

Executive Summary

Purpose of the Business Plan: Malaria in Nigeria is endemic and constitutes a major public health problem. About 97% of the country's 149.2 million people are estimated to be at risk of the disease. Priority interventions are drawn from the recent national malaria strategic Plan (NMSP 2009-2013).

The interventions are basically, prevention and case management. Prevention covers the provision of Long Lasting Insecticidal Nets at free or subsidized costs at public and private facilities including communities and the prevention of malaria in pregnancy through IPT with the use of SP. The use of IRS will be complimentary to LLINs. Case management involves distribution of ACTs free or subsidized at public and private facilities. Home based management of malaria is a strategy to ensure prompt treatment of malaria within the community particularly in children under 5 years old. Diagnosis will be strengthened through distribution of RDTs and microscopes. These interventions are to be supported by a strong community involvement through strengthening of Health Systems and Behavioral Change Communication. The goal is to reduce malaria burden by 50% by the end of 2010, in line with the Global Malaria Action Plan (GMAP).

Objectives: The objectives of the business plan are to: mobilize the Nigerian tax payers and other stakeholders and partners towards the provision of adequate resources for effective Scale-up of the RBM programme. It is also to provide first hand information for the Stakeholders and Partners/Donors. It includes performance tracking procedure that equips Nigeria with the much needed information to manage the tasks needed to execute the strategies through the development of an operational plan which can align stakeholders around tasks and timeline. As an operational plan, it will enable resource mobilization by meeting donors' requirements.

Process of Developing the Business Plan: A wide consultative and open process for development of the Business Plan was done and comprised final inputs from the SWOT analysis done during the mid-term review of the strategic plan, results of the NEEDS, Assessment Process and GFATM Round 8 Proposal.

Strengths of the Business Plan: This plan is harmonized with national health systems and is aligned to the planning frame-work. The Business Plan has taken into consideration the need to address the realities of scaling up the program in the context of existing weak health systems and builds on the National Malaria Strategic Plan 2009-2013.

Threats: A persistent global financial crisis represents a potential threat to the implementation of the Business Plan in terms of funding from the partners.

Exchange rate fluctuation is also another potential threat to the implementation of the Business Plan.

Manufacturers' capacity for production of the commodities to meet the volume of demand is also a possible threat to the implementation.

Mitigation: To cushion the effect of the global financial crisis, it is important for Nigeria to embark on an aggressive internal funds mobilization to ensure the achievement of the goals of the Business Plan.

To avoid the effect of exchange rate fluctuation, funds should be disbursed timely.

Manufacturers with proven capacity for production and delivery of commodities should be used.

This Business Plan is founded on the National Malaria Strategic Plan, which is in line with the revised Abuja RBM targets towards scaling-up malaria interventions and Health System Strengthening. The baseline at 2008 still shows national low coverage of less than 10% (source NMSP). Significant disparities in coverage rates exist by state (up to 30% coverage in some states). This plan is aligned to the long-term reduction of malaria through universal coverage of the key interventions, with special focus on pregnant women, children under five and rural poor. It aims to rapidly "catch – up" to the RBM 2010 coverage target by adopting the following strategies: Promoting the use of BCC, monitoring mechanism (post campaign and bi-annual assessments) and MIS will be conducted in early 2009 and 2011.

Planning Cycle and Project Cost: The span of the Business plan is from 2009 to 2010 (i.e. two years) the first year being 2009. The strategic plan is for five years while the implementation plan is for two years. The total cost of the programme is estimated to be **USD 1,273,954,749** Therefore this business plan is to serve as a resource mobilization tool to bridge the identified gap of **USD 608,315,185** and total commodity pledge being **USD 665,639,564**

Implications for States and Local Government Authorities: It is intended that the Business Plan will provide direction and guidance for the States and LGAs in the bid to evolve their state malaria control programmes and subsequently state operational plans to enhance both their financial and implementation capabilities.

It is therefore important that the Business Plan enhances the operational and cost effectiveness of the implementation of the NMSP, in such a way that milestones are achieved or reached as planned and on target.

Key Assumptions: The key assumptions on which the Business Plan is developed are:

- that there will be steady progressive ownership, commitment and allocation of resources by all the three tiers of government (Federal, States and Local governments),
- that the RBM Partners both local and international will provide assistance including technical, financial and materials,
- that the health system will strengthen its capacity for effective service delivery, including human resources management,
- that a strengthened monitoring and evaluation team will ensure programme performance framework is in place to assess the achievement of programme indicators as contained in the NMSP.
- that the behavioural change and communications will mount adequate propaganda machineries that will ensure positive health seeking behavioural changes in the people,

The major impact of the Business Plan is to mobilise resources towards reduction of malaria morbidity and mortality by 50% by 2010 compared to year 2000 figures.

CHAPTER 1

1.0 Malaria Situation in Nigeria

1.1 Epidemiological Background: Malaria is endemic in Nigeria with 97% of the population at risk of infection, excluding the Sahel regions and the high mountainous area of the Plateau. Nigeria contributes a quarter of the total African malaria morbidity and mortality burden. Transmission of malaria is stable and perennial in most parts of the country. Malaria accounts for 11% of maternal mortality. Malaria also results in lower mean maternal haematocrit and 10% incidence of low birth weight. The HMIS reports 300,000 annual deaths. In children, malaria is responsible for 25% of all infant-related mortality and 30% of child-related mortality. Based on the climatic and ecological data and historical data on malaria parasite prevalence rates,

the MARA Project has compiled a model of likely distribution of malaria prevalence. Taking into account this distribution as well as the population density it can be estimated that approximately 30% of the population live in areas of high to very high transmission intensity and 67% in the moderate transmission zone and these proportions have been used in the calculations. It results in an estimated number of fever and malaria episodes per person and year of 3.5 and 1.5 respectively for children under 5 and 1.5 and 0.5 for those that are 5 years old and a total of 70-110 million clinical cases per year. The current malaria related annual deaths for children under 5 years of age are estimated at around 300,000 (285,000-331,000), and 11% of maternal mortality. Malaria's economic impact is enormous with about \$12 billion lost to Malaria annually in form of treatment costs, prevention and loss of man hours.

The malaria situation analysis report of FMOH 2000 indicated that people still hold traditional beliefs about the cause of malaria and only few people relate the cause of malaria to mosquitoes. It further indicated Poor management of cases of malaria at the health facility and home based management. Eighty percent of cases are inadequately managed.

The National Population Commission survey on Key Health Indicators 2003 indicates areas of further concern, mainly:

That only 12% of the over 29million households own a bed net and 2% of HH own insecticide treated net, while 6% of children under 5 years sleep under a bed net. It further indicates that 5% of pregnant women sleep under a bed net.

Treatment actions are initiated within twenty four hours of the onset of the symptoms of the disease, however due to inadequate and sub standard drugs obtained from the Patent Medicine Vendors 15% of treatment actions were appropriate. 51% of the sampled mothers obtained drugs from the PMVs and 89% of the drugs were substandard. 85% of the public health facilities in the rural areas had exhausted their stocks and there were no treatment guidelines in over 60% of the sampled health facilities. There was also poor laboratory diagnostic support for the diagnosis of malaria.

The Malaria situation analysis report further indicated poor use of health facilities where only 5% of mothers reported malaria cases to health facilities, most of them use traditional medicine or faith based healing

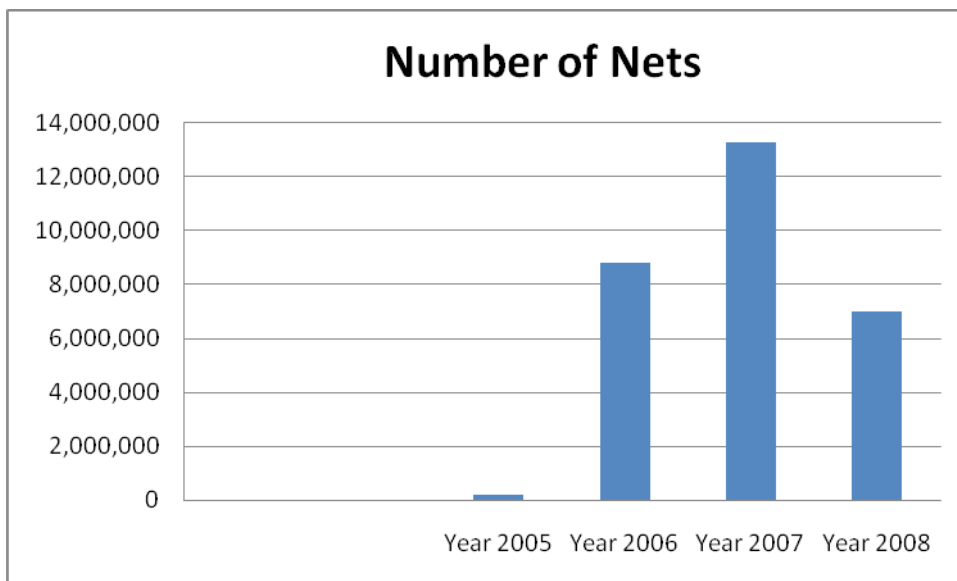
Reports indicated poor record keeping and reporting of malaria in the country and forty percent of patients with severe malaria cases die due to lack of or poor quality health care. Malaria accounts for 46% of the curative health care cost incurred per household with a mean per month of \$2.00.

1.2 Historical Perspectives

Following the Abuja Summit of African heads of States which resolved to tackle the scourge of Malaria in the continent, coupled with the need to achieve the Health sub component of the Millennium Development Goals of Improved Quality of life for all Nigerians, the Federal Government developed the National Malaria Control Strategic Plan 2000 - 2005, 2006 - 2010 which due to limited resources was targeted on the vulnerable groups of pregnant women and children under 5 years old. The interventions focused on the use of LLIN & ACTs in selected States of the federation; through the distribution of ACTs at no cost at public health facilities and at subsidized rates in the private health sector; while the distribution of LLINs was integrated with Ante Natal Care, immunization as well as stand alone campaigns. SP for IPT was also implemented on a limited scale due to inadequate resources and late attendance of ANC by pregnant women.

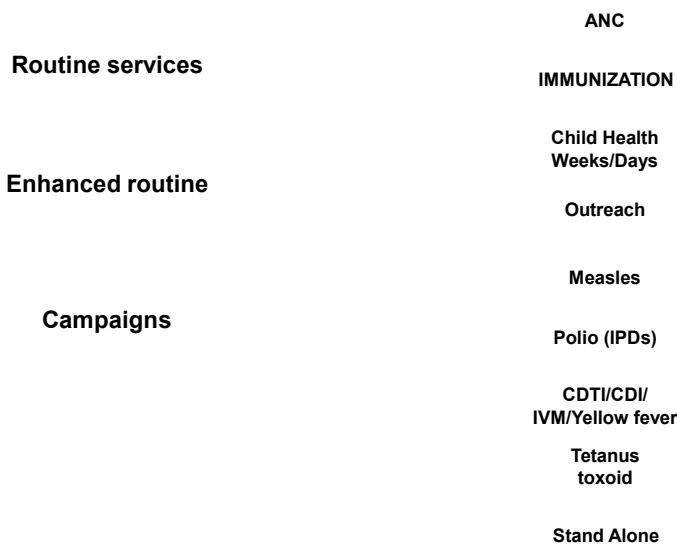
LLIN Coverage

Map of Nigeria indicating LLINs distribution coverage of children less than five years old.



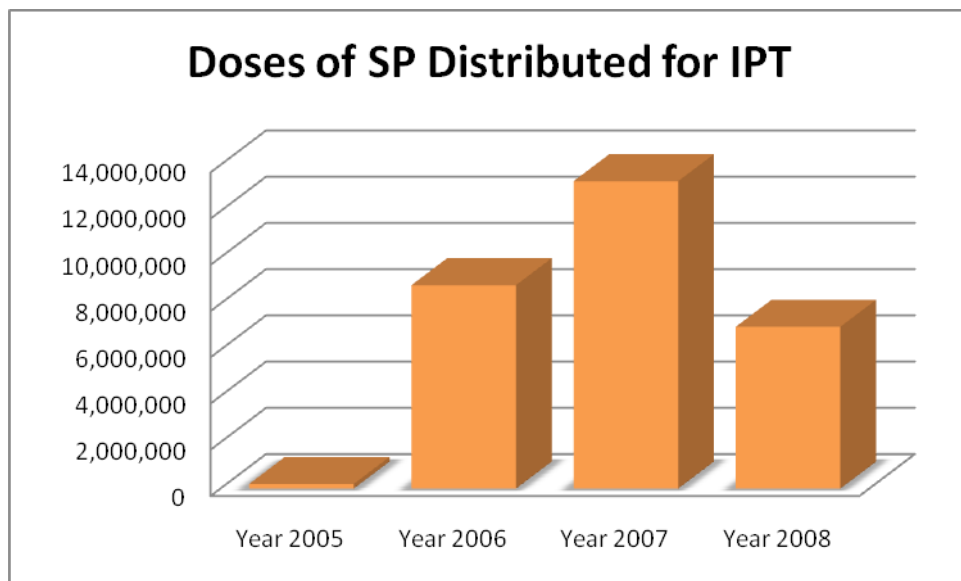
Bar chart indicating LLIN distribution from 2003-2007. LLIN distribution improved tremendously from about 350,000 in 2006 to about 3,200,000 in 2007 with injection of funds by MDG DRF, GFATM, WB Booster Programme as well as other Partners.

Models for delivery of LLINs

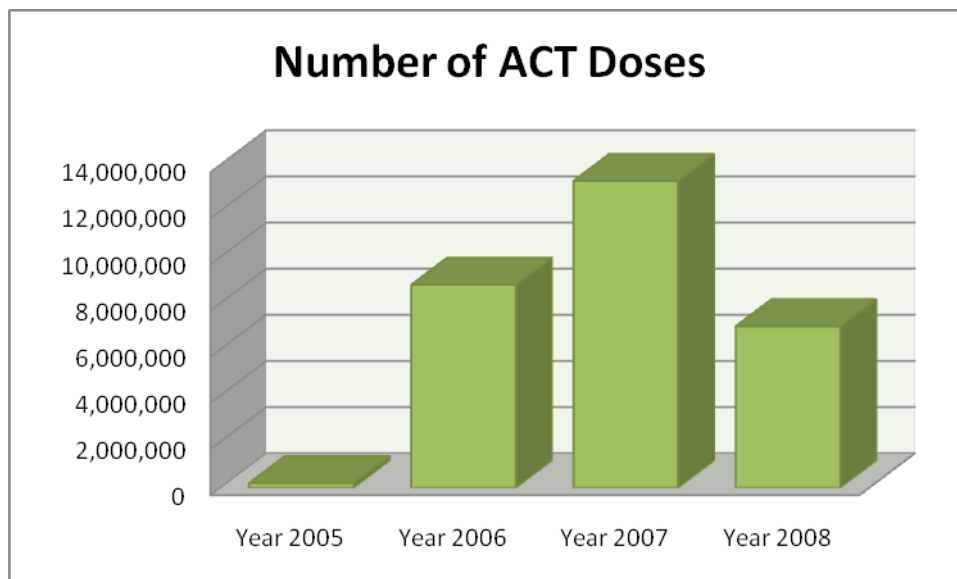


The main method of distribution of LLIN is through campaigns especially during Immunization Plus Days (IPDs) or measles as well as stand alone campaigns.

The method of distribution changed from random distribution to targeted LGAs. This led to higher coverage and outcomes as shown above.



There was increase in SP distributed from less than 2,000,000 in 2006 to about 2,800,000 in 2007.



Following change of policy to ACTs as first line treatment of malaria in 2005, implementation began in earnest in 2006 from over 8,000,000 to over 13,000,000 in 2007.

1.3 Challenges and Lessons Learnt (Regional and National)

The global and regional experience on the business of malaria control has compelled nations to adopt new approaches in their malaria control programmes to ensure the achievement of the programme objectives. Thus Nigeria Malaria Strategic Plan has reflected this trend in the design of the planning and the implementation stages. The technical approach to the interventions is evidence based. Cost effective multiple interventions are being targeted on specific communities of the countries where such interventions have proven to be effective in the past.

Efficient M&E has been identified as a key aspect for the achievement of the programme objectives. Therefore the planners of this NMSP have defined parameters and indices for the measurement of the achievement of the programme objectives as indicated in the strategic Plan.

The project has been designed, taking cognizance of the lessons of the past malaria control programmes. The concept of spreading programme ownership across the three tiers of Government: Federal, States and Local Government Authorities (LGA) has been captured in the design to ensure other tiers of Government are actively involved not only in the funding, but also in the mechanisms of the delivery of the interventions.

It was observed too that the ability to deliver the interventions to the target group promptly rests on the strength of the health system in the country. Therefore the need for increased capacity building has been reflected in the NMSP 2009 – 2013 particularly in the areas of National Health Management Information

System which has amongst its major elements to increase the timeliness of reporting, quality of reporting and the number of Public and Private Health Facilities that are reporting to the national level.

The capacity of the health system is intended to be improved through the employment of human resources strategies that will focus on increasing the technical competencies of the existing personnel. The plan is envisaged to train over 50,000 people of various categories of medical and paramedical personnel in various courses, seminars and workshops both locally and internationally over the five year period.

The realization of a strong community support system as a foundation for success of any programme has compelled the planners of this strategic plan to factor into the interventions, the use of Community Based Organizations (CBOs). The distribution of LLINs and the use of Role Model Mothers (RMMs) in the home management of malaria represent major steps in this direction.

1.4 Lessons from the Implementation of the Last National Malaria Control Strategic Plan

The execution of the 2005 - 2010 strategic plan which was later reviewed indicated areas of weaknesses that needed to be improved upon. The current 2009 – 2013 plan has tried to correct these weaknesses. The identified challenges include:

- the need to increase the coverage from vulnerable groups to universal coverage largely dictated by the global dimension of malaria control,
- the disparities in the coverage of 2005 - 2010 arising from inadequate resources have prompted the need to design malaria control programme for the remaining areas thereby reflecting equity in the RBM effort,
- the weakness and the insufficiency of the public awareness campaigns due to inadequate means and resources was also a major area that needs attention. Therefore, in this NMSP 2009 – 2013, the need to scale up behavioural change and communication activities will be emphasized through the use of electronic and print media, including use of role plays and traditional methods of communication to pass the message to targeted groups,
- the need to strengthen the Health System to enhance the delivery of the interventions particularly in the areas of coordination between the private and public health sectors was highlighted in the last exercise. In this NMSP, it is planned that there will be increased coordination of private and public health sector, such as the use of PMVs to distribute ACTs at a subsidized price, improvement of the

NHMIS and the specific need to enlarge the role of M & E through the combination of operational research and increased disease surveillance at the sentinel sites,

- areas of weaknesses of the last 2005 – 2010 which were identified and corrected in the 2009 – 2013 NMSP through a detailed micro and macro planning as contained in this business plan which makes the tracking of the programme performance easier and enables partners to time their disbursement into the activities and sub activities of the Nigeria RBM Programme along specific timelines. The need to map out areas for partners for the distribution of LLINs and the importance of haulage of LLINs direct to States and LGAs are measures that are aimed at improving the performance of this NMSP as compared to the last program,
- the implementation of the IRS as an intervention has been redefined in this NMSP by highlighting selected areas where it can be deployed in a cost effective and sustainable manner.
- the importance of public-private partnership has been emphasized in the design of the strategic plan to increase the cooperation between the public, private not for profit and the private for profit organizations. The use of PMVs to increase access to ACTs, the use of NGOs in the delivery mechanisms of the interventions represent areas of cooperation with the private sector in these interventions.

1.5 Findings from the 2008 Mid – Term Review of the NMSP include:

Weaknesses

- a. **Limited funding to scale up malaria control interventions** One of the main weaknesses identified was limited sources of funding to procure, supply and distribute malaria control commodities which had a limiting effect on the provision of access of the key affected populations. The Government spending on health is at 5%, below the recommended 15% Abuja target, and the Federal Government malaria control spending is at 1% of the approved national budget. Although resource mobilization has increased with inflow of donor funding, a gap still exists in mobilizing resources. As a result, interventions have been mainly fragmented and targeted to individual States /Local Government areas and these have achieved higher outcomes in terms of coverage (ACTs -30%, IPT -LLINs -30-40%) use. This has led to insufficient numbers of the commodities for malaria control, and has led to low coverage of interventions at national level. In addition, targeting the vulnerable

groups, in an effort to distribute the scarce resources, has not translated to meaningful impact.

- b. **Uneven spread of resources and barriers to access** The 2007 MICs Survey revealed that ownership of LLINs and ACTs use was highest in the higher economic quintile and the urban areas. In addition, since the power to purchase is largely dependent on the head of the household, women and children are disadvantaged. The way forward is the implementation of pro-poor approaches based on free or highly subsidized programs servicing all the rural, hard to reach areas and vulnerable population groups.
- c. **Weak engagement of the private sector:** Poor public health service has led to the increased use of the private sector in the country. A situation analysis report 2002 indicated that the split in terms of sub-sector health utilization is about 40% - 60% in favor of the private sector. However, the private sector continues to be relatively expensive and fragmented, providing products and tools that are often not in line with the approved national malaria guidelines. It has also been a challenge to monitor the services provided through the private sector. Disparities also exist in the quality of services provided by this sector. The focus of support initially has been mainly to the public sector with free and subsidy programs and this has led to overall low provision of a comprehensive package of malaria interventions in the private sector.
- d. **The distribution of commodities:** The distribution of commodities from the national to state levels, LGAs and health facilities levels was difficult; this necessitated the use of Sub Recipients (SRs) to solve the logistic problems. The synergistic forces of the existing PRs and SRs will be deployed to effect delivery of the interventions at the remotest LGAs and facilities. It is critical that a national distribution plan within the context of strengthened existing systems is developed. The use of outsourcing for distributing malaria commodities may have to be considered.
- e. **The problem of data generation:** The problem of data generation collation and transmission was resolved in the last malaria control exercise through the provision of financial incentives to RBM managers at states and LGA levels for monthly supervisory visits and meetings. It is planned that these incentives will be sustained to enhance programme performance.

f. **Financial disbursement of funds:** Financial disbursement of funds to the states and LGA levels was

improved through the use of disbursement solution providers. It is the calculation of the planners that

this system will be maintained to improve performance of the programme.

g. **Low community awareness and demand for malaria preventive and curative services:** Weak

Behaviour Change Communication program due to limited funding and not taking advantage of the

CSOs. This is demonstrated by the low uptake of interventions such as ACTs, LLINs and IPT. For

instance, 2.4% of children under five years were receiving ACTs within 24 hours of onset of fever in

2007, 3.5% of children under 5 were sleeping under an LLIN and 2.9% of pregnant women

were receiving IPT2. This has led to low utilization of preventive measures such as LLINs and poor

health seeking behavioural patterns.

h. **Lack of uniformity of priorities and political commitment at sub-national levels** The states

have the final authority in how finances and technical resources will be allocated. Experience has shown

that although the political commitment is improving at the national level, higher levels of commitment

are required at the States and LGA levels. The challenge will be to profile malaria as a major public health

problem in view of other equally important and conflicting priorities. In this regard advocacy for

implementation of this proposal will rely on State level buy-in to enhance State level funding. To further

ensure this States were involved in the development of the current proposal.

1.6 Key Gaps remaining are:

- access to treatment (ACTs) in the private sector due to the high cost of drugs and deployment at community level.
- imbalanced distribution of resources raises concerns for an inequitable health system that has disadvantages on the poorer households,
- delivery of malaria control interventions in the context of weak health systems,
- low political will at the State and LGA levels,

- low coverage of malaria control interventions,
- funding gap exists in delivering a comprehensive package of preventive and curative interventions to all the population at risk.

CHAPTER 2

2.0 The Current Malaria Strategic Framework

Nigeria has developed a new malaria strategic plan. The programme's goal is to reduce by 50% the 2000 malaria morbidity and mortality figures by 2010 and minimize the socio-economic impact of the disease. The control of malaria which is aimed at alleviating the poor health status of the population has been designed to enhance national development, alleviation of poverty and above all health development.

2.0.1 Programme Goals

The following are the major targets for malaria control during the two year period:

- Reduction of malaria related mortality by 50% by the year 2010 compared to 2000 translating into a child mortality rate reduction from 207/1,000 live births to 176/1,000 in 2010 and 158/1,000 in 2013;
- Reduction of malaria parasite prevalence in children less than 5 years of age by 50% by the year 2013 compared to baseline of 38% in 2007.

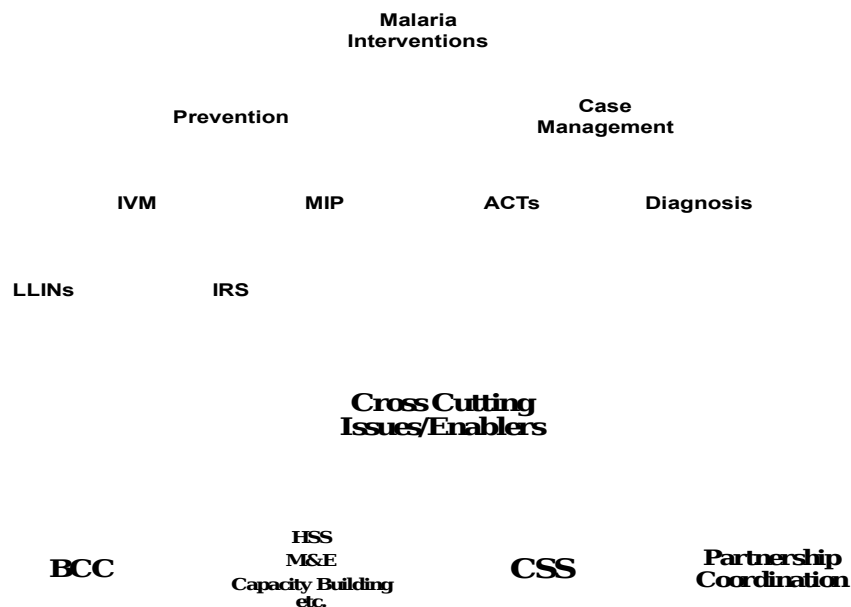
2.0.2 Programme Targets

- at least 80% of households with two or more LLIN/LLIN (one net to two people) by 2010,
- achieve at least 80% of children less than 5 years of age and currently pregnant women sleeping under LLINs by 2010 and sustain coverage thereafter,
- at least 80% of fever patients attending health facilities receive a diagnostic test by 2013,
- at least 80% of fever/malaria patients receive appropriate and timely treatment according to national treatment guidelines by 2013,
- at least 80% of pregnant women attending ANC services and 50% of all pregnant women receive at least 2 doses of IPT by 2010 and this rate increase by 2013 to 100% and 75% respectively.

2.1.0 Overview of Malaria Interventions

Chart 1

Overview of Malaria Interventions



2.2.0 Overview of the Current Malaria Strategic Framework

As indicated above, the NMSP is centred on integrated vector management and case management.

2.2.1 Integrated Vector Management (IVM)

IVM essentially aims at reducing vector human contact through the use of preventive measures of LLINs and the reduction of vector population by IRS and destruction of breeding sites of vectors.

2.2.2 Intermittent Preventive Therapy in Pregnancy (IPTp)

This represents another preventive measure targeted at pregnant women in their second and third trimesters of pregnancy through the use of Sulphadoxine Pyramethamne (SP) at the private, public health facilities and the Community. It is hoped that the intense BCC activities will increase the use of ANC by pregnant women from the current level of 60% attendance thereby enhancing IPT in this target population.

2.2.3 Case Management

The Case Management aims at increasing access to prompt and effective treatment through access to affordable ACTs within 24 hours of onset of fever especially the under 5. In the older children, proper diagnosis of the disease through microscopy and RDTs is encouraged. It will be deployed through the public facilities as well as community level.

2.2.4 BCC/Advocacy Communication and Social mobilisation (ACSM)

The **ACSM** has an overbearing impact on all the interventions and it is meant to engender positive health seeking behaviour in the population at risk of infection. It will be conducted through community outreach programmes and transmission of specific messages through electronic and print media targeted at households and individuals.

2.2.5 Health Systems Strengthening: The health systems strengthening seeks to provide supportive environment to the delivery of the interventions, through strengthening of the National Health Management Information Systems (NHMIS), overall monitoring and evaluation, capacity building of the human resources and the Procurement Supplies and Management (PSM).

2.3.0 Key Assumptions

- that there will be steady progressive ownership, commitment and allocation of resources by all the three tiers of Government, Federal, States and Local Government,
- that the RBM Partners both local and international will provide assistance including technical, financial and materials,
- that the health system will strengthen its capacity for effective service delivery including human resources management,
- that the monitoring and evaluation team will ensure adequate programme performance framework is put in place to assess the achievement of the indicators of input, output, outcome and impact,
- that the behavioural change and communication will mount adequate propaganda machineries that will ensure positive health seeking behavioural changes in the people.

2.3.1 Linkage to Health Systems and Other National Development Issues

- The current strategic plan fits in the National Health Policy which amongst others, aims to reduce the burden of disease on Nigerians (of which malaria is a key

component) through increased access to quality health care services while providing leadership and direction for health care strategies at the three tiers of Government. The NMSP aims at increasing access to quality health care through the combination of facility based management at the three levels of care and home based management of Malaria.

- The new malaria control strategic plan has equally taken into consideration the need for the achievement of the health sub component of the Millennium Development Goals which appreciates the need for improved quality of life through provision of qualitative health care services
- The NMSP has been linked to the Millennium Development Goals through the use of various interventions that are community focused to enhance access to health care services, where there are limited public health facilities.
- The NMSP equally dovetails into the current National Poverty Eradication Programme of the Government. The focus of the NMSP strategies on the rural poor is aimed at reducing the burden of malaria on the 54.4% of Nigerians that live below the poverty line thereby increasing their productivity; particularly in the agricultural sector which employs over 50% of Nigerians.
- The concept of gender sensitivity has also been reflected in the National Malaria Control Strategic Plan through the management of malaria in pregnancy. Provision of LLINs at no cost to the pregnant women and the home based management through the use of Role Model Mothers are some of the devices of protecting the vulnerable groups of the society, women and children.
- The resultant benefits of increased social and economic activities of the NMSP will be a further fulfilment of the need for inter-sectorial planning for the achievement of the National Economic Empowerment and Development Strategies.

2.4.0 Planning Cycle

Nigeria's financial year starts on 1st January and ends December 31st of each year. It is the calculation of the planners of the NMSP to reflect the practical realities of the Nigerian financial planning cycle in the design of the malaria control strategies.

The budgetary planning for the 2009 commences in the 2nd quarter of the year 2008. Delay is often encountered in the appropriation and approval processes, disbursements are not effected until about the 1st month of the second quarter of year 2009. To this extent, the activities and sub activities involved in the implementation of the strategic plan have been structured to fall in line with these variances.

CHAPTER 3

3.0 The Operational Plan 2009-2010

3.1 Preventive

Long Lasting Insecticidal Nets (LLINs)

3.1.1 Objectives: To achieve universal coverage of the population at risk of malaria infection in 2010 through 100% coverage and 80% use of LLIN and sustaining this through to 2013.

This programme plans to distribute:

- Through Catch-up campaign, at least two nets to each household, translating to an average of one net for two people. A total of 62,471,069 LLINs will be distributed over a period of two years. The LLINs have a life span of 3 years (It is estimated that there will be about 10,000,000 LLINs in circulation at the start of January, 2009).
- Through Keep-up strategy (Child Welfare Clinic, ANC based distribution) 27,432,000 LLINs.

3.1.2 Annual Target

Table 1

COUNTRY TARGETS OF LLINs DISTRIBUTION		
Year	2009	2010
Mass Campaign	27,958,000	34,513,064
Children Under 1	6,000,000	6,192,000
Pregnant Women	7,500,000	7,740,000
Total	41,500,000	48,500,000

Assumptions: Population growth rate of 3.2%, Under 1 population of 4% and pregnancy is 5%

3.1.3 Main Strategies

- Distribution through:
 - Mass campaigns
 - ANC and Child Welfare Clinic
 - Social Marketing
 - Commercial Marketing
- Promote utilization through:
 - Advocacy, Communication and Social Mobilization (ACSM) campaigns
 - Hang-up campaigns (follow up after 3 months of the campaign)
 - Retention campaigns (follow up after 9 months of the campaign)
- M&E
 - Baseline Malaria Indicator Survey first quarter 2009
 - First post campaign M&E (as part of the hang-up campaign)
 - Second post campaign M&E (as part of retention campaign)
 - Malaria Indicator Survey (MIS) in first quarter 2011

3.1.4 Main Activities

- Alignment of State and LGA Operational Plans with the Business Plan by April 2009

- Procurement and handling of LLINs to State/LGA level, including port clearance.
- Training of supervisors/distributors for campaign, mop up and routine delivery.
- Roll-out campaigns.
 - First campaign (10,000,000 nets) January to June 2009.
 - Series of campaigns (50,000,000 nets) September 2009-June 2010.
- Routine distribution (ANC and Child Welfare Clinic)
- Supervision.
- Monitoring.

Table 2**Indicators**

Type of Indicator	Indicator	Frequency of Measurement	Means of Verification
Output	Proportion of Child welfare clinics with no stock out the last three months	Quarterly	LMIS
Output	Proportion of ANC facilities with no stock out in the last three months	Quarterly	LMIS
Output	No. of LLINs distributed	Annually	Quarterly distribution reports
Outcome	% of HH with at least 2 LLINs	1st Quarter 2011	MIS
Outcome	% of children U5 sleeping under LLINs	1st Quarter 2011	MIS
Outcome	% of pregnant women sleeping under LLINs	1st Quarter 2011	MIS
Impact	Reduction in all cause mortality of children under 5	2011	DHS

Impact	Parasite prevalence rates amongst children under 5	2011	MIS
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Milestones: Major milestones to be covered towards the delivery of the intervention include:

Table 3

Phase		2009				2010			
		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Macro & Micro Plans Developed	Milestone								
Advertisement, Bid Evaluation and Selection	Activity								
Order Placed with Manufacturer	Activity								
Training for Campaigns	Milestone								
Distribution to State & LGA Stores	Activity								
Delivery to End Users	Milestone								
Mop up	Activity								
M&E	Milestone								

The shaded portion indicates the time the milestones are expected to be covered. (See Management Tool for details).

3.1.5 Indoor Residual spraying

3.1.6 Objective: To reduce malaria vector population by covering 20% of the National total households and 80% of structures in selected areas by 2013.

Table 4

3.1.7 Annual country target (in HH to be covered) in selected areas

	2009	2010	Total
% of HH to be covered	20%	40%	60%
Number of HH to be covered	1,231,028	2,540,843	3,771,871

3.1.8 Main strategies

- Conduct epidemiological and base line survey
- Increase acceptability of IRS through ACSM
- Institute Quality Assurance in line with WHOPES and NAFDAC requirements
- Establishment of IRS teams at National, State and LGA levels

- Monitoring and Evaluation of IRS
- Operational Research

3.1.9 Main activities

- Planning and Management of IRS operations
- Advocacy visits to states, LGAs and community leaders
- Selection and procurement of approved IRS commodities
- Mapping and quantification of eligible structures
- Developing and printing of M&E tools
- Training of operators
- Supervision
- Monitoring and evaluation

IRS will be selectively used only in areas of proven efficacy sites of malaria vector. It will be used as a complimentary intervention to LLINs in the programme, meaning that IRS will be used where it is more cost effective and practicable.

Table 5

Indicators

Type of Indicator	Indicators	Frequency of Measurement	Means of Verification
Output	% of structures sprayed in relation to target	Annually	M & E Records
Output	% of population protected by IRS	Annually	M&E Records

Milestones: To successfully implement IRS some of the critical milestones to be covered include:

Table 6

Phase		2009				2010			
		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Advocacy to states and LGAs	Milestone								

Establishment of IRS teams at 3 tiers of government	Milestone								
Procurement	Milestone								
Conduct training	Activity								
Mapping of eligible structures	Activity								
Spraying of eligible structures	Milestone								
Monitoring insecticide resistance	Milestone								
Operational Research	Activity								
Pharmacovigilance	Activity								

3.2.0 Malaria in Pregnancy (MIP)

3.2.1 Objective: The objective of this intervention is to protect pregnant women and their new born children

from the ill effects of malaria thereby achieving reduction in maternal and infant mortality.

3.2.2 Target: Coverage of 80% of all pregnant women attending ANC with IPTp through the use of SP by 2010 and increasing coverage of all pregnant women to 80% by 2013.

Table 7

COUNTRY TARGET (In Doses of SP)	
2009	2010
7,007,800	9,964,000

3.2.3 Main Strategies

- Promote the attendance of ANC by pregnant women through:
 - ACSM campaigns
 - Health system strengthening
- Provision of LLINs
- Provision of IPTp through the use of SP in the second and third trimester of pregnancy
- Integration of the activities of MIP into the on-going work of reproductive health/maternal and child health unit of Ministry of Health

3.2.4 Main Activities

- Alignment of the Reproductive Health Operational Plan with the Business Plan

- Procurement and provision of LLINs to women attending ANC
- Procurement and provision of SP for IPT at both public and private facilities

Table 8

Type of Indicator	Indicator	Frequency of Measurement	Means of Verification
Output	Proportion of ANC facilities with no stock out the last three months	Quarterly	LMIS
Output	Proportion of pregnant women attending ANC	2011	DHS
Outcome	Proportion of pregnant women receiving IPTp2	1st Quarter 2011	MIS

Table 9

Phase		2009				2010			
		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Procurement	Milestone								
Clearance									
Distribution to Facilities	Activity								
M&E	Milestone								

3.2.5 Prompt and Effective Treatment of Malaria

3.2.6 Objective: To increase access to ACTs within 24 hours of onset of malaria illness in up to 80% of cases

by 2013.

Table 10

COUNTRY TARGET OF ACTs (IN DOSES)	
2009	2010
40,388,920	83,362,730

3.2.7 Main Strategies

- Promoting early health seeking behaviour through:
 - ACSM campaigns

- Home based management of malaria (RMMs)
- Improving quality and continuity of care at facilities
- Treatment of patients with ACTs at no cost at public health facilities
- Provision of ACTs at highly subsidized rates at PPMVs and pharmacies.

3.2.8 Main Activities

- Procurement and distribution of ACTs from Central Medical Store through State Stores to public sector clinic.
- Training of health care providers (public and private sector health providers) and RMMs.
- Production and distribution of IEC materials for public and private sector health facilities.
- Supervision
- Monitoring and Evaluation.

Table 11

Type of Indicator	Indicators	Frequency of Measurement	Means of Verification
Output	% of facilities with no reported stock out of ACTs in the last 3 months	Quarterly	LMIS
Outcome	% of U5 children with fever receiving appropriate treatment with ACTs within 24 hours	1st Quarter 2011	MIS
Outcome	% of children 5 years and above with malaria receiving appropriate treatment with ACTs within 24 hours	Annually	ACT Watch/MIS
Impact	All cause under 5 mortality	1st Quarter 2011	DHS

Milestone: Milestones to be covered include:

Table 12

Phase		2009				2010			
		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Procurement (Develop & Publish Tender)	Milestone								
Training	Activity								
Distribution to Facilities	Activity								
Partnership Coordination	Activity								
Regulatory System in Place to Maintain Fair Access to Drugs	Milestone								

3.2.9 Diagnosis (RDTs and Microscopy)

3.3.0 Objective: To scale up parasitological diagnosis of malaria in patients above 5 years at public and private health facilities to 80% by 2013.

Table 13

Country Targets (in RDTs)	
2009	2010
2,920,572	6,028,060

3.3.1 Main Strategies

- Procurement and distribution of RDTs and microscopes largely to primary health care centres, state facilities and tertiary facilities for proper diagnosis of malaria in over 5 years population
- Ensuring proper usage by installing quality assurance procedures at the facilities
- Training of targeted staff on diagnostics.

3.3.2 Main Activities

- Mapping and analysis.

- Procure RDTs and microscopes including Quality Assurance Testing before delivery.
- Develop and implement quality Control System for RDTs at LGA and health facility level.
- Distribute RDTs to health facilities.
- Train personnel on RDTs
- Develop quality assurance procedures
- Roll out quality assurance procedures
- Supervision
- Monitoring and Evaluation.

Table 14

Type of Indicator	Indicators	Frequency of Measurement	Means of Verification
Output	Proportion of Primary Health Facilities with RDTs	Quarterly	LMIS
Output	Proportion of secondary and Tertiary health facilities with at least one microscope for malaria diagnosis	Quarterly	LMIS
Output	Number of people trained	Quarterly	Training records/ reports
Output	Proportion of trained staff performing to QA standard	Quarterly	Supervision reports
Outcome	Proportion of persons 5 years and above presenting with fever and tested by microscopy/RDTs.	1st Quarter 2011	MIS

The milestones to be covered for the successful implementation of the Diagnosis intervention include:

Table 15

Phase		2009				2010			
		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Procurement	Milestone								
Distribution to Facilities	Activity								
Institution of Quality Assurance standards at service delivery interface	Milestone								

3.4.1 Advocacy Communication and Social Mobilization (ACSM)

3.4.2 Objective: To reach at least 80% of the population at risk (communities, families, care providers and health workers) by 2010 through ACSM for awareness and appropriate action on malaria prevention and treatment.

3.4.3 Target groups: Specific messages will be designed to reach the total population at risk of infection, particularly heads of families and households.

Table 16

COUNTRY TARGET IN NUMBER OF PEOPLE REACHED			
Year 1		Year 2	
6 Months	12Months	18Months	24Months
36,969,263	73,938,525	105,732,091	127,174,264

3.4.4 Main Strategies

- Integration of **ACSM**

into social activities

- Advocacy visits to policy makers at the three tiers of government
- Dissemination of messages through the media
- Interpersonal communications using peer education through CSOs, RMMs and ward development committees.

3.4.5 Main Activities

- Develop harmonized operational plan for ACSM
- Develop, adapt, produce and disseminate IEC materials

- Campaign to improve treatment seeking behaviour for all age groups
- Campaign on the importance of early ANC attendance and protecting pregnant women with LLINs and IPTp
- Campaigns on use of LLINs (Hang up campaign) prior to and during retention campaign following the distribution of LLINs in each state.
- Broadcast radio and television jingles to deliver specific messages
- Disseminate messages through sports and other social events
- Adoption of drama and documentaries.
- Advocacy visits to leaders at three tiers of government and community.

Table 17

Type of Indicator	INDICATORS	Frequency of Measurement	Means of Verification
Output	Number of people reached by community outreach activities	Annually	KAP Survey
Output	Number of people reached by mass media activities	Annually	KAP Survey

Table 18

Phase		2009				2010			
		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Defined Indicators to track ACSM	Activity								
Advocacy Visits to National, State, LGA & Community Leaders	Activity								
Targeted Communities Reached	Milestone								
Impact measured	Milestone								
Media Content Development	Activity								

3.5.1 HSS

3.5.2 Objectives: To contribute to strengthening of supportive environment and the health systems for the delivery of malaria control activities.

Table 19

	2009	2010
Health facilities submitting timely and complete report	14,360	19,140

3.5.3 Main Strategies

- Strengthening National Health Management Information System (NHMIS).
- Strengthening capacity for Monitoring and Evaluation (M&E).
- Strengthening linkage between programme implementation and operational research.
- Strengthening the sentinel sites for drug, insecticide resistance and pharmacovigilance.
- Strengthening of supervision at sub national levels.
- Strengthening governance and ownership at the Federal, States and LGAs.

3.5.4 Main Activities

- Strengthen routine data generation and flow from public/private facilities and Communities to NHMIS.
- Updating and reprinting of M&E data capturing and reporting tools.
- Strengthen capacity for M&E at all levels.
 - Expand M&E units at national and State levels.
 - Coordinate M&E at all levels.
- Scale up support and networking for data generation and reporting from the community to health facility, LGA, State and Federal levels.

- Support monitoring and supervision at sub national levels.
- Conduct baseline, mid-term and end-term evaluation surveys.
- Hold stakeholders meetings to review operational and implementation research priorities and/or evidence.
- Advocacy visits to states and local government authorities and community leaders.
- Strengthen pharmacovigilance systems for anti malarial drugs in collaboration with NAFDAC.
 - Assess resource capacity for pharmacovigilance
 - Conduct training for improvement
 - Update protocols for drug specific active pharmacovigilance
 - Conduct pharmacovigilance surveillance of first line malaria drugs.
- Conduct drug efficacy testing and trials, insecticide resistance monitoring and maintain routine surveillance.

Table 20

Type of Indicator	INDICATORS	Frequency of Measurement	Means of Verification
Output	Number of health facilities submitting timely and complete reports	Quarterly	Reports from states
Output	Number of staff attending training on programme management and M&E	Annually	Training records from NMCP
Outcome	Number of people practicing competently in line with performance standards.	Quarterly	Quarterly M&E reports
Outcome	Number of National Institutions and States Supporting the NMSP	Annually	State reports

Impact	Incidence of confirmed malaria cases in sentinel demographic surveillance sites per total population of the sites in which the sentinel site is located	1st Quarter 2011	MIS
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For the successful implementation of the HSS interventions, the followings are some of the critical milestones:

Table 21

Phase		2009				2010			
		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
MIS Tools Launched and in Use	Milestone								
Organizational Assessment for Management Scale Up	Milestone								
Human Resources Recruitment (Candidates on Board)	Milestone								
Performance Audit	Activity								
Annual Review Meetings	Milestone								

3.6.1 Community Systems Strengthening (CSS)

3.6.2 Objective: The objective of the community systems strengthening is to mobilize community support for active participation in malaria control activities.

3.6.3 Main Strategies

- Promote community participation in planning, management, monitoring and evaluation of the local government health system i.e. the PHC system
- Improve inter-sectoral collaboration in primary health care delivery
- Enhance functional integration of the health system
- Strengthen managerial process for health development at community level.

3.6.4 Main Activities

- Support to revitalize Ward Health Development Committees to increase awareness at the community level.
- Mobilize local community resources for health promotion, to increase demand and access to health services.
- Lead integrated approaches to training, service delivery, supervision and monitoring in collaboration with community based organization/FBO to increase access to health care.
- Village health committees to coordinate distribution of LLINs, mobilize community and facilitate data collection for health facilities.

Table 22

Type of Indicator	Indicators	Frequency of measurement	Means of Verification
Output	Number of Village/Ward Health Development Committees formed	Quarterly	NMCP supervisory reports
Output	Number of Committees coordinated by civil societies	Quarterly	NMCP supervisory reports

Table 23

Phase		2009				2010			
		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
WHDCs Maps Available	Milestone								
Gaps Identified	Milestone								
Community Sensitized and Mobilized	Milestone								
Institutionalize Supervision and Feedback Mechanism	Milestone								

3.7.1 Procurement Supply and Management

Given the fact that the PSM represents a critical issue that cuts across most of the interventions, it will be examined in two parts.

3.7.2 PART 1 :This part examines the PSM specifications of each commodity

3.7.3 Procurement of LLINs: The procurement will be in line with international best practices and standards. The tendering will be staggered based on the availability of funds. There will be waiver of import duties on the LLINs as worked out with the Ministry of Finance.

3.7.4 Quality Assurance: Only items that are WHO approved and NAFDAC registered will be procured. The LLINs will be tested by Standards Organization of Nigeria (SON). Only WHOPES certified LLINs will be procured.

3.7.5 Delivery and Distribution: The LLINs will be delivered in tranches by the procurement agent. The LLINs will be delivered to designated points.

3.7.6 Procurement of ACTs

ACTs: Artemeter Lumefantrine and Artesunate Amodiaquine

The procurement is to be done in accordance with international best practices. The procurement is vested in the hands of the Director of Pharmaceutical Services and the Tenders Board. A procurement agent will be selected. The procurement of ACTs is planned to be integrated into that of LLINs.

3.7.7 Quality Assurance

There will be pre shipment inspection of the ACTs in line with NAFDAC regulations and quality assurance test will be conducted on the ACTs on arrival at the port by NAFDAC officials. The ACTs must still have at least 80% of their shelf lives intact and they are expected to be prepackaged with country specific instructions. It is planned that for the ACTs for the private sector will be distinguishable from that of the public sector. It is intended that the packaging will have instructions in local languages to ensure proper use of the ACTs.

3.8.0 Distribution

Distribution agents are expected to move the ACTs from federal Medical Stores to State stores and LGAs.

The ACTs will be stored in the federal Medical Stores and dispatched to the States stores based on demand, the State facilities are expected to dispatch ACTs to the facilities at LGA. A total of 23,486 public facilities exist at the three levels of facilities.

The LGAs supplies the primary health facilities, while tertiary facilities will receive their stock from State stores.

The logistics firm is expected to deliver the ACTs to a team; consisting of the State malaria programme manager, Chief Pharmacist and health facility representatives. This team will develop the distribution plan to the LGAs and Tertiary facilities.

The role model mothers will receive their seed stock from public health facilities, the stock will be replenished after return of empty sachets and proper documentation of the beneficiaries.

3.8.1 Distribution to Private Sector: The essence of this is to ensure that ACTs are available at an affordable price in private sector. The ACTs for the private sector will be distributed through SRs to the Private Sector health providers, pharmaceutical shops and Patent Proprietary Medicine Vendors. Sub recipients are expected to distribute the ACTs to the PPMVs and private health sector facilities at a subsidized rate.

3.8.2 SP

The PSM for SP will follow the same pattern with that of ACTs but the distribution will be at only the public sector facilities and the SPs are only for IPTp

3.8.3 Procurement of RDTs

This intervention aims at ensuring diagnosis of malaria in patients that are over 5 years through proper diagnosis of the disease at health facilities. One of the challenges of this intervention is thermal conditioning; therefore capacity for cold chain management is a major criterion in selecting the SRs or the haulage firm

3.8.4 Specifications: Single species RDTs. HRP – 2 tests with proof of heat stability. Moisture proof package, with charts will be procured. RDTs that are WHO recommended will be procured.

The procurement of RDTs will be in line with international best practice through competitive and transparent bidding process. The procurement of RDTs is intended to be done with the ACTs.

The bidding procedure is expected to be fair, transparent and competitive.

3.8.5 Mapping and Delivery: All RDTs are expected to be deployed to the facilities under cool chain conditions. An analysis of facilities requirement for RDTs and Microscopes will be carried out to determine the distribution of both items. Stocks of RDTs will be kept at the state medical stores and these will be distributed on regional basis by the SRs and their distribution agents to the private clinic.

Part 2: This part examines main strategies and activities that are being put in place to strengthen the PSM function of the interventions, this cuts across all the interventions.

3.8.6 Objective : To ensure the timely availability and appropriate use of safe, effective, quality anti malaria medicines and other health commodities and services at all levels of health care delivery system.

3.8.7 Main Strategies

- Installation of effective Procurement Procedure and Standards inline with international best practice
- Establishing clear Quality Assurance guide lines for anti malarial drugs and commodities
- Strengthening the logistics management information system
- Institute anti-leakage plan

3.8.8 Main Activities

- Demand forecast through analysis of historical data and examination of the variables likely to drive up the demand
- Monitoring and evaluation of the Procurement process
- Design an anti-leakage plan
- Development and adoption of PSM tools
- Train PSM officers in the federal, states and LGAs on PSM activities
- Development and adoption of PSM training manuals
- Conduct baseline survey on inventory Management of anti malaria commodities

Table 24

S/No	Indicators	Frequency of Measurement	Source of Verification
1	Number of anti malarial commodities that were procured at central level from qualified supplier in the past two years	Annually	LMIS
2	% of commodities (ACTs, SPs, LLINs and Insecticides) that got expired in the last one year period at all levels	Quarterly	Quarterly PSM report
3	Proportion of staff trained on LMIS at National, States and LGAs	Annually	Training Report
4	% of health facilities submitting timely and complete PSM reports	Quarterly	PSM report
5	% of health facilities where there is available and usage of complete inventory control tools	Quarterly	PSM report
6	% of health facilities that experience stock-out for a period of three months	Quarterly	LMIS

Milestones

Table 25

Phase	2009	2010
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		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Demand Forecast	Milestone								
Facility level order submitted to states or National government	Milestone								
Install anti-leakage plan	Milestone								
Logistics Management information system (Assessment completed)	Milestone								
LMIS designed and installed	Milestone								

3.8.9 Commitment to Performance, Monitoring and Impact Evaluation

The commitment to performance monitoring has made it imperative for adequate structures, systems and activities to be put in place to ensure the delivery of the interventions. To this extent, the following structures, systems and activities have been put in place at national, state and local government levels for the successful implementation of the NMSP.

3.9.0 Systems – Nigeria recognises the need to strengthen National Health Management Information System (NHMIS) for the effective delivery of the interventions even at the remotest communities, therefore, there will be increased coordination between and amongst the three levels of facilities; primary, secondary and tertiary facilities. This is with the aim of ensuring timely and quality reporting from the PHC to the states. The States Government will also be made to increase the coordination of public and private health facilities and capture data on malaria control activities and the delivery of the various interventions at the private sector interface.

The NHMIS is being strengthened through the appropriate health bill compelling states to report to Federal level; it is envisaged that the much required data for improved planning will be generated and reported to the Federal level.

It is equally planned that valuable data on the private health sector facilities, including PPMVs through whom ACTs will be distributed will be generated by the state and reported to national level.

The logistics management information system will be strengthened through the provision of the developed PSM tools and training of PSM Officers. There will be quarterly tracking of anti-malaria commodities to determine availability and timeliness.

3.9.1 Accountability & Inventory Management

In order to maintain accountability for the products, adequate inventory management measures are being put in place to include the use of Inventory Management Software to generate and manage stores information, it is planned that information and data on distribution, utilization records and uptake of the commodities will enhance demand forecasting at facility and community levels.

3.9.2 Networking

Adequate support is being provided for scaling up of data generation and timely reporting, through networking of public health facilities at the states, and Federal level. This would be done through upgrading of IT facilities and acquisition of new software and hardware.

3.9.3 Structures & Tools

The country has put in place structures that enhance decision making and programme monitoring. This includes:

- The Constitution of a PSM working group which ensures procurement processes are in line with the best international procurement practices
- The M&E Technical Working Group
- M&E Officers, 37 at state level including FCT and 20 at national level
- The 37 States Programme Managers including FCT
- The LGA malaria focal persons.

3.9.4 Performance

In order to ensure adequate performance monitoring, reporting and data generation, some of the activities that are being carried out which will further be strengthened at National, State and LGA levels include:

- (i) Quarterly supervisory visits to states & LGAs by National M&E Officers
- (ii) Monthly supervisory visits of LGAs and health facilities by State Malaria Programme Managers
- (iii) Monthly supervisory visits of health facilities and (RMMs) by the malaria LGA malaria focal person
- (iv) Monthly coordination of LGA focal persons at the State levels for proper reporting and situation report
- (v) Meetings of the M&E Working Group at the National level.

3.9.5 Feedback System: From the above, it is expected that adequate feedback data and information will be generated to enhance programme performance monitoring.

3.9.6 Performance Audit: There will be a continuous performance audit of the processes which will focus on the effectiveness of the processes of distribution, delivery, patient administration and end user. The performance audit will be conducted by an independent consultancy firm. This will provide a continuous feedback information and data which will assist in improving the programme performance.

3.9.7 The Monitoring and Evaluation

The national monitoring and evaluation framework continues to be the system of M&E. However, in line with the need to achieve maximum programme performance, the following activities will be carried out:

3.9.8 Tools

The standardisation and reshaping of M&E tools are major steps to be taken to enhance the monitoring of the implementation of delivery strategies.

- (i) M&E tools
- (ii) PSM tools
- (iii) Reporting formats

3.9.9 Capacity building of M&E Officers

The M&E Officers will be trained at the Federal and State levels on the system of accountability installed in the system, new tools and modern techniques of monitoring and evaluation. Forty M&E officers from 6 zones will be trained in year 1 and 2 and repeated in year 3 and 4.

There will be training for the health facilities workers at both private and public health facilities on proper recording procedures.

3.9.9.1 Measurement of Outcome and Impact

The evaluation of the achievement of outcome and impact of the implementation will be vigorously pursued through the conduct of the following surveys.

Table 26

Activity	Frequency
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Assessment of coverage in selected areas	Annual
Assessment of core indicators	Mid term and End term
Demographic and Health Surveys (DHS)	2011
Multi Indicator Cluster Surveys (MICS)	2011
Assessment of the performance of the business plan	Quarterly

See full details in M&E framework.

3.9.9.2 Operational Research

To constantly improve strategies of delivery of the interventions specific and well targeted operational research will be conducted in the following areas:

Table 27

Factors influencing acceptance and use of LLINs
Current treatment seeking behaviour with respect to fever in general and malaria in particular
Attitude and practices of health care providers
Monitoring of drug sensitivity of currently used malaria treatments as well as candidates for future use for uncomplicated malaria, severe malaria, IPT, HMM etc
Monitoring of insecticide resistance to local vectors and other entomological studies
Assessment of environmental impact of vector control interventions
Quality of IRS and LLINs
Impact of BCC interventions including compliance and user satisfaction
Test delivery strategies for LLINs, ACTs and Diagnostics
Assess cost-effectiveness of intervention delivery mechanisms

CHAPTER 4

4.0 Programme Management, Coordination and Partnerships

Implementation of the Business Plan will be managed collaboratively involving the Government, Financing and Implementing Partners. The implementation will be guided by the principles of three ones “one plan, one coordination mechanism led by government and one monitoring and evaluation framework”.

Chart 2 Stakeholders' Analysis



NB: The structure provides a basic idea of the relationship and does not represent a rigid water tight compartment. Organizations like NMCP, SFH, YGC play multiple roles of implementers, donors and service providers.

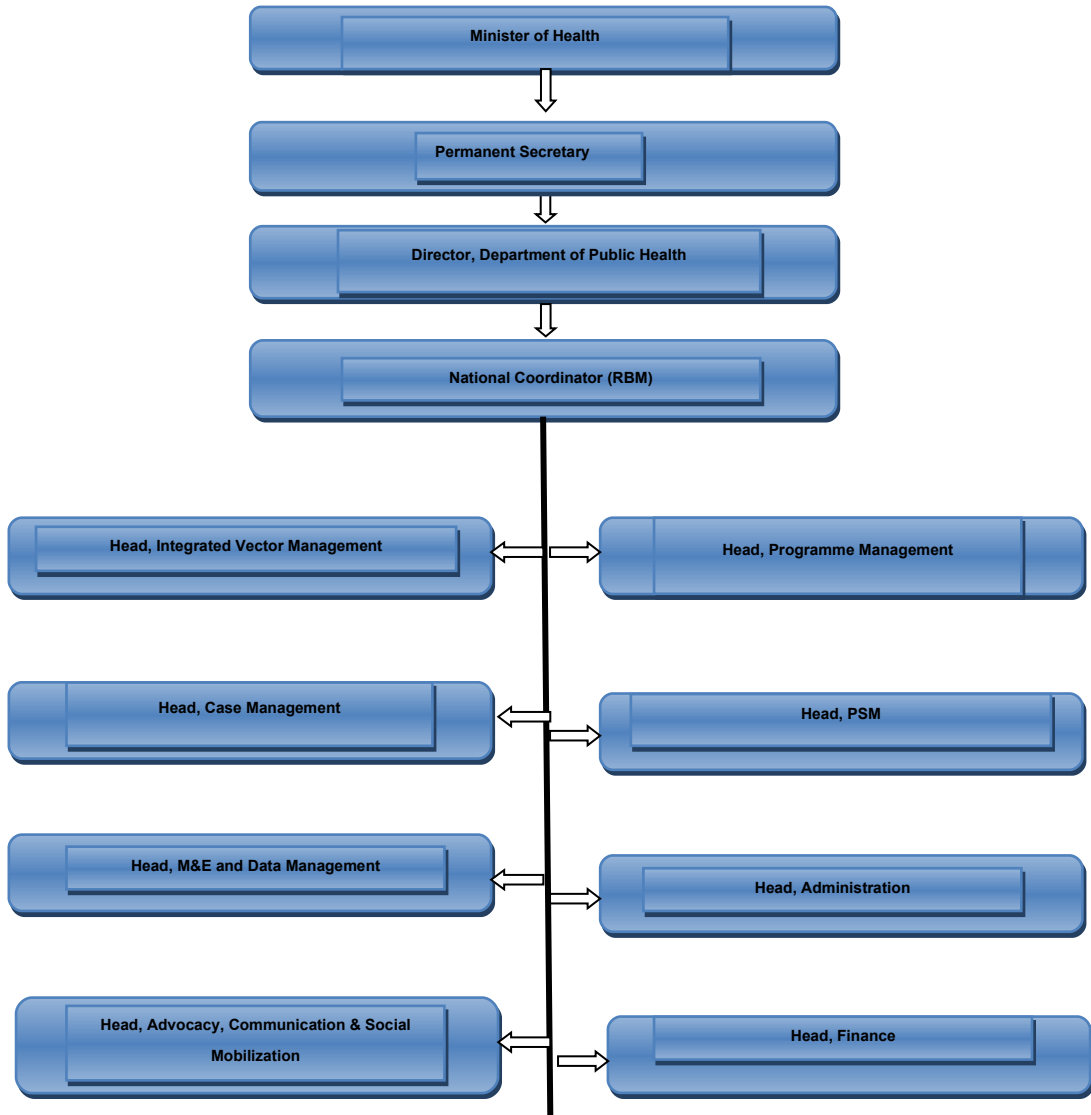
4.1 National Malaria Control Programme

The malaria control programme comprises of activities managed at the Federal, State and Local Government level.

4.1.1 Federal Level Organogram

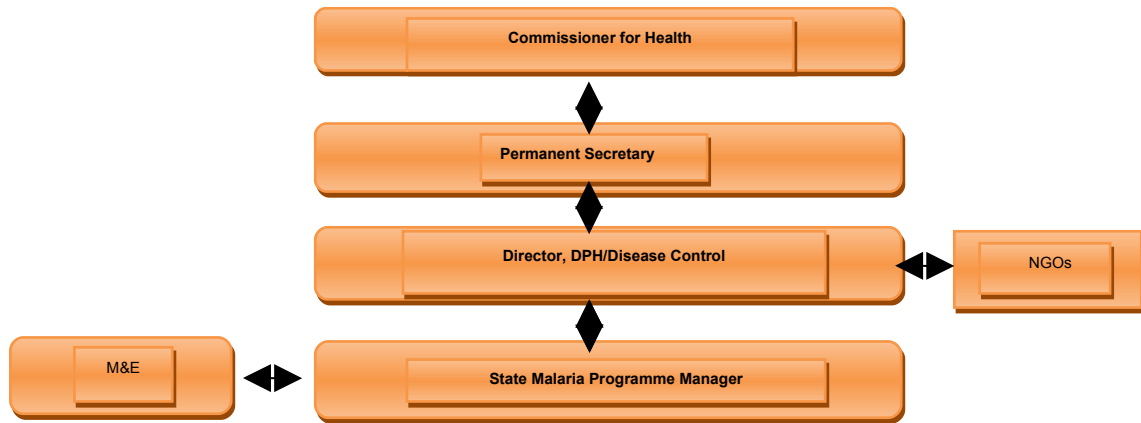
The Organogram for the implementation of the NMSP at the National level is as indicated below:

Chart 3



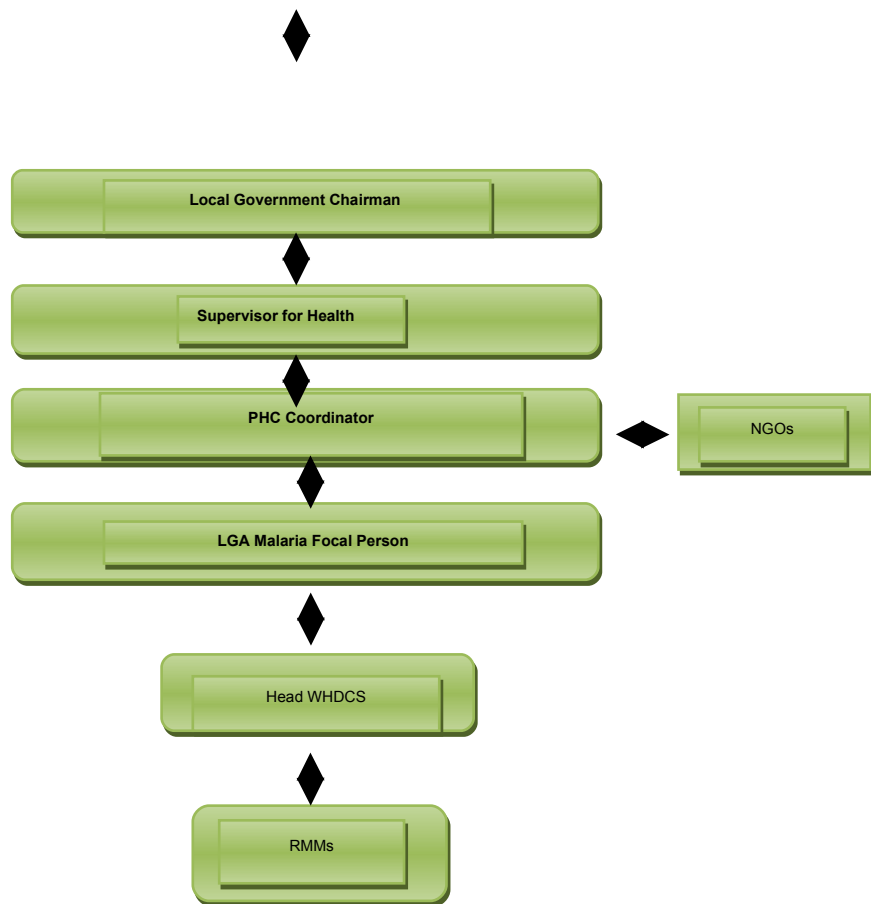
4.1.2 State Level Organogram

Chart 4



4.1.3 LGA Organogram

Chart 5



4.2.0 National Health Policy Formulation

All National Health Policies are formulated by the Federal Ministry of Health while there are departments and agencies to implement these policies. The Department of Public Health supervises the Malaria and Vector Control Division to provide inputs. The Malaria Vector Control Division is headed by the National Coordinator. Each state has a Malaria Control Programme Manager, that oversees the implementation of malaria control activities. Each Local Government authority has a malaria focal person that coordinates malaria control activities.

4.2.1 RBM Partnership

The National coordinator works with the partnership of both donors and implementers. The implementers include:

4.2.2 The Private Sector: This NMSP has extensively involved the private sector. The private sector in Nigeria includes the private for profit which includes large organizations like Exxon Mobil, Chevron, Shell while there are also private not for profit organizations.

The large private organizations will be involved in the funding of the NMSP, some of them have pledged commodities which includes LLINs and ACTs (see financials). The private for profit sector will extensively be involved in the distribution of commodities through the use of haulage firms in the distribution of anti-malarial commodities. The use of large logistics organizations like Manufacturers Delivery System and UACN is in line with the principle of private sector participation. It is even planned that a network of private warehouses and storage facilities will be used for storage of commodities particularly the LLINs. The inclusion of PMVs and Pharmacies for the delivery of the commodities to the end users is all in the principle and practice of public private cooperation and participation.

The social mobilization strategies will make active use of the private sector through soliciting for sponsorship of social events related to malaria control for the sales promotion of their products. The BCC strategies will make active use of the private facilities in the dissemination of messages.

4.2.3 Non Governmental Organizations (NGOs)

The strength of Non Governmental Organizations existing in the country will be tapped through their involvement in the commodity support, The Red Cross, the Canadian Red Cross and other NGOs have pledged

support of commodities. The service delivery mechanism of Community Based Organizations, Civil Societies and Faith Based Organizations will be tapped for the delivery of the commodities. The NGOs will also be involved in capacity development through provision of Train the Trainers Courses on a contractual basis. This includes Gede Foundation, a non profit organization registered in Washington, Africare is also one of the NGOs that has a long standing experience on the provision of technical training on the basis of Train the Trainers Courses.

Inter Gender Development Centre is an NGO that will assist in community system strengthening through social mobilization and partnerships with community groups.

4.2.4 Implementing Partners

The partners involved in the implementation include Non Profit Organizations like Yakubu Gowon Centre, Society for Family Health, Access JNCI, etc. These NGOs are expected to serve a dual role in implementation process. Organizations like YGC and SFH are expected to serve as principal recipients (in some cases) in terms of receiving funds, procurement decisions on commodities and distributions of items to the private and public sector facilities for the delivery of commodities to the end users.

Family Health International FHI: The good working relationship with FHI will continue. This is more so particularly in the areas of logistics and distribution of items to the public and private facilities.

Health Alive Foundation has been involved in the distribution of LLINs and ACTs. This organization will assist in distributing the commodities from their depot/warehouses to public and private facilities.

Association of Civil Society Organizations in malaria, immunization and nutrition has 600 member organizations throughout the country. The members of this association will assist in community mobilization through mobilization of the Ward Health Development Committees.

- **Technical Assistance:** In the implementation of the NMSP, technical assistance will be provided by WHO, WB, UNICEF, USAID, DFID, SFH, YGC and MC.
- **Research Institutes:** The implementation of the NMSP requires collaboration for comparative advantage. Institutions like Universities will be involved in some of the researches and processes to be conducted. While some of the operational researches to be conducted will involve the National Bureau of Statistics, National Population Commission, etc.
- **Coordination**

- The harmonization and coordination of the implementation will be based on the principle of the “3” ones of the Paris conference of Aids effectiveness .This coordination will cut across all levels.
- **The Local Government Level** The local government focal persons will coordinate the malaria control activities in the areas of distribution of commodities and delivery, coordination of RMMs, work closely with ACOMINs in mobilizing the grass roots for social activities and assist in revitalization of the WHDCs. The Local Government Malaria Focal person provides feedback to his State malaria programme manager on monthly basis.

4.2.5 The State Level

- The state programme managers will coordinate activities at public and private health facilities and work closely with other implementing partners in terms of commodities distribution and delivery. The State Malaria Focal person is expected to hold monthly meetings with the LGA focal persons to resolve field experiences. The State malaria programme managers will provide feedback in form of reports to the federal level on a monthly basis.

4.2.6 The Federal level

1. Quarterly meeting of the NMCP Committees – This advisory Committee meeting facilitated by the NMCP of FMOH on a quarterly basis, includes the other line ministries and Malaria implementing partners at the federal level to monitor programme progress against the annual plan and to preemptively identify and address problems.
 2. Annual programme review meeting – This will involve Directors of Public Health of State Ministries of Health, Programme Managers from each state, Technical Partners and NMCP to review the annual progress of the NMCP and plan for the coming year
 3. At the Federal level, there will be quarterly performance assessment
 4. Section review meetings in which all the heads of sections meet to review progress
 5. Partners review meetings for implementation review
 6. Last quarterly later in-year review of budget for the following year. (See section of financials)
 7. External review of implementation progress by external assessors
 8. Publications.
- The PR-PR, (where the use of PR is a donor requirement), there will be meetings on a quarterly basis which will provide opportunity for examination of implementation process and improved financial management. This will equally be improved through a monthly coordination meeting of PRs to evolve joint planning and implementation of cross cutting issues and share field experiences.

4.2.7 Human Resources

The objectives of the human resources function of the interventions are to:

- 1 Identify human resources needs and challenges to the interventions
- 2 Mobilize adequate human resources to deliver the interventions at the levels of health facilities and communities for service delivery.

The human resources needs of the interventions will be examined at the National and sub national levels.

4.2.8 Household level: Nigeria consists of 29.8 million households (National Population Census 2005). Based on the plan that 1RMM will provide services to 10 HHs, the country will require about 2.4 million RMMs for 80% coverage of the population at risk. Currently in 2008 there are 5,964 RMMs, the country plans to have 6,155 RMMs in 2009 and 6,352 RMMs in 2010.

These RMMs will be trained and they are to provide malaria control services at the household level and report on activities and Challenges on a monthly basis.

4.2.9 Community Level: At the community level, there will be 1 malaria focal person at the village development committee. Operating from the fact that there are about 5 communities per ward. This will require 50,000 people to cover about 10,000 wards. This number of people will need to be mobilized at the community level to ensure delivery of the interventions. The available skills of health care practitioners within the community will be tapped and fresh ones will be oriented to provide adequate services and support as determined in the community systems strengthening.

4.3.0 Ward Level: Nigeria is made up of 9,550 wards and there are about 10 wards in each local government. For the successful coordination of the various WHDCs, there will be 1 malaria focal person who will be supported by 1 NGO focal person from ACOMINS. This implies that the country will require about 95,550 at the rate of 2 persons per ward. They will support malaria communities based activities.

The NGO focal persons are expected to serve as link between the Community Services to the formal health Sector.

4.3.1 LGA Level: It is planned that there will be 1 malaria focal person at the local government health development communities. This focal person at the LGA level will be supported by a team of 3 officers consisting of 1PHC Coordinator, 1 M&E person and 1 logistics/Essential Medicine Person.

The Country has 774 local governments, therefore at 4 persons per local government the country will require 3,096 persons for effective service delivery.

The team of 4 people will be empowered through appropriate training and they will liaise with the private sector providers, liaise with other community health development programme and support ward and facility level malaria activities.

4.3.2 State: For effective service delivery at the state level, the state malaria programme manager will need to be supported by a team of 4 people. 1 training officer, 1 M&E officer, 1 IVM officer and a procurement and logistics person. The total number required for each state for proper coordination is 5 people per state at 36 states and 1 federal capital territory, a total of 185 persons will be required.

4.3.3 National Level: The National Coordinator is supported by 30 other people of varying skills at the national level, this team in concert with technical partners provide guidance and direction for malaria programme in the states at both facility and community levels they liaise and provide support for private sector care providers and resolves issues of HSS.

It is planned that adequate training will be provided and capacity building intensified.

4.3.4 Available Number of Personnel

The identified skill mix above and the ability to mobilize them within the country does not pose a major problem. Within the country, there exists a high caliber of health care professionals with proven technical competence that have gathered valuable experience in the field of malaria control exercise.

At the community level coordination of the WHDCs and VHDCs will be done through a 600 organization members of ACOMINS.

4.3.5 Available Human Resources at the 3 Levels of Facilities

The available statistics of HRH (FMOH 2007) is as indicated below:

Table 28

S/N	TYPE	TOTAL No.
1	DOCTORS (NIGERIANS)	52408
2	DOCTORS (ALIENS)	2968
3	NURSES	128918
4	MIDWIVES	90489
5	PHARMACISTS	13199
6	ENVIRONMENTAL HEALTH OFFICERS	4280
7	COM. HEALTH OFFICERS	19268
8	MEDICAL LAB SCIENTISTS	12703

SOURCE : HRH,

FMOH

It is the calculations of the planners of this programme that these categories of personnel indicated above will be available for the execution of the interventions. It is expected that

the NET GAIN from new entrants of new graduates to the profession minus the attrition rate, will provide a fairly stabilizing effect on the numerical strength. This is achievable if the various levels of Government are willing to employ at the three levels of facilities.

4.3.6 Personnel Cost

The required personnel does not constitute a direct personnel cost in terms of salaries and wages, this is for the fact that they will be selected from a pool of Health care professionals already employed and paid for rendering other health services apart from Malaria control .The RMMs will be volunteers therefore they will not be paid , however cost of human resources development will be borne by the programme (See Management Tools).

4.3.7 Risks & Sensitivity Analysis

The objective is to examine the general and specific risks that constitute threats to the successful implementation of the Business Plan with a view to determine coping strategies for:

- The NMSP is largely dependent on international donors therefore a persistent global financial crisis constitutes a major threat to the implementation. It therefore becomes an imperative for the country to embark on an aggressive fund raising and resource mobilisation internally to bridge any shortfall in disbursed funds.
- Exchange rate fluctuations as a result of devaluation also constitutes a potential threat to the implementation. Therefore, the whole financial projection is based on a stable exchange rate which assumes a stable local currency within the time frame of the NMSP;
- Manufacturer's capacity of the producers of the commodities largely determines the availability of the products. It is planned that only manufacturer's with installed and capacity utilization that could produce in a timely manner will be engaged;
- External disruption of supply chain is equally considered as a threat to the effective implementation of the NSMP. To this extent haulage firms with proven competence and SRs with similar experiences will be used for deliveries.

CHAPTER 5

5.0 Financial Management

The Finance and Accounts Unit of Roll Back Malaria (RBM) Programme is headed by a professional accountant. The role of this unit is to keep proper accounting records. Maintain sound internal control system. The unit reports to the National Coordinator.

The style of book keeping is in line with the financial regulations of the Civil Service of Federal Republic of Nigeria. The financial regulations are drawn from the Accounting Standard Practices of Nigeria designed by Nigerian Accounting Standards Board. The Nigerian Standards Board ensures good financial management practices of international standards.

5.0.1 Income

The RBM Programme gets money through budgetary allocation and redeemed pledges from the donors/partners. All cash inflow is lodged in a designated account, kept with the Federal Ministry of Health.

5.0.2 Expenditure

Expenditures are incurred by securing the necessary approvals. Once an approval is secured, a cheque is drawn in order to carryout planned functions. This process must be in line with the existing internal controls and must be transparent (due process).

5.0.3 Audit

There are two layers of audit put in place to achieve the objectives of proven internal control mechanism and financial transparency. They are – Internal Audit and External Audit.

5.0.4 Internal Audit

Budgetary allocation and grants received by RBM programme from the Federal Ministry of Health is audited internally by appointed Auditors who are also staff of the Federal Ministry of Health. The goal is to ensure strict compliance with the Financial Management regulations.

The Internal Auditors report to the Minister in charge of the Ministry. Grants obtained from the donors like Global Fund and World Bank is being audited internally by an appointed Auditor e.g. Local Funding Agent (LFA) appointed by the Global Fund and reports directly to donors periodically.

5.0.5 External Audit

The budgetary allocation and local grants released to the RBM programme is being audited externally by the office of the Auditor-General of the Federation. The weakness in internal control, if any, is first brought to the notice of the National Coordinator and later forwarded to the Minister of Health. The External Auditor will produce the yearly financial statements and Management Letter. The financial statement takes into account: Income and Expenditure as well as the balance sheet (Assets and Liabilities). The Management Letter essentially takes care of the strength and weakness of the Internal Control System.

5.0.6 External Audit (donor) The books of account of the donor, Global Fund, World Bank and USAID are maintained by the principal recipients. The donor hires the services of a professional audit firm to audit the finances in line with international best practices usually once in a year. Two distinct reports are compiled: The Financial Statements and Management Letter. The audit firm reports directly to the donors. The audit is conducted in accordance with the financial guide of Global Fund and World Bank.

5.0.7 Funds Management

First Bank has a history and wealth of experience in funds management and project financing. The bank works in collaboration with the principal recipient at YGC to manage, disburse funds meant for allowances for State and LGA personnel during monthly meetings.

5.1 PROJECT BUDGET

NATIONAL GAP ANALYSIS 2009 - 2010

INTERVENTION: LLINs – 2009

Stakeholders' Contribution

Source	Number of Nets
Federal/State/LGA	1,500,000
World Bank Booster	8,000,000
DFID Malaria Project	1,500,000
SFH – Commercial	100,000
USAID (Compass/Net Mark	1,340,000
UNITAID	6,500,000
Nets for Life	18,000
Harvest Field	120,000
Syngenta/Patemglobal	400,000
Vestergard Fransen	300,000
Global Fund Round 8	30,376,323
Global Fund Round 4	1,208,000
Total	51,662,323

INTERVENTION ACTs 2009

Stakeholders' Contribution

Source	Number of Treatment Courses
Federal/States/LGA	9,500,000
SFH	4,350,000
USAID	500,000
World Bank	13,500,000
DFID Malaria (Subsidized to private sector)	2,000,000
Global Fund Round 8	59,401,650
Total	87,451,650

INTERVENTION IPT (SP)-2009

Stakeholders' Contribution

Source	Number of Doses
Federal /State/LGA	2,000,000
DFID	850,000
World Bank	3,500,000
Total	6,350,000

INTERVENTION RDTs - 2009

Stakeholders' Contribution

Source	Number of RDTs
Federal/State/LGA	1,624,003
World Bank	2,000,000
Global Fund Round 8	2,178,288
Total	5,802,331

INTERVENTION ACSM - 2009

Stakeholders' Contribution

Source	Number of Household Demonstrating Health Awareness
Federal/State/LGA	2,500,000
World Bank	11,753,528
Global Fund	5,964,286
Total	20,217,813

INTERVENTION: LLINs – 2010

Stakeholders' Contribution

Source	Number of Nets
Federal/State/LGA	2,000,000
World Bank Booster	1,000,000
DFID Malaria Project	1,500,000
SFH – Commercial	50,000
USAID (Compass/Net Mark	1,340,000
Nets for Life	18,000
Harvest Field	120,000
Syngenta/Patemglobal	500,000
Vestergard Fransen	300,000
Global Fund Round 8	15,190,160
Total	27,018,160

INTERVENTION ACT s 2010

Stakeholders' Contribution

Source	Number of Treatment Courses
Federal/States/LGA	9,500,000
USAID	500,000

World Bank	500,000
DFID Malaria (Subsidized to private sector)	2,000,000
Total	12,500,000

INTERVENTION IPT (SP)-2010

Stakeholders' Contribution

Source	Number of Doses
Federal /State/LGA	2,000,000
Total	2,000,000

INTERVENTION RDTs - 2010

Stakeholders' Contribution

Source	Number of RDTs
Federal/State/LGA	589,913
World Bank	4,000,000
Global Fund Round 8	7,000,000
Total	11,589,913

INTERVENTION ACSM - 2010

Stakeholders' Contribution

Source	Number of Household Demonstrating Health Awareness
Federal/State/LGA	39,600,671
World Bank	6,500,000
Global Fund	5,964,286
	52,064,957

Financial Resources by 2009 - 2010

Organization	2009	2010
Federal Ministry of Health	964,391	667,000
Global Fund Rd 2/4	11,700,000	-
Global Fund Rd 8	294,100,375	39,628,030
USAID/PMI	40,000,000	60,000,000
WB Booster	40,000,000	60,000,000
UNICEF	2,500,000	2,500,000
WHO	3,400,000	3,400,000
DFID(SuNMAP)	20,200,000	24,500,000
MDG/State/LGA	31,000,000	31,079,768
Total	443,864,766	221,774,798
Grand Total for two years	665,639,564	

Commodity - 2009

Intervention	Country Target		NEEDS Already met		Gap for the Year	
	Number	Cost USD	Number	Cost USD	Gap	Cost USD
LLINs (Nets)	41,500,000	286,350,000	42,884,323	259,874,229	-	-
ACTs Courses	40,388,920	60,583,380	87,451,650	131,177,475	-	-

IRS (HH)	1,231,028	14,772,336	299,586	3,595,032	931,442	11,177,304
RDTs	2,920,572	6,103,995	5,802,331	5,048,028	-	-
IPT(Courses)	7,007,800	16,047,862	6,350,000	5,524,500	657,800	572,286
Total		370,343,400		441,219,264		11,749,590

Commodity - 2010

Intervention	Country Target		NEEDS Already met		Gap for the Year	
	Number	Cost USD	Number	Cost USD	Gap	Cost USD
LLINs (Nets)	48,500,000	334,650,000	27,018,160	186,425,304	21,481,840	148,224,690
ACTs Courses	83,362,730	144,217,523	12,500,000	18,750,000	70,862,730	106,294,095
IRS (HH)	2,540,843	30,490,116	618,481	7,421,772	1,922,362	23,068,344
RDTs	6,028,060	5,244,412	11,583,913	10,083,224	-	-
IPT(Courses)	9,964,000	8,668,680	2,000,000	1,740,000	7,964,000	6,928,687
Total		504,097,303		224,420,300		284,515,809

COST OF PROCESSES

PROCESS	2009	2010
	\$	\$
ACSM	4,779,413	7,583,820
ACSM Coordination & Partnership	3,160,852	244,893
HMM	13,356,076	13,804,599
HSS-Health Worker	72,234	73,305
HSS – Information	10,538,860	3,039,666
HSS-Service Delivery	<u>5,496,985</u>	<u>719,043</u>
	\$374,044,420	\$25,465,326

Total Project Cost in USD

Commodity 2009	-	370,347,400
Process 2009	-	<u>374,044,420</u>
Total		744,391,820

Gap 2009		
Total Needs	-	744,391,820
Total Commitment	-	443,864,766
Gap	-	300,527,054

Commodity 2010	-	504,097,303
Process 2010	-	<u>25,465,326</u>
Total		529,562,929

Gap 2010		
Total Needs	-	529,562,929
Total Commitment	-	221,774,798
Gap	-	307,788,131

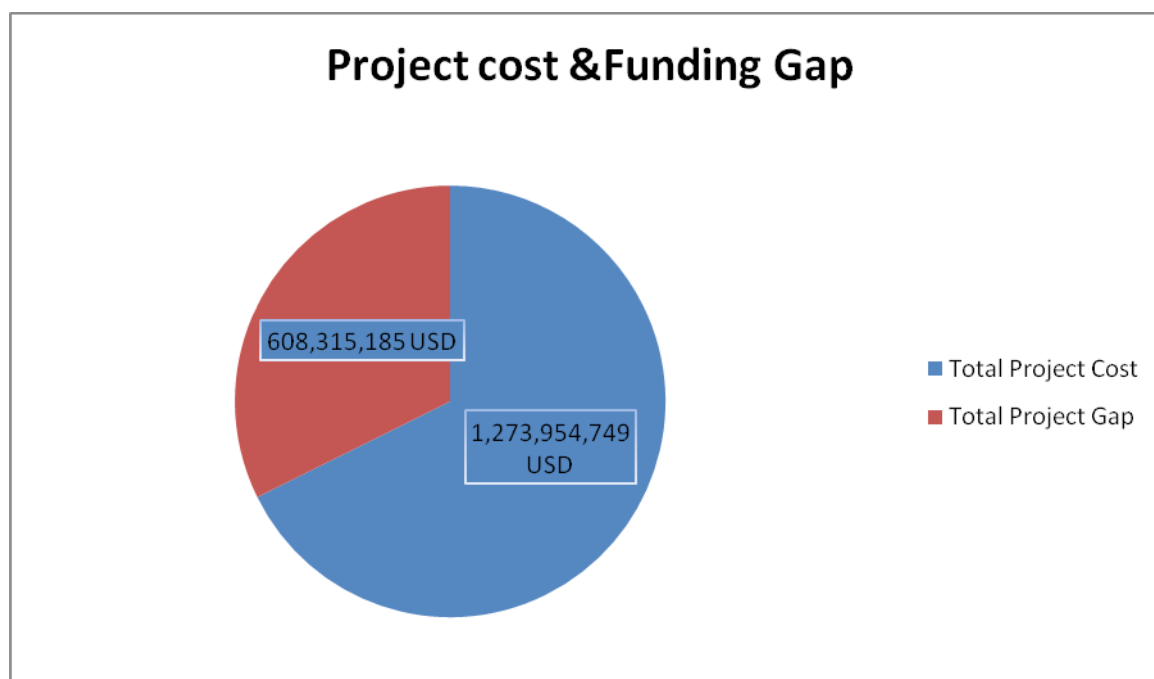
Total Project Cost	(2009 – 2010)	1,273,954,749
Total Pledges	(2009 – 2010)	665,639,564
Total Project Gap (2009 – 2010)		608,315,185

*Unit cost Assumption

Items	Unit Cost USD
LLINs	6.90
ACTs	1.50
RDTs	0.87
IPT	0.82
Exchange Rate	115 Naira to 1 USD

Further information on the Budget may be obtained from the Management Tool.

Note: Pledges for ACSM and HSS not included.



5.1.1 Mobilization of Resources

Internal mobilization of resources can be achieved in order to bridge the gap in part. The organized private sector will play a key role.

5.1.2 Material and Financial (Three Tiers of Government)

Apart from the pledged contributions of the Federal, States and Local Governments, enormous materials in commodities, cash and cash equivalent could further be generated from same to fill the gap.

5.1.3 Organized Private Sector (OPS)

The economy of Nigeria is largely driven and sustained by the organized private sector. The OPS is favourably disposed to contribute to the RBM programme. This includes, the financial institutions, oil & gas sub-sector, manufacturing and service providers.

Partnering with the OPS would assist in bridging the gap by at least 60%. However, this must be accompanied by series of advocacy.

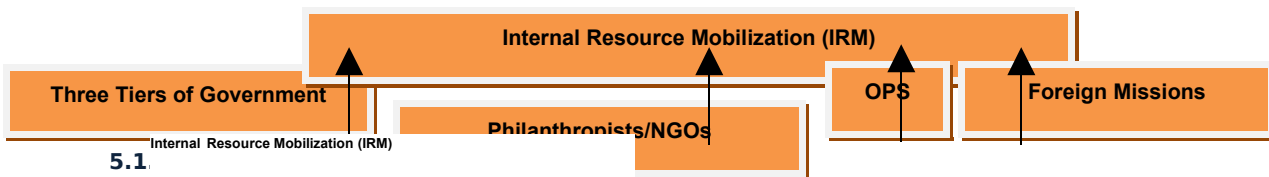
5.1.4 Philanthropists & NGO's

These are also potential contributors to internal resources mobilization strategy.

5.1.5 Friends of Nigeria

By way of advocacy, the NMCP/RBM could be boosted by the generosity of foreign missions and embassies.

Chart 6



The existing structure of the partnership will be used to monitor the performance of the Business Plan. Stakeholders are expected to review the performance of the business plan on a quarterly basis.

5.1.7 Performance Framework for the Business Plan

To enhance performance of the Business Plan, the following strategies, milestones and activities will be covered over the timelines stated below.

5.1.8 Marketing the Business Plan

- Partners' round table meeting within the country to enlist the commitment of all partners.
- Negotiations with the GFATM, World Bank, DFID, etc. to buy into the Business Plan.
- Meeting with State Governors and other officials to discuss the Business Plan and the critical roles they are expected to play in the Business Plan implementation.
- Aggressive internal fund raising strategies should be put in place as a proactive measure against a persistent global financial crisis.

Table 31

Milestone/Activity	2009				2010				Cost Estimate USD (\$)	Supporting Partners
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8		
Advocacy to National, States & LGAs (to be inculcated into the ACSM intervention)									-	
Partners' round table meeting within the country									2,420	
Preparation of Business plan for 37 states including FCT at the cost of \$26,100 per state									965,700	
Development of local funds mobilization strategic plan									46,250	
Fund raising activities									1,025,000	
Projected returns									1,950,000,000	
Evaluation of the Business Plan performance by Independent Assessors									58,000	