

## **Introduction**

Globally, millions of deaths attributable to malaria are still being recorded. The disease constitutes a huge epidemiologic burden in Africa and continues to cripple the economic development in the region. In Nigeria, the disease is responsible for 60% outpatient visits to health facilities, 30% childhood death, 25% of death in children under one year and 11% maternal death. The financial loss due to malaria annually is estimated to be about by 132 billion Naira in form of treatment costs, prevention, loss of man-hours etc; yet, it is a treatable and completely evitable disease.

### *The Vision*

A malaria free Nigeria

### *The Mission*

The government and the entire people of Nigeria believe that: every Nigerian has the right to access highly effective malaria preventive services and curative care delivered as close to the households as possible.

### *The Goal*

To halve the burden of malaria by the year 2010 and thus ensure that the disease no longer constitute a public health problem.

## **Strategic interventions**

RBM in Nigeria anchors on the global strategies for malaria control which are multi-pronged and of proven efficacy. These include Prompt and Effective Case Management; Intermittent Preventive Treatment of malaria in pregnancy and Integrated Vector Management including Use of Insecticide Treated Nets (ITNs), Indoor Residual Spraying (IRS) and Environmental Management. Other cross-cutting interventions include Advocacy, Communication and Social Mobilization, Effective Programme Management, Monitoring and Evaluation, Partnership and Collaborations.

## **Progress So Far**

Since the inception of the Roll Back Malaria Initiative, malaria control in Nigeria has undergone an evolution that has resulted in the attainment of several milestones which have served to set the stage for the next phase in the implementation process: rapid scaling up of interventions.

These milestones include among others, development and adoption of national policies and guidelines development of training manuals; sensitization and training of health workers and stakeholders on all interventions.

More specifically, for case management, Artemisinin-based Combination Therapies (ACTs) was adopted in place of chloroquine; a Presidential Committee on local manufacturing of ACTs was inaugurated; consultations on prepackaging of ACTs for home management of malaria with PMG of MAN; distribution of ACTs to under-five children free of charge with the support of GFATM (6m doses distributed 2006 – 2007) and phasing off of monotherapies.

To ensure prompt access to care, a stakeholders' meeting on planning and implementation of the Home-based Care strategy for malaria was held and a road

map to jump start the process was drawn based on lessons learnt from operational research carried out under the TDR project. A baseline survey to precede implementation is in the pipeline.

For IVM, the milestones include updating of the National ITN Policy and IVM Implementation Framework; inauguration of IVM Steering Committee; securing tax and tariff reductions for ITNs; procurement and distribution of ITNs by Federal Government/RBM Partners totaling about 10 million ITNs distributed to children and pregnant women between 2000 – 2005, and an additional 1.6 (2006 – March 2007) and collaboration with NPI and Community Directed Interventions in the country. Nigeria launched three IRS study sites in Lagos (Epe), Borno (Damboa) and Plateau (Bakin Ladi) in 2006.

To scale up prevention of malaria in pregnancy, MIP Guidelines have been produced and disseminated; 1.07 million doses of Sulphadoxine-Pyrimethamine (SP) were distributed to 12 states supported by GFATM and 1.5 million doses to 25 states & FCT through the MDG Funds. An MIP Technical Working Group, composed of development partners, Reproductive Health division, NMCP, ACCESS, NetMark and other stakeholders has also been set up and a pilot project on LLIN distribution to pregnant women using the Voucher System is being designed to take off in 3 LGAs soon.

To strengthen effective communication for behavioural change, guideline for BCC and IEC materials have been produced and disseminated; educative drama and playlets were presented in 770 communities of the country; jingles are aired on TV and Radio; bill boards are erected in strategic locations and Africa Malaria Day is commemorated annually.

A draft Monitoring & Evaluation Framework and Community Tracking Forms have been developed.

A baseline survey was conducted in the 9 States participating in the World Bank Malaria Booster Project in 2007 and supportive supervision was carried out in the 36 States & FCT

### ***Coverages of Interventions***

An evaluation of the RBM interventions in the country in 2005 revealed that use of IPT by pregnant women was 17%, under-five utilization of ITN was 6.5% while 34% of under-fives have access to treatment (non-ACT) within 24 hours of on-set of symptoms.

However, in 2006 and 2007, more commodities were procured and distributed to the vulnerable groups nation-wide. Over 17 million doses of ACTs were distributed to health facilities for treating uncomplicated malaria in under-five children, about 3 million doses of SP for pregnant women and over 3 million long-lasting insecticidal nets (LLINs) for both pregnant women and children under five years of age. This massive deployment of interventions would have changed the coverage levels found in the 2005 survey.

A national household survey to ascertain current coverage of these interventions is planned for 2008.

### **Future Direction**

The current global focus is to reduce the burden and geographical extent of malaria in endemic areas and to support elimination where feasible. The goal is to

increase effective treatment and prevention coverage to 80% in 54 countries by 2010.

Considering the current status of implementation in Nigeria, and being one of the 54 countries chosen, there is an urgent need to rapidly scale up control interventions to cover the whole population at risk and not just the vulnerable groups as in the Abuja Targets, if the RBM goal and indeed the MDG goals related to malaria must be achieved.

### ***Renewed Abuja Targets***

The new strategic plan for 2006-2010 proposes that

- At least 80% of those suffering from malaria will have access to effective and affordable treatment within 24 hours of the onset of symptoms
- At least 90% of pregnant women who are at risk for malaria, especially those in their first pregnancies, have access to intermittent preventive treatment (IPT)
- At least 80% of those at risk for malaria, particularly children under age five and pregnant women, sleep under insecticide-treated nets
- IRS, Larviciding and Environmental Management to be intensified

### ***Opportunities***

Windows of opportunities exist to achieve the vision of a malaria free Nigeria. These include the renewed political commitment (international and national) to Roll Back Malaria; improved funding by Government, funding agencies and partners; debt relief funds and commitment to MDGs; integration of programmes (Integrated Maternal, Newborn and Child Health) among others.

#### **Global Fund Malaria Grants**

The revised Round 4 Phase 2 grant in 18 states (61.6 million USD) has now been signed to run from 2007 – 2009 and it will involve both public and private sectors. The objectives are to procure over 14 million doses of ACTs, 4 million doses SP for IPT, 4.1 million LLINs, strengthening malaria monitoring, procurement supply management and IEC/BCC activities.

#### **World Bank Booster Project**

Nigeria secured a World Bank credit of 180m USD to boost malaria control over 5 years (2007 – 2011) in seven selected states including Anambra, Akwa Ibom, Bauchi, Gombe, Jigawa, Kano, and Rivers states. The criteria for selection of the states included mortality rate among under-fives exceeding 260/1000; documented Plasmodium falciparum resistance to chloroquine and SP exceeding 85 percent; demonstration of commitment by the state to implement (i) large scale campaigns to cut child-mortality and/or (ii) a comprehensive malaria booster program and the absence of other significant donor aid for malaria control in the state.

The project became effective 15<sup>th</sup> May 2007 with the inauguration of a National Project Steering Committee. Implementation has thereafter commenced with the procurement of 1.8 million LLINs, which have been distributed through collaborations with EPI. Other commodities e.g. for IRS, are being procured and programme management for the project is being strengthened.

### ***Resource Gap***

In spite of the increased funding for RBM in Nigeria, the huge population and vast geographical area of the country make the need for more resources imperative. The table below is an estimate of the cost of the operational plan for 2006-2010, the resource available and the gap in funding based on the vulnerable groups as target populations.

	2006	2007	2008	2009	2010	Total (\$)
<b>Cost of Operational Plan</b>	65,000,000	80,000,000	80,000,000	80,000,000	74,000,000	379,000,000
<b>Resource Envelope</b>	30,980,000	59,700,000	65,480,000	44,852,000	40,340,000	\$21,692,000
<b>Gap</b>	34,020,000	20,300,000	14,520,000	35,148,000	33,660,000	<b>\$137,648,000</b>

### *Next Steps*

- **Need Assessment:** In order to meet up with the global challenge of scaling up to 80% of the all populations at risk by 2010, it is expedient to conduct a need assessment that will inform the development of a comprehensive business plan for the country – January 2008.
- **Stakeholders meeting** on scaling up towards a malaria free Nigeria – Feb. 2008
- **Gap Analysis by States**
- **Development of a new Business Plan** - February 2008
- **Resource mobilization** – from Feb. 2008
- **Intensified Implementation** - 2008 – 2010.
- **Develop Plan for a Malaria Free Nigeria** - 2010 – 2015.