10/90 gap and focus research efforts on diseases representing the heaviest burden on the world's health, by improving the allocation of research funds and by facilitating the collaboration among partners both in the public and private sectors. It played an important role in the negotiations that led to the creation of the Medicine for Malaria Venture. The Forum has begun a project to identify all significant public-private partnerships and to map their origins, participants, aims, governance structures, degree of success, constraints, and difficulties. The Forum hopes that by facilitating the exchange of information among potential partners, this database will promote and guide the development of new public-private partnerships.

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Selected web sites

Organisation	Internet Address
Baby Milk Action	http://www.inbc.org/
Global Forum for Health Research	http://www.globalforumhealth.org/
International Trachoma Initiative	http://www.trachoma.org/abouttrachoma.html
Malarone Donation Programme	http://www.malaronedonation.org/
Mectizan Donation Programme	http://www.taskforce.org/MDP/
Task Force for Child Survival & Development	http://www.taskforce.org/
UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR)	http://www.who.int/tdr
World Health Organization	http://www.who.int/
WHO Control of Tropical Diseases (Filariasis)	http://www.who.int/



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