

**NIGERIA ROLL BACK MALARIA CONSULTATIVE MISSION:  
ESSENTIAL ACTIONS TO SUPPORT THE ATTAINMENT OF THE  
ABUJA TARGETS**

**20 – 25 October 2003**

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## **1. EXECUTIVE SUMMARY**

The Roll Back Malaria Board, representing the global RBM partners, requested the RBM Partnership Secretariat to conduct a series of country consultative missions to determine what additional inputs Category 1 countries would require to support the attainment of the Abuja Targets. The purpose of the country consultative missions is to re-invigorate co-operation between the RBM partnership and countries to support progress towards achieving the Abuja Targets.

The Country Consultative Mission for Nigeria took place 20-25 October 2003.

Nigeria's broad based RBM partnership has made some progress on malaria prevention and control. However, coverage levels for key interventions are still low; but some building blocks for achieving Abuja targets are now in place. If the NMCP and its partners are able to access Global Funds effectively and efficiently, strong commitment is exhibited by authorities at federal, state and LGA levels and co-operation and co-ordination with the private sector is maximised, it is envisaged that the current low coverage levels of Abuja targets may increase significantly by the end of 2005.

The following essential actions were identified to ensure that the Abuja targets are met and long-term sustainability of an effective malaria control programme is realised

- Formulate and implement a comprehensive MIP/IPT policy and guidelines
- Implement subsidy for IPT
- Design and implement mass campaigns for net treatment and re-treatment.
- Supply and distribution of ITNs
- Stimulate the private sector for production of PPDs
- Design and implement comprehensive home based management of malaria
- Building capacity of health workers and community based workers
- Strengthening programme management at RBM Secretariat
- Initiate and implement operational research to support RBM implementation
- Develop and implement comprehensive communication strategy to support essential actions to achieve Abuja Targets
- Strengthening monitoring and evaluation

Additional key elements contributing to reaching the Abuja targets will include strengthening programme management at all levels, developing and implementing a comprehensive communications strategy; designing and implementing comprehensive delivery mechanism for commodities, increasing the NMCP's capacity for monitoring and evaluation and building capacity of both health staff and community based health workers

The essential actions listed above were discussed and agreed at a Consensus Meeting attended by 36 participants representing the Ministry of Health and national and international partner organisations and agencies

It should be emphasised that the gaps, resource requirements and essential actions identified are additional and complementary to those currently planned and budgeted for within the existing resource envelope in the country, including Global Fund monies.

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### 3. ABBREVIATIONS

ANC	Ante-natal Care
BASICS	Basic Support for Institutionalizing Child Survival
CBO	Community Based Organizations
DFID	Department For International Development
FCT	Federal Capital Territory
FGN	Federal Government of Nigeria
FMOH	Federal Ministry of Health
GFATM	Global Fund Against AIDS, Tuberculosis and Malaria
IEC	Information Education and Communication
IMCI	Integrated Management of Childhood Illness
IMPAC	ITN Massive Promotion and Awareness Campaign
IPT	Intermittent Preventive Treatment
ITM	Insecticide Treatment Material
ITN	Insecticide Treated Net
LGA	Local Government Authority
M&E	Monitoring and Evaluation
MOU	Memorandum of Understanding
MTCT	Mother To Child Transmission
NAFDAC	National Institute for Food, Drugs Administration and
NGO	Non- Governmental Organization
NPO	National Professional Officer
NIMR	National Institute of Medical Research
NMCC	National Malaria Control Committee
NMCP	National Malaria Control Programme
PPD	Pre-packed anti-malaria Drug
PRSP	Poverty Reduction Strategy Paper
SON	Standard Organization of Nigeria
USAID	United States Agency for International Development
UNICEF	United Nations International Child Emergency Fund
WARN	West Africa Roll Back Malaria Network Control
WHO	World Health Organization
WHO/ICP/MAL	World Health Organization Inter-country Programme for Malaria

#### 4. INTRODUCTION

The Roll Back Malaria (RBM) Board representing the global RBM partners requested the RBM Partnership Secretariat to conduct a series of country consultative missions to determine what additional inputs Category 1 countries<sup>1</sup> would require to support the attainment of the Abuja Targets. The RBM Partnership Secretariat requested the West Africa RBM Network (WARN) – which represents partners in the sub-region – to participate in these country consultative missions.

The purpose of the country consultative missions is to re-invigorate co-operation between the RBM partnership and countries to support progress towards achieving the Abuja Targets.

The expected outcomes of the missions are:

- Status of RBM implementation in relation to the Abuja plan and targets and the milestones set for the remaining two years of the Abuja plan period
- Identification of the essential actions (beyond those already planned) that need to be implemented during 2004 and 2005 to maximise country action to achieve the Abuja Targets
- A Country Support Package that details the additional investments required to carry out these essential actions

The mission team comprised: Dr Edugie Abebe (Director Public Health, FMOH), Dr M E Mosanya (NMCP Manager, FMOH), Mrs Chioma Amajoh (NMCP Vector Control, FMOH), Mrs Olapeju Otsemobor (NMCP M &E, FMOH), Dr E N U Ezedinachi (NPO Malaria, WHO Nigeria), Dr B.M. Afolabi (NPO Malaria, WHO Nigeria), Dr Bayo Fatumbi (NPO Malaria, WHO Nigeria), Dr E.I. Gemade (UNICEF Nigeria), Yomi Oduwole (Futures Group/DFID Nigeria), Dr A. A. Akinpelumi (USAID/BASICS Nigeria), Dr. Jackson Sillah (WHO/ICP/MAL, West Africa and WARN), Dr James Banda (RBM Partnership Secretariat, Geneva) Ms Prudence Smith (RBM Partnership Secretariat, Geneva), Dr Ifeanyi Ibe (NetMark Nigeria and WARN), Dr Kojo Yeboah-Antwi (Malaria Consortium West Africa and WARN) and Dr Aaron Offei (Consultant, Malaria Consortium)

#### 5. METHODOLOGY

The methodology employed included document review (Annex 3) and meetings with Senior Government Officials at the FMOH and Partners. A 3 day workshop was organized to review progress, identify gaps and develop the action plans. This culminated in a Consensus Meeting where the Essential Actions and Country Support Package were agreed upon. Finally, there was a Round Table conference during which the Essential Actions and Country Support Package were adopted; partners indicated their commitment and next steps agreed on with the Director of Public Health, Federal Ministry of Health.

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<sup>1</sup> The RBM Partnership Secretariat categorised African countries into 3 groups. Category One countries are those considered most ready to rapidly scale up the coverage of interventions. Nigeria is classed as a Category One country.

## 6. SUMMARY SITUATION ANALYSIS

### 6.1. Malaria transmission and burden

Malaria is highly endemic in Nigeria and it remains one of the leading causes of morbidity and mortality in the country with prevalence rate of 919/100,000. Malaria accounts for 40% of disease burden reported at the OPD. It accounts for 30% of all childhood deaths and is associated with 11% of maternal deaths.

Transmission of malaria is stable and perennial in all parts of the country. In the northern part of the country transmission is intense during the short wet season and lower during the long dry season. In the southern part of the country, transmission is intense, stable and uniform throughout the year. It is perennial in the forest ecotype and sub-perennial in the dry savannah ecotype where transmission is relatively low during the dry season (November/December to April/March)

The economic burden due to malaria in Nigeria is substantial. Every year the nation loses over N132 billion due to absenteeism from school, work, or farm and the direct costs of malaria treatment.

Malaria is both a cause and a consequence of underdevelopment.

### 6.2. Policy and strategy environment and partnerships

The Nigeria Government's Poverty Reduction Strategy Paper (PRSP) has yet to be finalised and published, however it is already being used to direct Government strategy and decision-making. A key element of the policy is investment in education, health and other social services to lay a solid foundation for longer-term growth. The government also intends to build the capacity to fight immediate threats to the country's well being, such as malaria and the emerging HIV/AIDS epidemic.

Below is the total national spending on health in 2001. The total expenditure on health is US\$526,902,350 (excluding donor contribution) with per capita spending of US\$4.40

	<b>Total national health spending (USD) 2001</b>	<b>Spending per capita (USD)</b>
<b>Public</b>	202,021,048	1.68
<b>Private</b>	324,881,302	2.7
<b>Total</b>	526,902,350	4.4
Donor contribution	277,211,302	2.3

There is a strong political commitment for the RBM programme.

The first national malaria control plan of action (1996-2001) was developed in 1996.

Following the launch of Roll Back Malaria in 1998, a five year Strategic plan for RBM was developed (2001 to 2005) and costed at US\$204,814,000.

The objectives of the strategic plan are as follows:

- To reduce morbidity and mortality by malaria by 25% by the end of the year 2005.
- To reduce mortality due to malaria among pregnant women by 25% by the end of the year 2005

- To reduce malaria case fatality by 10% in pregnant women and children by the year 2005

The key elements of the strategic plan are:

- Disease Management
- Multiple preventive measures (chemoprophylaxis, use of ITMs and environmental management)
- Information, education and communication and social mobilisation
- Operational Research
- Health systems development and strengthening.

*RBM Partnership at Country level:*

Nigeria has a broad based RBM partnership made up of Federal Ministry of Health, multi and bilateral organizations, the private sector including pharmaceutical companies, net manufactures, insecticide dealers and oil companies; research institutions, NGOs, Community Based Organizations (CBOs) and regulatory bodies. Current partners include WHO, UNICEF, DFID, USAID, Futures Group, BASICS, NetMark, CIDA, major pharmaceutical companies (Neimeth, May & Baker, and SWIPHA), Mosquito Net Manufacturing Companies (SUNFLAG, NSF and Mabol), insecticide dealers (Syngenta, CHI/NetMark and Harvestfield), the National Agency for Food, Drugs Administration and Control (NAFDAC), Standard Organization of Nigeria (SON) the National Institute for Medical Research (NIMR), AGIP Oil Company, ExxonMobil, and Chevron.

**Partnership Co-ordination:** The partnership is co-ordinated by the RBM Secretariat, which is hosted by the NMCP. There is a National Malaria Control Committee (NMCC) which is mandated to meet quarterly and comprises the FMOH, development partners, research institutions, private sector and NGOs. The NMCC has four sub-committees: Case Management and Policy (Chaired by WHO), ITNs and Environmental Management (Chaired by UNICEF), Monitoring and Evaluation (Chaired by NIMR) and Mobilization and Publicity (Chaired by WHO)

### **6.3. ITNs and Environmental management**

Policy Guidelines for the implementation of ITNs have been produced and disseminated. The Objective of the ITN policy is to provide clear directives of the Federal Government of Nigeria on the various aspects of ITNs, with the aim of creating an enabling environment for the smooth implementation and scaling up use of ITNs in Nigeria in accordance with the provisions of the Abuja declaration and the Nigeria Strategic Plan.

The key elements of the National ITN policy are:

- Create a fiscal environment to promote local manufacturing and distribution of nets and insecticides
- Decrease the price of nets and insecticides by creating competition among dealers and improving demand
- Social marketing of ITNs by a combination of product development, demand creation, advertisements and IEC.
- Development of solidarity mechanisms and targeted distribution of subsidized nets to the vulnerable groups and those unable to pay.

Ongoing social marketing projects have been successful in the promotion of ITNs and are creating a favourable environment for scaling up.

Each of the core partners has concentrated activities in selected states as a way of achieving the desired impact: UNICEF is working in 4 States - Ogun, Bauchi, Enugu, and Federal Capital

Territory (FCT); Futures Group/DFID in 4 States - Ekiti, Jigawa, Benue and Enugu; USAID/BASICS in 3 States - Lagos, Kano and Abia; NetMark is working in 6 states - Edo, Rivers, Lagos, Kano, FCT and Abia, and FMOH and WHO are in all 37 States.

An ITN massive promotion and awareness campaign (IMPAC) has been officially launched by the President of the Federal Republic. This initiative seeks to provide ITNs as a reward to children under 5 years of age who complete immunization and pregnant women who attend ANC services. There is a Memorandum of Understanding (MOU) between the Federal Government and the State Governments that states that the FGN will supply 40% of total quantities of ITNs while the State will provide 60%. Advocacy for IMPAC has been carried out at national, state and LGAs level. Training of Zonal TOTs has been completed in all states. Currently, IMPAC is being implemented in four states (UNICEF Focal states). About 800,000 ITNs have been received out of 1,000,000 ITNs purchased by the Federal Government, and these are awaiting distribution to the states for IMPAC implementation. Every effort is being made to ensure that the gains of IMPAC are not eroded.

It is estimated that the major net manufacturing companies (Sunflag, NSF, Mabol) are currently producing 1.5 to 2.0 million nets annually but the capacity could be increased to meet all local demands. The quality of the nets being produced is good but the companies are not actively promoting their goods. To encourage the local production of mosquito nets, 40% taxes and tariffs have been imposed on imported mosquito nets.

There is also a large quantity of nets on the open market through the informal sector, notable among which are the Kano producers. There is a need to assess the contribution made by the informal sector in terms of quality of net products and coverage.

Insecticide dealers, including Syngenta, CHI, and Harvestfield have shown commitment and great potential to meet the country's demand for insecticides. However, with the exception of Syngenta which has gone into massive brand advertising, the rest are not promoting their commodities. All insecticides for net treatment attract zero tax.

There is collaboration among net manufactures and insecticide dealers. It has been observed that insecticide dealers buy nets from net manufacturers and package them with their insecticides for sale and vice versa. This is a very good development and should be encouraged and supported.

There is a vibrant ITN public-private partnership.

#### **6.4. Access to effective treatment**

The use of pre-packaged anti-malaria drugs (PPDs) as a means of making effective treatment accessible has been accepted by the Federal Government. Consequently arrangements and collaborations have been established with pharmaceutical companies to produce the pre-packaged drugs. Major pharmaceutical companies have formed a group known as the Pharmaceutical Manufacturers Group (PMG), an affiliate of the Manufacturing Association of Nigeria (MAN). The leader of the PMG represents the other manufacturers on the National Malaria Control Committee. Three major companies (Neimeth, May and Baker, SWIPHA) have accepted the challenge and have indicated their commitment to produce pre-packed anti-malarial drugs for different age categories, with different colour packaging for each category of treatment dose. Production has commenced and PPDs are currently available on the market. The PMG members have the potential to produce the total requirement for pre-packaged drugs

for both health facilities and home based management. They are however requesting the government to assist in promoting the drugs and orienting health staff on the initiative.

As part of the IMPAC Initiative, guidelines on the use of PPDs have been developed and orientation of health workers and some community agents has started in some states.

**Training in Case management** is ongoing and is being implemented in collaboration with the Integrated Management of Childhood Illness (IMCI) programme. TOTs have been trained at the national level and this has been followed by cascade training through Zones, States and to community level. The training covers health workers, NGOs, CBOs, Patent Medicine Vendors (PMVs), Traditional Healers, Traditional Birth Attendants and Village Development Committee Members. So far, 24 TOTs have been trained at National level, 144 at Zonal level, 740 at State level. Currently, about 4,000 people have been trained by the TOTs at the operational level. Checklist for follow up of trained personnel and support supervision is being updated. Planned training for laboratory staff has not yet taken place.

Drug efficacy testing has just been completed and the results will soon be discussed with a view to informing policy as appropriate. Six surveillance sites have been established to monitor drug resistance and there are plans to increase this number to twelve.

### **6.5. Malaria in pregnancy**

Even though the Federal Government has adopted Intermittent Preventive Treatment (IPT) as an alternative to chemoprophylaxis to prevent malaria in pregnancy, nationwide implementation has not begun. Sensitization of health workers and promotion of IPT has however started in some states. IPT implementation is currently being piloted in Oyo State as part of a WHO/PREMA-EU collaboration to pilot malaria in pregnancy monitoring tools.

To date, no policy documents or manuals have been developed for the nationwide implementation of MIP/IPT. There is some evidence of growing commitment among the partners for the implementation of MIP/IPT. Some pharmaceutical companies are producing SP, the drug of choice for IPT.

### **6.6. Supportive strategies**

#### *Monitoring and Evaluation (M&E)*

In July and August 2001, Nigeria conducted a baseline survey to collect information to serve as the baseline for repeat surveys for the evaluation of RBM. The report was widely disseminated and shared with all partners. The results were used to revise and update the national RBM policy and also for advocacy efforts towards mobilising resources from local partners and from the Global Fund Against HIV/AIDS, Tuberculosis and Malaria (GFATM).

In 2002 the NMCP received support for the establishment of a RBM composite database and for developing linkages and partnerships through networking for the evaluation of RBM. A plan/calendar of events to involve other partners in data collection for the evaluation of RBM was also developed and disseminated among stakeholders.

The NMCP has appointed a focal person for monitoring and evaluation and works in close collaboration with the M&E Subcommittee of the NMCC. The structures designed to strengthen monitoring and disease surveillance in general and malaria in particular are present at the State and LGA levels. M&E and malaria programme staff exist at both levels and are responsible for compiling data from health facilities and communities and forwarding it to the higher level. However, equipment at these levels is very limited.

### *Communication*

Lack of an umbrella communication strategy has handicapped awareness and demand creation activities. The level of advocacy is low. Consequently, commitment at state and LG levels is low in spite of the existence of a signed MOU.

## **6.7. Malaria control and health systems**

### *Organisation of malaria control:*

Malaria control activities are carried out by the National Malaria and Vector Control Division, which is within the Department of Public Health.

The division is organized into 5 units:

1. Epidemiology and Training
2. Case Management
3. IEC/Social mobilization
4. ITN/Environmental Control
5. Monitoring and Evaluation

The National Malaria Control Programme Manager is the head of the division and there are respective programme managers at the State levels. Policy guidelines are provided at the Federal level while implementation is carried out at the state and Local Government levels (LGA). The respective State and Local Governments fund malaria control activities in the various States and LGAs. Activities are further decentralised to the LGA levels to bring them closer to the people.

The Lack of adequate space for the RBM secretariat at the Federal level is hampering effective organisation and functioning.

Transport and communication are weak with an absence of vehicles for monitoring activities and a lack of e-mail/internet connections.

### *Health System development*

The federal Government is currently committed to strengthening the health system through health sector reforms.

### *Human resources*

As regards human resources, recent reviews carried out concluded that generally health staff numbers are adequate, but their allocation to the different States may not be fully equitable. The priority identified for human resources is improved capacity of existing staff through training, provision of guidelines, etc.

### *Financial resources*

Federal Government funding for RBM has been inadequate and release of funds has been infrequent during the last two years. This has affected the pace of implementation of programme activities. However, the Federal Government is committed to promoting and strengthening community based health insurance. There are also opportunities through the Pan African Health Foundation initiative for the purchase of some commodities (e.g. ITNs).

## **7. ABUJA TARGETS – WILL THEY BE MET?**

The National Strategic Plan and Abuja 2005 targets are:

- 60% of under-fives and pregnant women sleeping under ITNs by 2005.

- 60% of pregnant women receiving IPT1 and IPT2 by 2005.
- 60% of under-fives with fever receiving effective treatment within 24 hours by 2005.

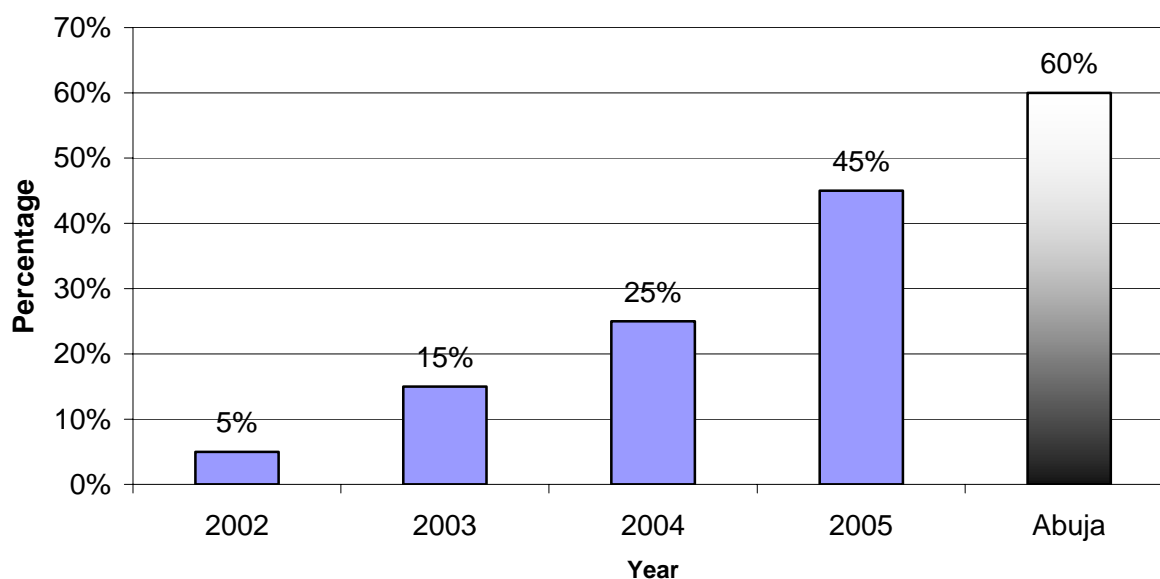
Due to the lack of empirical data and models that would allow us to make firm estimates, the estimates given below should be interpreted as broad indications. Moreover, the estimates share a number of assumptions.

### 7.1. ITN coverage among under-fives and pregnant women

It is estimated that by the end of 2005, 45% of under-fives and pregnant women will be sleeping under an insecticide-treated mosquito net if the following occurs:

Year	Assumptions and actions
2002	Coverage estimated based on anecdotal evidence Coverage is 5.5%
2003	<ul style="list-style-type: none"> <li>• All ITN programmes maintained</li> <li>• Local net supply adequate to meet demand</li> <li>• Distribution of reward nets by FMOH commences</li> <li>• New states added by partners</li> <li>• Increased advocacy to states to improve participation</li> <li>• Coverage increases to 15%</li> </ul>
2004	<ul style="list-style-type: none"> <li>• Access Global Fund</li> <li>• All ITN programmes maintained</li> <li>• Local net supply adequate to meet demand</li> <li>• Awareness campaign increased</li> <li>• Expansion to new states</li> <li>• Annual review meeting initiated</li> <li>• Increased provision of reward ITN</li> <li>• Targeted subsidy initiated</li> <li>• Festival promotions by partners</li> <li>• Re-treatment programme initiated</li> <li>• Promotion of treatment of other nets increased</li> <li>• Integration of "small scale ITN providers" into partnership</li> <li>• Improved planning for and commemoration of African Malaria Day</li> <li>• Intensive networking among ITN partners and stakeholders</li> <li>• Coverage increases to 25%</li> </ul>
2005	<ul style="list-style-type: none"> <li>• Access Global Fund</li> <li>• All ITN programmes maintained</li> <li>• Local net supply adequate to meet demand</li> <li>• African Heads of State will be enthusiastic to assess progress towards Abuja target</li> <li>• Awareness campaign increased</li> <li>• Expansion to new states</li> <li>• Annual review meeting initiated</li> <li>• Increased provision of reward ITN</li> <li>• Targeted subsidy initiated</li> <li>• Festival promotions by partners</li> <li>• Re-treatment programme initiated</li> <li>• Promotion of treatment of other nets increased</li> <li>• Integration of "small scale ITN providers" into partnership</li> <li>• Improved planning for and commemoration of African Malaria Day</li> <li>• Intensive networking among ITN partners and stakeholders</li> <li>• Programme monitoring and evaluation</li> <li>• Coverage increases to 45%</li> </ul>

Percentage of under-five and pregnant women sleeping under ITNs



### 7.2. IPT coverage among pregnant women

It is estimated that by the end of 2005, 60% of pregnant women will be receiving 2 doses of IPT (IPT1 and IPT2) if the following occurs:

Year	Assumptions and actions
2002	<ul style="list-style-type: none"> <li>Coverage was estimated based on available data from the implementation report</li> <li><b>Coverage is 1% (both doses).</b></li> </ul>
2003	<ul style="list-style-type: none"> <li>Guidelines developed</li> <li>Guidelines finalised and adopted</li> <li>Guidelines disseminated</li> <li>MIP/IPT focal person identified in the National MCP</li> <li>Partnership strengthened with PMG-MAN for increased production of SP</li> <li>Advocacy to policy makers (including National Council for Health) for IPT in the context of MIP done</li> <li>Advocacy to health professional groups (SOGON, Nursing and Midwifery Council, Community Health Practitioners Board), on IPT done</li> <li>Data gathering from all available sources (e.g. –project reports, academia, public sector)</li> <li><b>Coverage increases to 5%.</b></li> </ul>
2004	<ul style="list-style-type: none"> <li>Baseline survey on IPT/MIP conducted</li> <li>IPT stakeholders meeting initiated</li> <li>Linkages established with Safe Motherhood/PMTCT programmes to enhance regular ANC attendance</li> <li>Minimum care package for pregnant women established</li> <li>Training of health workers (public &amp; private sectors ) at all level</li> <li>Advocacy to the mass media executives for increased support on RBM/MIP conducted</li> <li>Continued advocacy for subsidised IPT at all levels</li> <li>Health communication partnerships including local broadcasters for RBM program support forged and strengthened</li> <li>Implementation in 12 focal/pilot states commenced</li> <li>Community health practitioners (CHPs) trained on counselling on IPT</li> <li>Communities/CBOs mobilised</li> <li>BCC material on IPT developed</li> <li>Mass media campaign initiated and ongoing</li> <li>Mass media information kit on MIP developed and used for training media personnel</li> <li>Checklist for monitoring pregnant women developed</li> </ul>

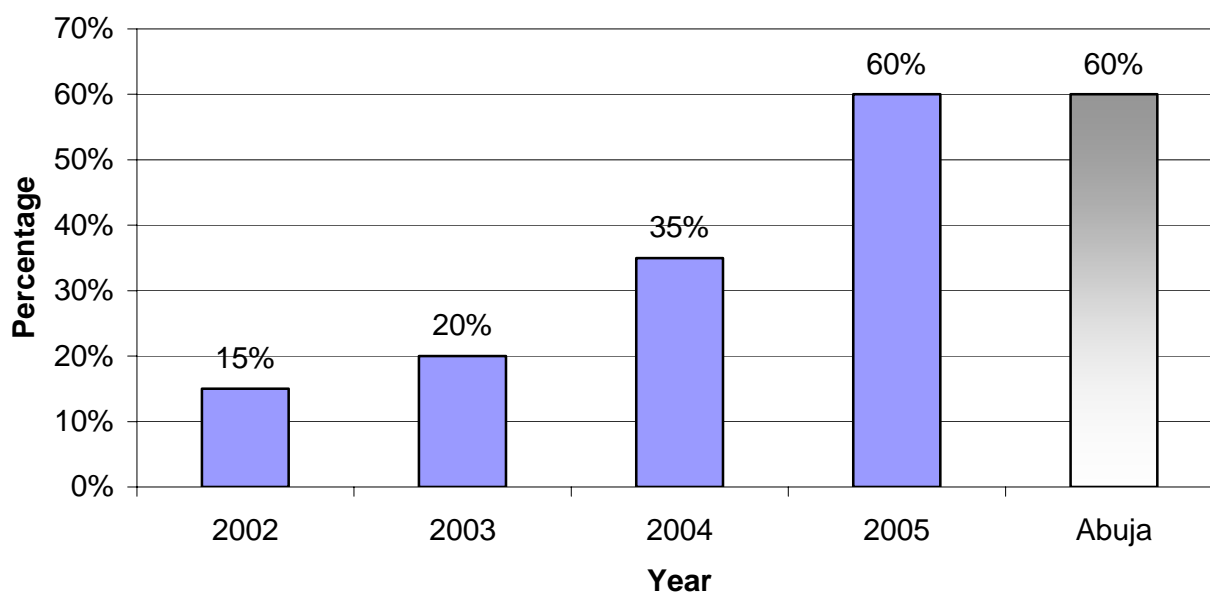
	<ul style="list-style-type: none"> <li>• Implementation activities monitored and evaluated</li> <li>• Adequate management of all data collected</li> <li>• Annual review of project implementation</li> <li>• <b>Coverage increases to 20%</b></li> </ul>
2005	<ul style="list-style-type: none"> <li>• Scale-up of implementation activities as outlined for 2004 to include to 36 states + FCT</li> <li>• Operational research on IPT</li> <li>• Information from operational research disseminated</li> <li>• Information from baseline survey disseminated</li> <li>• Continued promotion of IPT by the media, CHPs, CBOs</li> <li>• Continued training of the CHPs, CBOS on counselling on IPT</li> <li>• Activities of trained CHPs, CBOs on counselling on IPT monitored...</li> <li>• <b>Coverage increases to 60%</b></li> </ul>

### 7.3. Access to effective treatment for under-fives

It is estimated that by the end of 2005, 60% of under-fives with fever will be receiving effective treatment within 24 hours if the following occurs:

Year	Assumptions and actions
2002	Coverage estimated based on Strategic Assessment baseline data Coverage is 15%
2003	<ul style="list-style-type: none"> <li>• Steady increase in community awareness</li> <li>• (<i>Massive awareness campaign; RBM ambassadors</i>)</li> <li>• Improvement in stock-out/out of stock syndrome (<i>needs assessment &amp; quantification of drug needs</i>)</li> <li>• Improvement in funds/resource allocation</li> <li>• Improvement in compliance with treatment guidelines</li> <li>• <b>Coverage increases to 20%</b></li> </ul>
2004	<ul style="list-style-type: none"> <li>• Access to Global funds</li> <li>• Improved participation of partners</li> <li>• Scales-up of activities at state level</li> <li>• Increased collaboration and integration, between components of the RBM</li> <li>• Six more sentinel sites established to monitor drug efficacy (Action)</li> <li>• Provision of seed stock</li> <li>• Review/change existing drug policy based on findings of efficacy trials</li> <li>• <b>Coverage increases to 35%</b></li> </ul>
2005	<ul style="list-style-type: none"> <li>• Access to Global funds</li> <li>• Improved participation of partners</li> <li>• Scale-up of activities at state level</li> <li>• Increased collaboration and integration between components of the RBM</li> <li>• Provision of seed stock</li> <li>• <b>Coverage increases to 60%</b></li> </ul>

Percentage of under-five receiving effective treatment within 24 hours



### Summary

Coverage levels for key interventions are still low. However, some building blocks for achieving the Abuja targets are now in place. If the NMCP and its partners are able to access Global Funds effectively and efficiently, strong commitment is exhibited by authorities at federal, state and LGA levels and co-operation and co-ordination with the private sector is maximised, it is envisaged that the current low coverage levels of Abuja targets may increase significantly by the end of 2005.

## 8. THE ESSENTIAL ACTIONS

The essential actions given below are those deemed necessary by the RBM Country partnership, WARN and RBM Secretariat to accelerate implementation and reach the coverage rates given in the previous section. It should be emphasised that these essential actions only include those that are not currently planned and budgeted for within existing resources available in the country, including Global Fund resources.

### 8.1. ITN Supply

The total ITNs required to reach the Abuja target is estimated at 15 million. Current pledges and availability total approximately 2 million nets. The Global fund when accessed will provide nets for 12 States currently without ITN programmes. Supply from local net manufacturers must therefore expand rather quickly to meet the anticipated increase in demand. ITN availability in peri-urban and rural areas is hampered by weak distribution channels/network. Local ITN distributors are not making enough profits to invest in sustaining and developing distribution channels. Weak distribution and logistics also affect public sector ITN provision. There is therefore the need to support both private and public distribution. Logistic capacity must be strengthened for distribution through private sector participation. There is currently no re-treatment programme in place and it is estimated that there are substantial numbers of nets in the system that have not been treated with insecticide. The current net re-treatment rate is very low.

- Supply and distribution of ITNs (USD 19,200,000.00).

- Design and implement mass campaigns for net treatment and re-treatment (USD 321,960.00)

## **8.2. Access to treatment**

Even though the pharmaceutical companies have taken up the challenge to produce PPDs, the current production level is very low and PPD availability is limited to a few urban areas, with no availability at health facilities. The cost of the pre-pack is also beyond the means of many individuals and so access for children under five is low. The private sector is advocating for bulk purchase by the Federal and State governments in addition to massive promotion to serve as incentives for them to go into large-scale production. PPDs given to children under five at subsidized prices or at no cost will go a long way towards addressing access to treatment for this vulnerable group. With over sixty percent of the population having poor access to health facilities, it is essential to promote expanded home management of malaria.

- Provision of free PPDs for < 5yrs (US \$23,300,000.00)
- Design and implement comprehensive delivery mechanism for home based care for malaria (US \$200,000.00)

## **8.3. IPT**

Given that IPT is a new intervention for Nigeria, it will be important to put in place a comprehensive strategy and guidelines to aid implementation. It will also be important to bring together all stakeholders and make general improvements to the health system to ensure effective implementation. Putting in place some form of subsidy will go a long way towards ensuring that pregnant women have access to the drugs.

- Formulate and implement a comprehensive MIP/IPT policy strategy. (US\$ 4,445,051.00)
- Implement subsidy for IPT (US \$ 4,860,000.00)

## **8.4. Capacity building**

The priority identified for human resources is improved capacity of existing health staff through training and provision of guidelines and community based health workers

- Building capacity of health workers and community based workers (US \$14,700,000.00)

## **8.5. Programme management at RBM secretariat**

Human, material, and financial resources at the RBM Secretariat at all levels require strengthening. Implementation of RBM interventions is greatly hindered as a result of the weakness of the Secretariat. It is therefore important to provide adequate office facilities and equipment at all levels of the RBM secretariat, to strengthen human resources and review the systems to identify and address bureaucratic bottlenecks that hinder progress.

- Strengthening programme management at RBM Secretariat (US\$2,430,000.00)

## **8.6. Operational Research**

There is a need to implement a system for carrying out operational research to provide quality data that can be used in reviewing and formulating national policies, strategy development, planning, implementation and evaluation of the malaria control program. It is important to constantly monitor efficacy of anti-malaria drugs in use, efficacy of potential alternative drugs and efficacy of insecticides.

- Initiate and implement operational research to support RBM implementation (US\$256,000.00)

### **8.7. Communication and Advocacy**

Lack of a broad communication strategy has handicapped awareness and demand creation activities. The level of advocacy is currently too low to attain the desired results. Advocacy to stimulate support from political leaders and policy makers for implementation is essential and involvement of States and LGAs is required. There is therefore a need to develop a strategic communication framework, to develop and review existing IEC materials and to co-ordinate the various communication campaigns in use by programmes.

- Develop and implement a comprehensive communication strategy to support essential actions to achieve Abuja Targets (US\$ 20,000,000.00)

### **8.8. Monitoring and Evaluation**

Even though some structures for monitoring and evaluation of RBM do exist, these structures need strengthening to support data collection, compilation, analysis and ultimately use.

- Strengthening monitoring and Evaluation (US\$ 781,250.00)

## 9. PROPOSED COUNTRY SUPPORT PACKAGE: ESSENTIAL ACTIONS AND INVESTMENTS REQUIRED

#	Essential actions (in addition to ongoing activities)	Products	Investments needed						Meeting the Gap	
			Human resources	Commodities	Equipment	Cost 2003	Cost 2004	Cost 2005		Total cost
1.	Formulate and implement a comprehensive MIP/IPT policy and guidelines	Policy and training manuals produced and disseminated	TA			62500	382551	0	445,051	
2	Implement subsidy for IPT	Increase use of IPT	TA	SP		270000	1350000	3240000	4,860,000	
3	Design and implement massive net treatment and re-treatment.	Increase in number of nets treated	TA	Insecticides		0	321960	0	321,960	
4	Supply and distribution of ITNs	Increase in ITN availability		ITNs		0	8400000	10800000	19200000	
5	Stimulate the private sector for production of PPDs	Increase quantity of PPDs		PPDs		4050000	7110000	12140000	23300000	
6	Design and implement comprehensive home based management of malaria	HBM of malaria widely practiced	TA			0	200000	0	200,000	
7	Building capacity of health workers and community based workers	Improved skills of HWs and CBHWs	TA			0	7350000	7350000	14700000	
8	Strengthening programme management at RBM Secretariat	Strong and responsive RBM Secretariat	TA		Office space, office equipment	91000	1725000	614000	2430000	
9	Initiate and implement operational research to support RBM implementation	Generated data used to support implementation and policy	TA	Reagents and other consumables	Computers and accessory, Lab equipment,	0	128000	128000	256,000	
10	Develop and implement comprehensive communication strategy to support essential actions to achieve Abuja Targets	Implementing partners for communication identified Local capacity for management and oversight in place Developed comprehensive communication strategy in use. Partnership for communication	TA	IEC materials	Communication equipment	0	13000000	7000000	20000000	
11	Strengthening monitoring and evaluation	RBM implementation monitored and evaluated	TA, Data Manager			0	390625	390625	781,250	
	Total					4473500	40358136	41662625	86494261	

## 10. FOLLOW UP ACTIONS

At the Round Table Meeting, partners committed themselves to carrying out the essential actions identified during the mission. Partners' commitments and pledges came to US\$20 million. Partners resolved to mount a vigorous advocacy and mobilization campaign to fill the remaining gap of US\$66.5 million.

The follow up actions listed below were agreed on by partners attending the Round Table Meeting.

- Ambassadors for RBM promotion to be appointed at Federal and State levels
- A post mission conference to be held 2<sup>nd</sup> or 3<sup>rd</sup> week of November.
- A special committee comprising FMOH, WHO, UNICEF and BASICS should be convened to plan advocacy strategies
- Special advocacy messages to be developed and submitted from RBM through the office of the Vice President to all State Governors to solicit their support for RBM.
- Special advocacy letters to be sent through the FMOH to the Federal Executive Council, National Council on Health and National Council of State in order to put malaria on the national agenda.
- RBM Partnership Secretariat to provide general materials for adaptation to enhance advocacy.
- A communication subcommittee was established made up of FMOH, NETMARK and John Hopkins University and supported by RBM Partnership Secretariat and charged to look at ways of developing a comprehensive communications strategy

**11. ANNEX 1. List of persons consulted / participated in the workshop**

	<b>NAME</b>	<b>ORGANISATION</b>
1	Professor Eytayo Lambo	Minister of Health FMOH
2.	Mr Umaru Aji	Permanent Secretary, FMOH
3	Dr Edugie Abebe	Director Public Health, FMOH
4	Dr M.E. Mosanya	RBM Program Manager, FMOH
6	Dr Adenike Adeyemi	RH, FMOH
7	Dr James Banda	WHO/Mal (Geneva)
8	Mbong G.N	RBM/FMOH
10	Odujoku J.B.	RBM/FMOH
11	S.O. Banjo	RBM/FMOH
12	Okoh F.O	"
13	Aro M.A.	"
14	Mrs A.O. Etta	RH/FMOH
15	Dr E.N.U. Ezedinachi	RBM/WHO
16	Dr B.M. Afolabi	"
17	Yomi Oduwole	Futures group
18	Dr. Kojo Yeboah-Antwi	Malaria Consortium/WARN
19	Dr Aaron Offei	Malaria Consortium/ consultant
20	Akinpelumi A. A.	Basics
21	Mrs Olapeju Otsemobor	RBM/FMOH
19	Bayo S. Fatumbi	WHO/MAL/NIGERIA
21	Dr E.I. Gemade	UNICEF, Abuja
22	Dr Isah Y. Vatse	MFCT-MOH
23	Ms Prudence Smith	RBM Partnership Secretariat
24	Mrs Chioma Amajoh	RBM/FMOH
25	Mrs. O.E. Ibe	Policy Project Abuja
26	Olanpeleke O.A.	RBM/FMOH
27	Ajaegbu N.R.	"
28	Dr. Ifeanyi Ibe	Netmark
29	Stalin Ewoigbokhan	Arch Project
29	Essien U.J.	RBM/FMOH
30	Dr Jackson Sillah	WHO/ICP/MAL

*Participants at the consensus Meeting*

<b>NO.</b>	<b>NAME</b>	<b>ORGANISATION</b>
1	DR. EDUGIE ABEBE	FMOH
2	DR. M.E. MOSANYA	FMOH
3	DR. O.J. EKANEM	MALARIA SOCIETY OF NIGERIA
4	MRS. OLAPEJU OTSEMOBOR	FMOH/RBM
5	CHILMA AMAJOH	FMOH/RBM
6	MBONG G.N.	FMOH/RBM
7	ODUJOKO J.B.	FMOH/RBM
8	S.O. BANJO	RBM/FMOH
9	OKOG, F.O	RBM/FMOH
10	ARO M.A.	RBM/FMOH
11	OLANPELEKE O.A	RBM/FMOH
12	AJAEGBU N.R	RBM/FMOH
13	ESSIEN U.J	RBM/FMOH
14	MRS. A.O. ETTA	RH DIVISION, FMOH
15	DR. E.N.U EZEDINACHI	RBM/WHO/MAL
16	DR. B.M. AAFOLABI	"
17	CATHY CLARENCE	SOCIETY FOR FAMILY HEALTH
18	JAMES BANDA	RBM SECRETARIAT/WHO
19	YOMI ODUWOLE	FUTURES GROUP
20	KOJO YEBOAH-ANTWI	MALARIA CONSORTIUM/WARN
21	AARON OFFEI	MC
22	AKINPELUMI A.A	BASICS

23	BAYO S. FATUNMBI	WHO/MAL/NIGERIA
24	DR. JACKSON SILLAH	WHO/ICP/MAL
25	MS. PRUDENCE SMITH	COMMUNICATION ADVISOR, RBM PARTNERSHIP SECRETARIAT
26	DR. E.I. GEMADE	UNICEF, ABUJA
27	DR. IFEANYI IBE	NETMARK NIGERIA (OFFICE)
28	DR. (MRS) O.E. IBE	POLICY PROJECT, ABUJA
29	DR. HENRY E. NSA	RBM/CROSS RIVER STATE MIN. OF HEALTH (PROGRAMME MANAGER)
30	OLAMIDE GEORGE	CHESTRAD INTERNATIONAL
31	STALIN .E EWOIGBOKHAR	ARCH PROJECT
32	SIR PATRICK IKEMEFUNA	SYNGENTA, LOGOS
33	MRS. TOYIN OWORU	STATE MIN. OF HEALTH, PHC & DE DEPT. ABEOKUTAA, OGUN STATE, ROLL BACK MAL PROG. MANAGER
34	PROF. INNOCENT UJAH	UNICEF, ABUJA
35	PRO. OBIOMA NWAORGU	GLOBAL HEALTH AND AWARENESS RESEARCH 3 FOUNDATION (GHARF)
36	Dr ISAH Y. VATSE	MFCT-MOH

*Participants at the Round Table Meeting*

NO.	NAME	ORGANISATION
1	DR. EDUGIE ABEBE	FMOH
2	DR. M.E. MOSANYA	FMOH
3	DR. O.J. EKANEM	MALARIA SOCIETY OF NIGERIA
4	MRS. OLAPEJU OTSEMOBOR	FMOH/RBM
5	CHILMA AMAJOH	FMOH/RBM
6	MBONG G.N.	FMOH/RBM
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15	DR. E.N.U EZEDINACHI	RBM/WHO/MAL
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19	KOJO YEBOAH-ANTWI	MALARIA CONSORTIUM/WARN
20	AARON OFFEI	MC
21	AKINPELUMI A.A	BASICS
22	BAYO S. FATUNMBI	WHO/MAL/NIGERIA
23	DR. JACKSON SILLAH	WHO/ICP/MAL
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30	STALIN .E EWOIGBOKHAR	ARCH PROJECT
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32	MRS. TOYIN OWORU	STATE MIN. OF HEALTH, PHC & DE DEPT. ABEOKUTAA, OGUN STATE, ROLL BACK MAL PROG. MANAGER
33	PROF. INNOCENT UJAH	UNICEF, ABUJA
34	PRO. OBIOMA NWAORGU	GLOBAL HEALTH AND AWARENESS RESEARCH 3 FOUNDATION (GHARF)
35	DR. AWUDU TINORGAH	UNICEF HEALTH OFFICER, NIGERIA

36	MR. M.R. JUNEJA	SUNFLAG-GROUP, NIGERIA
37	EMMA O. EBERE	MPSN.FPC PHARM, MNIM

**12. ANNEX 2. TIME SCHEDULE FOR THE WEEK**

<b>Date</b>	<b>Activity</b>	<b>Tasks</b>	<b>Responsible officer(s)</b>
Day 0	Pre-mission meeting	<ul style="list-style-type: none"> <li>Meeting with the team and local organizers to finalise mission agenda</li> </ul>	Mission team leader
		<ul style="list-style-type: none"> <li>Adoption of the methodology</li> </ul>	
		<ul style="list-style-type: none"> <li>Finalisation of administrative issues</li> </ul>	
Day 1 (morning)	Courtesy call and briefing of national authorities and local heads of partner agencies	<ul style="list-style-type: none"> <li>Presentation of mission objectives to the MoH and NMCP and local partner agencies</li> </ul>	Mission team leader NMCP
Day 1 afternoon) to day 3 (morning)	Workshop organized by the team with all stakeholders	<ul style="list-style-type: none"> <li>Presentation of workshop objectives</li> </ul>	<ul style="list-style-type: none"> <li>Consultant</li> </ul>
		<ul style="list-style-type: none"> <li>Review of Abuja PoA and targets</li> </ul>	<ul style="list-style-type: none"> <li>Mission team leader</li> </ul>
		<ul style="list-style-type: none"> <li>Review of the national strategic Plan and implementation plan for 2000 to 2003</li> </ul>	<ul style="list-style-type: none"> <li>The NMCP manager</li> </ul>
		<ul style="list-style-type: none"> <li>Discussion to examine fit between Abuja Plan &amp; Implementation Plans</li> </ul>	<ul style="list-style-type: none"> <li>Consultant and workshop participants</li> </ul>
		<ul style="list-style-type: none"> <li>Review of progress on implementation</li> </ul>	<ul style="list-style-type: none"> <li>The NMCP manager supported by State Managers</li> </ul>
		<ul style="list-style-type: none"> <li>Brainstorm lessons learned: SWOT analysis</li> </ul>	<ul style="list-style-type: none"> <li>Consultant and workshop participants</li> </ul>
		<ul style="list-style-type: none"> <li>Presentation of desk analysis report and discussion.</li> </ul>	<ul style="list-style-type: none"> <li>Consultant</li> </ul>
		<ul style="list-style-type: none"> <li>Prioritize Actions towards Abuja 2005</li> </ul>	<ul style="list-style-type: none"> <li>Consultant and workshop participants</li> </ul>
		<ul style="list-style-type: none"> <li>Prioritize country needs for implementation of actions</li> </ul>	<ul style="list-style-type: none"> <li>The NMCP manager supported by Regional and District Managers</li> </ul>
		<ul style="list-style-type: none"> <li>Ascertain existing capacity of local Partnership to meet needs and identify gaps</li> </ul>	<ul style="list-style-type: none"> <li>Chair RBM Malaria Control Support Team (MCST)</li> </ul>
		<ul style="list-style-type: none"> <li>Based on identified gaps, articulate needs to be met by National &amp; Global Partnerships</li> <li>Identify essential actions and support package with budget</li> </ul>	<ul style="list-style-type: none"> <li>Chair RBM Malaria Control Support Team, Consultant and participants</li> </ul>
Day 3- Evening	Debriefing of Hon. Min. of Health	Presentation of draft report to Minister	Director PH NMCP Manager
Day 4- morning	Continue workshop	Finalize essential actions and support package with budget	Consultant and participants
Day 4 afternoon	Consensus Meeting	Presentation of essential actions and support package to national authorities	Director PH NMCP Manager
Day 5	Round table Meeting	National adoption of essential actions and support package and agree on next steps	Chair Director of PH

**13. ANNEX 3: DOCUMENTS REVIEWED DURING COUNTRY CONSULTATIVE MISSION**

1. Desk Review for Roll Back Malaria Essential Actions Progress.. Investment gaps (REAPING), Nigeria, July-August 2003
2. Strategic Plan for Rolling Back Malaria in Nigeria, 2001-2005
3. Report on the review of the implementation of RBM Interventions 2001-2002 in Nigeria, 25-29 November 2002, (Malaria Consortium)
4. Technical report of the National RBM Monitoring and Evaluation Baseline Survey 2001
5. Report on the Review of the implementation of RBM interventions In Nigeria (2001-2002) 25-29November 2002
6. Policy for the implementation of Insecticides Treated Mosquito nets (ITN) in Nigeria 2002
7. DFID/Futures Group Europe ITN Project (Nigeria). Output to purpose review. 27 march 2003
8. Scaling up Roll Back Malaria (RBM) in Nigeria: Promoting use off the Insecticide Treated Nets (ITNs), Improving Home Management of Malaria and initiating Intermittent Preventive Treatment (IPT) for pregnant women. July 2002

## 14. ANNEX 4: DETAILED OVERVIEW GAPS ANALYSIS PREPARED DURING COUNTRY CONSULTATIVE MISSION

### 14.1. Gap Analysis: ITNs Group

#### a. SWOT analysis

##### Strength

- Private sector enthusiasm higher than anticipated-very encouraging
- Indigenous entrepreneurs encouraged by current tariff
- Market priming encourages local business
- Vibrant ITN public-private partnership
- Vibrant and growing local manufacturing capacity
- Active participation of regulatory agencies-NAFDAC, SON
- Strong govt. commitment at federal level
- LLN will reduce re-treatment need
- Olyset net technology transfer

##### Weakness

- IMPAC nets have slowed commercial net sales in urban centres
- Consumers delay patronage of commercial ITN, awaiting government “free” nets.
- Weak distribution channel
- Low level of participation at state and local govt levels.

##### Opportunities

- Global fund will open up new areas
- Different strategies provide platform for assessment of best practices

##### Threats

- Lack of indigenous insecticide manufacturing capability
- High tariff
- Poverty
- High cost of yarn

#### b. Essential Actions

##### Identify majors gaps hindering meeting Abuja targets

- ITN supply to meet target
- Distribution network, both public and private
- State and LG participation
- Advocacy and Communication
- Health System
- RBM Management and Coordination
- Financing

##### For each gap identified, give a brief description

- ITN supply: IMPAC seeks to reward completion of immunization and ANC attendance with ITN, improving ITN coverage and creating demand. Total ITN required for the groups is 15 million. Current pledges and availability are less than 2 million.

Supply from local net manufacturers must expand rather quickly to meet anticipated increase in demand.

- **Distribution:** ITN availability in peri-urban and rural areas hampered by weak distribution channels/network. Local ITN distributors are not making enough profits to invest in sustaining and developing distribution channels. Weak distribution logistics also affect public sector ITN provision.
- **State and Local Government participation:** Commitment at state and LG levels low in spite of MOU signed. Low level of participation, with little provision of ITNs.
- **Advocacy and Communication:** Lack of a broad communication strategy has handicapped awareness /demand creation. The level of advocacy provided too low to attain desired results.
- **Health System:** IMPAC implementation is facility based. The weakness of the health system at all levels has impaired effective programme implementation.
- **RBM Management and Coordination:** Human, material, and financial resources at the RBM secretariat require strengthening. Implementation of decisions is affected by bureaucracy.
- **Financing:** ITN operations limited by low public financial budgets and lower releases, and inadequate donor support. Private sector investment low because of low demand.

For each gap what essential actions are needed to be taken to reach the coverage rates stated

- *ITN supply:*
  - Mobilise resources to provide 7 million nets
  - Local nets procurement to stimulate local production expansion
  - Local insecticide procurement
  - Treatment and re-treatment campaign
  - Coordinate operations of informal sector
- *Distribution network*
  - Support private sector distribution in rural and peri-urban areas
  - Logistics training for RBM staff
  - Distribution studies to track depth of ITN distribution
- *State and LG participation*
  - Advocacy to stimulate support from political leaders/policy makers for implementation of MOU
  - Involvement of States and LGs in review meetings
- *Advocacy and Communication*
  - Develop strategic Communication framework
  - Develop and review existing IEC materials
  - Coordinate communication campaigns by programmes
- *Health System*
  - Training of health personnel
  - Integration with other health projects and functions
- *RBM Management and Coordination*
  - Office facilities for RBM secretariat
  - Manpower development
  - Systems review to reduce bureaucratic bottle neck
- *Financing*
  - Global fund release
  - Increase commitment by donors/partners
  - Re-direct Partners activities in line with this plan
  - Increase in govt funding of RBM

## 14.2. Gap Analysis: Access to Treatment Group

### a. SWOT analysis

#### Strengths

- Malaria control is top priority in the health agenda of Nigeria
- High political commitment to RBM
- Availability of National RBM strategic plan, implementation plan with emphasis on appropriate case management
- Presumptive malaria diagnosis, treatment, health education and community mobilisation are bases for malaria control for PHC in Nigeria
- Availability of formal and informal health care providers
- Introduction of pre-packaged drugs for malaria treatment
- Capacity and potentials for local manufacturers to meet the demand for anti-malarials
- Availability of evidenced-based base-line information
- Strong partnership mechanisms to mobilise resources for malaria control (e.g. Global fund & MAC)
- Availability of human resources
- Some states have introduced free malaria treatment for vulnerable groups

#### Weaknesses

- Under-utilisation of health services & community resources
- Strong political commitment is not matched with the allocation and release of funds for malaria control
- Inequitable distribution of manpower needs between States and between urban & rural
- Stock-out/out of stock syndromes
- Preponderance of fake/adulterated drugs
- Lack of compliance to drug policy in terms of prescription & sales of anti-malaria drugs
- Lack of regular supervision
- Lack of regular quality control of drugs

#### Opportunities

- Partnership mechanisms
- Access to global funds
- Home management is widely practiced, using presumptive diagnoses and self prescription
- Patent medicine dealers are patronised by mothers are willing to be trained to improved their skills in case management
- Communities perceive malaria as a serious problem

#### Threats

- Huge disease burden
- Drug resistance
- Poverty

### b. Essential Actions

Identified major gaps hindering Abuja targets

- Non-availability of PPD in the market
- Limited awareness of PPD
- weak health system with poor health care services

For each gap identified, give a brief description

- Apparent unwillingness of Pharmaceutical companies to use their distribution channels to support PPD action
- Lack of promotion activities
- PPD stock not available in health facilities and personnel not aware that PPD exists

**For each gap what essential actions are needed to be taken to reach the coverage rates stated**

- Stimulate the private sector for production of PPDs - bulk purchase of PPD , *Incentives to private sector*)
- Mass Media Campaign, including PMV training, CBO mobilization
- Advocate for the use of PPD at the State and LGA level
- *Monitoring and evaluation*

### **14.3. Gap Analysis: IPT Group**

#### **a. SWOT analysis**

Strengths

- High ANC attendance
- Evidence of implementation by RBM partners in some parts of the country
- Evidence of PMG MAN members producing SP
- Strong political commitment
- Desire to reduce maternal mortality is a top health priority in Nigeria

Weaknesses

- No policies, guidelines and manuals on MIP/IPT
- Weak coordination of the MIP component of RBM
- Negative Health care providers attitude

Opportunities

- Experiences from other countries to learn from
- Awareness of need for ANC is high amongst men & women
- Increase regional and global attention on MIP
- GFATM for Malaria
- Collaboration with more partners e.g. MAC

Threats

- High poverty level
- Restrictive Traditional beliefs attitudes and practices during pregnancy
- Self-medication

- Fake drugs

#### b. Essential Actions

Identify majors gaps hindering meeting Abuja target

- No policies, guidelines and manuals on MIP/IPT
- Weak coordination of the MIP component of RBM
- Negative Health care providers attitude
- Political commitment
- Capacity building
- Functional ANC system
- Programme management support
- Insignificant awareness about use of IPT in the community
- Limited pharmaceutical companies producing SP (limited availability of SP at ANC level)
- Communication, IEC, Campaign
- Quality assurance of drugs
- Adequate reporting, monitoring and Evaluation
- Data collection, compilation and analysis

**For each gap what essential actions are required to reach the coverage rates stated?**

*No policies, guidelines and manuals on MIP/IPT*

- Organize a stakeholders meeting on MIP/IPT
- Desktop review of MIP/IPT in Nigeria
- Formulate a comprehensive malaria policy with an MIP/IPT component
- Develop guidelines and training manuals on MIP/IPT
- Disseminate draft policy and guideline

*Political commitment*

- Advocacy at Federal State and Local government levels

*Capacity building for Health Workers*

- Cascade training in formal sector
- Training in informal sector (TH, TBAs)

*Functional ANC System*

- Integrate RH, IMCI, PHC, HMIS
- Availability of drugs (SP) (and ITN) at ANC level (Provision and distribution of SP)
- Effective delivery of drugs (and ITN) to ANC level
- Reporting

*Communication*

- Grassroot mobilization
- Develop/modify and adopt existing IEC materials on IPT
- Awareness creation on administration and use of SP
- Orientation of policy makers and key health officials/ decision makers on IPT
- Advocacy to the top management board of Schools of Nursing and Midwifery and

- Schools of Health Technology to include IPT and other strategies e.g. ITN in their pre-service curriculum

*Monitoring and Evaluation*

- Adequate reporting, monitoring and evaluation
- Quality assurance of drugs
- Programme management support at National, State and LGA levels
- Data collection, compilation and analysis (This necessitates training, equipment and supplies)

*System support*

- Incentives for those who produce the drugs
- Distribution of drugs
- Targeted exemption

## 15. ANNEX 5. COMMUNICATION PRIORITY ACTIONS IDENTIFIED BY REAPING ASSESSMENT

**Essential Action:** Identify and build Health Communication Partners at country level (and or sub regional level) to:

- develop comprehensive communication strategy to support Essential Actions for RBM Nigeria to achieve Abuja Targets.
- identify a range of implementing partners i.e. health communication, local and national broadcasters and;
- develop local capacity to manage/oversee and coordinate implementation of Communication strategy.
- Communication Strategy to be endorsed by all partners and guide coordination of communication activities.
- Communication Strategy would need to address priority activities for ITN, IPT, Case Management/Access to Treatment using best practices , and include:
- Increasing Community Awareness using variety of approaches including social mobilisation around environmental sanitation activities, mass media (Radio +TV, Print), RBM Ambassadors/ popular figures, road shows etc.
- Essential Behaviour Change Communications activities among target groups ie. Communities, health workers
- Intensive Advocacy activities directed at all levels: policy makers; politicians; management Boards of appropriate institutions, health personnel and health trainers; community leaders, churches etc
- Targeted Information and Education materials directed at health workers, carers, and community members
- Mass media campaign packages to address behaviour change, encourage people to sleep under ITNs, buy and use correctly PPDs, and benefit from IPT