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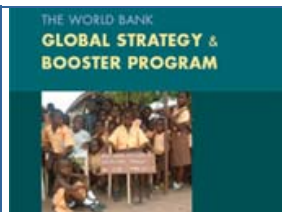
“The Malaria Burden in Africa”  
by **Anne Marie Pierre-Louis**,  
Lead Specialist and  
Coordinator World Bank  
Malaria Program for the Africa  
Region.

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- [Lancet Editorial](#)
- [Critics' Viewpoint](#)
- [Bank Response](#)
- [Speak Out](#)
- [OpEd by Roger Bate, Resident Fellow, American Enterprise Institute \(AEI\)](#)
- [More Debate](#)

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- [WHO RBM](#)
- [World Bank](#)
- [WB Africa Region](#)
- [Booster Countries Action Plan for Africa](#)

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**Contact:** Editor: Alexander S. Preker (Lead Economist) [apreker@worldbank.org](mailto:apreker@worldbank.org)



## The Malaria Burden in Africa



Author **Anne Marie Pierre-Louis**  
Lead Specialist and Coordinator  
The World Bank Malaria Program for the  
Africa Region

Malaria kills over 1.1 million people—most of them children under five years old—every year. More than 80% of these deaths occur in sub-Saharan Africa. Malaria is the biggest killer of African children, and half those deaths could be avoided if their caretakers had access to diagnosis and affordable drugs. Pregnant women and their unborn children are particularly vulnerable to this disease and it is a major cause of perinatal mortality, low birth weight, and anemia.

As noted by WHO, malaria's public health impact is compounded by high economic costs. In Africa alone, the total yearly economic burden of malaria is estimated at about US\$12 billion. Comparative figures reveal even more clearly how malaria undermines economic development. Annual economic growth between 1965 and 1990 averaged only 0.4% in malarious countries, less than one-fifth of the figure for malaria-free nations, which grew an average of 2.3% per year over the same period (Sachs and Malaney, 2002). Although the disease is preventable and curable with available technologies, coverage with effective interventions has remained tragically low, particularly among poor and rural populations.

Malaria also has a significant impact on reaching key MDG targets in countries.

- Education: Malaria is a leading source of illnesses and absenteeism in school-age children and teachers
- Child Mortality: Malaria is a leading cause of child mortality in endemic areas
- Maternal Health: Malaria causes anemia in pregnant women and low birth weight in infants
- Nutrition: Approximately half of the malaria deaths in children can be attributed to the compounding effect of malaria and malnutrition.

But, there is hope-- recent developments in countries such as Eritrea, Niger, and Zambia remind the world that significant progress is possible, but needs to be taken to scale through a joint effort of partners and countries.

### What is the Booster Program?

On April 25, 2005, The World Bank Global Strategy and Booster Program for Malaria Control was launched as a renewed commitment to achieve, in collaboration with partners, the global Roll Back Malaria Targets of halving the world's malaria burden by 2010.

Immediately after, the Africa Region of the World Bank translated this strategy into an outcomes-driven assault on malaria in Africa. The Booster Program is a country-led effort designed to augment and reinvigorate existing programs, and does not constitute an

independent initiative. This effort will build on a revitalized Roll Back Malaria Global Partnership (RBM) and complement the efforts of other partners both at national and regional levels in an effort to bring malaria under control.

The Booster Program is planned to last ten years, including an intensive phase spanning the Bank's fiscal years 2006–2008, meaning July 1, 2005 through June 30, 2008, during which the Bank will contribute to an aggressive effort to achieve control of malaria. The decade-long timeline reflects the difficulty of fighting this entrenched, deadly disease in Africa. It is important to stress that long-term financial and institutional commitments from governments and partners alike will be required to sustainably reduce malaria prevalence.

During the initial three-year Intensive Phase, the Program will assist approximately 20 sub-Saharan countries in achieving the Abuja targets by 2008.

The core target setting in the Booster Program is grounded firmly in the Bank's country-specific dialogue, as part of the project preparation and supervision process. Each country, based on their RBM Strategic Plan and health sector strategy more broadly, will be assisted to set ambitious but achievable targets in accordance with country-specific baseline data, monitoring and evaluating capacity, and service delivery opportunities. The private sector is envisaged to play a key role in expanding and sustaining intervention coverage. Bank Task Teams will assist countries in preparing programs that respond directly to gaps in country strategic plans. Achievement of the targets in the national plan will be a joint effort with all RBM Partners in the country.

The Booster Program's first three-year phase corresponds to the three-year IDA 14 cycle and its success is measured against contribution to meeting the targets set in Abuja during the African Heads of State Conference on Rolling Back Malaria in 2001. As the Booster Program supports national malaria control strategic plans, the Bank's role is one of partner, along with other donors, who together with the Government will work to achieve the targets of the national plan. Key outcome indicators include increased coverage of preventive technology and vector control (such as insecticide treated bednets (ITNs) and indoor-residual spraying (IRS) where appropriate, intermittent preventive treatment (IPT), and access to prompt and effective treatment.

**Scaling-Up for Impact (SUFI):** Unlike many other public health problems, malaria cannot be satisfactorily controlled with incremental methods because its vectors are too efficient. Indirect measures, including the long-tried approach of strengthening the general health system, without concurrent and aggressive malaria control, amounts to **business as usual**—yielding limited progress, to judge by the results in Africa over the last decade.

Successful malaria control requires bold, decisive steps to obtain high coverage quickly. Accordingly, the Booster Program is working to support clients implementing effective interventions such as ITNs and effective treatment (including ACTs), facilitating sufficiently high coverage to ensure large scale impact. The Bank's efforts fit within the broader framework of the

RBM partnership and will build on the recent progress in Africa to increase coverage of essential interventions.

**The Program:** The Bank's approach is proactive while supporting country leadership and ownership. In the initial three-year intensive phase the Booster program will commit approximately US\$500 million in IDA allocations to support countries willing and ready to improve and expand their malaria control efforts. In addition, a Regional Allocation is proposed to address issues that have cross-border externalities (operations research, resistance surveillance, anti-counterfeiting measures, et cetera), multi-country malaria control activities, and coordination and implementation bottlenecks across the region. At the end of the initial three years, it is expected that a stock-taking review will be conducted to formulate an expanded second phase program that will seek to consolidate the gains achieved and extend control to remaining endemic areas.

**Design:** Exact Booster Program activities and targets will depend on the needs and baseline coverage levels of individual countries. The health sector is not necessarily the only entry point for supporting malaria control efforts. Indeed, a number of sectors such as education, infrastructure, and water and sanitation can play a significant role in controlling malaria and linkages for joint work programs in these areas will be explored.

The Booster Program has a two-pronged approach:

- A serious up-front effort by the World Bank to help countries control the disease, using a combination of proven interventions
- Design malaria control programs in countries to complement ongoing efforts by the Bank and other partner to strengthen and improve overall health systems

## Key Features of the Booster Program

### 1. Implementation Flexibility

- No fixed prescription: approaches and targets will vary from country to country depending on the specific context (national strategic plans)
- Free choice from existing Bank instruments, such as Sector Wide Approaches (SWAp), and/or free standing operation
- Reliance on existing instruments and institutions at country and regional levels

### 2. Regional Component

- To address cross-country and cross-border issues.

### 3. Results Based

- Strong M&E support will be provided nationally and regionally through a clear strategy, focused monitoring, and allocation of resources.

### 4. Complementarity

- The Booster Program will *complement* the efforts of RBM partners and the financing from the Global Fund and other donors.

**Country Selection:** Approximately 20 countries are currently proposed for inclusion in the Booster Program's first phase. Selections are based primarily on the readiness assessments made by the Roll Back Malaria (RBM) partnership in 2003, which divided countries into three categories. Most countries in the first category—those most ready to take action—are included in the Booster Program. The list is meant to be indicative and is not closed. The Bank will also exploit windows of opportunity when interest is expressed by other countries, which is why some in categories II and III are also included among the countries where the Booster Program has begun. World Bank Country Directors and their country teams will take the initiative in developing malaria programs as an integral part of their country programs.

## One Year Later: Turning Strategy into Action

One year later, we are turning strategy into action in the Africa Region, with a results focused program that seeks to scale-up malaria control to achieve disease control impact:

**Commitment:** Five projects have been approved by the World Bank Board of Directors, in the Democratic Republic of Congo, Eritrea, Niger, Zambia, and Burkina Faso. Preparations are moving rapidly in eight countries (Senegal, Ethiopia, Kenya, Mozambique, Benin, Nigeria, Sudan, and Malawi) and a regional program (The Senegal River Basin Booster, as part of a larger Senegal River Basin Infrastructure Project, covering Senegal, Mali, Mauritania and Guinea).

The Bank has also established a resource team based in Washington that manages the program for the region. The Malaria Implementation Resources Team (MIRT) is responsible for overseeing quality and monitoring of The Booster Program for the Africa Region, for providing support as needed to task teams preparing and implementing malaria control activities in the region and serves as the main interface of the Program with external partners and the media.

**Building on Partnership:** The success of the Booster Program depends on strong partnerships, with each partner maximizing its comparative advantage. The Program is firmly embedded within the Roll Back Malaria Partnership, to which the Bank remains entirely committed. We are working with partners such as, UNICEF, Exxon Mobil, WHO., USAID/PMI, the Global Fund, the Gates Foundation and Civil Society Organizations, to name a few. Internally, we are collaborating with a number of sectors outside of health to address key cross sectoral issues in malaria control.

**Donor Harmonization:** Through the Roll Back Malaria Partnership, we are leading an effort to develop a comprehensive framework to harmonize for impact at the country level for malaria control in collaboration with countries and donors. At country level, we are working with RBM Partners to support countries in developing their strategic plans, around which support can be harmonized and sustained. A framework paper on **Harmonizing for Impact** in Malaria Control is currently being finalized in collaboration with all partners in the RBM Partnership. The paper identifies ways to increase aid effectiveness for malaria control by harmonizing development assistance among

donors. It emphasizes aid alignment with country-led strategies and local financing mechanisms.

**Focusing on Results:** The key to maintaining and being held accountable for results under the Booster Program, is an effective monitoring and evaluation strategy. Through the Booster we are working with partners at the global, regional, and country levels to ensure that we keep the focus on outcomes as opposed to inputs. To this end, the Bank has developed a results-monitoring matrix –The Malaria Indicator Template–that tracks dollar inputs against concrete results - such as insecticide-treated net utilization, and access to effective treatment. Through this

matrix, we are not only monitoring Bank support, but also that from other partners and from the countries themselves, to monitor the impact of our combined investments on clear outcomes in malaria control. This matrix has already been presented to partners through the RBM Monitoring Evaluation Reference Group (MERG), to reach consensus on the way forward.

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## References

- Roll Back Malaria. WHO and UNICEF, 2005. The World Malaria Report. Geneva, WHO, 2005.
- Malaria is a potentially deadly disease caused by infection with the *Plasmodium* parasite. *Plasmodium* is transmitted to humans through the bite of infected *Anopheles* mosquitoes. Four species of malaria parasites can infect humans: *Plasmodium falciparum*, the deadliest and most common form in sub-Saharan Africa, *P. vivax*, *P. malariae*, and *P. ovale*. Climatic conditions in the sub-Saharan are unfortunately favorable for highly efficient vectors such as *A. gambiae* and *A. funestus*. For further details see: [www.who.int](http://www.who.int)
- Sylvia Meek. 2005. *Tackle Malaria Today Give Tomorrow a Chance*. UK House of Commons. All-Parliamentary Group on Malaria.
- WHO/AFRO, Malaria Control Unit, Annual Report, 2004.
- The Abuja targets were originally set for 2005, a schedule now widely regarded as very difficult to achieve in many countries. Broadly speaking, they call for at least 60% utilization of effective malaria prevention and treatment.
- Since 2003, some countries may have moved to another category.

### There is a Buzz in Town

There was a buzz in the air again at the time of the World Bank/IMF Spring Meetings in Washington, DC. This is not unusual. The event attracts world leaders, Ministers of Finance, the press, and a wide range of interest groups. They come to town to discuss development policy and – when the weather is nice –enjoy the cherry blossoms around the Jefferson Memorial.

No one knows in advance how the event will turn out. But one thing is certain. There will be lots of Bank/IMF bashing. Protesters range from well-meaning critics to disruptive anarchists. Each year the focus is different. Each year the main outcry comes from a new lobby.

In the past, when the topic of the meetings was globalization, the anti-globalization protesters turn out in hoards. When the focus was on debt relief, advocates of a new economic order were full of gratuitous advice.

This year the central focus was on Africa. Why does development in Africa continue to stagnate behind other regions? What can be done to improve the decaying infrastructure of its public services? How can the Bank and aid agencies ensure their money does not end up in the pocket of corrupt politicians and business men? These are some of the questions that were discussed in hi-tech meeting rooms and during champagne and caviar dinner parties.

But this year a major buzz came from a different direction. The Africa region, in collaboration with several of its partners, was hosting a special day on Malaria just after the Spring Meetings. The objective was to sensitize donors, client countries, civil society and others to the importance of addressing the problem of Malaria in Africa.

Malaria is a major scourge. It kills over a million each year. It is the cause of tremendous physical and financial hardship for those that are afflicted. It can have a serious negative impact on labor productivity and economic growth. So there are good reasons to be worried about malaria.

Fortunately, there are also well-known ways to prevent, treat and stop the spread of malaria. Most interventions are affordable to even poor households. And patients, health care providers, donors, advocacy groups and governments alike agree it should be a major priority in public health.

So why was everyone in a flap? Why would the critics be upset about the Bank's involvement in malaria?

Well, someone had discovered that funding for malaria during the past few years had not lived up to previous lofty proclamations of intended support. The smell of blood was in the air. The critics quickly seized the chance to have a feast.

But maybe this time they were both misguided and disingenuous. First the Bank genuinely wants to help countries address the public health challenge they face. But things are not so simple. Grants and lending volumes are poor indicators of development impact because they often merely substitute for domestic spending. A dollar of donor aid and loans translate into much less than a dollar in increased spending on the targeted programs for which the money is intended (fungibility). When governments receive money from donors for their priority public health programs, they spend their own money on other things.

Second, donors, the Bank and the major advocacy groups do not have a good track record of staying on course. The international community went through heightened concern about child and maternal mortality during the 1990s. At the turn of the millennium there were slogans of massive attacks on infectious diseases. This was soon displaced by a call for donor money for HIV/AIDs, TB and Malaria. But the baby that cried the loudest got the milk. HIV/AIDs got the big money and malaria lost out.

Such shifts in priorities lead to major fluctuations in the funding for any one program. When attention shifts, funding for the previous priority programs quickly drops (volatility).

Finally donor money spent directly on a specific priority program such as malaria does not lead to a strengthening of the underlying institutions and financing systems needed to sustain such action into the future (vertical program funding versus broad systemic capacity building). Addressing problems such as malaria needs both systems strengthening and effective program interventions.

Scaling up financing for malaria in the future could mean that fewer resources (administrative budgets and staff time) will

be allocated to other programs (opportunity cost). The overall budget envelope for donor aid is not set according to pledges made at press conferences or the worthiness of specific programs. It is based on the overall IDA allocation made by donor countries and the relative share of this pie that will be received by any given country. And the IDA grant received by a country then has to be shared across all programs in the economy and are not just used by one specific priority in the health sector.

The success of any one program in attracting money often has unintended negative consequences for other programs. For example, the marked scaling up of HIV/AIDs activities during the past 5 years led to a significant decrease in funding for other health programs, including malaria. Furthermore, staff are already working long hours of overtime to manage their current overloaded portfolio. There are only 24 hours in a given day and 7 days a week. Some things get dropped when new mandates come along.

If the Bank's comparative advantage is really financing and helping countries improve the underlying economic architecture for development – as some critics indicated during the recent exchanges – then perhaps counting the dollars spent directly on malaria is the wrong yard stick by which to measure commitment and success. Perhaps it would be better to track progress in implementing activities that strengthen overall health system capacity, including intermediate process variables such as absenteeism, supply stockouts, and facility utilization.

To use a metaphor, perhaps the Bank's efforts would be better spent if it focused on helping countries improve the underlying hardware platform on which to run a number of software packages – ranging from malaria, to TB, to HIV/AIDs to child and maternal health etc. – rather than to re-invent the dedicated and long extinct Wang typewriter for malaria.

During the lead up to the creation of the Global Fund on AIDS, TB and Malaria (GFATM) there was much debate on such topics. Should the future of the GFATM focus on specific disease interventions or include strengthening of the underlying health systems and financing architecture? The disease lobby won and the systems lobby lost.

Now several years and billions of dollars later, why is there still a need for countries to take loans from the World Bank – loans which have to be repaid – for activities that are supported by the GFATM? Why not ask the GFATM to scale up its efforts in the area of malaria, in parallel to a major push by the Bank on strengthening health systems and financing? Is it really effective for the Bank to do both?

Addressing the underlying causes of malaria and treating this scourge effectively is more complicated than swatting a few mosquitoes, getting people to sleep under bed nets, spraying clothing with mosquito repellants and being ready to treat those cases that are not prevented. It requires a complex interaction between health interventions, draining pools of still water and a range of other broad development activities.

Surely tracking lending volumes on targeted disease programs and bashing the Bank for its failure to meet its past commitments misses the central point of this whole debate, especially at a time that the Bank is genuinely committed to making a contribution in this area.



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