

# **The World Bank's Booster Program for Malaria Control in Africa: Phase II Strategy – Executive Summary**

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## **Executive Summary**

### **Introduction**

The World Bank, in response to requests from its member nations and other partners, launched the Booster Program for Malaria Control in Africa in 2005. The Booster is a 10-year program designed to help African nations to meet the malaria control targets to which they agreed in Abuja, Nigeria, in 2000. The Abuja targets set for 2005 were not reached by most countries and were revised for 2010 to ensure that at least 80 percent of those at risk of, or suffering from, malaria benefit from major preventive and curative interventions.

This document describes the purpose and context of the Booster Program, its first three years of operation (Phase I from July 1, 2005 to June 30, 2008), and the proposed design of Phase II (from July 1, 2008 to June 30, 2011) of the program. Phase II seeks to build on the successes of and lessons learned from Phase I and to enable the World Bank to play its expected role in scaling up and sustaining malaria control interventions to reach the new ambitious but achievable global goal set by the RBM partnership of eliminating malaria as a major public health problem in Africa by 2015. The Bank has subscribed fully to this agenda as illustrated by statements made by senior management in several public fora.

The primary audience for this version of the document is the World Bank's senior management. After incorporating input from that group, the Booster team will make the final document available to its clients and partners and to the interested public.

### **Background**

Malaria is both preventable and treatable. Yet approximately 1 million people die from it annually—including 3,000 children per day. Malaria is a parasitic disease transmitted by the *Anopheles* mosquito. Over 500 million cases of malaria are estimated to occur each year. Ninety percent of malaria deaths occur in Sub-Saharan Africa, where the most severe form of the disease prevails. Deaths and disability (both short-term and long-term) from malaria have enormous social and economic costs. The disease kills more children under the age of five in Sub-Saharan Africa than any other single disease, and it is a major cause of complications, including death, in pregnant women.

Malaria is not only a health problem but also a development problem. In economic terms, malaria costs African countries an estimated \$12 billion per year in lost productivity. Treatment of severe episodes can cost up to one-quarter of a household's monthly income and accounts for up to 40 percent of public sector health expenditures in the most affected countries. Operating in a vicious cycle, it is both a cause and consequence of poverty. Because of its wide-ranging effects, malaria is both a health and development priority for the World Bank.

Malaria keeps countries as well as households in poverty—annual economic growth in countries with high malaria transmission has historically been lower than in countries without malaria. Leading economists have estimated that malaria is responsible for an “economic growth penalty” of up to 1.3 percent per year in malaria-endemic African countries. It has been well documented that malaria discourages internal and foreign investment and tourism, affects land use patterns and crop selection resulting in sub-optimal agricultural production, reduces labor productivity through lost work days and diminished on-the-job performance, and affects learning and scholastic achievement through frequent absenteeism and, in children who suffer severe or frequent infections, cognitive impairment and in some cases permanent neurological damage.

Thankfully, tools exist to control malaria. Artemisinin-based combination therapies (ACTs) are a highly effective way to treat the disease. Prophylactic use of other drugs can prevent malaria in pregnancy. Long-lasting insecticidal nets (LLINs) reduce mosquito populations and, thus, malaria transmission, as does indoor residual spraying (IRS) where this is epidemiologically appropriate. The Copenhagen Consensus 2008 estimates that providing a combination of malaria prevention and treatment interventions to at-risk populations in Sub-Saharan Africa would yield a benefit-cost ratio of \$20 for every \$1 spent. Some recent analyses have argued that malaria control can be made even more cost-effective if access to both preventive and curative interventions can be rapidly increased.

The Roll Back Malaria (RBM) partnership, of which the World Bank is a key member, aims to remove any obstacles to the widespread, consistent use of these and other appropriate interventions. These obstacles include the prohibitive cost of interventions given the very low incomes of those most affected, the ability of the mosquito and the parasite to develop a resistance to insecticides and drugs respectively, and the need for people and systems to be ready to adopt and maintain new practices. However, with a concerted effort, these challenges can and must be overcome. In partnership with governments, international agencies, donors, civil society, the business community, and many others, the World Bank seeks to bring about a dramatic and sustainable increase in the use of a comprehensive package of malaria control interventions by providing IDA resources, technical support, and other forms of assistance to malaria-stricken countries wherever necessary and appropriate.

### **The Booster Program for Malaria Control in Africa**

The World Bank’s funding for malaria control was very limited between 2000 and 2005 (just US\$50 million in all of Sub-Saharan Africa) and primarily focused on improving health systems. Given that this approach failed even to stabilize malaria rates in Africa, much less to reduce them, the Booster Program has taken a different approach.

## Approach

The Booster Program's approach makes available flexible, cross-border, and multi-sector funding for country-led initiatives to scale up proven malaria control interventions and to strengthen health systems. Countries take the lead in prioritizing, planning, implementing, and evaluating the malaria control initiatives within their borders.

Within the context of the RBM partnership, the Bank uses its comparative advantages vis-à-vis other partners to help countries to identify and fill gaps in financing, to break through bottlenecks, and to achieve the goals of their National Malaria Control Plans. The Bank has created a small team to coordinate activities under the Booster Program—the Malaria Implementation Resource Team (MIRT). The MIRT advises the Bank on technical and financing strategies, supports the Bank's malaria task teams and clients, ensures program quality and documentation, develops both internal and external partnerships, and promotes the generation, management, and sharing of knowledge on the subject of effective malaria control.

## Phase I Results

Phase I of the Booster operated in 19 countries, covering a vast area inhabited by a total of 258 million people. It committed US\$455.2 million to malaria control activities, with an additional US\$15.0 million in the pipeline, together totaling US\$470.2 million. This represents a nine-fold increase in the Bank's funding for malaria control since the start of the Booster Program in June 2005. During the program's Phase I, US\$139 million was spent on purchasing and distributing key malaria control commodities that are crucial for interrupting transmission and on strengthening the effectiveness of health systems in providing these and other essential services. By the end of 2008, this figure will have increased to US\$304 million (or approximately 67 percent of **total** commitments).

Of the 258 million people living in the areas covered by Phase I, 45 million are children under the age of five years old and 11 million are pregnant women. One example of a successful initiative supported under Phase I is Benin's LLIN campaign, which distributed 1.7 million nets (1.4 million of which were purchased with IDA funds) nationwide—the first LLIN distribution to cover Benin's entire under-five population. Phase I of the Booster Program also engaged new partners such as the Russian Federation, organized the conference that led to the Dakar Appeal that called for better coordination of resources, planning, and M&E so that countries can use the funds at their disposal more efficiently, and monitored the outcomes of investments.

## Phase I Lessons

The implementation of Phase I yielded several lessons that have been useful inputs into the design of Phase II.

1. The funding level, while nine times the amount that the Bank had committed between 2000 and 2005, was insufficient for most Booster countries to develop and implement plans for a full, nationwide scale up of their key malaria control activities.
2. The Bank could have been better at exploiting its comparative advantages in devising innovative financing mechanisms, supporting more cross-sectoral projects, and providing more regional (as opposed to country-specific) support.
3. A major impetus on monitoring and evaluation (M&E) is still needed to put into practice the consensus among development organizations about the importance of tracking progress on meeting malaria control objectives and to intensify M&E for decision-making at country level.
4. Country programs needed more supervision and technical support from the Bank than was funded by the budget.
5. Countries need to strengthen their implementation capacity in order to be able to use their malaria funding effectively.
6. Having a core Bank team dedicated to managing the Booster Program in the Africa Region is crucial for maintaining a focused, well-coordinated program and for enabling the Bank to play a leadership role in the fight against malaria.
7. Country leadership is key in implementing successful malaria control programs.
8. Scaling-up the coverage and use of effective malaria control interventions while strengthening health systems is essential for yielding positive health outcomes.

## **Phase II**

The international community has established two goals for the near term: reduce the burden of malaria in Africa by 50 percent by 2010; and, eliminating malaria as a major public health threat in Africa by 2015. Phase II of the Booster Program will contribute to the achievement of these goals and by 2015 malaria will no longer be a leading cause of child mortality in areas covered by the Booster Program.

The design of Phase II reflects three factors: (i) key challenges in the fight against malaria, (ii) lessons that have emerged from Phase I, and (iii) the comparative advantages of the World Bank within the international development community.

Phase II will focus on massive front-loaded efforts (“front-loaded” meaning to make a strong and concentrated effort at the outset of an initiative) to scale up effective malaria control interventions and on moving Africa closer to eliminating malaria. The funding requirements for the three years of Phase II are estimated to be US \$1.125 billion from IDA’s country and regional envelopes.

### Context and Challenges

The ambitions of countries and their development partners have grown considerably since the launch of the Booster Program. Global funding has increased by 300 percent because malaria control is seen both as achievable and essential for development. Acknowledging the long-term need to and possibility of eradicating malaria with the help of new tools being developed, the development community, including the Bank, has adopted the medium-term goals of scaling up for impact (SUFI) in all affected countries and of sustaining that scale up to eliminate malaria as a major public health problem. **Malaria is the only major disease for which major reductions in morbidity and mortality are possible within the next five years.** Malaria control represents a “low-hanging fruit” that could have tremendous impact on health outcomes in a short period of time. Reducing the number of malaria cases by interrupting transmission is possible, but only when enough people have access to tools that have been proved to be effective in the fight against malaria (for example, 80 percent of households currently have and use insecticide-treated bednets). The expectation is that SUFI will not only save 3.5 million lives over the next five years but that it will also shrink the malaria map, making eradication more feasible. In this context, an announcement of a new effort to mobilize human and technical resources for SUFI in the context of the elimination agenda was made at the Davos World Economic Forum in January 2008 by key development leaders, including the World Bank’s President Robert Zoellick.

The RBM Partnership has adopted a Global Malaria Business Plan to increase the engagement and the efficiency of the Partnership, and the United Nations has announced a new Framework for Action calling for universal coverage of effective interventions by 2010 to which all partners have subscribed. SUFI and elimination will require donors to commit most of their resources **early and up-front** to achieve the full impact. This is very different from what has been done in the past when resources were spread too thinly to make a significant difference at the national level.

Phase II reflects the Bank’s commitment to this new agenda set forth by RBM partners and the United Nations. This commitment has been evident in a variety of official statements such as the Bank’s participation in the Millennium Development Goal Africa Steering group and President Robert Zoellick’s emphasis on malaria control as a global public good, as well as the institution’s Africa Action Plan, its Strategy for Addressing Climate Change in the Africa Region, and its Health, Nutrition, and Population (HNP) Strategy. The HNP Strategy, in particular, states that investments in disease control

programs and in the strengthening of health systems are mutually reinforcing and necessary to achieve and maintain positive health outcomes.

There are some significant challenges to realizing SUFI and the elimination of malaria, but these can be overcome with better collaboration among development partners and with adequate resources. These challenges are not exclusive to the Bank but are faced by all governments and organizations engaged in the fight against malaria. They include:

- *Commodity procurement delays* caused by weak supply chain management and bureaucracy in countries and within the Bank, often resulting in drug stock-outs and the arrival of LLINs after the peak transmission period when they were most needed.
- *Difficulties in coordinating among donors* because of their different systems, timelines, and other constraints, resulting in inefficiencies in program planning, implementation, and evaluation. Progress has been made on this front but more needs to be done.
- *Insufficient capacity at the country level* to implement, link, and monitor a complex set of related activities.
- *Incomplete and untimely data* because many countries still have limited capacity for collecting and using data in program-related decision-making.
- *Health system constraints* such as shortages of health workers, the insufficient training and motivation of health workers, and weak supply chain management.
- *Delays in the introduction of ACTs*, due to understandable time lags at the country level between changes in policy and their implementation, the initial high cost of ACTs, and the lack of long-term ACT financing schemes.
- *The need for an extra US\$2 billion per year* to close the funding gap for controlling malaria in Africa over the next five years.

### Consultative Design Process

The Malaria Implementation Resource Team (MIRT) set up a high-level advisory committee consisting of representatives of key partners and client countries, to provide input into the design of Phase II. The MIRT also brought together a broader group of more than 40 key stakeholders, including three Ministers of Health and representatives of client governments and the African Union, global partners and donors, the private sector, malaria advocates, non-governmental organizations (NGOs), and World Bank staff. The broader group's task was to review progress, challenges, and successes stemming from Phase I and to come to agree on the priority actions that the Bank needed to undertake in Phase II as part of the global partnership. The advisory committee continues to review and provide input on the strategy and will continue to provide advice to the program once the Bank has approved the Phase II strategy.

## Phase II Design

The design of Phase II has been endorsed by all members of the RBM partnership and by the Bank's client countries. There are several key differences between Phases I and II. First, the level of ambition is higher in Phase II and consequently so is the amount of funding that will be required to achieve its goals. Second, Phase II puts more emphasis on maximizing impact in the largest high-transmission countries and on favoring strategic funding rather than the opportunistic initiatives that were necessary to launch Phase I. Third, Phase II will provide more support to countries and task teams to help them to implement the Booster projects. Fourth, Phase II will further strengthen M & E so that reliable data can be gathered on results and outcomes. Fifth, it will capitalize on the Bank's comparative advantages in being able to provide regional support and flexible, innovative financing. Finally, Phase II will put more emphasis on maximizing the effectiveness of the global anti-malaria partnership and on strengthening advocacy to and communication with the public.

Phase II of the Booster Program is built on five pillars, reflecting country-defined needs and the agreement of all the Bank's partners on how the Bank can capitalize on its comparative advantages in supporting malaria control.

- *Pillar 1—Regional and cross-border prevention and control.* Malaria has no borders. The progressive elimination of malaria depends not only on a country's own national program but also on the efforts made by its immediate neighbors. Among donors, the Bank is uniquely placed to support regional and cross-border investments in malaria control.
- *Pillar 2—Intensified support to the two high-burden countries with high unmet need, the Democratic Republic of Congo (DR Congo) and Nigeria.* These two countries account for 50 percent of malaria infections and deaths in Africa. The overall targets for Africa cannot be achieved if these two countries do not make substantial progress toward theirs. Financial support for malaria control in these high-burden, largest population countries is disproportionately low in per capita terms. Country assessments conducted by the RBM Partnership will provide the information from which to develop comprehensive intervention packages for n both countries. The Bank will play a leading role in these countries as determined the countries themselves and by its RBM partners.
- *Pillar 3—Sustained support for ongoing programs and a targeted approach to new country efforts.* Most Phase I investments are relatively new and therefore are just beginning to generate results. Phase II investments will help to sustain and increase the impact of these first investments and will support new, focused, strategic activities based on demand from countries, the efforts of other donors, and the cost-effectiveness of different types of interventions, as needs assessments are being updated by RBM in those countries.

- *Pillar 4—Facilitation of policies and strategies to increase equitable access to effective treatment.* Access to effective treatment is still far from universal. Pillar 4 will support innovative approaches through the private sector and communities to increase the access of poor and rural families to high-quality, effective treatment. It will also support global efforts to make treatment more affordable.
- *Pillar 5—Strengthening of essential health systems in Booster countries to scale up the delivery of malaria interventions.* Phase II will help address key bottlenecks in most national health systems that constrain the effective control of malaria (and other diseases) by: (i) improving procurement and supply chain management, (ii) decentralizing resource planning and management, and (iii) strengthening monitoring and evaluation. The program's support for strengthening health systems will be customized to each country's needs.

Each of these pillars has a specific goal and rationale, as well as a selection of activities that will be tailored to meet country and regional needs. Phase II of the Booster Program is specifically designed to complement and leverage the efforts of other donor partners, especially the Global Fund to Fight AIDS, TB and Malaria and the U.S. President's Malaria Initiative. This complementarity is particularly evident in the focus on regional and cross-border control of malaria and health systems strengthening, which have been inadequately addressed by other donors and are comparative advantages of the Bank. It can also be seen in the concentration of the Bank's efforts in large high burden countries such as Nigeria and DRC, where the resource needs are extremely high. In these contexts, coordinated and complementary financing strategies with other donors are necessary to provide equitable access to essential malaria prevention and treatment services for the whole population. In fact, Nigeria's Global Fund Round 8 application is designed to establish this complementarity and explicitly takes into account the Bank's investment in malaria and health systems.

Phase II will also strengthen the program's M&E component, which is now even more critical given that elimination is the ultimate goal. Not only is it important to ensure that investments translate into results on the ground, but it is also essential to be able to discern where problems persist in order to prevent malaria transmission from reoccurring, which could seriously jeopardize the attainment of the elimination goal. Phase II will therefore focus further on building country capacity in the area of M&E by developing a monitoring system within the Bank to track progress in each project, improving coordination with the Bank's partners on M&E, and tracking overall progress to allow the MIRT to make program adjustments as necessary.

## The Resource Envelope for Phase II

It is estimated that US\$1,125 million will be required from IDA-15 for the three years of Phase II. It is expected that these resources will come directly from IDA's country envelopes and, in the case of the regional program for Sub-Saharan Africa, two-thirds will come from the regional budget as matching funds for IDA's country contributions. **The front-loaded expenditures in Phase II will be crucial in controlling the disease in Africa. Therefore, it is anticipated that the Africa Region will make available significant amounts of resources available from its IDA-15 envelope.**

## Financial and Operational Implications

Phase II will continue to stress the importance of monitoring outcomes and, therefore, will aim to strengthen M&E capacity at both the country and the regional levels. The MIRT will play a direct role in developing and managing the regional and cross-border pillar of Phase II and in coordinating the provision of increased resources to Nigeria and DR Congo. The Region will also strengthen its quality assurance program in line with the increased accountability required in Phase II.

## **Conclusion**

The Bank's clients and the international community have come to expect the Bank to be committed to fighting malaria in Africa at the highest institutional level and believe that its full engagement is critical to achieving success. Demand from clients for International Development Association (IDA) funding for malaria control activities remains high, the Bank's leadership role and collaboration with its partners has increased, and the critics of the Bank's involvement in the malaria field have fallen silent. If at this juncture the Bank were to choose to withdraw from the effort to roll back malaria in Africa, its clients, partners, and critics would question both its credibility and its leadership in its commitment not only to malaria control but also to achieving the Millennium Development Goals.

Furthermore, malaria control is so entwined with the goals, strategies, and policies of the World Bank in the Africa Region that withdrawing would undermine its Africa Action Plan (AAP), its Health, Nutrition, and Population (HNP) Strategy, its Regional Integration Strategy, its impact within the International Health Partnership (IHP), and its evolving strategy for mitigating the impact of climate change in Africa.

The international community is gearing up for a major assault on one of the major public health challenges in the world—malaria in Africa. African nations and their development partners have realized that not eliminating malaria as a public health threat would devour resources for decades if not centuries to come. These African

nations have asked the World Bank to make available to them over the next three years a substantial share of the resources required to reach the targets that they and the international community have set.

Quickly scaling up for impact will allow many of these countries to reach the Abuja Targets, and a sustained commitment will help them to reach Millennium Development Goals 4, 5, and 6 (reduce child mortality by two-thirds, reduce maternal mortality ratio by three-quarters, and combat HIV/AIDS, malaria, and other diseases). At the moment, the estimated funding gap between available funds and the amount needed to achieve these targets is approximately US\$2 billion per year. A contribution of US\$1.2 billion from IDA-15 will shrink that gap by approximately US\$240 million per year. Other donors are expected to increase their support as well. Because the World Bank is well positioned to help to save 1 million lives per year and to stimulate economic development on the African continent, it has been called upon to do its part in reaching the ambitious goals for malaria control. Phase II of the Booster Program for Malaria Control in Africa is the Bank's affirmative and emphatic response to that call.