

USAID/NIGERIA'S PROPOSED MALARIA PROJECT

SECTION C – DRAFT PROGRAM DESCRIPTION FOR COMMENTS

Strengthening Malaria Prevention and Control in Nigeria

I. INTRODUCTION

Overview of Planned Activity

Through this draft PD, comments will be incorporated as necessary into the resulting Request for Applications (RFA).

USAID/Nigeria plans to implement a 5-year comprehensive malaria program to increase coverage and use of life-saving malaria interventions in support for the Nigeria National Malaria Strategic Plan and the National Malaria Control Program (NMCP). This project will complement USAID's new Target State High Impact Project (TSHIP) and work in three or more states, one of which is expected to be Cross River State and two remain to be determined. The Recipient of this RFA will implement a comprehensive malaria control activity that will use an integrated approach in program implementation, aligned with international state-of-the art malaria control and prevention technical standards appropriate to Nigeria. This project will function as the primary mechanism for malaria interventions in Nigeria, exclusive of commodity procurement, and also exclusive of the indoor residual spraying program. The program may expand to additional states based on performance and availability of funds.

The RFA will seek applications from U.S. and non-U.S. based non-governmental organizations/private voluntary organizations and any proposed partners based in Nigeria or third countries. USAID/Nigeria welcomes applications from organizations new to USAID. The Recipient will work under the overall leadership of USAID/Nigeria Health, Population and Nutrition (HPN) Team, and in direct collaboration with the State and National Malaria Control Programs (NMCP), other USAID implementing partners and other malaria control stakeholders.

USAID/Nigeria anticipates awarding a cooperative agreement for up to \$110,000,000 contingent upon the availability of funds. Funds will be incrementally dispersed unequally over the five year period with projected annual increases. Implementation is expected to start in the second quarter of Fiscal Year 2010 (FY10) and continue through September 2014. An initial allocation of \$3.4 million has been programmed in the Nigeria Malaria Operational Plan (MOP) for Fiscal Year (FY) 2009, which represents Year One of this project. The budget for subsequent years will be allocated annually as part of the Malaria Operational Plan and is subject to availability of funds.

The objective of the RFA:

To increase the quality, access and uptake of malaria control interventions.

Sub-objectives to achieve this overall objective will (but not limited to):

1. Support an integrated delivery and scale up of proven malaria interventions. This includes four components:

- a. Expand coverage and use of insecticide treated bednets (ITNs), particularly among vulnerable groups of pregnant women and children under 5 years of age
 - b. Improve access to good quality artemisinin-based combination therapies (ACTs) at community level and ensure prompt and appropriate treatment of malaria, particularly for children under 5 years of age
 - c. Expand use of rapid diagnostic tests (RDTs) in peripheral health facilities for diagnosis of malaria in all patients over 5 years of age
 - d. Provide consistent delivery of intermittent preventive treatment to pregnant women (IPTp) using sulfadoxine-pyrimethamine at ANC clinics
2. Strengthen management capacity of the State Ministry of Health and Local Government Area health personnel to provide planning and oversight of malaria interventions.
 3. Promote positive behaviors through behavior change communication (BCC) activities and interventions to facilitate community mobilization and individual acceptance of malaria control methods.
 4. Improve capacity of the focus states and the NMCP to monitor and evaluate malaria interventions and data to guide programmatic decisions.

II. BACKGROUND

A. General Health Context in Nigeria

Nigeria is the most populous country in Africa, with approximately 150 million people. It has been ranked 154 out of 179 countries in the 2006 United Nations Development Program, a combined index for overall quality of life (UNDP Human Development Index).

The health system has been neglected for the past two decades and while the 2008 Nigeria Demographic Health Survey (NDHS) shows some significant improvements, the situation is still dire. Under-five mortality has dropped significantly, from 201 in the 2003 NDHS to 157 in the 2008 NDHS, however, this is still much higher than the median for sub-Saharan Africa. The fertility rate at 5.7 remains unchanged over this period, and in line with this the use of modern contraceptive methods remains extremely low increasing slightly from 8.2% in 2003 (NDHS) to 9.7% in 2008 (NDHS). In the recent 2008 Report on the State of the World's Mothers¹, Nigeria ranked 70 out of 71 less developed countries as one of the worst places in the world to be a mother. Only 23% of children are fully vaccinated (2008 NDHS) and about one million Nigerian children die each year before their fifth birthday. Malaria remains largely unchecked and kills an estimated 300,000 children each year. These statistics suggest that the national healthcare system is largely ineffective and is struggling to meet the minimum standards.

In general, the development, health, and fertility indicators are worst in the states of the northern regions of Nigeria. For example, the 2003 NDHS found the under-five mortality rate across the North Western states to be 269/1,000 and in the North Eastern states to be 260/1,000, while the rate in next highest region ("South South," including the delta region) was 176/1,000 and in the South Eastern region was 103/1,000.

¹ 2008 State of the World's Mothers, Save the Children, 2008

B. Nigeria's health system

Nigeria operates through a three-tier health system.

The Federal Ministry of Health (FMOH) generally provides policy and technical guidance for the health sector and supports and manages tertiary level care, research, and academic “centers of excellence.” The FMOH also contributes to human resource capacity development through the training of medical doctors, nurses, midwives, and community health officers at all levels. Along with other sectors, international donor aid to the health sector is overseen by the National Planning Commission.

The Federal Ministry of Finance (FMOF) provides funds to the FMOH, the states, and the Local Government Authorities (LGAs) based on the National Revenue Allocation Formula. About half of all Federal revenues, which derive mostly from petroleum exports, are sent directly to states and local governments giving them considerable, albeit unstable, financial resources.

State Ministries of Health (SMOH) also have important policy setting and technical direction roles within their states. In addition, they fund and manage state hospitals, maternities, and teaching colleges. SMOHs also are responsible for the development of health manpower for secondary and primary health care, from midwives and nurses to Community Health Extension Workers (CHEWS). The FMOF channels funds to the LGAs through the states. State governments allocate funding to Local Government Areas (LGAs), generally in the form of non-earmarked grants that are meant to include funding for health services.

Local government is presently tasked with planning, managing, staffing, supporting, and implementing primary health care services. About 71 percent of Nigerians have access to a primary health care (PHC) facility that is within a five kilometers radius of their homes; however, many of these centers are not functional due to lack of equipment, essential supplies, and qualified staff. Up to 64 percent of the PHC facilities have not received any drugs from the government in the past two years. LGAs are made up of approximately ten wards. Each ward contains a collection of settlements or communities. Originally established for election purposes, with one councilor elected from each ward, wards do not have an official government function or offices. Wards and settlements generally have traditional leaders, sometimes on government payroll, who settle disputes, advocate for the ward and mobilize the community around issues, such as polio and other interventions.

The LGA level especially remains critical in making Nigeria's health system function. However, there is a fragmentation of responsibility (personnel managed by the Ministry of Local Government, resources by the LGA) and limited numbers of qualified personnel that make the LGA level perhaps the weakest link in health service delivery.

In actual terms, the blurring of the roles of each of the three tiers contributes to overlapping and unclear (or contested) responsibilities or fragmented support for service delivery. The picture is further complicated by the roles of other government institutions. Most important among these is the National Primary Health Care Development Agency (NPHCDA). In 1992, prior to the latest Nigerian military dictatorship, the NPHCDA was established as a strong federal institution that was directly involved in establishing primary health care services nationwide. However, the NPHCDA waned in importance under the Abacha government. The lead role of the NPHCDA in primary health care was never fully re-established despite the return of non-military government in the late 1990s. However, NPHCDA works closely with the Ministry of Health on delivery of health care at the community level through the Ward Health System.

The National Malaria Control Program (NMCP) is a division within the Department of Public Health of the Federal Ministry of Health. It has technical offices for Programme Development & Administration;

Integrated Vector Management; Case Management & Drug Policy; Procurement and Supply Management; Advocacy Communication & Social Mobilization; and Monitoring & Evaluation & Data Management. Working groups under each technical office, or for specific programs (e.g. LLIN campaigns) serve as a mechanism to coordinate government and donor input.

In terms of public sector facilities, there are 53 tertiary and specialized hospitals, 855 secondary health facilities in the 36 states and federal capital territory, and approximately 13,000 PHCs, of which a sizable proportion are not fully functional.

The GON's strategy for community level interventions is based on Village Health Workers (VHWs) and Traditional Birth Attendants (TBAs) who fall under the Village Health Committees (VHCs). The Chairman of VHCs are members of their respective Ward Health Committees (WHCs), which among other things is responsible for mobilizing local resources to meet health needs, including motivation for the VHWs². In only a relatively small proportion of wards is this system functional, however, several non-government organizations have developed highly functional community-based delivery systems. Key among these has been the WHO African Program for Onchocerciasis Control and the Carter Center Global 2000 programs which have supported a community-directed intervention (CDI) approach to deliver ivermectin annually for onchocerciasis control using community-directed distributors (CDDs). In recent years these programs expanded their scope to deliver vitamin A, albendazole for lymphatic filariasis and intestinal worms, and ITNs for malaria and lymphatic filariasis³. The WHO/TDR recently carried out operational research in three countries, including four sites in Nigeria, to assess the effectiveness of CDIs to address major health issues in Africa. In this study the CDDs were also responsible for treatment of malaria in children under five years of age. Results demonstrated significant increase in appropriate treatment of malaria in children under five with fever as compared with control areas.⁴

The private health care system consists of formal tertiary, secondary, PHC health facilities, pharmacies as well as informal patent medicine vendors (PMV) and drug sellers. The private sector comprising the not-for-profit and for-profit health facilities provides health care for a substantial proportion of the population. For example, it is estimated that 72% (n=2,147) of secondary health facilities and 35% (n=7,000) of PHC facilities are private. There are 2,751 registered pharmacies giving a ratio of 42,421 people per pharmacy and the informal private sector consists of about 36,000 PMVs (2002 estimates) and an unknown number of drug sellers. Although the PMVs are known to deliver sub-standard care, because of misdiagnosis, delivery of low quality and/or inappropriate drugs, there is evidence that PMVs will significantly improve their delivery of appropriate antimalarial with motivation and training⁵

C. Malaria situation in Nigeria

Malaria is a major cause of morbidity and mortality in Nigeria, directly contributing to poverty, low productivity, and reduced school attendance. According to the "Strategic Plan for Malaria Control in Nigeria 2009-2013" there are a total of 70-110 million clinical cases and 300,000 (285,000-331,000) deaths among children under 5 years of age, accounting for about 30% of deaths in this age group. Malaria is also responsible for an estimated 11% of maternal mortality. The disease's economic impact is

² Introduction to Ward Health System, NPHCD, April 2006

³ Blackburn BG et al. Successful integration of insecticide-treated bed net distribution with mass drug administration in central Nigeria. *Am J Trop Med Hyg* 75(4), 2006 pp 650-655

⁴ Community-directed interventions for major health problems in Africa: A multi-country study Final Report, WHO/TRD, 2008

⁵ Greer G et al. Improving management of childhood malaria in Nigeria and Uganda by improving practices of patent medicine vendors. *BASICS*. 2004 Jun. 66p. <http://www.basics.org/pdf/ImprovingMalariaMgmtPMVs.pdf>

enormous with about \$880 million lost to malaria annually in the forms of treatment costs, prevention, loss of man hours etc.

Targets laid out in the 2009 – 2013 Strategic Plan are:

- By 2010 malaria related morbidity and mortality is reduced by 50% and level of coverage is sustained to 2013
- By 2013 malaria parasite prevalence in children less than five years of age is reduced by 50% compared to baseline of 38% in 2007
- By 2010 at least 80% of households have two or more ITNs/LLINs and level of coverage is sustained until 2013
- By 2010 at least 80% of children less than five years of age and pregnant women sleep under an ITN and coverage is sustained until 2013
- By 2013 at least 80% of fever patients above five years of age attending health facilities receive a diagnostic test for malaria
- By 2011 at least 80% of fever/malaria patients receive appropriate and timely treatment according to national treatment guidelines and coverage level is sustained until 2013
- By 2011 all (100%) of pregnant women attending ANC receive at least two doses of IPTp and coverage level is sustained until 2013

The challenge in reaching these targets is illustrated in the table below that presents the results for standard malaria indicators from the 2007 MICS and the 2008 DHS. The low coverage for ITNs argues against the approach used over the past few years which focused on private sector marketing and mass distribution to areas within states rather than statewide coverage.

| Recent Estimates of Malaria Indicators: 2007 Nigeria MICS; 2008 Nigeria DHS | | |
|---|-----------------------|-----------------------|
| Indicator | MICS 2007 | DHS 2008 |
| Proportion of households with at least one insecticide-treated bed net (ITN) | 4.0 | 8.0 |
| Proportion of children under five years old who slept under an ITN the previous night | 3.5 | 5.5 |
| Proportion of pregnant women who slept under an ITN the previous night | NA | 4.8 |
| Proportion of women who received two or more doses of Intermittent Preventative Treatment (IPTp) during their last pregnancy in the last two years | 2.9 (last 2 years) | 6.5 (last 5 years) |
| Proportion of children under five years old with fever in the last two weeks who received treatment with an antimalarial according to national policy within 24 hours of onset of fever | 35.9 | 15.3 |
| Proportion of children under five years old with fever in the last two weeks who received treatment with artemisinin-based combination therapy (ACTs) | 2.4 | NA |

††ACTs were adopted as first line therapy in 2005

D. USG Response to Malaria in Nigeria

1. Overview of USAID Malaria Activities in Nigeria

In fiscal year 2008 (FY08) USAID provided approximately \$8 million for malaria activities in Nigeria. The FY09 budget doubled to \$16 million. Further increases are projected given funding decisions by the USG and USAID.

The Nigeria plan for FY2008 and FY2009 was developed with input from a broad range of multilateral, bilateral, and NGO partners. USAID in Nigeria has been fortunate to have a strong set of committed malaria control partners. The NMCP receives substantial financial and technical assistance from the Global Fund, the World Bank Booster program, DFID, UNICEF, and WHO, along with a well-established network of NGOs that is available to help reach the most remote communities.

In Nigeria the USAID HPN Team works closely with the NMCP, the State MOHs and other partners to support a comprehensive malaria control effort under the guidance of the national program. This program will help Nigeria to rapidly scale up three proven and effective malaria control methods:

- 1) Insecticide-treated mosquito nets . USAID has been a long term supporter of the Netmark program, which has worked over the past seven years to improve public knowledge of and demand for insecticide treated nets, the retailing of nets through the private market, sometimes with subsidies through voucher programs, the branding and packaging of nets, the shift from periodic to one-time treatments to LLINs, and the local import and/or manufacture of bednets. This has linked to other USAID supported programs in terms of mass distribution (e.g. under the USAID Community Participation for Action in the Social Sector (COMPASS) project) and with outside partners (Canadian Red Cross in the Cross River State Integrated Measles Campaign). USAID has joined with other partners in supporting the current two year effort (2009-2010) to distribute two LLINs to all households in Nigeria. The key focus in years following this campaign will be on how to achieve “mop-up” and “keep-up” distribution of nets along with improving actual household usage of nets.
- 2) Indoor residual spraying campaigns. Although the NMCP has identified IRS as a major component of malaria control (with an eventual target of 20% of households nationally), only pilot programs have been carried out so far and the role of IRS compared to LLINs remains to be defined. USAID has not yet supported IRS in Nigeria and support for IRS in the future would be under a separate project.
- 3) Intermittent preventive treatment for pregnant women (IPTp) has been supported by USG both as part of integrated maternal and child health/family planning (MCH/FP) services (under COMPASS and soon under TSHIP), as linked to preventing mother to child transmission (PMTCT)/HIV services (under the Global HIV/AIDS Initiative in Nigeria (GHAIN) project) and as part of behavioral change communication (BCC) efforts. IPT protects pregnant women and unborn children from serious illness episodes of malaria. Activities will help to educate mothers and communities regarding the risks of malaria during pregnancy and the importance of receiving two doses of IPTp, beginning in the fourth month of pregnancy.
- 4) Malaria Case Management. USAID has supported social marketing of improved malaria treatments in the private sector and will introduce a socially marketed child ACT in 2009. In the public sector USAID has supported the training of providers and promotion of ACT use in the general population (e.g. under COMPASS and soon under TSHIP). The USG program will continue to provide support to improve the diagnosis and treatment of malaria. In addition to encouraging the

more widespread use of ACT therapy, the program will help improve the accuracy and speed of malaria laboratory tests at different levels of the health system through provision of equipment and training of laboratory technicians.

2. Current USAID-Supported Activities for Malaria Control in Nigeria

Among the USG-funded projects conducting malaria control activities in Nigeria, several will be especially relevant to the Recipient. These include TSHIP, C-Change, IMAD, DELIVER and one or more social marketing projects. Each fills a crucial niche with respect to FY08 work and FY09 work plans. However some of these projects may end during the implementation period of the new project and the recipient may need to progressively take on more comprehensive USAID malaria programming.

Target State High Impact Project (TSHIP) (JSI Research and Training Institute, Inc.). This project will start work in Bauchi and Sokoto states by the end of 2009. It will support statewide improvement of a range of maternal/child health, reproductive health and family planning interventions in the public sector. This will include substantial support for improved malaria services. The recipient will coordinate closely with TSHIP to share approaches to malaria control and lessons learned.

C-Change Project (Academy for Educational Development). Website: <http://www.c-changeprogram.org>. This project will assist the NMCP and relevant partners in the development of the full range of appropriate BCC materials, both in terms of media and interpersonal approaches. It is expected that these materials will be used by other USAID supported malaria programs including TSHIP and the recipient.

Improved Malaria Diagnostics (IMaD) Project (Medical Care for Development International) Website: <http://www.mcdi.mcd.org/imad.htm>. This project will partner with the NMCP to review and improve malaria diagnostics. It is expected that this will include partnering with the TSHIP project and the recipient for improved malaria diagnostics in the project states.

DELIVER Project GPO-I-03-06-00007 TO3 for Malaria (John Snow International) Website: <http://deliver.jsi.com/dhome/taskorder/tomalaria>. The DELIVER project, another centrally funded mechanism, has provided support in Nigeria for the procurement of LLINs and ACTs. Its role in the coming years will expand to include technical support for the logistic aspects of both the LLIN campaigns and improved logistics for routine malaria programs. Both TSHIP and the recipient are expected to work closely with DELIVER to improve malaria logistics in the target states, whether the commodities are procured through DELIVER or other means. DELIVER also coordinates commodity procurement in other areas of USAID health programming, such as HIV/AIDS.

Prepackaged Treatment (PPT) (11/2004-11/2010) (Society for Family Health): This project has provided subsidized private sector provision of prepackaged anti-malarial treatment. In 2009 they will introduce Kid ACT, a prepackaged ACT for children which will be supplied to private sector providers in selected states (potentially including USAID malaria project states). Although this project ends in 2010, a follow-on USAID social marketing project might include ACTs.

NetMark (2004-2009): NetMark supported reduction of malaria associated morbidity and mortality by increasing the use of insecticide treated nets (ITNs), particularly by pregnant women and children under-five. Key activities included: Support to local net manufacturers to increase quality, quantity, sale, and distribution of a variety of local ITNs; and mass awareness campaigns, demand creation and adoption of long lasting insecticidal net (LLIN) technology. NetMark ended in 2009. USAID will provide limited funding to the follow-on global LLIN social marketing project (yet to be awarded). This new project may play a role in further promotion and/or distribution of LLINs to the private or public sector.

ENHANSE (ended 2009). This project focused on improving policies for health and education programs at the national level, including several key malaria policies. A follow-on project that will include a malaria component is under design.

IFRC (International Federation of the Red Cross). USAID will support the IFRC and Canadian Red Cross (CRC) in a conversion LLIN campaign in Cross River state (following the vulnerable group campaign in late 2008). The CRC will work closely with the Cross River government and communities to achieve a high rate of ownership and use of LLINs, with a round of distribution planned for early 2010. The Recipient will work with the IFRC/CRC to take over ongoing support for malaria control activities in Cross River state during 2010.

Measure Evaluation. This project will support malaria post-LLIN Campaign surveys in Kano in 2009 and possibly Cross River state in 2010.

Voice of America (VOA) Hausa Services: Radio listening is high in northern Nigeria, especially among men. VOA is contracted to reach them with key health messages.

USAID/PEPFAR programs occasionally have malaria related activities. For example, programs to support OVCs have included distribution of bednets, but this activity is small compared to the ongoing national campaign. USAID is also piloting the provision of IPTs through PMTCT services under the GHAIN project in 2009.

3. Other USAID/Nigeria assistance activities

There are other areas of USAID assistance where malaria investments may complement, and be complemented by other health and non-health investments in ways that deliver “win-win” outcomes. Most prominent among these are:

a. PEPFAR Malaria/HIV Integration:

There may be opportunities to strengthen the linkages between Malaria and HIV/PEPFAR programming within USAID and in collaboration with other donors and the Government. Key areas of potential collaboration include:

- PEPFAR support for PMTCT reaches a large number of women and may be a mechanism to improve IPTp therapy, as is already being piloted under the GHAIN project.
- HIV clinical services may be a good venue for bednet distribution and education on malaria prevention and treatment for HIV patients and their families.
- Community support programs for HIV patients and for OVCs have established links and activities both at the community level and at local health services. These might be used to help bring malaria services to the community level.

b. Governance:

Many of USAID/Nigeria’s current health activities effectively involve a governance dimension through their involvement with communities and increasing government capacity and accountability for preventive and curative health services. The program being proposed under this RFA can potentially help to create partnerships between state governments, LGAs and communities for the betterment of health systems related to malaria.

E. Key Malaria Control Partners Including Global and Bilateral Organizations

1. National Malaria Control Program

The National Malaria Control Program (NMCP) is the lead agency for malaria control in Nigeria. It sets national policy and standards for prevention and care and oversees all malaria control activities carried out with donor support. All donors are expected to be members of the Roll Back Malaria partnership and to coordinate their activities with NMCP and each other. Although NMCP has a leadership position in malaria, each state is able, to some extent, to adopt its own malaria policies and implement its malaria programs according to local preferences.

2. Other Development Partners

The following organizations or groups provide significant support for malaria control efforts in Nigeria:

Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) Nigeria has received grants for malaria from the global fund in rounds two and four and is in the process of being awarded a large round eight grant. The round four grant is still being dispersed through two principle recipients (Yakubu Gowan Center for public sector activities and Society for Family Health for private sector activities). The main remaining activity under this grant is provision of child ACTs to eighteen states (public and private sectors). This should be completed by 2010.

Nigeria has been awarded a large round eight malaria grant (approximately \$500 million). This grant covers a number of areas including provision of enough LLINs to allow for a universal coverage strategy, ACTs for all age groups covering the entire country, substantial supplies of diagnostic materials and support for implementation of improved malaria services. It is hoped that this grant will meet the bulk of needs for LLINs and ACTs for the country, but actual coverage remains to be seen. It is expected that ACT distribution to the private sector will occur through the Society for Family Health (as principle recipient) using an expansion of the system currently used for GF round four (and branding the child ACTs as “Kid ACT”, as will be done under the USAID funded PPT project).

Affordable Medicines Facility for Malaria (AMFM). Nigeria is one of the pilot countries for this facility, which is being managed through the Global Fund. An application was submitted in July 2009, and if successful, would provide another source of funds for subsidized ACTs. Total quantity of drugs that would be available through this mechanism is not currently known.

The World Bank Malaria Control Booster Project. This program provides support for the full range of malaria program activities at the national level and in seven states (Akwa Ibom, Anambra, Bauchi, Gombe, Jigawa, Kano and Rivers). The initial credit was for \$180 million equivalent with an effectiveness date of May 2007. Nigeria is in the process of obtaining additional financing of \$100 million (focused on the same states). There is a possibility of an additional \$200 million program in 2011 or 2012 which would go to additional states, but this remains uncertain. The World Bank purchases both LLINs and ACTs for its states.

UK Department for International Development (DFID) started a five year \$80 million equivalent program called Support for the National Malaria Program (SuNMaP) in 2008. SuNMaP provides support to both the national level malaria control program and to up to seven states (currently Lagos, Ogun, Anambra, Kano, Katsina, Niger) in both the public and private sectors. SuNMaP will purchase LLINs but does not expect to purchase ACTs.

UNICEF supports malaria control activities as part of Integrated Management of Childhood Illness (IMCI) training, with a special focus on selected states. UNICEF also coordinates donations of LLINs through UNITAID.

World Health Organization provides technical leadership in malaria control through the Roll Back Malaria mechanism and supports selected trainings.

NGO and private organizations. A variety of non-governmental and private organizations are active in malaria control in Nigeria. These include local partners of donor projects, which support implementation of control measures at the grass roots, national advocacy organizations, such as the newly established Nigeria Interfaith Action Association for Malaria, which works to incorporate faith based organizations in planning and support of malaria control activities, private companies who manufacture, distribute and sell malaria related products (particularly bednets and treatments) and the media, which has a keen interest in malaria control.

F. Current Status of Malaria Control Interventions in Nigeria

1. Prevention

Insecticide-treated nets (ITNs)

Nigeria hosted and was one of the original signatories to the Abuja Declaration of 2000, which aimed to reach 60% coverage of African children under five sleeping under a treated bednet by 2005. Until recently, the main approach to reach this coverage has been the promotion of treated bednets in the private sector (with a recent switch from post-treatment ITNs to LLINs). In the last few years there has also been an upsurge in mass distribution of LLINs to vulnerable groups (children under five and pregnant women), most often at the LGA level and usually in combination with immunization events. Overall, the results of such coverage at the national level have been disappointing. Although knowledge of LLINs appears to be high, market demand has been limited and mass distribution has been too sparse to make much large scale progress. The 2008 DHS, which was done in the rainy season (when nets are more likely to be used) showed only 8% of households nationally owned an ITN (17% owned any sort of net) and only 5% of children under five and pregnant women slept under a net (12% under any sort of net). While this is an improvement over levels in 2003, it is too slow a rate of progress to get effective population coverage in any reasonable length of time.

The largest scale targeted campaign took place in December 2008 in Cross River state. In 2009, with the availability of much larger supplies of LLINs through donors, the strategy has shifted to mass distribution of two LLINs to all households in the country. Kano and Anambra state have been covered in May-August 2009, with approximately ten states to be covered in waves every six months until the end of 2010 (although LLINs for the last five states are not yet available). It is hoped that these campaigns will result in high rates of LLIN ownership and use nationally, but the results will only become clear over the next few years. Even if successful, mop-up, keep-up or periodic campaign activities of some sort will be needed indefinitely to attain and maintain high rates of utilization since the lifespan of the LLINs is limited to about three to five years.

Indoor residual spraying (IRS)

Indoor residual spraying has not been a part of large scale malaria control activities in Nigeria. The NMCP is interested in the possibilities of this approach, and with assistance from WHO IRS pilot projects have been carried out in a number of sites. The NMCP would like to expand the IRS approach in Nigeria, but at this point the comparative cost-effectiveness of this versus an LLIN approach and the locations where IRS might be superior to LLINs in terms of successful coverage have not been defined. Also, with

the current campaign to cover every household in Nigeria with two LLINs, how to keep IRS from duplicating protection in the short to medium term remains unclear. In spite of these limitations continued experimentation with the IRS approach will continue and IRS may come to play a larger role in the Nigerian malaria control program in future years.

Intermittent preventive treatment of pregnant women

The NMCP has adopted IPTp using sulfadoxine-pyrimethamine (SP). A number of projects and the global fund grants have purchased SP and trained providers in IPTp in a number of states. However overall coverage appears to remain low. One problem is that in the period only 58% of pregnant Nigerian women made any ANC visits (unchanged in 2008 compared to 2003). The use of anti-malarials in pregnancy has increased, from 20% in the 2003 DHS survey to 34% in the 2008 survey. Unfortunately, women who clearly reported getting IPTp (two doses of SP on separate visits) only increased to 6% in 2008 from 1% previously. IPTp is a component of all donor funded malaria control programs that are now underway, so it is hoped that effective coverage of IPTp will increase more rapidly in coming years.

2. Case Management

Diagnosis

Although exact figures are not available, the bulk of all malaria cases are diagnosed clinically. Most peripheral facilities do not have adequate microscopy to provide a laboratory diagnosis and RDTs are not widely used. The Global Fund round eight grant includes substantial funds for improving microscopy and for purchase of RDTs. It is hoped that with this support laboratory diagnosis will become more widespread for patients age five years and older.

Treatment

Ensuring prompt, effective, and safe treatment with an artemisinin-based combination therapy (ACT) to $\geq 85\%$ of patients with confirmed or suspected cases of malaria will represent a major challenge in Nigeria. The NMCP views malaria case management as one of the major strategic areas in the improved control of malaria and adopted a new anti-malarial drug policy after studies had shown increasing treatment failure using the first-line drug, chloroquine. Artesunate-amodiaquine (AA) and Artemether-lumafantrine (AL) combination therapies were chosen as new first-line treatments of malaria in 2005.

Implementation of the new policy has faced numerous obstacles, including the high price of ACTs compared to chloroquine and SP, the availability of a number of artesunate monotherapies, which are also somewhat cheaper than ACTs, the large number and high prices of branded ACTs and the limited reach and size of programs to provide free or low cost ACTs in the public and private sectors. Although recent national figures will only be available with further analysis of the 2008 DHS survey, prior smaller scale studies in Nigeria have consistently shown that ACTs are only capturing a portion of the malaria treatment market and that chloroquine and SP are still widely used in spite of their limited efficacy. Artesunate monotherapy also remains popular. Most studies find that private sector providers, in particular PMVs are the most common source of care for children with fever. Public sector facilities are often (or even usually) out of stock of ACTs. Nigeria has also suffered from widespread counterfeit and fake drugs, which has been especially common with chloroquine and SP, but which is also a danger with ACTs.

The figures on the rate of antimalarial treatment of children under five who have a fever in 2008 is 33%, which is unchanged from 2003. The proportion who receive prompt treatment (within 24 hours) is only 15%. Figures on what proportion received ACTs and the balance between public and private sectors are

not available at this time but should be available at both the national and state level as part of the full analysis of the 2008 DHS.

Strengthening of the MOH antimalarial drug management system and promoting safe and effective use of ACTs in government health facilities through pre- and in-service training as well as supporting home based management of malaria with ACTs is a priority for the NMCP.

Since most malaria cases are managed outside of public sector facilities, engagement of private sector stakeholders is widely acknowledged to be crucial for improved case management in Nigeria. Private pharmacists, patent medicine vendors, and the more informal agents at the community level all have roles to play.

3. Monitoring and Evaluation

Monitoring and evaluation (M&E) remains weak in Nigeria, both for malaria programs and for the entire health sector. Although a national health information system and standard set of forms and reports has been developed, the adoption of this system varies by state and by facility within states, with many other systems still in place. Reporting from public sector facilities is incomplete and inconsistent, making even routine public sector statistics difficult to interpret. Most treatment occurs in the private sector which generally does not report on services. Finally, most malaria is diagnosed clinically, making accurate counts of cases all be impossible. There is no functioning logistic information system for malaria commodities, other than what is provided for various projects and donors and there is no consistent way to track stock supplies or identify stock outs.

The NMCP has established a network of fourteen teaching hospitals to carry out malaria surveillance, including routine drug efficacy monitoring. This system carried out the drugs studies in 2004 and plans a follow-up study in 2009-2010. However this is not a national system of malaria sentinel sites (other than what individual institutions or states may have arranged for themselves) and there is no tracking of national malaria trends through such sites.

The best source of data has been periodic surveys. These include the Demographic and Health Surveys (in 2003 and 2008), the Multiple Indicator Cluster Survey (in 2007) and a planned Malaria Indicator Survey (for 2010). Some of these surveys include state level data, making them more useful for program management. There have been a variety of smaller surveys and studies often as part of a particular project or campaign.

With greatly increased investments in malaria control, there is a need to strengthen and harmonize sources of information to improve the availability of programmatically useful information. NMCP's ability to conduct surveillance on malaria morbidity and mortality and to monitor the status of implementation of prevention and control activities throughout the country needs to be strengthened. USAID is hoping to support the establishment of sentinel sites within its project states to provide a consistent source of data on malaria morbidity trends.

Monitoring of results is a key element of USAID programs. USAID will seek data and information to improve performance and effectiveness, as well as to inform planning and management decisions. Accurate and timely monitoring will enable the project to adapt to changing conditions and make mid-course corrections as necessary, resulting in a fluid, dynamic project capable of adapting to 'moving targets.' Data also must be available to demonstrate program impact.

4. Building NMCP and state capacity

Given the expanding malaria program resources and activities resulting from the two GFATM malaria grants, the World Bank Booster program and other donor support, strong and effective supervision at all

levels of the program will be critical to the success of malaria control efforts in Nigeria. Substantial support to strengthen the NMCP comes from the DFID/SuNMaP program, the World Bank and USAID (in specific areas such as logistics). In the Nigerian setting, given the central role that states and LGAs have in program implementation, it is equally important to strengthen capacity at these levels. That is why a variety of donors are focusing efforts on building capacity in specific states to plan, conduct, supervise, monitor, and evaluate malaria prevention and control activities. Efforts are also being directed at strengthening coordination and communication among the NMCP and its various partners.

G. Overall USAID Assistance to the Government of Nigeria

1. Overview

The US government is one of the largest donors to Nigeria with a portfolio of over \$500 million per year. Most of this is through the PEPFAR program for HIV/AIDS, which is funded mainly through USAID and US-CDC. There are also important USAID programs in peace, democracy and governance; economic growth and trade (with a focus on agriculture); education; and health population and nutrition.

2. USAID Health, Population and Nutrition Programs in Nigeria

For FY2009 USAID will provide about \$52 million in health population and nutrition (HPN) support for Nigeria, of which \$16 million is in malaria and the remainder split almost evenly between maternal and child health and reproductive health/family planning programs. The largest HPN program in prior years was the COMPASS project, which incorporated all HPN areas (and education sector funding). The new flagship project is TSHIP, which will provide support for the full range of MCH/RH/FP activities in Bauchi and Sokoto states over the next five years and which includes malaria activities. Other important HPN projects that do not include malaria include ACCESS, which focuses on improve maternal care, in particular emergency obstetrics; ACQUIRE, which supports development of national capacity to identify, repair and rehabilitate patients with vaginal-vesical fistulas; IRHIN, which supports the social marketing of contraceptives; PSP1 which supports private sector RH/FP providers; DELIVER and CCP for support of contraceptive logistics; ENHANSE to support policy development at the national level; polio programs (partially through WHO); and a number of smaller activities.

III. PROGRAM OBJECTIVES/SPECIFIC PROGRAM ELEMENTS

A. Program Framework

This RFA is intended to support a core set of malaria control activities, initially in three states with the possibility of expanding to more states depending on availability of funds. The Recipient should take two important factors into consideration when designing approaches to achieve the project objectives.

One factor is that while efforts to improve the control of malaria in Nigeria have had relatively modest impact over the past 10 years, Nigeria has, over the past two years, been able to obtain much higher levels of donor assistance (mostly from the Global Fund, the World Bank and DFID/SuNMaP) which is allowing it to take a “Scaling Up For Impact (SUFU)” strategy. The increase in funding is not enough to pay for all high priority interventions, and additional USAID resources are both welcome and needed, however the Recipient will need plan carefully so as to complement the large amounts of assistance available from other sources.

Another important consideration is that a large proportion of Nigerians do not seek care in the public sector and achieving higher coverage with appropriate interventions must go beyond the public health

facilities. A large proportion seeks care in the informal private sector, particularly PMVs, who are probably the largest source of malaria treatment in Nigeria⁶. Working to improve the quality of drugs and service provided by community-based PMVs may be one alternative to increasing access to appropriate treatment. Another approach to expand access for treatment has been the use of community or home-based management of malaria, using community volunteers.

The project aims to achieve the following:

1. Support an integrated delivery and scale up of proven malaria interventions. This includes four components:
 - a. Expanding coverage and use of insecticide treated bednets (ITNs), particularly among vulnerable groups of pregnant women and children under 5 years of age

Currently the vast majority of Nigerians do not use ITNs. There is now a national strategy to distribute two long-lasting insecticide treated bednets (LLINs) to every household with funding in place and a schedule to complete all states by the end of 2010. Should the national LLIN campaign have not reached a project state prior to startup the Recipient will assist in its successful implementation. The LLIN campaigns will undoubtedly greatly change the coverage and hopefully the use of ITNs. However, there will still be a need to promote use, to reach those who may have been missed by the campaign, and to implement “keep up” strategies over the long term, given that LLINs need to be replaced every three to five years. There are several strategies to solve these problems which could be considered, i.e. giving free bednets during antenatal care, linking keep up to periodic immunization campaigns, using community based distribution, increasing sales of bednets in the private sector, etc. There is some limited experience with these approaches both internationally and in Nigeria, but not enough to give clear guidance as to which is the best way forward in all settings. Therefore the new program will experiment with the most promising alternative methods for maintaining prevention objectives in its states and widely adopt those that produce the best results. . . Although this project will not provide support for IRS, the presence of any IRS in the project state will also need to be taken into account in planning for ITN coverage.

- b. Improve access to good quality artemisinin-based combination therapies (ACTs) at facility and community level and ensuring prompt and appropriate treatment of malaria, particularly for children under 5 years of age

New national policies for evaluation and management of fever cases and malaria exist, including the adoption of ACTs as the first-line treatment, but so far training programs to promote these newer standards have not had the desired effect in either the public or private sector. This appears to be largely due to limited supplies and the high prices of ACTs, but is also due to inadequate follow-up and reinforcement of training, to the difficulty in changing ingrained practice habits, to poor public education and demand for correct therapy, and to the relatively small scale of these programs. The Recipient will ensure state-wide training and follow-up in the public and private sectors (including clinics, pharmacies and patent medicine vendors) coupled with assured supplies of needed commodities (from other donor projects or from other USAID projects as needed). Community-based distribution using VHWs, home based treatment, or other means should be considered as an alternative approach in states where a significant proportion of the rural population are not readily served by either public or private outlets.

⁶ (Malaria Treatment in Nigeria: The Role of Patent Medicine Vendors, Oladimeji Oladepo et al. The Communication Network, 2009; <http://www.comminit.com/en/node/288012>)

- c. Expand use of microscopy and rapid diagnostic tests (RDTs) in health facilities for diagnosis of malaria in all patients over 5 years of age

Improving the use and quality of microscopy in facilities with this capacity and establishing proficient use of RDTs in public health facilities that lack microscopes will help reduce unneeded treatment among older children and adults with relatively expensive ACTs. This should also be extended to private facilities where feasible. Children under 5 should continue to be treated presumptively in areas of high transmission, which at present is all of Nigeria. The centrally funded Improved Malaria Diagnostic (IMaD) project will work with the NMCP and partners to develop state-of-the-art materials and state-levels plans for training and supervision on the assurance of quality microscopy and use of RDTs. As an implementing partner, the Recipient will work closely with IMaD to rollout the implementation plan in the focus states.

- d. Provide consistent delivery of intermittent preventive treatment to pregnant women (IPTp) using sulfadoxine-pyrimethamine at ANC clinics

The coverage of intermittent preventive care in pregnancy is partly limited by the fact that only 58% of pregnant women receive any antenatal care (ANC)(NDHS 2008) and only a small fraction of those who attend antenatal care appear to receive appropriate therapy. The problem appears to be a combination of inadequate coverage and follow-up of training, of the failure to link training to supplies, and of inadequate public education regarding the need for this therapy. The project will attempt to solve these problems among women who attend ANC (in either the public or private sector). Heavy investments to improve overall attendance at ANC are beyond the scope of this project but general promotion of ANC can be supported as part of malaria focused behavior change and communications.

2. Strengthen management capacity of the State Ministry of Health and Local Government Area health personnel to provide oversight of malaria interventions.

Working with the NMCP and partners, the Recipient will identify major system deficiencies, policy, resource and program constraints, and opportunities for improved delivery of high impact malaria interventions and develop and implement a plan to strengthen the policy environment and management capacity within each focus state at each level. This includes the ability to plan, budget and implement all areas of the malaria program, including resource allocation, financial management, service organization, personnel management, training, supervision, commodities, logistics, communications and monitoring/evaluation. This should extend, where needed and depending on the willingness of the state, to oversight of private providers, as well as public and community levels. Supportive supervision, including post training follow-up and other quality assurance interventions are essential to achieve and maintain high quality for the delivery of services. Linkages between health facilities and communities need to be strengthened with improved communication, community advocacy and oversight, support of community activities and referrals. The combined resource inputs of states, localities and donor projects for malaria control should be tracked, analyzed and reported, and states should be encouraged to take over more of the routine support needed for malaria control as the project progresses. Support for state capacity building needs to take into account the integrated nature of services. Coordination with complementary programs (e.g. IMCI, CDI) is encouraged and the project should avoid setting up separate systems if at all possible.

3. Promote positive behaviors through information, education and communication (IEC) and behavior change communication (BCC) activities and interventions to facilitate community mobilization and individual acceptance of malaria control methods.

The NMCP has developed a national strategy for IEC/BCC and significant investments are part of the Global Fund Round 8 proposal. Other partners are also aware of the need for culturally appropriate, integrated IEC/BCC to increase positive health behaviors and create knowledge about and demand for malaria prevention and treatment products. The centrally funded C-Change project will provide technical input to the NMCP and partners to develop state of the art communication approaches and materials. As the implementing partner, the Recipient will roll out the communication strategy in the focus states. BCC activities are expected to result in establishing use of ITNs as a cultural and community norm; in increased awareness of the benefits of appropriate health practices related to malaria; and in early recognition and health care seeking behaviors for illnesses compatible with malaria in children.

4. Improve capacity of the focus states and the NMCP to monitor and evaluate malaria interventions and data to guide programmatic decisions, this should include but not be limited to rigorously managed sentinel sites.

The Recipient will work with the NMCP and partners to develop appropriate monitoring and evaluation strategies to provide timely output and outcome data from malaria interventions and implement these in the focus states. This will increase the quality and use of information for decision-making at all levels. The strategy should provide a clear vision on how data will be used to motivate and guide health care workers and the malaria interventions. Sentinel sites, where cases can be diagnosed by microscopy and/or RDTs, will be established in each of the focus states to monitor trends in malaria cases. In addition the state routine information system, for clinical services, for logistics and for resource planning, will be strengthened. The project will need periodic household surveys for programmatic decision-making and to track key outcomes, but these need to be coordinated with national surveys that collect state specific information and which may take place during the project period (e.g. DHS, MIS, MICS).

B. Funding

Year One (estimated funding: \$3.4 million)

Funding Breakdown for the Recipient and other Partners in Year One (from FY2009 MOP)

Nigeria FY09 Malaria Operational Plan: RFA Recipient

| Activity | Mechanism | Year 1 Budget |
|--|-----------------------|---------------|
| IEC/BCC to promote IPTp at ANC visits, LLIN use among pregnant women and children under 5 and rapid treatment of malaria with ACTs. | New malaria bilateral | 250,000 |
| Train laboratory technicians in malaria microscopy and RDTs using local university or technical school staff. | New malaria bilateral | 150,000 |
| Strengthen malaria case management in facilities and at community level as part of a malaria package that also strengthens IPTp in facilities and encourages LLIN use in three states. | New malaria bilateral | 3,000,000 |

Nigeria FY09 Malaria Operational Plan: Other Partners Implementing Activities that Support RFA Recipient

| Activity | Mechanism | Year 1 Budget |
|---|------------------|----------------------|
| Conduct a needs assessment of lab and diagnostic capacity, and develop a plan to train workers on use of RDTs and strengthen reference and facility-level labs and quality assurance for microscopy and RDTs. | IMaD | 100,000 |
| IEC/BCC targeting caregivers to promote rapid treatment of malaria infected children with ACTs, increase the use of LLINs by pregnant women and children under 5 and promote use IPTp. | C-Change | 350,000 |
| Strengthen supply chain management of antimalarials | DELIVER | 1,000,000 |

Year Two

If large increases in funding take place in Year 2, this should make it possible to ramp-up all activities in the three states to reach all LGAs in each state, and to consider adding new states to the project.

C. Relationship of this Award to Other USAID-funded Malaria Control Partners

Three centrally funded projects will be funded by USAID/Nigeria to provide technical leadership and input at the national and state levels. C-Change is the USAID flagship project for IEC/BCC and is expected to work with the NMCP and partners to refine and adapt as needed the national malaria communication strategy and materials. IMaD is the USAID flagship project for malaria diagnosis and will assess the diagnostics in each focus state and work with the NMCP and partners to refine and adapt standardized training materials and develop a training and supervision/quality assurance plan for each focus state. DELIVER will be working with NMCP to track national malaria logistics and will help design state level systems for logistics for both private and public sectors. The Recipient is expected to work closely with these three partners in order to implement the strategies for IEC/BCC, improved diagnostics and logistics.

IV. STRATEGIC PROGRAM PRINCIPLES

The Recipient must act in accordance with the following principles:

Involve the FMOH and NMCP

- Adapt and apply relevant policy and strategy decisions for malaria made at the national level in the project states.
- Keep the national level informed of the project activities and participate in strategy and policy dialogue with federal and state decision makers.
- Contribute to national level learning about effective approaches and take learning from other states into account in planning project activities. This includes providing credible evidence through program experience, operations and evaluation research.
- Share findings and data from the project widely

Linkages with other implementing partners and donors

The Recipient must know about and coordinate with other projects and donors active in the same states that have complementary activities (e.g. IMCI).

The recipient is dependent on outside sources for all commodities and must provide adequate information on commodity receipt, distribution and use to allow these sources to plan for subsequent supplies.

As with the FMOH/NMCP other implementing partners and donors need to be kept informed of project activities and findings, and the project is to take part in national level discussions which allow consensus building among all actors.

Contribute to scale-up

The project is expected to cover the entire state and maintain statewide coverage until the end. However, expenditures in a state should be only enough to achieve and maintain high coverage of the key interventions, with the state or other projects taking on as much of ongoing expenses as possible. This will allow additional of more states as the project proceeds.

Build capacity

To the extent possible project functions should be taken over by state and local authorities as quickly as they develop the capacity to carry them out. Project staff should take as much a background role as is compatible with maintaining high rates of coverage of key interventions.

Gender Considerations

This award is expected to result in positive health benefits for both male and female children under five. The activity will have an additional focus on improved malaria interventions for pregnant women. A majority of health workers to be trained by the recipient are expected to be female. The disaggregation of training and other specific results by gender will be necessary to enable the design and targeting of appropriate interventions to improve the health of both genders.

V. MANAGEMENT PLAN

1. Management Structure

The management and office structure are expected to be cost effective and rely on local professional as well as support staff to the maximum extent possible.

The Applicant shall propose a configuration of local and international, long-term, short term and home office technical, administrative, and logistical staff required for the effective implementation of this program. The application should describe technical qualifications and experience and position descriptions for key personnel and other staff proposed.

2. Key Personnel

The applicant shall propose a maximum of five (5) key personnel who will be identified by name and position. Each key personnel position requires USAID approval, as noted in substantial involvement provisions in ADS 303.3.11 (b).

The Chief of Party (COP) is deemed a Key Personnel and is a mandatory position. The COP will be authorized to represent the Recipient in all matters pertaining to the execution of all cooperative agreement activities, with the possible exception of agreement issues and amendments, for which authority shall be delegated according to the discretion of the Recipient. The COP shall serve as the Recipient's representative in Nigeria for all purposes of the agreement, and shall be responsible for the activities of all long- and short-term personnel under the agreement. The COP shall work with the USAID Mission to respond to any questions and formal obligations relating to the agreement. The COP shall be responsible for the overall planning, implementation and management of the project and to establish the administrative framework to monitor and assure progress toward the achievement of the goals and objectives of the project.

Other Key Personnel include a Malaria Technical Advisor and a Financial/Grants Manager with 100% of their time allocated to the project. The Malaria Technical Advisor will provide the key technical inputs to guide implementation of the project. In addition to overall financial management and control, the Financial/Grants Manager will be responsible for designing, awarding and overseeing any sub-grants to local NGOs.

Applicants are invited to propose and justify any alternative staffing structure, including a different configuration of key staff positions, if they feel that a different structure is more conducive to achieving the desired project results.

VI. PERFORMANCE MONITORING

1. Annual Work plan

The Recipient is required to prepare and submit an annual implementation plan on a schedule established by the USAID Agreement Officer Technical Representative (AOTR) following the award. A first draft of the Year One work plan will be due within 60 days of the award of the Cooperative Agreement. This work plan shall be reviewed and USAID written comments forwarded to the Recipient within one month of submission, and then finalized by the Recipient no later than two (2) weeks after Recipient's receipt of USAID's written comments.

2. Monitoring and Evaluation Plan

Within 90 days of the award of the Cooperative Agreement, the Recipient shall submit a Performance Monitoring Plan for the timeframe of the project to USAID/ Nigeria. USAID expects that all performance measures will be part of a coherent system that will objectively assess the overall project progress and, to the extent possible, impacts of project activities with the ultimate goal of achieving the expected objective outlined in the program description. This performance monitoring plan must include indicators pertinent to activity-level management and monitoring; baselines and/or a plan to establish any missing baselines within a three month period), and annual targets. The set of indicators should include the core PMI indicators provided above.

The Recipient must use effective and efficient mechanisms to monitor progress, impacts, and successes of their activities and performances at all levels. USAID expects that the Recipient will be innovative and creative in their efforts to capture, document, and report all the outcomes of USAID assistance and comply with the reporting requirements under the PMI, while strengthening and using relevant national, regional and district level reporting systems.

At any time during program implementation, USAID may conduct one or more evaluations to review overall progress, assess the continuing appropriateness of the project design, and identify any factors impeding effective implementation. USAID will utilize the results of the valuations to recommend any

mid-course changes in strategy if needed and to help determine appropriate future directions. Site visits may be scheduled at a time convenient to both the Recipient and USAID

VII. REPORTING REQUIREMENTS

Quarterly and Annual Status Reports

On a quarterly basis following submission of the first work plan, and within thirty days following the close of each three month period (based on the USG fiscal year), the Recipient shall prepare and submit to USAID/ Nigeria written status reports (Quarterly Reports) that:

- Identify and relate the benchmarks and achievements , as identified in the applicant’s annual monitoring and evaluation workplan, of the three month period of the approved work plan;
- Provide status on relevant indicators identified in the performance monitoring plan;
- Identify key problems or issues encountered, how they were or will be resolved, and, if/as required, recommended Mission-level intervention to facilitate their timely resolution;
- Include a brief summary of achievements during the concluding quarter towards planned targets; and
- Present success stories that the Mission might use in reports to either the GON or USAID/Washington.

The final quarterly status report of the fiscal year will serve as the annual status report for the concluding year, and shall be submitted within thirty days following the close of the fourth quarter (July-September). In addition to meeting the above requirements, the annual report shall include a discussion, supported with quantitative and qualitative evidence, (which evidence shall remain auditable under the terms of the agreement and USAID program implementation procedures), of impacts achieved to-date. This shall include clear identification of which impacts achieved were within the manageable interests of the Recipient and which were likely catalyzed by Recipient-supported initiatives, leading to substantial, sustained achievement of results. This discussion will be instrumental in helping the Mission to complete Annual Reports to USAID/Washington.

Quarterly Financial Reports

The Recipient must present a quarterly financial status report to USAID/Nigeria on activity implementation, including actual and accrued expenditures for the concluding period and planned expenditures for the subsequent quarter.

ANNEX 1: LIST OF ACRONYMS

| | |
|---------|---|
| AA | Artesunate-Amodiaquine |
| ACCESS | Access to Clinical and Community Health Services |
| ACT | Artemisinin Combination Therapy |
| ACQUIRE | Access, Quality and Use in Reproductive Health |
| ANC | Antenatal Care |
| AL | Artemether-Lumafantrine |
| AMFM | Affordable Medicines Facility for Malaria |
| AOTR | Agreement Officer Technical Representative |
| BCC | Behavior Change And Communication |
| CCP | Central Contraceptive Procurement |
| CDD | Community Directed Distributors |
| CDI | Community Directed Intervention |
| CRC | Canadian Red Cross |
| CRF | Code of Federal Regulations |
| CHEW | Community Health Extension Worker |
| COMPASS | Community Participation for Action in the Social Sector |
| COP | Chief of Party |
| DFID | Department for International Development |
| DHS | Demographic and Health Survey |
| ENHANSE | Enabling Environment, HIV/AIDS and Social Sector Services |
| FMOF | Federal Ministry of Finance |
| FMOH | Federal Ministry of Health |
| FP | Family Planning |
| FY | Fiscal Year |
| GFATM | Global Fund for AIDS, Tuberculosis and Malaria |
| GHAIN | Global HIV/AIDS Initiative in Nigeria |
| GON | Government of Nigeria |
| HIV | Human Immunodeficiency Virus |
| HPN | Health, Population and Nutrition |
| IEC | Information, Education and Communication |
| IEE | Initial Environmental Examination |
| IFRC | International Federation of the Red Cross |
| IMaD | Improved Malaria Diagnostics |
| IMCI | Integrated Management of Childhood Illness |
| IPTp | Intermittent Preventive Therapy in Pregnancy |
| IRHIN | Integrated Reproductive Health in Nigeria |
| ITN | Insecticide Treated Bednet |
| IRS | Indoor Residual Spraying |
| LGA | Local Government Authority |
| LLIN | Long Lasting Insecticidal Net |
| MCH | Maternal and Child Health |
| M&E | Monitoring and Evaluation |
| MICS | Multiple Indicator Cluster Survey |
| MIS | Malaria Indicator Survey |
| MOH | Ministry of Health |
| MOP | Malaria Operational Plan |
| NDHS | Nigeria Demographic and Health Survey |
| NGO | Non Governmental Organization |
| NMCP | National Malaria Control Program |

| | |
|--------|--|
| NPHCDA | National Primary Health Care Development Agency |
| OVCs | Orphans and Vulnerable Children |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PHC | Primary Health Care Center |
| PMI | President's Malaria Initiative |
| PMTCT | Prevention of Mother to Child Transmission |
| PMV | Patent Medicine Vendor |
| PPT | Prepackaged Treatment |
| PSP | Private Sector Project |
| RDT | Rapid Diagnostic Test |
| RH | Reproductive Health |
| RFA | Request for Application |
| SMOH | State Ministry of Health |
| SP | Sulfadoxine-Pyrimethamine |
| SUFI | Scaling Up For Impact |
| SuNMAP | Support for the National Malaria Program |
| TBA | Traditional Birth Attendant |
| TDR | Tropical Disease Research |
| TSHIP | Targeted States High Impact Project |
| UNDP | United Nations Development Fund |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| US-CDC | United States Center for Disease Control |
| USG | United States Government |
| VHC | Village Health Committee |
| VHW | Village Health Worker |
| VOA | Voice of America |
| WHC | Ward Health Committee |
| WHO | World Health Organization |

[END OF PROGRAM DESCRIPTION]