



CHAPTER 4

Program of Action

The Booster Program will be an umbrella program for intensified work, including analytical and advisory services, lending, and grants. Table 4.1 is an indicative schedule of deliverables and major activities by fiscal year.

4.1 The Program and Deliverables

Implementation of the Booster Program implies an increase in the deliverables to be planned and achieved by regional vice presidential units (VPUs), country units, and sector units that are working on malaria control from fiscal 2006 onwards. The Program would support operations at the subregional and country levels. Depending on specific contexts, the operations would include proactive engagement of CSOs and the private sector to the extent that it is compatible with their comparative advantages. Such engagement could include contracting and/or financing of activities to be undertaken by CSOs and the private sector. In order to promote sustainability and mitigate the risks of distortions, this Program will supplement and be concurrent and synergistic with programmatic approaches such as health SWAs and PRSCs. Contingent upon the commitment of IDA resources for the Booster Program, the Bank will seek cofinancing or performance-based buydowns from partners, including but not limited to foundations and multinational corporations.

The program document for the Booster Program will address, among other things: (i) operational aspects of complementarity with the GFATM, of which there is an emerging example in Angola; (ii) procurement of commodities for malaria prevention and treatment; (iii) technical support for teams with primary responsibilities for work at the country level, particu-

larly to overcome implementation bottlenecks; and (iv) better utilization and improvement of local capacity for implementation. The program document will include guidelines and sample terms of reference for speedy application at the country level, with considerable room for country teams to customize it to local contexts, given the importance of local adaptation and flexibility for successful malaria control. Furthermore, it will make explicit the linkages with other major providers of development assistance for health, namely, the GFATM.

Under Phase I of the Booster Program, which began in fiscal 2005, the Bank-wide Malaria Task Force, with guidance from a high-level Steering Committee, started developing operational guidelines and discussing arrangements with strategic partners to enhance programmatic operations so that they are better designed and supported to achieve more rapid progress in malaria control. The Malaria Task Force will also undertake or commission analytical work, jointly with economists in the Development Economics (DEC) and regional VPUs, to improve the knowledge base for the economics of malaria control, such as what the medium- to long-term economic implications would be for clients should they undertake more intensive efforts to control malaria and the optimal deployment of treatment given increasing rates of drug resistance and the costs of new treatments. Concurrent efforts to develop a learning program on malaria control for World Bank staff and a strategic communications program aimed at internal and external audiences will increase both clients' and Bank counterparts' understanding of the Bank's new Global Strategy and Booster Program.

During Phase II (fiscal 2006–7), contingent upon Board approval in fiscal 2006 of the Booster Program, the emphasis will be on the application of the operational guidelines and arrangements developed in fiscal 2005 to: (i) enhance programmatic operations to achieve rapid progress in malaria control and (ii) support project preparation and implementation at the country and subregional levels, including malaria-specific operations, where appropriate. By the end of Phase II, at least five countries will have enhanced their programmatic operations by increasing significantly their financial resources or strengthening technical support for malaria control. Such financial increases will be on budget and reflected in MTEFs as appropriate. In addition to strengthened malaria control under programmatic operations, given existing client demands, the Task Force will support country and regional teams to deliver at least 10 Malaria Control Projects (or MDG-related communicable disease control projects) at the country or

subregional level by the end of fiscal 2007. All country or subregional operations will be managed by regional VPUs.

Other key activities in Phase II will include the completion and application of analytical work on the economics of malaria control, further development and application of tools and support mechanisms to enable country and program teams to do their work effectively, including Web-based resources, and a Malaria Advisory Service. Phase III (fiscal 2008) will include lending (programmatic and disease-specific if required), analytical, and advisory services, as well as an evaluation of the Booster Program. The Booster Program will be adjusted in line with country needs and corporate priorities, or phased out as required.

Deliverables

The timeline and deliverables are indicative (see table 4.1). The execution of this program will be responsive to the needs of clients, with emphasis on results and concurrent improvement of country capacity for implementation. It will be flexible, rather than sequential and rigid. This combination of emphasis on outcomes with flexibility in approaches and lending instruments will make the Booster Program relevant and adaptable to a variety of countries in every region, including LICUS and postconflict countries. The program will be results-driven, with the goals of increasing malaria intervention coverage, reducing illness, minimizing productivity loss, and decreasing deaths attributable to malaria.

4.2 The International Finance Corporation and the Private Sector in Malaria Control

The private sector is essential for the supply, distribution, and sale of inputs needed for tackling malaria, such as drugs and ITNs, as well as in the delivery of related services. However, until now, the private sector has been constrained in many of these activities. The market for these needed goods is often unpredictable and difficult to forecast. Although needs are high, the ability of poor households to pay for these goods and services is limited. Current public financing arrangements are limited and not dependable, and even donor-supported aid offers only short-term predictability. The Global Strategy and Booster Program will play an important role in stimulating

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Table 4.1: The Booster Program for Malaria Control: Deliverables

DELIVERABLES	COMMENTS
1	Phase I: Fiscal Year 2005 (start-up phase)
1.1 Global Strategy and Booster Program, which provides the basis for future actions.	Completion date: April 2005.
1.2 Booster Program for Malaria Control.	<p>For preparation in fiscal 2005 and early fiscal 2006, followed by presentation to the Board of Directors in fiscal 2006.</p> <p>Potential sources of cofinancing or performance-based buydowns include major foundations and multinational corporations. Further exploration of such cofinancing is contingent upon World Bank commitment to a stronger effort to control malaria.</p> <p>The program document will address operational aspects of complementarity with GFATM (example from Angola), procurement of commodities, support for Teams with primary responsibilities for work at the country level, and better utilization and improvement of local capacity for implementation. It will address collaboration with WHO, UNICEF, and other key partners such as foundations and multinational corporations.</p> <p>The program document will include guidelines and sample terms of reference for speedy application at the country level, with considerable room for country teams to adapt guidelines to local contexts.</p>
1.3 Development of practical guidelines for Task Teams on (i) assisting countries to enhance PRSCs or health SWAps to strengthen malaria control; (ii) programming incremental resources from the HIPC initiative; (iii) ensuring complementarity among the Booster Program, health SWAps, and PRSCs; (iv) developing malaria-responsive PRSPs; and (v) developing malaria-responsive Country Assistance Strategies (CASs) as part of results-based CASs.	To be done jointly with RBM Secretariat and subregional networks as appropriate.
1.4 Report of first phase of analytic and advisory services (AAA) on the operational and budgetary implications of policy shifts to artemisinin-based combination therapies in selected countries.	Ongoing, jointly with USAID.

Table 4.1: The Booster Program for Malaria Control: Deliverables (*continued*)

DELIVERABLES	COMMENTS
1.5 Formulation of a learning program on malaria control for World Bank staff. Concurrently, five learning sessions for Bank staff on important aspects of malaria control.	
1.6 Formulation and implementation of the first stages of a Communication Strategy.	To address both internal and external communication needs.
1.7 Development of procurement guidelines for malaria commodities.	Jointly with OPCPR and RBM Partnership Secretariat.
2 Phase II: Fiscal Years 2006–7	
2.1 At least five countries have enhanced programmatic operations, increased significantly their financial resources to and strengthened technical support for malaria control from funds already committed under PRSCs, other multisectoral operations, or health SWAps. All increases within budget and reflected in MTEF as appropriate.	Jointly with WHO, MACEPA, Roll Back Malaria (RBM) Partnership Secretariat and subregional networks. Intense country support (for example, attendance at all joint sector review meetings, technical assistance between reviews) combined with cofinancing or performance-based buydowns of parts of credits spent on malaria control. Additional financing will meet the incremental resources needed for effective malaria control.
2.2 Preparation of at least 10 Malaria Control Projects (investment operations) at the country or subregional level, depending on the combination of client demands, feasibility, and pattern of disease. (Includes malaria-specific operations wherever appropriate.)	Jointly with WHO, MACEPA, Regional Collaboration Center in Ouagadougou, RBM Partnership Secretariat, and subregional networks. Intense country support combined with cofinancing or performance-based buydowns of parts of credits spent on malaria control. The number of operations will depend upon client demand.
2.3 Implementation of learning program for Bank staff. Continuation of learning sessions for Bank staff on important aspects of malaria control, with emphasis on operational effectiveness.	Jointly with the World Bank Institute and the Global Development Learning Network.
2.4 Report of AAA on modalities to engage the formal and informal private sector, given the importance of such engagement in reaching and sustaining coverage. Commissioning of applied research on epidemiology, service delivery, and quality of care.	Jointly with Africa Region (ongoing private-public partnerships work) and IFC. Jointly with technical and academic partners. Findings to be applied to ongoing and planned operations as part of broader monitoring and evaluation (M&E).

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Table 4.1: The Booster Program for Malaria Control: Deliverables (*continued*)

DELIVERABLES	COMMENTS
2.5 Web-based directory of technical and managerial resources for malaria control programs.	Jointly with RBM Secretariat, WHO, MACEPA, and others as appropriate.
2.6 Continued implementation of the first stages of a communication strategy.	To address both internal and external communication needs.
3 Phase III: Fiscal Year 2008	
3.1 Preparation of 20 country-specific or subregional Malaria Control Projects (cumulative total of investment operations) under the Booster Program.	<p>Subject to Board approval of a Booster Program and client demand.</p> <p>To be managed by regional VPUs, with incremental operating budget from one or more of Bank budget, trust funds, or credit lines.</p> <p>The Bank-wide Malaria Task Force will support country teams.</p>
3.2 A cumulative total of at least 10 countries have enhanced programmatic operations, increased significantly their financial resources to and strengthened technical support for malaria control from funds already committed under PRSCs, other multisectoral operations, or health SWAps. All increases within budget and reflected in MTEF as appropriate.	Jointly with WHO, MACEPA, RBM Secretariat, and RBM subregional networks. Intense country support (for example, attendance at all joint sector reviews) combined with cofinancing or malaria-related debt buydowns (for example, ACT or ITN investments) will be employed to improve the incentive system for clients to use Bank monies for malaria control. Additional financing would help mitigate the increasing costs of malaria control.
3.3 Malaria control is mainstreamed into the major development instruments in all malaria-endemic countries (all CASs, PRSPs) beginning in fiscal 2006.	<p>Regional VPUs will be responsible for this.</p> <p>The Malaria Task Force will provide support.</p>
3.4 Continued implementation of the Communication Strategy.	To address both internal and external communication needs.
3.5 Malaria Advisory Service established and operational.	Jointly with WHO, MACEPA, RBM Secretariat, and one or more foundations.
3.6 Evaluation.	Operations Evaluation Department or external evaluation team (or both).

wider involvement of the private sector by providing more predictability and stability to the market.

The IFC could potentially finance private companies involved in a number of activities, such as manufacturing of drugs, nets, and diagnostics, and drug distribution. To date the private sector has not sufficiently engaged in these activities to meet demand. There are several roles the Bank could undertake with proposed financing that could facilitate involvement of the private sector. The draft business plan of the Roll Back Malaria Initiative calls for “stimulating development, manufacturing and widespread distribution of long-lasting insecticidal nets” and sets out a useful framework within which the private sector and potentially the IFC could engage. Several of these roles are more broadly applicable:

- *Advance purchase contracts for drugs, nets, diagnostics, or other inputs with a medium-term duration (seven years or longer):* Guaranteed markets would give manufacturers incentive to invest
- *Buydowns of drugs, nets, diagnostics, and so forth:* Buydowns would close the gap between ability to pay and demand
- *Grant funding to cover first loss or a Debt Service Reserve Account:* If the IFC were to finance a local producer directly or through a financial intermediary, grant funding could potentially cover a first loss or support a Debt Service Reserve Account.

For a private company, activities that the Bank may support to increase the attractiveness of investment, and the market more generally, include:

- *Loan buydowns and other mechanisms to lower the cost of capital*
- *Improved transparency and streamlining of regulatory frameworks:* Currently these serve as a major barrier to entry in a number of countries. Improving transparency and streamlining regulatory frameworks would benefit a company’s bottom line and enhance the incentive to supply a given market
- *Efforts to lower taxes and tariffs:* Taxes and tariffs may introduce unfair barriers to entry and discourage market entry.

If some of the initiatives above are undertaken and the right market conditions exist, the IFC could then undertake the following:

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- Identify and finance private sector partners to fill these gaps
- Use trust fund money to identify manufacturers, distributors, and others essential to achieving overall goals.

Though they require further consideration, other products the IFC could offer for small enterprises and NGOs for which the transaction costs of doing business with the IFC are too high include:

- Fund or line of credit for small manufacturers and distributors
- Loan guarantees to back local banks' financing of small companies
- New grassroots initiative that provides a mixture of grants and small loans to small companies and NGOs.

4.3 Cooperation with the Global Fund and Other Major Partners in Malaria Control

The Bank's work will continue to be done with country leadership and in collaboration with major partners. The RBM partnership provides the global mechanism for interagency collaboration in malaria control. The Bank will be proactive in seeking major sources of cofinancing for country-led operations, including but not limited to the GFATM, major bilateral and multilateral organizations, the Bill and Melinda Gates Foundation, the United Nations Foundation, and large corporations. In all partnerships, the Bank will emphasize an orientation toward measurable outcomes at the country level, and collective actions to utilize and improve local capacity for sustainable programs.

The GFATM "only finances programs when it is assured that its assistance does not replace or reduce other sources of funding, either those for the fight against AIDS, tuberculosis and malaria or those that support public health more broadly. The GFATM actively seeks to complement the finance of other donors and to use its own grants to catalyze additional investments by donors and by recipients themselves."¹⁸ The Bank will work closely with the GFATM to increase synergies and avoid overlaps and gaps, while keeping in mind the GFATM's mandate as an additional source of financing and the Bank's comparative advantage in development economics,

financing, system-wide development, capacity building, and implementation support.

For some countries, over the short term, the Booster Program and Task Force may place more emphasis on analytical and advisory services and the removal of implementation bottlenecks and less emphasis on increased lending, given existing GFATM commitments. Other countries face short-term financial constraints or long-term uncertainties; IDA resources are needed in these contexts. The deployment of ACTs is one area in which the importance of collaboration between the Bank's Booster Program and the GFATM is evident. Currently, clients have concerns regarding the sustainability of short-term health sector investments (through increased drug financing) without both medium- to long-term guarantees of financing or returns (economic and health) and the establishment of a timeframe over which greater investments will be required. Other challenges include stimulating local production capacity for commodities used in malaria control, reducing market and demand uncertainties for drug companies, and completing procurement in a timely manner.