Making Zambia a Malaria-Free Zone

The Zambia Malaria Booster Project is showing that one of Africa’s most intractable public health problems can be controlled.

Malaria. *Malaria*. Bad air. Even its name conjures up images of a toxic villain.

No continent suffers its ravages more than Africa; and in Africa no country bears more of malaria’s burden than Zambia. Consider the following:

Endemic in all nine provinces, malaria has been Zambia’s leading cause of morbidity and the second highest cause of mortality, with an estimated 4.3 million cases and 50,000 deaths a year.

Malaria has caused the country’s GDP to drop 1.5 per cent every year, sparking enormous losses in productivity and worker absenteeism.

It is responsible for 45 percent of hospitalizations, 40 percent of under-five mortality, and 20 percent of maternal mortality. In sum, Malaria threatens the well-being of Zambia’s population, healthcare system, and economy.

STRIKING BACK

Recognizing the fixed link between malaria and poverty, in 2006 Zambia’s government launched the 2006–2011 National Malaria Strategic Plan. With a program implementation budget of over USD 169.5 million through 2010, the plan set out ambitious targets for scaling up the national response to the disease, including:

- Reduce the incidence of malaria by 75 percent and child mortality by 20 percent
- Find treatment for at least 80 percent of new malaria cases within 24 hours of symptom onset
- Provide protective measures, such as treated bed nets or indoor spraying, for at least 80 percent of those at risk of malaria, particularly pregnant women and children under 5 years of age.

DESIGNING THE RIGHT SUPPORT PROJECT

To bolster the government’s intense malaria control agenda, the World Bank responded with the *Zambia Malaria Booster Project*—a venture designed to work hand-in-hand with Zambia’s National Malaria Program.

The booster project was based on three components: (a) Strengthening the national health system to improve service delivery; (b) Community Malaria Booster Response, which focused on community demand-driven interventions; (c) Program management, which included building institutional capacity in the Ministry of Health.

Overall, the project intended to increase access to and use of interventions for malaria prevention and treatment by the target population, especially children under the age of five years, pregnant women, and everyone infected with malaria. In line with the national program’s goals, the project hoped to:

- Increase the percentage of children under-five sleeping under a treated bed net from 23 to 40 percent by 2008
- Add to the percentage of pregnant women receiving a complete course of intermittent presumptive treatment for malaria from 62 to 70 percent by 2008
- Increase the percentage of people sleeping in indoor residual sprayed structures from 27 to 60 percent by 2008.
BUT BEFORE STARTING...

The project planners knew they had to address weaknesses in the health system, particularly the human resource crisis. Thus, several health system interventions appeared in the project design, including a HR retention scheme and support for the district health management team.

Procurement presented another weak area; so project structure had to include new ways of handling the large quantities of goods to be accommodated in the system.

Finally, communities wanted support to develop activities that would promote health, including awareness campaigns, cleaning up breeding sites, and transporting malaria cases. Planners knew that empowering communities would be a vital part of making outcomes sustainable.

OUTCOME: A BIG BOOST FOR TREATMENT, RECOVERY AND OCCURRENCE

Assuming that the best way to measure results was to... measure them, the malaria team in 2008 conducted the Malaria Indicator Survey to gauge the project’s impact between 2006 and 2008. The findings were remarkable.

The percentage of households with one long-lasting insecticide-treated bed net increased from 48 to 72 percent.

Indoor residual spraying coverage increased from 15 (2006) to 36 districts (2008); Population coverage increased from 1.2 million to 3.5 million people.

The percentage of children with parasitemia decreased from 28.8 to 10.2 percent as did the percentage with anemia from 13.3 to 4.3 percent.

Malaria cases and deaths in children under five declined 29 and 33 percent respectively; for all age groups, malaria cases declined 31 percent while deaths declined 37 percent.

THE WORLD BANK AND ITS PARTNERS

Zambia is one of 18 countries receiving support through the Bank’s Malaria Booster Program. Over US$ 460 million has been committed for Phase I of the Booster Program (2005-2008) — a nine-fold increase from what the Bank committed between 2000 and 2005. Of this amount, US$ 20 million has been marked for the four-year Zambia MBP.

The Bank was the first large-scale financer of the Zambia’s malaria strategy and, at the start of this project, the largest financial contributor. Since then the Global Fund and PMI have increased their support and will be financing a substantial part of the program this year. Technically the key partners— MACEPA, USAID, WHO—have worked jointly to support the Ministry of Health to develop annual plans, provide technical support for procurement processes, and monitoring and evaluation.

NEXT STEPS

A number of core interventions are on the calendar for 2009:

- Maintain coverage of preventive activities through support for the IRS campaign and LLIN procurements and distribution.
- Increase utilization of existing nets through the strengthening of IEC/BCC for effective implementation and behavior change.
- Improve case management through improved diagnostic capacity (procurement of RDT’s and capacity building for health workers) and the strengthening of the logistic management system to improve commodity availability at health facility level.
- Strengthen epidemic response and operations research.

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