Executive Summary

Introduction

This Global Strategy and Booster Program is a significant upgrade of the World Bank's support for malaria control, with emphasis on closing the gap between knowing and doing. It provides the basis for a new Booster Program for Malaria Control, which is designed to accelerate malaria control and progress toward the Millennium Development Goals (MDGs, box 1).

The World Health Organization estimates that there are more than 1.1 million deaths per year from malaria, mostly among children less than five years old (WHO 2002).[1] The disease is preventable and curable with available technologies. However, in the absence of strong and sustained malaria control efforts, coverage with effective interventions is low, particularly among the poor. At least 85 percent of deaths from malaria occur in Africa, 8 percent in Southeast Asia, 5 percent in the Eastern Mediterranean region, 1 percent in the Western Pacific, and 0.1 percent in the Americas (Arrow, Panosian, and Gelband 2004). Globally, there are more than 500 million cases of malaria per year; a recent study put the number of cases from a particularly severe form of the malaria parasite, *Plasmodium falciparum*, at 515 million in 2002 alone (Snow et al. 2005).

Rationale

The Global Strategy and Booster Program responds to the inadequacy of global efforts to control malaria and the modesty of the Bank's current efforts relative to its potential. The Bank was a key contributor to recent successes in malaria control, including those in Brazil, Eritrea, parts of

Box 1: Malaria and Selected MDGs

Goal 2: Achieving universal primary education

- Malaria is a leading source of illnesses and absenteeism in school-age children and teachers. It adversely affects education by impeding school enrollment, attendance, cognition, and learning.

Goal 4: Reducing child mortality

- Malaria is a leading cause of child mortality in endemic areas.

Goal 5: Improving maternal health

- Malaria causes anemia in pregnant women and low birth weight.

Goal 6: The combating of HIV/AIDS, malaria, and other diseases

- Malaria morbidity and mortality are increasing in Africa.

Goal 8: Developing a global partnership for development, including as a target the provision of access to affordable essential drugs

- There is a lack of access to affordable essential drugs for malaria.

India, and Vietnam. It cofounded and supports the global RBM Partnership.[2] However, the Bank's efforts have been severely understaffed and underfunded, in terms of both funds committed to malaria control at the country level and the internal budget for the Bank's Malaria Team—a budget that declined during much of the period since RBM was founded in 1998. On balance, the Bank's activities were very useful, but not sufficient for success on a larger scale.

The rationale for a stronger World Bank effort includes the following:

- Malaria impairs economic growth and human development in many of the World Bank's client countries, particularly in Sub-Saharan Africa.
- The disease is preventable, curable, and controllable on a large scale, with good returns on investment.
- Malaria control has positive externalities and is a global public good.
- At the regional and global levels, there is a wide gap between what is feasible and the current level of effort. Despite successes in a few countries, measurable progress in malaria control is well below the 60 percent coverage target set by countries and development agencies for 2005 in terms of coverage with preventive and curative interventions.[3]

- The Bank has the capacity to do a lot more than it has in malaria control, including financing, policy advice, and implementation support.
- Clients, partner agencies, independent observers, civil society organizations, and potential cofinanciers are requesting that the Bank play a more decisive role in malaria control. There is much unmet demand for the Bank's financing and advisory services.

At the macroeconomic level, annual economic growth in malarious countries between 1965 and 1990 averaged 0.4 percent of gross domestic product (GDP) per capita, compared with 2.3 percent in the rest of the world, after controlling for the other standard growth determinants used in macroeconomic models (Sachs and Malaney 2002). These analyses do not constitute proof that malaria is a cause of low incomes and poor aggregate growth, but that the disease must be considered a legitimate contributor (Arrow, Panosian, and Gelband 2004). At the microeconomic level, estimates of the "total" (direct plus indirect) costs of malaria vary: 0.75 percent of gross national product (GNP) in Pakistan (Khan 1966); 7 percent of household income in Malawi (Ettling et al. 1994); 9–18 percent of annual income for small farmers in Kenya, and 7–13 percent in Nigeria (Leighton and Foster 1993). One multicountry study attempted an Africa-wide estimate of total costs of malaria based on extrapolations from case studies of areas in Burkina Faso, Chad, the Democratic Republic of Congo, and Rwanda. The totals reported translated to 0.6 percent of total Sub-Saharan African GDP (Shephard et al. 1991).

Malaria control gives good value for money. In Vietnam, at a cost to the government of about US$11 (1998 costs) for a clinic visit plus drugs to treat an episode, the direct costs saved were about US$9.5 million, which is about twice the amount spent on malaria control each year. To this is added about US$14 million in reduced out-of-pocket health care costs to households (Laxminarayan 2004). In Brazil, compared to what would have happened in the absence of the malaria control program, nearly 2 million cases of malaria and 231,000 deaths were prevented. The overall cost-effectiveness was US$2,672 per life saved, or US$69 per disability-adjusted life year (DALY),[4] which compares favorably to many other disease control interventions (Akhavan et al. 1999). Other sources indicate that insecticide treatment of existing mosquito nets costs US$4–10 per DALY saved, providing nets and retreatment costs US$19–85 per DALY saved, and intermittent presumptive treatment of pregnant women through existing prenatal services costs US$4–29 per DALY saved (Goodman, Coleman, and Mills 1999).

Priorities and Business Model

The Bank's priority is enabling countries to achieve and sustain large-scale impact in malaria control. More specifically, the Bank will support countries to develop and implement programs to (i) cost-effectively reduce morbidity, productivity losses in multiple sectors, and mortality due to malaria, particularly among the poor and vulnerable subgroups such as children and pregnant women; and (ii) address the challenges of regional and global public goods. The Bank will achieve the stated priorities through a new business model that combines an *emphasis on outcomes* with *flexibility in approaches and lending instruments.*[5] Products and services will be tailored to different client segments in a way that meets their needs and maximizes the institution's comparative advantages. This approach is consistent with the new Global Strategic Plan of RBM (RBM 2004a). The Bank participated actively in the formulation of that strategy.

The Booster Program for Malaria Control

In the short to medium term, a new Booster Program for Malaria Control will provide increased financing and technical support to accelerate program design and implementation, increase coverage, and improve outcomes more rapidly than in the recent past. The Booster Program for Malaria Control will be global in scope and consist initially of an intensive effort over a five-year period. It may include one or more Horizontal Adaptable Programs[6] at the global or regional level, covering many countries, with emphasis on country ownership, measurable outcomes, and rigorous application of epidemiology. While the immediate objectives are fixed—increasing coverage, improving outcomes, and building capacity—the means will be flexible. The financial commitment is subject to consideration by the Board of Executive Directors of the World Bank.

The new business model and the Booster Program for Malaria Control take into account lessons learned from successful malaria programs and experiences from the Multi-country HIV/AIDS Program (MAP). They constitute a substantial departure from the Bank's previous approach to malaria control. There is a need for decisive action on a large scale in order to achieve impact. Experience of the past five years shows that a pledge of commitment, such as that made by the Bank in Abuja in 2000, with neither a

clearly funded program for malaria control nor the internal budget to ensure that the Bank's malaria team can function effectively, does not lead to success on a large scale. A different and more robust approach is needed for success.

Drawing on lessons of the past five years, Bank management is designing a program for Board approval to ensure that the Bank responds to country demands with flexibility and speed. On the basis of initial demand from clients, the working assumption is that a total commitment of US$500 million to US$1 billion is feasible over the next five years. The Bank will mobilize financial and technical resources from within and outside the institution, including the public and private sectors, to stimulate the production of commodities such as insecticide-treated bed nets (ITNs) and antimalarial drugs; lower taxes and tariffs on such commodities; improve and maintain long-term commitment to malaria control by governments and civil society groups; and build public-private partnerships for program design, management, and evaluation. Several key partners have expressed interest in a collaborative and stronger effort. The International Finance Corporation (IFC), which has a particularly strong comparative advantage in working with the private sector, will play an important role in this enhanced effort by the World Bank Group.

Significant cofinancing will be leveraged by a demonstration of the Bank's own commitment up front, together with the emphasis on measurable results. Crucially, the Bank's approach will be proactive while respecting and supporting country leadership and ownership. It will complement the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), WHO, United Nations Children's Fund (UNICEF), the Bill and Melinda Gates Foundation, and others in ensuring sufficient financing as well as technical and implementation support for effective malaria control. Henceforth, malaria control will be mainstreamed into the Poverty Reduction Strategies and large sector-development programs that emphasize outcomes. The high coverage rates achieved in most countries would be sustained through combinations of domestic financing, programmatic operations, and budget support on a case-by-case basis. High coverage with preventive interventions will decrease the burden of disease and the pressures on health services.

Countries will have three main options for accessing more funds and technical support from the Bank. These options, which are not mutually exclusive, are outlined below.

- *Enhancing PRSCs and health SWAps to support malaria control.* In this option, the Booster Program for Malaria Control will be used to enhance Poverty Reduction Support Credits (PRSCs) and sectorwide approaches (SWAps) for health to include stronger malaria control programs, with additional financing when required, technical support, and results-based monitoring and evaluation. The recently approved PRSC for Rwanda is a useful example. It includes technically sound malaria control activities within the health sector plan of work, including the monitoring and evaluation matrix and the Medium-Term Expenditure Framework (MTEF). Beyond the health sector, PRSCs provide opportunities for cross-sectoral work on malaria through, for example, the education, agriculture, environment, and transport sectors.

- *Malaria Control Projects at the country or subregional level.* Based on country requests, the Booster Program for Malaria Control will support Malaria Control Projects, as in the successful examples of Brazil, Eritrea, India, and Vietnam. Project design and objectives will depend on the local context in terms of government policy, disease burden and distribution, the nature of the vector (the mosquito), and local management capacity. Countries may choose to use community-driven development (CDD) approaches, depending on the context. These Malaria Control Projects will supplement, not disrupt, systemic health sector development programs. Strengthening the health infrastructure will facilitate malaria control and help to sustain the gains to be achieved under the Booster Program for Malaria Control. For Low Income Countries Under Stress (LICUS) and postconflict countries, special implementation arrangements may include more extensive contracting of civil society organizations (CSOs) for service delivery, combined with technical and operational support from agencies such as WHO and UNICEF.

- *Combined HIV, Tuberculosis, and Malaria Control Projects.* Another option is to develop and implement operations covering HIV, tuberculosis, and malaria, such as those in Eritrea and Angola. In this option, the Booster Program for Malaria Control will support broader operations covering several disease control objectives in a way that is consistent with medium- to long-term sectoral and multisectoral development.

Implementation of the Booster Program implies an increase in the deliverables to be planned and achieved by Bank regional vice presidencies,

country units, and sector units working on malaria control from fiscal 2006 onwards. The Booster Program will support operations at the subregional and country levels. Depending on specific contexts, the operations will include proactive engagement of CSOs and the private sector to the extent that is compatible with their comparative advantages. Such engagement may include contracting or financing of activities to be undertaken by CSOs and the private sector. In order to promote sustainability and mitigate the risks of distortions, the Booster Program will supplement programmatic approaches such as health SWAps and PRSCs. The Bank would seek cofinancing or performance-based buydowns from partners, including but not limited to foundations and multinational corporations.

The Malaria Task Force and Steering Committee

The Malaria Task Force is a Bank-wide group drawn from corporate units, networks, operational vice presidential units (VPUs), and the IFC. It will support the Bank's country and regional teams to (i) increase rapidly the scale and impact of the Bank's support for malaria control at the country level and (ii) improve the institutional knowledge base regarding the economics of malaria at the household, sectoral, and macro levels, and channel that knowledge into the Bank's work on poverty reduction. A high-level Steering Committee will provide institutional oversight and guidance. The Steering Committee will include the Senior Vice President and Head of the Human Development Network; the Regional Vice Presidents for Africa, South Asia, East Asia and the Pacific; the Vice President for Operations Policy and Country Services; and the Senior Vice President and Chief Economist. The Poverty Reduction and Economic Management Network will provide guidance on the integration of malaria control into Poverty Reduction and Strategy Papers (PRSPs). Subject to satisfactory performance and resource availability, the Bank will continue its highly selective support for partnerships working on product development and applied research that are relevant to malaria control.

By the end of the fifth year of the Booster Program for Malaria Control, most of the eligible countries are expected to have achieved significant increases in coverage of essential interventions.