Annex 9

Roll Back Malaria

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Responsible Network and Sector: HDNVP
Recipient Agency: World Health Organization
Web Address: http://www.rollbackmalaria.org

Financial Arrangements for FY08 (Amount in US $ Million)

| Total Budget: | 12.00 |
| DGF Funding Request: | 0.98 |
| DGF Percentage: | 8% |

Objectives and Expected Outcomes

The Roll Back Malaria (RBM) global partnership was founded in 1998 by WHO, UNICEF, the World Bank, and UNDP, with the objective of halving the malaria burden worldwide by the year 2010. This goal will be achieved by scaling up a set of core interventions, including rapid effective treatment at the community level, controlling the malaria vector (the mosquito) through the use of insecticide-treated bed nets and indoor-residual spraying (where appropriate), prevention of malaria during pregnancy, and epidemic preparedness and response. Additional RBM goals include achieving the Millennium Development Goal (MDG) for malaria and contributing to the MDG for child mortality. RBM has now shifted its focus to the facilitation of partner’s efforts to support the implementation of RBM strategies on a national scale in endemic countries. The DGF grant will be utilized to (i) strengthen the partner coordination managed by the RBM Secretariat; (ii) facilitate support for implementation of the RBM strategy at the country and regional levels; and (iii) mobilize technical assistance to facilitate countries’ access to new financing for scaling-up for impact – including, but not limited to, the World Bank’s Booster Program for Malaria Control, the Bill and Melinda Gates Foundation-supported MACEPA Project, the Global Fund for AIDS, TB, and Malaria and bilateral agencies (USAID, CIDA, DFID, and others).

Main Components

In 2008-09, the partnership will intensify current efforts in the following key areas. (1) Follow through to ensure that countries implement key elements of the Global Strategic Plan for 2005-2015, which was launched in November 2005. (2) Intensify support for sub-regional networks, which in turn support implementation in high- and medium-readiness countries. (3) Continue coordination of technical support to countries that have committed to rapid scaling-up of interventions with support from World Bank, GFATM, MACEPA, and others. Several of these countries are beneficiaries of the Booster Program for Malaria Control in Africa. (4) Support Global Advocacy Plan to raise the profile of RBM activities (and of malaria control generally). (5) Continued facilitation of existing partnerships in developing new tools for malaria. (6) Develop and adapt strategies to increase private sector and NGO participation in RBM. (7) Increase the number of high-readiness countries in all regions that are scaling-up RBM interventions increased. (8) Continued increase Malaria integrated into country health sector review and planning in six countries. (8) Explore options to increase access to effective antimalarials among the poor.

Performance Indicators

(i) Countries assisted in the implementation of RBM strategic plans for impact. (ii) Countries assisted in developing, updating, and implementing rational anti-malarial drug policies within the context of national essential drug programs. (iii) Countries assisted in scaling up the use of insecticide-treated bed nets. (iv) Countries supported in implementing the RBM monitoring and evaluation framework. (v) Countries that have integrated malaria control activities into annual health sector plans and have allocated sufficient resources for implementation of those plans.
Progress and Achievements

The RBM Secretariat brokered T.A. to support the preparation of Bank-financed malaria control operations. Collaboration within the Partnership has enabled the Bank to move rapidly to provide financial and programmatic support to countries through the Booster Program for Malaria Control. By December 2006, about 16 months after its launch, the Booster Program for Malaria Control had committed US$352 million in grants and concessional credits through new operations in Benin, Burkina Faso, Democratic Republic of Congo, Eritrea, Ethiopia, Niger, Nigeria, the Senegal River Basin and Zambia. This was more than double the total Bank commitment of about US$150 million in the preceding five-year period.

Brokering technical support to countries during the preparation of GFATM grant proposals: There is evidence that proposals from countries that received support from the RBM Secretariat and partners had a much higher success rate than others.

High-Level Global Subsidy for Antimalarial Drugs: The Bank is leading an effort to translate into reality a proposal made by Professor Kenneth Arrow and colleagues in 2004 to maximize the number of lives saved by antimalarials and to delay as long as possible the emergence of resistance to these drugs. The proposal is based on the premise that a high-level global subsidy for artemisinin-based combination therapies (ACTs), working through both the public and private sectors, is the most economic and biomedically sound approach to achieving the two objectives. A Bank-supported analysis reconfirmed the conclusions reached by Arrow et al. In 2006 the Bank received a grant of US$4.08 million from the Gates Foundation to finance the work program. With joint leadership from the Government of the Netherlands and Ministers of Health from Cameroon, Nigeria, Sudan and Tanzania, we are moving rapidly to define, among others, the architecture of the facility, the flow of funds, specific options for seeking and receiving donations to the facility, and arrangements for its hosting and management. The Bank's role is to facilitate a rapid completion of this work program that should lead to an operational facility. There is neither an assumption nor an intention that the Bank would become the host or implementing agency for such a facility.

Harmonization for Impact. The Partnership developed a framework for harmonization of development assistance to support country strategies for malaria control. The World Bank chaired the Working Group that prepared the framework; the Minister of Health of Nigeria co-chaired the Working Group. The framework is now being used by all partners to improve harmonization at the country level. The World Bank and UNICEF are co-chairing this operational phase of the Working Group’s activities. It is closely linked to program development at the country level, and to increased emphasis on monitoring and evaluation, which is supported by the Monitoring and Evaluation Reference Group (MERG) of the partnership.

Partners

WHO, UNICEF, UNDP, malaria-endemic countries, official bilateral donors, Bill & Melinda Gates Foundation, corporations, NGOs, academia.

Governance and Management

RBM is coordinated by a Secretariat located at WHO headquarters in Geneva. The Secretariat engages relevant partners on various aspects of RBM and mobilizes and coordinates the support provided to countries. An RBM Board was established in 2002 to develop and monitor the activities of the Secretariat. The Board sets the goals and objectives of RBM partnership, approves the Secretariat’s workplan, and coordinates the input of partner agencies. The Secretariat reports on overall progress to the Board, which is accountable to the broader partnership through bi-annual Partners’ Forums. The Bank holds one voting seat on the Board. RBM uses working groups to develop and refine technical strategies for going to scale. Interagency Coordinating Committees in each country develop annual workplans and determine requirements for technical and programmatic assistance. Four African sub-regional networks, which are extensions of the RBM Secretariat, assist with planning and coordinating external support to countries scaling up RBM interventions.

Exit Strategy

Consistent with the emphasis in the new Health Sector Strategy on health systems and away from communicable disease programs, the DGF Council with the support of the HD Network, decided to move RBM from Window 1 to Window 2. The last year of funding will be FY10. An independent evaluation will be done in 2008.