

Summary Report

4th Global Partnership Meeting to Roll Back Malaria

April 17-18, 2001

**World Bank
Washington, D.C.**

Overview

The Fourth Global Partnership Meeting to Roll Back Malaria was held at the World Bank in Washington, D.C. April 17-18th, 2001. The meeting aimed to further expand the capacity of the RBM Partnership to achieve the scale of action required to significantly reduce the global burden of malaria. The themes of the meeting recognized that to achieve the targets set by the RBM Partnership we must increase the volume of actors and actions at country level. Presentations and discussion focused on how malaria-affected countries and their partners can mobilize action beyond malaria control programs, beyond the health sector and beyond the public sector.

The 200 participants included government delegations from 21 malaria-affected countries (covering every region of the world and including numerous ministers of health and finance), representatives of UN organizations, development banks, bilateral donors, foundations, industry, NGOs, research institutes and the media.

The Roll Back Malaria Partnership was launched by WHO, UNICEF, UNDP and the World Bank in October, 1998 to intensify and revitalize action against malaria. The Partnership has set a target of reducing deaths from malaria in half by 2010, and is intended to “draw on each participating agency’s special expertise, pooling resources in an effort to eliminate costly overlaps”. This statement recognizes that each partner, whether a UN agency, bilateral donors, development bank, OECD countries, the research community, industry, the private sector or NGO could make a greater and more coordinated contribution whether in financing, technical advice, research capacity, product development, ability to disseminate information, drugs, reagents, nets and insecticides, or in access to or knowledge of communities,

At its launch, RBM described a mode of operating unique to global public health initiatives, but consistent with current trends in development assistance to the health sector. RBM is intended to act as a “pathfinder” offering a new approach to the sustainable control of infectious disease, and operating within the context of health system strengthening.

I propose that together we roll back malaria. Not as a revamped vertical program, but by developing a new health sector wide approach to combat the disease.

Gro Harlem Bruntland at the launch of the Roll Back Malaria Partnership

Malaria affected countries and their partners recognize that achieving the aims of Roll Back Malaria demands a new way of doing business. The unsustainable efforts of the past, and current resurgence of malaria in many countries suggest that short-term, targeted, donor-led initiatives will not provide a long-term solution. The Partnership recognizes that what is required is a sustained commitment by malaria-affected countries to act on multiple fronts, and a sustained commitment by their external partners to support actions on the ground, while continuing to improve the tools available.

The Fourth Global Partnership Meeting highlighted some of the challenges inherent to rolling back malaria in a sustainable manner, and incorporating malaria control within

health system strengthening. For many, the pace does not appear fast enough, and more rapid results -- such as might be possible through more targeted and vertical approaches - - are desired. Some participants viewed the key obstacle to be overcome in order to get to scale as increased external financing for malaria. Yet, others view the greater challenges as building effective demand, increasing absorption of existing resources, and expanding implementation capacity.

Many of the presentations did reveal that there are increasing examples of countries who are incorporating malaria sector wide, as well as beyond the health sector; that there are increasing examples of countries who are effectively engaging partners outside of the public sector; and that some countries are beginning to take advantage of initiatives such as the Highly Indebted Poor Countries Initiative (HIPC) and Poverty Reduction Strategies to bolster their efforts to reduce malaria.

Progress and Remaining Challenges

The Meeting opened with an overview of global and regional progress and challenges. Although the burden of malaria remains unacceptably high, the Partnership has made considerable progress towards its goal of “creating a societal movement which will support malaria endemic countries and people at risk to reduce their burden of malaria”, and “creating an environment in which countries can establish policies and action to roll back malaria, which are effective, sustainable and respond well to the local context”.

The Partnership has improved the technologies that will assist malaria-affected communities and countries. Long lasting nets will eliminate the need for retreatment. Affordable combination therapy will reduce the risk of drug resistance and the need to continually develop and implement new first-line treatment options. Intermittent presumptive treatment for pregnant women will reduce the risk of anemia in mothers and the consequences for newborns, artemesinin suppositories for treating children with severe malaria will reduce the numbers who die because they cannot reach a hospital. Pre-package drugs will improve compliance with treatment. Improved strategies and tools for coping with complex emergencies and for identifying and responding to epidemics will reduce the high case fatality rates often found in these settings. Strategies to reduce reliance on DDT will ensure that countries that currently rely upon residual spraying with DDT will be able to modify their vector control strategies without adverse effects. Web-based information systems (e.g., Health Mapper) will support countries in making evidence-based decisions on their malaria control strategies. The great increase in institutions and resources for research and development of antimalarials, vaccines and approaches to treatment and prevention will further strengthen the arsenal of tools and techniques to combat malaria.

Within the Africa, Asia, Pacific and Latin American regions, meeting participants heard how functioning country partnerships have strengthened collaboration around common strategies and improved the coordination of inputs, and how many countries have now produced national strategies that recognize the potential contributions of NGOs, communities, the private sector and the public sector. The incorporation of efforts to roll back malaria within sector-wide approaches in Africa demonstrates how broad efforts at

health systems strengthening can affect malaria objectives, and within Latin America and Asia increased district health budget allocations for malaria demonstrate local commitment and a greater conviction that something can be done.

Sub-regional initiatives, such as the Health for Peace Initiative in The Gambia, Guinea Bissau, Guinea Conakry and Senegal, the North African Countries Initiative, the Haiti-Dominican Republic-Guyana Shield, the collaboration within the Mekong and Amazonas Regions and the Lumbombo Initiative (encompassing Swaziland, Mozambique and South Africa) demonstrate how countries are working across borders to share information and experience, design coordinated strategies, conduct surveillance and protect cross-border populations. Explicit inter-country agreements in the Amazonas, Mekong region and the Thai-Myanmar border are further examples of countries working in partnership.

The Africa Region has seen the establishment of additional sentinel surveillance sites, additional providers trained in case management and an increased availability and use of bednets. More countries have now indeed reduced or eliminated taxes and tariffs on bednets. African Heads of State, or their representatives, from 44 nations gathered in the city of Abuja in Nigeria in April, 2000 to jointly commit to addressing malaria. They signed a declaration committing to increase access to treatment, nets and intermittent treatment for pregnant women, and to reduce taxes and tariffs on nets and pharmaceuticals.

In the Amazon and Mekong regions, there are efforts to improve access to services for the poorest and marginalized communities, those in conflict, ethnic minorities, forest dwellers and displaced populations. South East Asia cites increased application of rapid diagnostics, collaboration in regional training, technical, surveillance and drug resistance networks and joint action against counterfeit drugs. Inter-sectoral action, particularly outside of Africa, has expanded. Examples include irrigation schemes in Sri Lanka and Brazil, tourism in the Dominican Republic, Indonesia and the Philippines, public works in Indonesia, Brazil and Peru, and with the defense forces in Sri Lanka and Bolivia.

Global attention to malaria has dramatically increased since the founding of the Roll Back Malaria Partnership. Over the past year, malaria was on the agenda of the G8 meeting in Okinawa, it was the theme of a meeting of African Heads of State and it has been addressed within numerous global communicable disease discussions over the past year (e.g., at the European Union and Winterthur). Multinational corporations are beginning to recognize that malaria deserves their attention; that it is both good business and socially responsible to invest in malaria.

The Partnership, in particular with the publication of the London School over the past year, has increased appreciation for the economic costs of malaria and the benefits of existing interventions, which should influence priority

Interventions

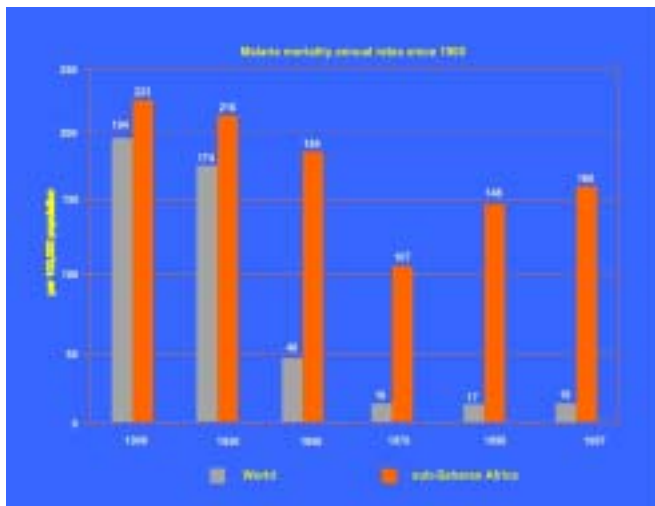
- *Early detection and prompt treatment*
- *Insecticide treated materials and other vector control methods*
- *Preventive intermittent treatment on pregnancy*
- *Disease surveillance, epidemic preparedness and response*

setting within malaria-affected countries and by development assistance agencies. There is an increased recognition that malaria needs to be considered in all development initiatives undertaken within malaria-affected countries. This is significant progress from five years ago, when malaria was receiving little attention from either donors or ministries of health, and no attention at all from ministries of finance. The Partners are now working on national programs that will impact upon malaria throughout each affected country and region, rather than limited, small-scale malaria projects.

Despite this impressive level of progress, the meeting also recognized that significant challenges remain. Accessing and effectively disbursing the resources available for malaria is frustrating parties on all sides. There

Funding is less of an issue than getting governments to focus on malaria. We are trying to make a case to financiers that this is central to the economic development of Africa.
World Bank President, James D. Wolfensohn

are substantial commitments from financiers and technical agencies that are not being fully utilized, and donors and Ministries of Finance frustrated by the inability to move resources committed or potentially committed to malaria. Yet, there are also malaria control program managers, districts health officers, service providers, NGOs and communities who are unable to implement activities for lack of resources. The dichotomy is exemplified in the fact that although the African Heads of State at Abuja called for debt cancellation as an intervention for rolling back malaria, only three out of 18 countries in Africa have included malaria objectives within their HIPC programs to date.



Africa continues to face the challenges of drug resistance, changing meteorological patterns, and population movement. Coverage with effective drugs, nets, insecticides and information in all regions is still insufficient. Greater utilization of private sector distribution mechanisms, and efforts to strengthen the capacity of drug peddlers and small pharmacies to provide quality treatment are required, as are strategies to support households in complying with appropriate

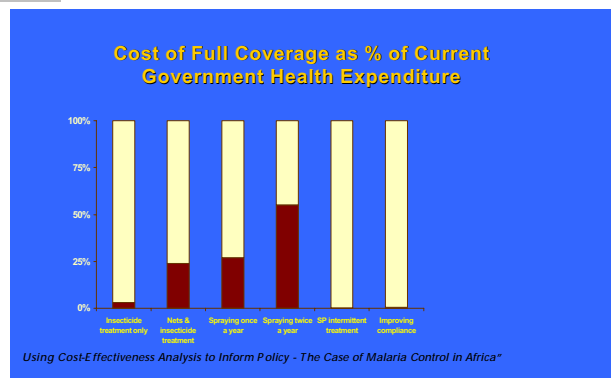
treatment practices. Although the prices of newer drugs and of insecticide treated nets have decreased, cost remains a barrier to greater coverage, especially among the poorest communities. Costs to households of nets are compounded by taxes and tariffs, and not all of the governments in Africa that signed the Abuja Declaration have yet reduced taxes and/or tariffs. Experiences in Asia and Latin America focused on accessing sufficient resources, particularly for sub-regional activities. Their experiences also highlighted the

challenge of redirecting the public sector towards a stewardship role and away from service delivery.

The country presentations caused David Alnwick, the RBM Project Director, to conclude that we need to recognize the evolving job descriptions for Malaria Control Program Managers who are operating in changing environments, where authority and decision making is decentralized, where resources for malaria must be lobbied for through more comprehensive development initiatives, and where the capacity to manage procurement and resource allocation will determine whether strategies can be effectively implemented. He proposed that what might be required to take advantage of these changing circumstances, might more accurately be considered “Malaria Engineers.”

Malaria and Poverty Reduction

The Partnership requires economic information to influence and inform priority setting and resource allocation, and to inform implementation strategies. A recent contribution to the knowledge base on the economics of malaria which was made this past year (and which was distributed to each country delegation at the Meeting) was “Using Cost-Effectiveness Analysis to Inform Policy - The Case of Malaria Control in Africa” by Catherine Goodman, Paul Coleman and Anne Mills of the London School of Hygiene and Tropical Medicine.¹

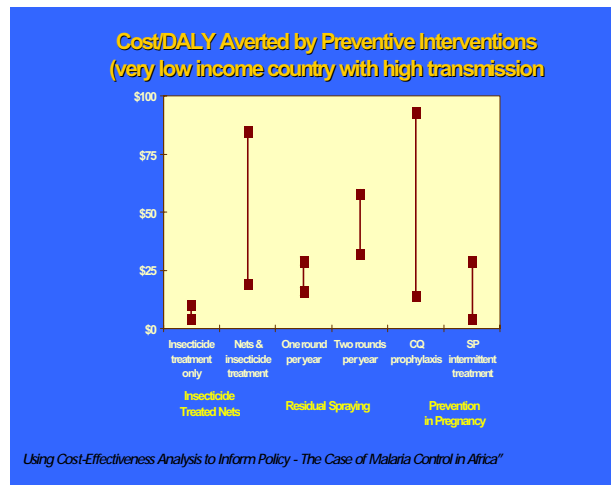


Policy makers will have to make choices and trade-offs, and the Partnership is promoting and undertaking efforts to build upon the economic information required to support those choices.

The high burden of malaria costs born due to treatment, provision of care, loss of income, and the impact upon educational attainment either through absenteeism or reduced learning capacity due to illness by poor households and the health systems of poor countries have received significant attention. The appreciation of the impact on poverty and development is expanding to recognize indirect, yet potentially significantly negative effects on the labor and land productivity, and reduced incentives to invest in productive activities and child schooling. A widely quoted assessment is that highly malarious countries have had growth rates decreased by 1.3 percentage points per year (controlling for other influences on growth), and that a 10% reduction in malaria over the period studies is associated with 0.3 percentage points higher growth per year.

¹ This publication can be acquired through the publisher, the Global Forum for Health Research c/o World Health Organization, 20 avenue Appia, 1211 Geneva 27, Switzerland Tel: (41 22) 791 4260, Fax (+41 22) 791 4394 , E-mail: info@globalforumhealth.org.

The Roll Back Malaria Partnership was founded on the premise that the cost-effective interventions required to reduce malaria exist, although the optimal package of interventions must be defined for each setting. Factors affecting the cost-effectiveness of interventions include the length of transmission season, the local price of commodities, compliance, drug resistance and infrastructure. Cost-effective interventions to improve the prevention and treatment of malaria include (i) interventions to improve



case management, such as prepackaging of drugs and improving access to second and third line drugs for treatment failures; (ii) chemoprophylaxis or intermittent treatment during pregnancy; and (iii) vector control through insecticide-treatment mosquito nets and indoor residual spraying.

The meeting included some debate as to whether, and how, to phase in activities in order to achieve the scale of action required. The relative importance of external funding versus national commitment was also debated. Some partners view national commitment as the key to mobilizing resources considering (i) the move towards government-led development financing (e.g., Sector-Wide Approaches, the Comprehensive Development Framework and PRSPs); (ii) the limited disbursement of available resources, and (iii) that in extremely resource constrained environments external funding is no guarantee of a real increase in resources for malaria.

Absorptive capacity and implementation capacity concerns were debated. The meeting highlighted the challenges of creating sufficient demand, and of strengthening implementation capacity. Commitments made within World Bank Credits or donor grants that do not disburse will not have an impact upon malaria. Bednets and antimalarials that sit in warehouses or on the shelves of clinics and stores will also not have an impact. The capacity limits of human resources, systems and procedures at country level must be overcome in order to implement activities to scale, and to demonstrate the ability to effectively absorb larger commitments to malaria. Human resource and infrastructures constraints may appear difficult to resolve in the short-run, but the presentations made during the parallel sessions of the Meeting emphasized that the public health sector can expand its implementation and absorptive capacity through recognizing the untapped internal resources such as NGOs, private service and drug providers, agricultural extension workers and schools which could deliver care, develop communication strategies, conduct training, market nets and insecticides, reach communities, and affect household behavior.

The Highly Indebted Poor Countries (HIPC) Initiative provides an opportunity for many malaria-affected countries to increase domestic resources for malaria. HIPC aims to

reduce the debt burden for very poor countries to a sustainable level, but ties debt relief to the existence of poverty reduction strategies (PRSPs), and the reallocation of budgetary expenditures towards the social sectors. A clear advantage inherent to this mode of support is that HIPC can result in an increased budget for health. These resources are not constrained by donor implementation requirements nor limited to investment. In some countries, contributions of additional resources made available to the health sector have been employed to create incentives for health workers (the deployment and motivation of health workers were recognized by participants as essential inputs to improving coverage and the quality of services). Again, the commitment of governments to address malaria within HIPC will determine what resources are allocated to malaria, and the ability of stakeholders to justify expenditures on malaria (the contribution to poverty reduction, the readiness of credible implementation strategies and budgets) will determine how additional resources are allocated across competing priorities. Among the 22 countries that had reached their Decision Point by the end of 2000, only two had explicitly stated a commitment to addressing malaria within the program.

Cameroon has recognized HIPC as an opportunity to scale up its response to malaria. In their presentation to the Meeting the presenters explained that the Abuja Declaration, and statements on how much malaria has the economic development of Africa, had influenced Cameroon's decision to include malaria objectives within its HIPC program. The Government of Cameroon has recognized rolling back malaria as a key contribution to poverty reduction. Within the initial resources made available under the HIPC program, the Government has allocated resources for the procurement of nets (although the Ministry is challenged to disburse these resources rapidly in order to access subsequent financing). They have also opted to use the opportunity to provide incentives for health staff, recognizing the contribution this could make to malaria objectives.

Uganda is addressing malaria within its Poverty Eradication Action Plan, and has created a Poverty Action Fund (PAF) with resources made available through HIPC. Financing from the Government of Uganda as well as donor financing is channeled through the PAF to the health sector, and disbursed to districts grants and national priority programs. Malaria is addressed through both of these avenues. The Health Policy and Sector Strategic Plan define the program for health sector, and external financing is intended to support this strategy. Uganda's Inter-Agency Coordination Committee provides a structure for coordinating Partners' support for malaria. The Sector Wide Approach is benefiting the national efforts to roll back malaria through increased transparency of funding, more effective partnerships, improved deployment of resources and infrastructure development.

Some of the challenges faced in effectively accessing and utilizing resources cited include the limited human resources (numbers and skills) at district level, limited infrastructure capacity, flow of resources from the center to the districts to the implementing level, and the reluctance of some donors to contribute through the PAF. Another concern is that the resources made available through the PAF are to date insufficient to replace direct project funding. The presentation highlighted the inability to employ malaria earmarked financing against cross-cutting inputs, such as health facilities,

salaries, drugs, and balancing the short-medium-term objectives of global initiatives with longer term objectives of health systems development.

Engaging All Actors

Increasing the scale of country level action requires involving NGOs and the private sector, and recognizing the complementary role of governments.

Defining the Role of Government

This session included presentations on how Tanzania was able to prioritize and support malaria control activities under its sector-wide health strategy, and how Peru worked with its neighbors in the Amazon Region to coordinate control activities. The role of government in providing subsidies for insecticide-treated materials was also discussed. Key messages from this session included:

- Government plays a role in coordinating, facilitating and monitoring the impact of work of all sectors and actors involved in malaria control, as they bear the responsibility for affected populations in their countries. As the number of actors and activities increases and broadens in scope, many governments struggle with how these activities fit into ongoing health sector development strategies. Leadership by government in setting national priorities and guiding external support is something which SWAps attempt to address.
- As the public health care system in most countries reaches a small minority of those affected by malaria, government can expand the scale of national action by engaging other parts of society (e.g., communities, NGOs, and the private sector) to contribute to efforts to roll back malaria. Government stewardship is required for NGOs and the private sector to work effectively. Government can also ensure that other sectors including agriculture, infrastructure, water, and finance also take action to achieve impact on malaria
- Public expenditure and public sector action can either complement or displace the private sector. We need to maximize the capacities of both public and private sector action to achieve scale. How can public subsidies best protect the poorest communities, mobilize private sector actions, and positively affect behavior?
- As malaria knows no borders, cross border action will be essential to reaching the goals of RBM. Government leadership plays an essential role in reaching across borders. Through efforts to combine forces with neighboring countries in their regions, share their experiences and expertise, and work together, rather than compete, governments can mobilize the necessary resources and capacity.

Expanding Capacity through Partnerships with NGOs

Examples of how NGOs have successfully expanded the scale and scope of malaria control activities in the Democratic Republic of Congo, Bolivia, and East Africa were presented in this session. Participants agreed that:

- NGOs have a comparative advantage in their experience and established infrastructure to work directly with communities.

- One of the greatest challenges for successful collaboration between NGOs and governments has been effective communication and coordination of the efforts amongst NGOs and between NGOs and government.
- If NGOs are to be effective partners in increasing the scale and scope of efforts to Roll Back Malaria, they require ongoing technical support and supervision.
- Additional resources will be needed if NGOs are to increase the scale of their activities. Resources could come through government contracts or from donor support, but all support should be coordinated through government to ensure effective and equitable resource deployment.

Engaging the Private Sector

Presentations in this session explored the diversity of opportunities for collaboration with various parts of the private sector, including developers and manufacturers of pesticides, producers of bed nets, and both formal and informal drug sellers. Opportunities for support of the private sector through the International Finance Corporation (IFC) and the Multilateral Investment Guarantee Association (MIGA), two World Bank agencies, were also presented. The following are some overarching themes derived from this session:

- The public sector cannot achieve the scale of action required on its own. The private sector can contribute to national capacity to absorb and deploy resources efficiently and effectively.
- The "private sector" encompasses a diverse array of actors and services, from providers of health care services to drug sellers to producers of essential drugs and commodities. Each of these groups has somewhat differing goals and needs, which may also differ from the public sector, but commonalities exist and provide opportunities development of partnerships.
- We need to move beyond traditional suspicions and acknowledge that the private sector provides essential products and services that the public sector in some cases could not provide as efficiently or as cheaply.
- Although the private sector is motivated by profit, it is not their only consideration in promoting products and services. Neither is this profit orientation necessarily contrary to the goals of RBM. Within the RBM Partnership, we can explore how the motivations of the private sector can serve the goals of reducing malaria.
- Government could benefit from exploring the full range of services that could be provided by the private sector. For example, rather than buying a bulk shipment of insecticide, governments could contract for a package that includes delivery of the product, training, removal of waste, and monitoring for resistance. Tenders might even be issued for particular outcomes (e.g., reduction of malaria cases).
- As we rely more heavily on the private sector and NGOs for provision of services, government can shift its focus to ensuring that the services and products provided are of high quality, through provision of training and supervision, development of standards for quality services, and regulatory oversight.

Working through All Avenues

Increasing action within and outside of the health sector can increase scale, as can recognizing the role of research in policy and program development.

Addressing Malaria throughout the Health Sector

Efforts to develop effective collaborations between RBM and the Integrated Management of Childhood Illness (IMCI) in both sub-Saharan Africa and the Americas were reviewed, as well as an example of country-level collaboration in Uganda. A successful collaboration between malaria control and reproductive health in the implementation of presumptive intermittent treatment (PIT) of pregnant women at antenatal clinics in Malawi was also presented. Unifying themes for this session included:

- Effective implementation of the core strategies of RBM requires the commitment and collaboration of many parts of the health sector. In particular, achievement of rapid, effective treatment goals will require partnering with those persons and programs responsible for maternal and child health, primary health care, essential drugs, hospital-based care, and IMCI. Similarly, partnerships with reproductive health and safe motherhood programs are required for effective prevention of malaria in pregnancy.
- IMCI and reproductive health programs should be recognized as resources – working through these initiatives can provide opportunities to expand the scale of implementation.. Such programmatic collaborations with the health sector should capitalize on the unique strengths of each of the partners.
- Leadership from high levels of the Ministry of Health is required if all necessary actors and programs within the health sector are to collaborate successfully. The Ministry of Health can set examples for addressing national health priorities through multiple health programs, although we must accept that different programs have different agendas.
- Two key elements for successful collaboration within the health sector are ongoing communication, including joint planning of activities, and financing leading to an environment in which programs are not forced into competition for scarce resources.
- Financing malaria objectives may imply financing inputs into IMCI or reproductive health services or broader health system support. Donor and lending agencies would make a significant contribution if they recognized that support for effective malaria control requires support beyond malaria control programs, and beyond traditional malaria control inputs.
- Roll Back Malaria, IMCI, and Making Pregnancy Safer initiatives should work through activities at community level based on what is feasible within that context, in order to truly go to scale.

Enlisting the Non-Health Sectors

This session highlighted the challenges of and some success with working in non-health sectors. In particular, examples of how the education sector has been engaged in RBM through the Focusing Resources on Effective School Health (FRESH) initiative were discussed, including its implementation in Senegal. A framework for incorporating

health impact assessments into projects and activities in other sectors (e.g., agriculture, infrastructure, water and power) was also presented. Participants agreed on the following points:

- The health sector cannot accomplish on its own all of the actions required to reach RBM goals of halving the burden of malaria.
- Development policies of other sectors should be reviewed for opportunities to improve or mitigate health impacts of activities in these sectors, bearing in mind comparative advantages and cost-effectiveness of various options.
- Schools in particular provide an opportunity to reach children and their families with behavior change strategies, preventive interventions, and possibly health care services. The FRESH initiative provides a platform for addressing malaria and health in schools.
- Leadership at the highest levels of government is needed to support inter-sectoral collaborations, similar to the high-level support being provided to initiatives addressing HIV/AIDS in many countries.
- The proper implementation of Health Impact Assessment and Health Risk Management will require the establishment of a policy framework, institutional arrangements, assessment criteria, procedures, and development of skilled human resources.
- De-compartmentalizing bilateral agencies for technical assistance, or allocating funds specifically for intersectoral action, is required to ensure malaria (health) is effectively addressed in development activities in other sectors.
- As part of on-going reforms within the public sectors (Agriculture, Education, Energy, etc. including health), governments should consider adopting procedures that ensure health opportunities are seized to the maximum in all non-health sector development projects.

The Role of Research in Strengthening Scale and Scope of National Malaria Control Programs

This session reviewed the barriers to using research results for evidence-based decision-making and presented examples from both Tanzania and Sri Lanka how these barriers were overcome. The experience from Cambodia of how research was essential in developing a comprehensive malaria treatment policy were also presented, as were the Multilateral Initiative on Malaria's (MIM) efforts to build research capacity in Africa. Discussions during this session concluded that:

- Research is a critical element of RBM
 - for development of evidence-based policies/plans
 - for refinement/change/introduction of cost-effective interventions
 - for monitoring and evaluation of progress toward the goals of RBM
- Researchers are important and influential voices in policy decision making and in garnering wide support for program implementation. They should be part of the RBM effort in every country.
- Research in the past has, at times, been ad hoc and uncoordinated. Priority research needs at the international, regional, and country levels should be clearly articulated to help direct research activities.

- RBM, at all levels, must embrace evidence-based decision-making. Research alone, though, is only one step in decision-making process. Team building, consensus development, and ownership of policy decisions require the larger partnership.
- Technical Networks and regional/sub-regional Networks can be important resources to help guide research priorities and implementation.
- The private sector plays a role in research, particularly in development of new drugs and technologies. Caution should be exercised to ensure that the goals of the private sector (e.g., to promote their products) are harmonized with those of the countries and the global RBM initiative.
- Financing of research should be incorporated into RBM program planning.
- Capacity building for research/researchers will be an ongoing need. Gaps still exist, particularly for operations and programmatic researcher and for those who can translate research results into policies and programs.

The Way Forward

Strengthening national commitment and accessing resources. The evidence is available, and we should be able to define messages and make the case that investments in rolling back malaria will reduce poverty.

Expanding capacity while recognizing and mobilizing the capacity which exists. The constraints on implementation and absorptive capacity in many settings should not preclude increasing the scale of action. Government oversight and coordination is essential, but critical capacity may reside outside of the public sector. Rapid action is possible where governments and Malaria Control Programs delegate to, and share responsibilities with, other partners. Additional skills are required (Malaria Engineers) related procurement, disbursement, how to work with resellers, wholesalers and industry, how to access HIPC and ensure that national Poverty Reduction Strategies prioritize malaria.

Improving the effective and efficient flow of resources. Although resource constraints exist at the level of implementation, at the same time resources often exist at the national and global level that are not disbursed. The Partnership is challenged with ensuring that more of these resources can be more rapidly and effectively deployed.

Sustaining Global Level Actions. National strategies should be informed by global experiences (e.g., on subsidies and treatment options). Tracking progress and monitoring financing and the outcomes of the investments is a critical role at the global level. Pricing, R&D and corporate contributions can be influenced by the global partners. Global communicable disease financing initiatives must continue to prioritize malaria, and malaria-affected countries rely on the global partners to ensure national plans receive support.

Recognizing the Role for Regional Level Actions. Initiatives such as the Amazonas and Mekong deserve recognition as potential models and require support. Certain actions may be more effective if undertaken sub-regionally or regionally (e.g., training, research,

surveillance, treatment standards, tariffs, DDT reduction), and such partnerships can expand the capacity of individual countries.

Prioritizing Country-Level and Country-Led Actions. Malaria will be rolled back at the country level; global and regional actions can only assist. Each country is unique, and demands individualized support to release the constraints to getting to scale. External partners need to continue to improve collaboration on the ground, and governments need to strengthen collaboration with NGOs, the private sector, research and the non-health sectors. Greater action is required at the household and community level. Lessons from experiences (such as working with the private sector effectively and/or accessing resources through PRSPs) need to be made available to malaria-affected countries.