Malaria Booster Program for Africa

Gaining Ground against a Major Challenge to Health and Development

Malaria control is a treatable and preventable disease — yet it remains a major challenge to achieving the Millennium Development Goals in Africa. It is not only a serious health problem, but an issue that cripples development.

Every year, malaria infects more than 500 million people around the world and is one of the leading causes of child deaths on in Africa, with 3,000 children dying from it every day. It is estimated that malaria costs Africa $12 billion a year in direct costs and lost productivity.

The disease strikes down farmers just after the rains, limiting their ability to reap the rewards of their harvest.

And it overwhelms health systems, accounting for as much as 40 percent of all outpatient attendance and 30 percent of all hospital admissions in hard-hit countries.

The World Bank response

In April 2005, the World Bank released its malaria-control framework — the Global Strategy and Booster Program — in an effort to meet the expectations and earlier promises made at the Roll Back Malaria summit in Abuja in 2000.

Following this release, the Booster Program for Malaria Control in Africa was launched in September 2005, translating the global strategy into a results-focused effort through which the Bank made a long-term commitment and pledged to leverage its unique comparative advantages to bring the disease under control on the continent.

The key features of the Booster Program are the following:

(i) Support for country-led operations to reduce illnesses and avoidable deaths from malaria while improving the capacity for service delivery. Countries that choose to participate in the Booster Program reallocate part of their resources from their IDA envelopes toward malaria control. With countries taking the lead role and prioritizing their own
resources, increased accountability and a greater likelihood of sustainability are encouraged.

(ii) Emphasis on both effective scale-up of critical disease control interventions and the strengthening of health systems. This dual strategy helps to distribute urgently needed medicines and bednets, implement indoor residual spraying where appropriate and simultaneously builds health system capacity for long-term sustainability.

(iii) Partnerships to broker global agreements and support country-led programs. Partnerships are at the core of the Booster Program and are critical to the successful control of malaria in Africa. The Booster Program is firmly embedded within the RBM Partnership, to which the World Bank remains fully committed. In addition, the Bank is working hard to leverage IDA resources by bringing other partners to the fight against malaria in Africa (Russian Federation).

(iv) Monitoring results against monies spent. The program is working with partners to strengthen monitoring and evaluation (M&E) efforts at global, regional and country levels. Baseline data has been collected in Booster Program countries and areas where projects have begun implementation. In addition, every Booster Program project has a comprehensive monitoring and evaluation component tailored to the national context. At global level, the World Bank has developed a Malaria Scorecard for tracking dollar investments and coverage progress for key interventions, such as the use of insecticide-treated bed nets, access to antimalarial treatment for children, intermittent preventive treatment for pregnant women, and indoor residual spraying.

(v) Knowledge generation and innovations to finance global public goods for malaria control. In this context, the Bank provides flexible, cross-border and multisector funding. These funding mechanisms allow for a rapid scale-up of proven interventions, as well as the ability to react to unforeseen circumstances.

The Booster Program has a ten-year horizon with an established target of US$500 million in IDA resources for Phase I of the Booster Program (July 2005–June 2008) to support the rapid scale-up of proven malaria interventions in approximately 20 countries through tailored designs aimed at supporting national malaria control programs.

As of January 2008, over US$460 million has been committed (IDA and multi-donor trust funds), with 16 Board-approved projects and two multi-donor trust funds. Two additional projects are under preparation.

This financing represents a nine-fold increase in Bank support for malaria control in Africa over the past 24 months compared to the preceding five-year period.

The Booster Program is currently developing a second phase of support to sub-Saharan Africa countries (July 1, 2008–June 30, 2015). This phase is being designed in the context of the recent call made for malaria elimination as a major public health threat in sub-Saharan Africa and will capitalize on the Bank’s comparative advantages in cross-sectoral projects and regional support.

More resources will most likely be committed under Phase II in response to strong country demand and in light of major financing requirements needed ($US 10 billion over the next 5 years).

The timing of this coordinated global effort to address malaria could not be better, given the success of the IDA replenishment discussions. The Booster Program is a clear demonstration of IDA at its best — catalytic, flexible, and collaborative. Through close work with RBM partners, we provide coordinated funding around specific goals that can yield results, with partners complementing each other.

Results
Due in part to the efforts of the Booster Program, countries and regions are closing gaps in their health systems and employing
effective malaria-control interventions and treatment strategies. Countries are benefiting from increased funding that is more flexible. Not only have the monies been allocated, but they are being spent on cost-effective and technically sound malaria-control interventions. The World Health Organization’s (WHO) Global Malaria Program has certified that interventions and activities supported by the Booster Program are in line with WHO policies and standards.

Early results are encouraging:

- In Zambia, about 44 percent of households now have at least one insecticide-treated bednet — from less than 5 percent just three years ago. In addition, 62 percent of pregnant women now receive preventive malaria treatment, tripling the coverage from three years ago.

- In Ethiopia, over 90 percent of households now own at least one bednet – from less than 5 percent just four years ago. Recent data suggest sharp declines in the number of malaria cases.

- In South Sudan, US$10.9 million worth of long-lasting bednets, malaria treatments, water purification, and oral re-hydration therapy have just arrived and are being delivered.

- Finally, in Benin, about 1.4 million nets were delivered in October of 2007. This delivery was Benin’s largest net distribution in history.

In total, more than 21 million LLINs and 42 million doses of ACT will be distributed under projects in the Booster Program’s first phase. About 240 million people — including more than 42 million children under age 5 and nearly 10 million pregnant women — are in areas covered by Booster Program projects.

**Future challenges**

One of the underlying principles fueling rapid demand for IDA resources under the Booster Program has been a desire by client countries to “front-load” malaria-control efforts. Unlike many other public health problems, malaria cannot be controlled with incremental approaches, largely because its vectors are too efficient.

Successful malaria control requires bold, decisive steps to obtain widespread coverage of key proven malaria-control interventions quickly, followed by a phase where those gains are sustained through recurrent public health services. The development community has labeled this concept of a heavy up-front effort, as opposed to a more incremental approach, “scaling-up for impact” or “SUFI.”

This rapid scale-up approach will save millions of lives, produce tens of billions of dollars in economic returns, and provide the springboard for the ultimate goal of eradicating malaria. Over five years, this effort is expected to:

- Save 3.5 million lives
- Prevent 672 million malaria cases
- Free up 427,000 hospital beds in sub-Saharan Africa
- Increase annual GDP in Africa by $30 billion.

**A funding gap is likely preventing full ‘scale-up for impact’:** The annual funding needed to control malaria in Africa has recently been estimated at as much as US$2.2 billion per year. The U.S. Government, the Global Fund to Fight Aids, Tuberculosis and Malaria (Global Fund) and the World Bank are the three largest malaria-control donors to Africa and collaborate closely as part of the RBM Partnership. These three donors have approximately US$2.5–2.8 billion in total commitments between them to be spent over the next 4–5 years for malaria control in Africa, or about US$500 million per year.

This leaves a critical gap in financing of approximately US$1.7 billion per year over the next five years to bring malaria under control in sub-Saharan Africa. While more intensive efforts are now underway in the RBM Partnership to quantify the needs (financial and technical) of what is required to control malaria, this number is a useful reminder that substantially more resources are necessary to bring the
disease under control in Africa.

**Lessons learned**

The early successes in some countries suggest that existing resources are beginning to yield concrete results. The Booster Program is working with partners, and encouraging emerging donors, to ensure that resources are available to accelerate and sustain progress.

While strides have been made, much work remains to be done: additional funding sources must be identified, and current donors must continue their commitments; supply-chain and distribution issues must be overcome and long-term solutions to eliminate malaria as a disease of public health importance from the continent must be implemented and maintained.

As the Booster Program enters the final year of Phase I, some important lessons are beginning to emerge:

- **IDA envelope constraints** as well as constraints in other partner resources have led to the design of programs with limited scope and size in several countries, resulting in a possible “sprinkling effect” at country level. Despite significant resources already mobilized by partners, national coverage has yet to become a reality for many countries. This approach raises questions of how likely countries are to achieve SUFI. The Bank has already begun using its comparative advantage in innovative financing, cross-sectoral projects and regional support but has not exploited these tools to the fullest.

- A major impetus is still needed on monitoring and evaluation to achieve high-level consensus around high-level results tracking at country level. One key question remains: is the current progress being made through incremental, country-by-country gains is satisfactory or should we capitalize on the unique opportunity and momentum that currently exists globally and consider a more continental approach?

The design of Phase II of the Booster Program will take into account these important lessons. The Bank has carried out consultations with key partners and client countries to ensure that Phase II will capitalize on the bank’s comparative advantage in the context of the elimination agenda.

As the Honorable Minister of Health of Ethiopia, Dr. Tedros Adhanom Ghebreyesus, recently said, “To truly bring malaria under control, we must begin to treat Africa as an island. We’ve made remarkable progress in some countries over the past few years, but many are being left behind. Malaria does not respect borders, and it’s time we find a way to eliminate malaria as a public health threat across Africa, building on the good work that individual countries are doing. We need to take the nets and drugs to a continental scale, and quickly, to break the back of transmission in Africa and free up scarce resources in the health system to tackle other pressing concerns.”

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