

CAN MALARIA CONTROL BE ACHIEVED WITHOUT A STRENGTHENED HEALTH SYSTEM?

Anne Mills

**Professor of Health Economics and Policy
Head, Department of Public Health and Policy,
London School of Hygiene and Tropical
Medicine**

AIMS OF TALK



- Examine the relationship between malaria control efforts and broader health system development
- Discuss the challenges that weak health systems pose for malaria elimination, drawing on historical evidence

HISTORY



- Historical tension and swings between vertical and horizontal approaches
- Evolution of donor/agency emphases over time
 - 1950s, 60s, early 70s: mass campaigns (malaria, yaws, smallpox)
 - Primary health care 1978 onwards
 - Selective primary health care
 - 1990s basic packages and health sector reform
 - 2000s Global health initiatives; Global Fund for TB, AIDS and Malaria
 - 2009 Taskforce on Innovative International Financing for Health Systems

CURRENT THEMES



- 4 concurrent ‘strands’ of thinking and emphasis
 - Specific disease control efforts (eg polio and malaria elimination)
 - Integrated interventions/services (eg IMCI; FP and STDs; TB and HIV)
 - Cost-effective interventions and minimum/basic packages (eg CMH, Taskforce)
 - Health system reform/development (eg results based financing)
- Disease-focussed and health-system-focussed initiatives share concern about ‘health system’ – but with different implications for changes

DISEASE AND HEALTH SYSTEM RESPONSES TO SCALING UP CONSTRAINTS



Constraint	Disease-specific response	Health system response
Financial inaccessibility: inability to pay, informal fees	Allowing exemptions or reducing prices for focal diseases	Developing risk-pooling strategies
Physical inaccessibility: distance to facility	Providing outreach for focal diseases	Reconsidering long-term plans for capital investment and siting of facilities
Inappropriately skilled staff	Organizing in-service training workshops to develop skills in focal diseases	Reviewing basic medical and nursing curricula to ensure that basic training includes appropriate skills
Poorly motivated staff	Offering financial incentives for the delivery of particular priority services	Instituting performance review systems, creating greater clarity about roles and expectations, reviewing salary structures and promotion procedures
Weak planning and management	Providing ongoing education and training workshops to develop planning and management skills	Restructuring ministries of health, recruiting and developing a cadre of dedicated managers
Lack of intersectoral action and partnership	Creating disease-focused, cross-sectoral committees and task forces at the national level	Building systems of local government that incorporate representatives from health, education, and agriculture and promoting the accountability of local governance structures to the people
Poor-quality care among private sector providers	Offering training for private sector providers	Developing accreditation and regulation systems

Source: Travis and others 2004.

RELATIONSHIP OF MALARIA INTERVENTIONS TO HEALTH SYSTEM INFRASTRUCTURE



Level of care	Malaria interventions
Hospital	Treatment of complicated malaria
Health centre/ health post	Treatment of uncomplicated malaria Intermittent preventive treatment of malaria during pregnancy
Outreach services	Epidemic planning and response Indoor residual spraying
Outside health sector or not involving direct service delivery	Social marketing of insecticide treated mosquito nets

THE COMPLEXITY OF HEALTH SYSTEMS



Overall policy and institutional context

**Design of regulatory systems & effectiveness of enforcement
Means to control drug quality**

Health systems

How to improve effectiveness of human resource management to ensure higher quality service (eg better compliance with treatment guidelines)

Organisational approach

Centrally organised versus district approach

Delivery strategy

Through public health centres only or also through private pharmacies/shops or home-based care

Intervention

New malaria drug

CURRENT CHALLENGES TO SCALING UP MALARIA CONTROL



I. Community/ household	Limited demand for malaria prevention and treatment.
II. Health service delivery	Shortage and maldistribution of appropriately qualified staff; lack of supplies; poor accessibility of services; poor quality diagnosis and treatment in public and private sectors.
III. Health sector policy and strategic management	Weak national malaria control programmes; weak drug policies and supply systems; inadequate regulation of retail drug sales and fake drugs; donor practices overload country management capacity
IV. Public policies cutting across sectors	Taxes and tariffs on malaria-related commodities; decentralization policies despite limited local technical capacity; inflexible government bureaucracy
V. Environmental and contextual characteristics	Weak government, weak rule of law; political instability and insecurity; physical environment unfavourable to service delivery.
VI. Global level	Multiple competing initiatives and agencies.

EVIDENCE FROM HISTORY



- Institutional challenges to malaria eradication:
 - Limited coverage of routine health services
 - Inefficient management – eg of spraying campaigns
 - Insecurity, war, armed struggles
 - Excessive demands on peripheral workers
 - Lack of technical expertise at local level
 - Cross-border spread through illegal activities



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