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ANNUAL REVIEW OF THE DFID SUPPORT TO THE NATIONAL MALARIA PROGRAMME (SuNMaP) NIGERIA

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ACRONYMS

ACTs	Artemisinin Combination Therapy
AMFm	Affordable Medicines Facility – Malaria
ANC	Antenatal care
BCC	Behaviour change communication
CHAN	Christian Health Association of Nigeria
CMT	Cut, make and trim
CSP	Commercial sector partners
DFID	Department for International Development
EU	European Union
FMCG	Fast-moving consumer goods
FOMWAN	Federation of Muslim Women Associations of Nigeria
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HERFON	Health Reform Foundation of Nigeria
HMIS	Health management information system
HPI	Health Partners International
IEC	Information, education and communication
IPT	Intermittent preventive treatment
IRS	Indoor residual spraying
ITNs	Insecticide treated nets
LGA	Local government area
LLIN	Long lasting insecticidal net
M&E	Monitoring and evaluation
MDG	Millennium Development Goals
MEDA	Mennonite Economic Development Association
MIS	Malaria indicator survey
NMCP	National Malaria Control Programme
OVGs	Other vulnerable groups
OVI	Objectively verifiable indicator
PATHS	Partnership for Transforming Health Systems
PATHS2	Partnership for Transforming Health Systems - Phase 2
PIPs	Project Implementing partners
PMG-MAN	Pharmaceutical Manufacturers Group of the Manufacturers

	Association of Nigeria
PMV	Patent medicine vendor
PRRINN	Partnership for Reviving Routine Immunisation in Northern Nigeria
PSM	Procurement and supplies management
RBM	Roll Back Malaria
RDT	Rapid diagnostic test
SFH	Society for Family Health
SMoH	State Ministry of Health
SMCP	State Malaria Control Programme
SMO	Social marketing organisation
SP	Sulphadoxine pyrimethamine
SuNMaP	Support to National Malaria Programme
TA	Technical assistance
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
US$	United States Dollar
WHO	World Health Organization
WHOPES	WHO Pesticide Evaluation Scheme

1. EXECUTIVE SUMMARY AND PRIORITY RECOMMENDATIONS

This review is of the 2nd year of work of the UK's Department for International Development (DFID) support to the national malaria programme (SuNMaP). The goal of the support is 'to achieve progress towards the health Millennium Development Goals (MDGs) in Nigeria'. Its purpose is 'to strengthen delivery of Nigeria's national malaria control effort'. This is planned to be achieved by the completion of six outputs, one each on: capacity building, harmonisation, prevention, treatment, demand creation and operational research.

The review team found that SuNMaP, with its 11 programme implementing partners (PIPs), is making good progress towards achieving the purpose and outputs of the support. Indeed, some areas of its work are highly impressive. Almost everyone we talked to was very positive about SuNMaP. Some quotes from discussion with various stakeholders during this review include:

- "Ability to think and work strategically"
- "Rewarding relationship and understanding team"
- "Have technical capacity"
- "Work is impressive, is having an impact"
- "Really good planning for the net campaigns"

SuNMaP's greatest, highly relevant achievements to date are:

- The bringing of institutions/organisations and people together to secure a common approach to e.g. operational plans, behaviour change strategy and net campaigns
- A functioning, effective partnership between government, DFID and SuNMaP in terms of collaboration, harmonisation and alignment. A true partnership between the 3 stakeholders is just emerging as the Federal Government appears to be committing more resources to malaria control commodities, though there are very few government resources currently available for operational costs.
- That while working well towards the Paris commitment of harmonization (Output 2), an unplanned consequence of SuNMaP's approach is that it is also addressing the commitments of ownership and alignment and to a certain extent that of managing for results. So SuNMaP is addressing 4 of the 5 Paris commitments/principles, and in doing so is bringing added value to the programme of support

SuNMaP's work is en route to being an exemplary model of support to a national malaria programme. What is making the difference compared with many other international programmes is the sound management being

exercised by SuNMaP. There is a good balance of strategic and day-to-day work, impressive leadership, attention to quality, evidence based work, effectiveness and efficiency and in the Abuja office, good team work.

The key findings and the aspects of SuNMaP's work that require attention can be summarised around the following issues:

The logframe and risks

When the design of the DFID support for the malaria including the logframe was finalised sometime in either late 2006 or early 2007, the indicators and milestones were probably right. However, the inception review report of June 2009 stated that some indicators in the logframe needed changing as they were either too easily achievable or because a review would find it difficult to distinguish between SuNMaP's contribution and that of the national malaria programme. This review has concluded that some more changes to the indicators are required. This is because of a mix of: (i) changes in the wider context; (ii) overlap of some indicators and some are missing given the wording of the outputs; (iii) some outputs do not have an appropriate set of indicators; and (iv) thinking on what is, and is not, useful to measure (see sections 4.1 and 4.2.2). All the assumptions in the logframe remain appropriate, but an additional one should be considered at the purpose level in relation to the forthcoming elections. There are 3 new risks that have been identified that could affect the achievement of the logframe outputs and milestones (see section 2.2.3).

In SuNMaP's year 2 work plan and it's reporting on performance for year 2, undertaken by the Abuja office for work at both Federal and State level, planning and progress is only reported against activities. There is no reference to the logframe outputs, indicators or expected results for 2010. So during the briefing sessions both at Federal and State level there was no indication of success or otherwise against planned results, only of progess in implementing activities. At State level the SuNMaP PIPs are, for the most part, not aware of the programme outputs or indicators. They are therefore working in something of a vacuum, not aware of what their work is intended to achieve.

Appropriateness of capacity building, strategic direction, coordination

SuNMaP has produced an impressive programme capacity building strategy that contains all the right terminology. However, during review discussions and on reading documents, a focus on training dominated e.g. 'state training plans' and the development of training modules. This is to the relative neglect of other aspects of capacity building crucially: mentoring, coaching, enhancing institutional capacity and strengthening the systems necessary to enable personnel to use their new skills and knowledge. Such approaches may be happening but their lack of 'visibility' raises questions about the level of ownership and commitment to working on/talking about more than training.

The strategic direction of the programme is sound, with the proviso that a significantly better understanding of the market and supply chain for nets needs to be developed as a basis for refining the incentives required to encourage greater commercial engagement. Potential was identified during the review to further enhance SuNMaP's strategic direction. This is by building upon the comparative advantage of those PIPs with expertise at the community level to enhance community engagement and ownership.

While SuNMaP has done important, useful work over the past year in bringing people together, it is doing so without stating what, in the context of the malaria programme, coordination is all about. It is unclear about what it is trying to achieve in relation to coordination. To date, coordination has focused on government stakeholders with an interest in malaria control and development partners including non-governmental not-for-profit organisations. At the Federal level and particularly at State level, there was little evidence during the review, of SuNMaP working on coordination with private providers of health care, nor any mention of inter-sectoral coordination.

Approach to, and management of, the commercial sector work

The radical change that occurred in the early stages of the project, that of the Federal Government of Nigeria deciding to achieve national coverage with LLINs with an initial free distribution of nets, has made engagement with the commercial sector more difficult – due to increased uncertainties in the market. Concerns raised about commercial sector activities in earlier reviews/reports have been partially addressed but significant concerns remain. Whilst two of the commercial sector partners (CSPs) are now performing reasonably well against modest targets, the third has serious weaknesses and retains around US$650,000 of funding advances for targets not yet met.

A new engagement strategy has been drafted but is not yet sufficiently advanced to provide the basis for investing the balance of £9 million in supporting the development of the retail net market. It needs to be costed and based more soundly on the key lessons learned during the first year of operation. These include:

- An assessment of the benefits of subsidies provided in terms of their appropriateness and effectiveness,
- The efficacy of the media interventions supported
- A more detailed assessment of the potential size of the (un-subsidised) retail market that reflects capacity and willingness to pay

The document should contain both options and recommendations for project intervention and should re-position the revised strategy within the context of the NMCP's strategic plan.

Whilst not a formal part of the terms of reference for this review, a separate paper has been drafted and made available to SuNMaP suggesting how this might look in practice. A number of other recommendations are made that reflect the need for: simplicity in approach and contractual relationships; working more closely with the Society for Family Health (SFH); ensuring that a senior member of the management team is given more time to oversee this critical phase of developing and implementing a new engagement strategy; and taking time to understand and engage with the private providers of health care.

SuNMaP's positive response to the introduction of the Facility for Affordable Medicines for Malaria (AMFm) in relation to ACTs, through assessing options to support this initiative or by utilising the available funds for promoting rapid diagnostic tests, is commended.

Management arrangements and internal coordination

With the exception of the commercial sector component, there are no major concerns with the management of the project. Such concerns as are raised relate mainly to the relationships with the state offices. They are the vital link between the head office and the people that the support for malaria control is seeking to help. At state level, it is not always clear what role the PIPs are playing nor that they understand the bigger picture of which they are a part. And in Ogun and Katsina there is work to be done to strengthen the relationship with the state authorities. Now would be a good time to review the provision of long term technical assistance (TA) to the National Malaria Control Programme (NMCP), to reassess what is required, and to take the opportunity to offer some capacity development in management to senior technical staff.

Approach to value for money

In general the programme has used the available resources sensibly. Additionally, both SuNMaP and DFID have shown considerable flexibility in responding to the changing circumstances on the ground.

As far as can be seen, the Crown Agent's procurement process for commodities has been fair and cost-effective. The Crown Agents have not been able to purchase LLINs locally, due to local suppliers not being competitive at international tender and unable to supply the specification required. Some concerns have been raised about the quality and timeliness of the Crown Agent's service in relation to the procurement of smaller items and about its ability to reconcile its financial information with that of DFID. DFID has addressed these concerns through a one-year extension of the Crown Agents contract, to which specific conditions are attached, and through the calling of regular meetings between the Crown Agents and DFID's project partners.

In terms of cost-effectiveness, a number of concerns are raised – relating to the engagement with the commercial sector (addressed above), whether in some cases state net campaigns could be delayed in order to improve delivery (even if the MDG targets set by the UN in New York are missed) and the opportunity to link SuNMaP's routine distribution of commodities to undertakings by the benefiting states to fund future requirements.

Options for possible future scale up

Finally, the review team was asked to look at options for a possible future scale up of project activities. After the field visits in particular, the key criteria used by the consultants was 'bringing benefits to the poor'. Following extensive discussions and a number of different ideas generated through group brainstorming sessions (see section 5 of this report) the consultants responsible for this report decided on 3 possible options. There was insufficient time to rigorously determine the value for money of any one of the options. The options, not listed in any order of priority are:

Option 1. Provide more commodities with the poor as the target - to be available at no cost by right

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Option 2. A geographical extension of agreed national BCC.

Option 3. Roll-out malaria diagnostic improvement at scale in the private health care provider sector in line with WHO guidelines on malaria case management including RDT/ACT combination.

PRIORITY RECOMMENDATIONS

The following priority recommendations can also be found in section 4 for each sub-section along with other recommendations.

No.	Subject	Time frame and by whom
On the logframe outputs and work plan		
1.	Revise logframe indicators and milestones for some outputs (see detail in section 4.1)	By end September, DFID and SuNMaP
2.	The year 3 output 1 workplan should include support to help the NMCP/FMoH develop a capacity building statement; (i) a system to evaluate performance of each TA person; and (ii) refers to BCC and capacity development personnel to work together on changing attitudes of health workers	By end August by SuNMaP with NMCP
On the appropriateness of SuNMaP's M&E and programme assumptions and risks		
3.	Secure final agreement including detail, with partners on how the incidence of malaria will be measured by end 2010	By end October, by SuNMaP with NMCP
4.	Help States develop an accurate, more evidence based picture of the pattern of malaria in their area	Ongoing with NMCP
On SuNMaP's approach, strategic direction and risk mitigation		
5.	Start planning the development of the 2011 state operational plans	By end August SuNMaP with SMCP
6.	Investigate in more detail how the estimated 70% of population living on less than $1 a day can own, use and replace nets and any implications for the strategic direction of SuNMaP.	By end December SuNMaP with NMCP and SMCP's
SuNMaP's approach and management of its commercial sector work		
7.	Record and analyse in more detail the lessons learned from the first year's experience of working with the commercial sector	By end August, by SuNMaP
8.	Develop a deeper understanding of the market for nets (both nationally and in the supported states), of capacity to pay and of the supply chain	By end October, SuNMaP
9.	In the light of 7) and 8) above, rework and cost the new engagement strategy	By October 2010, SuNMaP
10.	Ensure that a senior member of the management team is able to dedicate adequate time to supporting and monitoring the commercial team and where necessary bring in additional experience and expertise	Ongoing, SuNMaP

Effectiveness of coordination between SuNMaP and others		
11.	Active lobbying needed to ensure government operational costs are included in budgets and disbursed; and raise profile of sustainability issues within each of 6 SuNMaP supported states including determining the cost of a sustainable malaria control programme	Ongoing but to start immediately NMCP and SMCPs with SuNMaP
Effectiveness of management arrangements and internal coordination		
12.	Develop within the management team a formal process of recording, reviewing and applying the lessons learned	Ongoing, SuNMaP and NMCP
13.	Review and learn the lessons of the long term TA located in the NMCP	Ongoing, SuNMaP
Efficiency of approach to value for money		
14.	Consider delaying campaigns where the operational costs are not adequate to secure the required level of coverage	Ongoing
15.	Seek to link the routine distribution of commodities to undertakings by the benefitting states to fund future requirements.	Ongoing, SuNMaP and NMCP
16.	Engage more deeply in understanding how net coverage will be maintained, without which the current investment in achieving coverage up may not be sustained	Ongoing, SuNMaP and NMCP
Options for possible future scale up		
17.	Further explore the desirability, feasibility and mechanism(s) of the options	DFID

2. BACKGROUND

2.1 Human and economic costs of malaria

The human cost of malaria in Nigeria is staggering. In a country with the largest population in Africa, an estimated 160 million:

- Nigeria accounts for over 25% of all cases of malaria in Africa
- Over 300,000 Nigerians die each year of the disease
- The disease causes about 30% of childhood deaths
- 11% of maternal deaths are related to malaria
- This single disease accounts for about 60% of outpatient visits and 30% of hospitalisations

The economic cost is also enormous. It has been estimated that Nigeria loses at least US$ one billion each year as a direct result of malaria due to lost economic productivity and the costs of treating infections.

2.2 Partnerships against malaria in Nigeria

The NMCP of the Federal and State Ministry of Health is actively leading the fight against malaria and working towards its elimination and eradication, a malaria free Nigeria. It works closely with partners such as Roll Back Malaria (RBM), the Global Fund To Fight AIDS, Tuberculosis and Malaria (GFATM), The President's Initiative against Malaria, World Bank, DFID and a number of for profit and not for profit organisations.

At a global level DFID provides support for RBM and the GFATM. In Nigeria in recognition of the magnitude of the malaria problem and to help Africa and Nigeria achieve the Millennium Development Goals, DFID is a contributor to the NMCP through SuNMaP.

2.3 SuNMaP in brief

- £50 million programme (2008 – 2013)
- Supporting national malaria control efforts through 6 outputs:

Output 1: Capacity development
Output 2: Harmonization
Output 3: Prevention
Output 4: Treatment
Output 5: Demand creation
Output 6: Operational research

- SuNMaP is working at federal level and in 6 states (Anambra, Kano, Katsina, Lagos, Ogun & Niger) representing a potential coverage of a third of Nigeria's population.
- It offers both long and short term TA, operational and financial support for key interventions scale-up, selected commodities and support to the commercial sector.

3. REVIEW PROCESS

3.1 Objective of review

The objective of this review (in-country 2 – 16 June 2010) was to assess progress with project implementation and against the 2009 inception review recommendations and to propose recommendations for future action (see terms of reference at annex A).

3.2 Scope of work

The review team was tasked with reviewing progress made so far and to make recommendations to enhance programme effectiveness (also see annex A). The review was requested to focus in particular on the following:

- Progress against the logical framework (logframe)
- Appropriateness of SuNMaP's monitoring and evaluation (M&E) framework and logframe
- Progress on strategic and other issues
- Progress in the commercial sector
- Effectiveness of coordination and management and efficiency of approach to value for money
- Exploring options for possible future scale up

3.3 Approach to the annual review

The SuNMaP review team comprised two independent consultants, one with public health management expertise who was the team leader for the review and the second with expertise in the commercial sector and on social marketing (both are the authors of this report), a representative from the Federal Ministry of Health (FMoH), a representative each from the World Bank and USAID and various DFID staff. The team visited the 6 states covered by the SuNMaP programme as well as working in Abuja (see annexes B and C). A wide variety of people were met during meetings and interviews (see annex D).

Prior to arrival and during the review, a number of relevant documents were read (see annex E). As part of preparation for the 2 weeks in-country, the two independent consultants collated or summarised different aspects of the large amount of information that was made available prior to arrival[1]. This was with the intention of either being an aid during discussions or for follow-up comment. For example, a document was produced on each of the following:

[1] The same rigour could not be applied to the many documents received during the field work

1. Logframe indicators and scope of, and approach to, work
2. SuNMaP achievements and current and planned activities against each output in each State
3. SuNMaP progress against outputs - quarter by quarter
4. SuNMaP progress reports-conclusions & challenges
5. SuNMaP progress reports-M&E
6. SuNMaP progress reports-commercial sector
7. Progress in responding to the recommendations of the MEDA report on support to commercial interventions
8. Comparison of the use of national level, NMCP & SuNMaP malaria indicators
9. DAC evaluation criteria and Paris Commitments against the SuNMaP purpose and outputs

Additionally, soon after arrival in country, the consultants produced a list of core questions against the purpose and outputs for all team members. This was primarily because the review team was splitting up for the field visits; two teams each covering 3 states (see annex C). Also, while in country, all team members were given a document asking for their feedback on progress since the 2009 inception review. Two exercises were held jointly with NMCP and SuNMaP staff, one involved the development of a SWOT analysis of the national malaria programme (see section 4.3 and annex G) and the second was a brainstorming exercise to identify options for the scale up of malaria interventions (see section 5).

A questionnaire was sent to SuNMaP PIPs during the review. This was because the 2 independent consultants found it challenging to clearly understand the role and performance of the partners (see annex H for the summarised results). At annex I is the latest version of the DFID/SuNMaP logframe, which was given to the review team while in country. Annex J, provides more detail in support of section 4.4 - support to the commercial sector. In addition, the commercial sector independent consultant on the review team has developed a paper on 'developing the mixed model – defining the role of the commercial sector and how it might best be supported to develop a sustainable retail market'. It has been given to SuNMaP to help it to respond to the concerns raised in this and in earlier reports.

Finally, a presentation of draft review findings was made to government, other development partners, SuNMaP and DFID staff on the last day of the in country review. The day previously, the consultants had discussed the presentation with SuNMaP staff. This was seen as an important element of the participatory approach taken with the review. It ensured that there would be no surprises for SuNMaP during the formal presentation to the broader audience of stakeholders the next day, enabled open discussion, and acted as a test run ensuring that none of the information in the presentation was incorrect or had been misinterpreted.

4. FINDINGS ON PROGRESS

4.1 Progress against the logframe and work plan

Where relevant comments are made on the output indicators and/or milestones both within (in italics) and after each of tables 1-7 in this section. All the recommendations for this section 4.1 are as follows:

Priority recommendations

- Revise logframe indicators and milestones for some outputs. By end September 2010 by DFID with SuNMaP
- The year 3 work plan on output 1 should include: (i) support to help the NMCP develop a capacity building statement owned by all stakeholders; (ii) a system to evaluate performance of each TA person; and (iii) reference to BCC and capacity development personnel to work together on changing attitudes of health workers. By end August by SuNMaP with NMCP and FMoH

Other recommendations

- Consider adding a new assumption at the purpose level about the forthcoming elections. By end September by DFID with SuNMaP
- The year 3 work plan on output 2 should include support to develop a definition and statement on coordination in the NMCP. By end September, SuNMaP with NMCP
- The year 3 work plan on output 3 needs to give greater emphasis to strengthening the routine distribution of nets and creating capacity for regular demand projections – linked to a more formal written agreement with the parties involved that identifies the state's role in providing future supplies. By end September by SuNMaP
- In the year 3 work plans for SuNMaP Abuja headquarters and State levels there should be a link with the logframe outputs, indicators and expected results for 2011. By end September by SuNMaP

4.1.1 Findings: quantitative & qualitative progress against the logframe purpose

Table 1. Purpose: To strengthen delivery of Nigeria's national malaria control effort

No.	Indicator and Milestone	Progress
1	National indicator - Percentage of all children under 5 who slept under a ITN the night before the interview **2010 milestone:** 50%	Surveys in 2 states in 2010, Kano 43.8%, Anambra 42%. MIS to be done Sept/Oct 2010 and will provide data on other states. SuNMaP supporting joint RBM partners plan being implemented to distribute 63 million nets mid 2009-end 2010 SuNMaP led the development and closely supports the implementation of a joint RBM partners national plan to distribute 2 free LLIN per household, i.e. 63 million LLINs in total, over a period of 18 months (mid 2009 to end 2010). The programme has specifically played a pivotal role in: - shift in national policy from targeted to universal coverage - development of national universal coverage campaigns implementation guidelines and tools - design and set-up of innovative management and support structure for rapid scale-up - development of net retention and use evaluation survey and feeding surveys results into implementation approach improvement - This has leveraged unprecedented funding for malaria control from donors and Govt - Fed Govt aproved £40m for malaria control in 2010. SuNMaP has the opportunity to lead the implementation of the mix LLIN distribution model (i.e. through campaign, routine and

		commercial sector) for sustaining LLIN coverage targets -
2	National indicator - Proportion of all women with birth in last 2 years who received at least two doses of IPT **2010 milestone:** 10%	MICS/MIS surveys later this year will provide data. National quantification done & training package under development Distribution yet to happen. Joint RBM partners national quantification of SP done and training package for IPT almost completed. SuNMaP contributes to 26% of the national needs of SP for 2010
3	National indicator - Proportion of children age under 5 with a fever episode in last two weeks who received treatment with ACT **2010 milestone:** 20%	MICS/MIS surveys later this year will provide data. Procurement of ACTs in progress (funded by GFATM and WB). Joint RBM partners national quantification of SP done and training package for case management almost completed. Substantial progress in finalizing AMFM with grant about to be signed soon- *The wording of this indicator may need to be reviewed if focus changing to the use of RDTs*
4	State level indicator - Percentage of all children under 5 in supported states that slept under a ITN the night before the interview Milestone 2010: 50%	Surveys in 2 states in 2010, Kano 43.8%, Anambra 42%. MIS to be done Sept/Oct 2010 and will provide data on other states.
5	State level indicator - Proportion of all women with birth in last 2 years in supported states who received at least two doses of IPT **Milestone 2010:** 10%	MICS/MIS surveys later this year will provide data. Procurement for supported states made. Delivery systems for most supported states being developed in consultation with partners. Development of a training package nearing completion and training roll-out to start in the next couple of months
6	State level indicator - Proportion of children age under 5 with a fever episode in last two weeks in supported states who received treatment with ACT	MICS/MIS surveys later this year will provide data. Procurement of ACTs is in progress (funded by GFATM and WB). Joint RBM partners national quantification of SP done and training package for case management

	2010 milestone: 20%	almost completed. Procurement of significant quantities of ACTs for State in progress (GFATM grant). Substantial progress has been made by FGN and GFATM in finalizing AMFM, with grant about to be signed soon- *The wording of this indicator may need to be reviewed if focus changing to the use of RDTs*

4.1.2 Findings: quantitative & qualitative progress against the 6 logframe outputs

SuNMaP had, for the most part, addressed the recommendations in the June 2009 inception review report. However, the review team found that there was still a significant gap in the follow up of the following issue:

- Output 3 - the recommendations were related to indicators 4 and 5 on the commercial sector. This review found that there is still a need for more understanding of the market (including social marketing) and of the supply chain. This would help in building the capacity of the NMCP to deal with the commercial sector.

Table 2. Output 1: National, State and LGA capacity for policy development, planning and coordination are improved

No.	Indicator and Milestone	Progress
1	NMCP annual operational planning process in place **2010 milestone:** First plan produced & endorsed	- Milestone achieved: NMCP 2010 operational plan produced; 2011 operational plan planned to be ready by end 2010 - *The indicator should be combined with indicator 2 below and a new indicator developed on policy development given that it an important element of the output*
2	SMCP annual operational planning process in place in all supported states **2010 milestone:** First plan produced & endorsed	- 50% achievement as 2010 operational plan in 3 of 6 supported states (Lagos, Kano & Anambra)
3	NMCP coordination mechanism in place	- Milestone partially achieved. Little talk of, or reference to, coordination with private for

	2010 milestone: Coordination framework revised & endorsed. Partners forum & sub-committees revitalised	profit health care providers or of inter-sectoral coordination
4	SMCP coordination mechanism in place **2010 milestone:** Partners forum in place in all supported states	- 25% achievement (Lagos & Kano). But focus is on development partners & NGOs no talk of, or reference to, coordination with private for profit sector - *This indicator should be combined with indicator 3 above and a new 4th indicator developed, on the capacity building process*

Currently indicators 1 and 2 give weight to planning over policy, giving the (wrong) impression that it is OK to do planning in a policy vacuum or when policies have not been updated to reflect new thinking, technology and/or treatment regimes.

Table 3. Output 2: All agencies' support for the malaria sub-sector at federal, state and LGA levels are effectively harmonised

No.	Indicator and Milestone	Progress
1	Cumulative number of strategic areas for which harmonized methodologies and tools are developed and used by partners **2010 milestone:** 2	- Harmonised approach to LLIN's campaign impressive; BCC and operational research both harmonised at national level
2	Mechanism in place for public-private partnership coordination **2010 milestone:** Forum for interaction between NMCP, RBM partners & private sector partners in place	-Partially achieved. It does not appear that the private providers of health care (both for-profit & non-profit) haves been adequately defined or mapped, without which it is difficult to establish a coordination mechanism - *This indicator would benefit from more explicit re-wording re 'private sector partners'.*

The National Malaria Control Programme Strategic Plan 2009 – 2013 envisages the 'keep-up' phase of net-coverage being achieved through a 'mixed-model'[2] but does not enlarge on how this will be achieved or identify

[2] That is a blend of stand-alone campaigns, routine net distributions and support to the commercial sector'

the size and nature of the unsupported retail market (the only fully sustainable means of access to households). It also recognizes the role of private providers of health care but does not develop the theme. A deeper understanding of both is required - which should help to identify how best to build the forum for interaction between NMCP and its private sector partners

Table 4. Output 3: Improved population coverage of effective measures for the prevention of malaria

No.	Indicator and Milestone	Progress
1	% of HH in supported states with at least one ITN **2010 milestone:** 60%	Significant increase in coverage in Kano (69%) & Anambra (64%). 105% of campaign net targets achieved
2	% of nets from distribution campaigns still in households 4-6 months later **2010 milestone:** 90%	High levels of retained possession in Kano (89%) and Anambra (98%) 4-5 months after distribution
3	Cumulative number of sulphadoxine pyrimethamine (SP) doses distributed in supported states in public facilities **2010 milestone:** 7,300,000	55% achieved at mid-point of 2010 – 4.2 million SP doses procured and distributed
4	Cumulative number of LLINs sold by CSPs on the retail market **2010 milestone:** 2,500,000	- 379,000 ITNs sold out of a target of 770,000. There is a significant difference between the programme's 2010 milestone and the current CSP target
5	% of sampled outlets selling nets that have at least one LLIN branded on sale **2010 milestone:** 80%	2010 baseline determined May 2010 & given as 79% & 2013 target is 90% *- This indicator does not reflect access to nets (i.e. number of outlets with LLINs) – since the number of outlets could remain unchanged until 2013. Suggested revised indicator is 'Number of shops with at least one LLIN brand on sale per 1,000 shops screened in the sampled SuNMaP states'*

Table 5. Output 4: Access of the population to effective treatment for malaria improved

No.	Indicator and Milestone	Progress
1	Proportion of health facilities in supported states with adequate logistics compliance for ACTs **2010 milestone:** TBD	- Global Fund leading on this & difficult for SuNMaP to influence approach to assessment & design. Indicator therefore now not relevant *- Not sure that it is clear to everyone what is meant by 'adequate logistics compliance'*

2	Proportion of U5 malaria cases that were reviewed in sampled health facilities in supported states and were treated with ACTs **2010 milestone:** TBD	- Health facility assessment survey currently being implemented will help set milestone
3	Cumulative number of commercial sector ACTs sold by supported commercial sector partners **2010 milestone:** 1,500,000	- There has been significant progress in finalizing the AMFM initiative, with a grant for Nigeria about to be signed soon. If the AMFM works as planned, it will become unnecessary for SUNMAP to support commercial sector ACTs in the manner earlier envisaged. Work on this has therefore been suspended awaiting clarification as to how AMFm will work out in practice. Options for involvement have already been drafted by SuNMaP, to be finalised once the details of the AMFM are known. *Indicator may need to change*

There is currently no basis for assessing progress with the above output 4, pending finalization of the major initiatives relating to ACTs and pending the outcome of the health facility assessment survey that is currently under way.

Table 6. Output 5: Community awareness and demand for effective malaria treatment and prevention are improved

No.	Indicator and Milestone	Progress
1	Proportion of nets received from the distribution campaigns and retained by the household that were used by any household member the night before the survey **2010 milestone:** 80%	- In Kano State 74.1% & in Anambra State 70.5%
2	Proportion of women in child bearing age in supported states who know the preventive benefits of LLIN **2010 milestone:** Not applicable	Baseline conducted (57%). Next milestone data will be available in 2011. See output 2 - SuNMaP is leading the development of a joint partners strategic framework and implementation plan**-** *Is it enough that women 'know' about benefits? What about their use?*
3	Proportion of women in child bearing	Baseline conducted (29%). Next milestone

	age in supported states who know the preventive benefits of IPT **2010 milestone:** Not applicable	data will be available in 2011. See output 2 - SuNMaP leading development of joint partners ACSM strategic framework and implementation plan
4	Proportion of care givers in supported states who recognise need for treatment of malaria within 48 hours **2010 milestone:** Not applicable	Baseline conducted (86%). Next milestone data will be available in 2011. See output 2 - SuNMaP leading development of joint partners ACSM strategic framework and implementation plan- *Is it enough that need is recognised? What about some form of action e.g. taken to public or private health facility?*

Deleted: availble

Table 7. Output 6: Operational research into key areas of prevention and treatment provides the evidence base for more effective strategies

No.	Indicator and Milestone	Progress
1	Cumulative number of OR studies completed and disseminated **2010 Milestone:** 2 .	- National OR agenda for malaria developed with partners, and a methodology for setting priorities agreed. - Three OR studies have been agreed and are in the pipeline. Results expected between October 2010 & February 2011. Other proposals currently being evaluated, to be started by August 2010
2	% of OR studies that have confirmed current malaria strategies and practices or contributed to changes in malaria strategies or practices **2010 Milestone:** 0	- Too early to say

Significant progress has been made in bringing together the various parties that have an interest in operational research (OR), in securing agreement on the protocols for reviewing and prioritizing proposals, in commissioning the first three studies and in generating a second list of proposals from which the remaining three studies will be selected. Before finalizing the selection of the final OR studies, it will be important to engage more closely with the SMoH and SMCP in each of the supporting states to provide the opportunity for them to comment on the list and to suggest additional topics not currently included. The final decision on which topics are selected should also be relayed to them. Not only will this generate a sense of ownership within the states, but will also stimulate their interest in implementing the findings of the research.

4.1.3 Progress against the 2nd year work plan

Progress against the work plan looks sound [3]. Of the 56 activities listed in the performance matrix by output, almost half have a 100% level of achievement. Only 8 activities have 0% achievement, mostly through circumstances outside the control of SuNMaP. However, the performance matrix is the sum total of work undertaken by the SuNMaP office in Abuja and it's 6 field offices. During the field visits, progress was not quite so impressive, and some concerns were raised about the management of some of the state offices (see section 4.6 and also annex F, notes on Kano and Katsina).

[3] SuNMaP performance of year 2 plan (activity level) – undated document received by review team May 2010

Overall, the year 2 work plan was comprehensive but it only showed activities. There was no reference to the logframe indicators and the expected results. To include these in the future work plans would put the activities within a results framework. Perhaps because of the activities focus, the briefing presentations by the Abuja and state level field offices only highlighted achievements, not results against the indicators and milestones.

Similarly, it would be useful if the year 3 performance matrix reports against the indicators and milestones. Also, the matrix should show progress against the purpose in the logframe, not just the outputs. It took the review team sometime to link performance achievements with any indicators and milestones in the logframe. In doing so it highlighted that some work such as on coordination was not adequately addressed in either the work plan or the performance matrix.

The SuNMaP quarterly reports on progress against outputs are very clearly written. When the quarterly reporting on each output is collated to follow sequentially across reporting quarters, there is a logical, useful flow of the information including actual progress from one quarter to another.

4.2 Appropriateness of SuNMaP's M&E framework and logframe and changes in assumptions and risks

Priority recommendation

- Secure final agreement including detail, with partners on how the incidence of malaria will be measured by end 2010. By end October, by SuNMaP with NMCP.
- Help States develop an accurate, more evidence based picture of the pattern of malaria in their area. Ongoing with NMCP.

Other recommendation

- Revise risk ratings in light of the changing wider context and develop appropriate mitigation strategies for the medium and highs (including the 3 new risks). By end October, by SuNMaP.

4.2.1 Appropriateness of SuNMaP's M&E framework

The (undated) SuNMaP M&E framework is a good document. The attempt to ensure alignment with the NMCP routine M&E system is impressive. Also the intention to work closely with NMCP in supporting and contributing to the national M&E plan and on strengthening one of the most important M&E tools, the health management information system (HMIS). During the field visits, the

quality of data collection was sometimes mentioned as being weak. Related probably to the fact that at the local health facility level, there can be up to 18 different forms to fill in. It is also impressive that in the M&E framework, SuNMaP states its intention to provide feedback to states on their results and that this is actually happening in practice.

The M&E tools that SuNMaP is using are described in its' framework. Most of the tools are already in use by government. Those that are not, such as net tracking and market and provider surveys, are highly relevant and the intention is that they will be absorbed into national systems. Unlike some international organizations, SuNMaP had been commendable in using already established systems and tools and has avoided establishing its own vertical M&E system. One issue that arose during discussions was the need to secure final agreement with partners on the detail of how the incidence of malaria will be measured by the end 2010. The UN New York MDG office needs the result.

At the field level, during discussions with SMoH and other personnel including staff of SuNMaP offices, it was evident that some States do not have an accurate, comprehensive picture of the pattern of malaria in their area. More evidence is needed if interventions are to be shown to be relevant and also to help secure future funding.

4.2.2 Appropriateness of SuNMaP's logframe

When the logframe was originally designed for the DFID project memorandum sometime in either late 2006 or early 2007, the indicators and milestones were probably appropriate. However, the inception review report of June 2009 identified the need to change some logframe indicators. The suggested changes were agreed between SuNMaP and DFID by about November 2009. This has meant that for this review, progress was being assessed against some indicators that had only been in place for about 6 months.

This review has concluded that some more changes to the indicators are required. This is because of a mix of: (i) changes in the wider context; (ii) there is overlap of some indicators; iii) some outputs do not have an appropriate set of indicators; and (iv) thinking on what is, and is not, useful to measure has changed.

Changes in the wider context:

Output 4: Access of the population to effective treatment for malaria improved

No.	Indicator and Milestone	Progress
1	Proportion of health facilities in supported states with adequate logistics compliance for ACTs **2010 milestone:** TBD	- GFATM leading on this & difficult for SuNMaP to influence approach to assessment & design *Indicator therefore now not relevant and if it had stayed it is not clear to everyone what is meant by 'adequate logistics compliance'*

There is overlap of some indicators and some outputs do not have an appropriate or complete set of indicators:

Output 1: National, State and LGA capacity for policy development, planning and coordination are improved

No.	Indicator and Milestone	Progress
1	NMCP annual operational planning process in place **2010 milestone:** First plan produced & endorsed	- Milestone achieved: NMCP 2010 operational plan produced; 2011 operational plan planned to be ready by end 2010 - *This indicator could be combined with indicator 2 below and a new indicator developed on policy development given that it an element of the output*
2	SMCP annual operational planning process in place in all supported states **2010 milestone:** First plan produced & endorsed	- 50% achievement as 2010 operational plan in 3 of 6 supported states (Lagos, Kano & Anambra)
3	NMCP coordination mechanism in place **2010 milestone:** Coordination framework revised & endorsed. Partners forum & sub-committees revitalised	- Milestone partially achieved. Little talk of, or reference to, coordination with private for profit health care providers or of inter-sectoral coordination
4	SMCP coordination mechanism in	- 25% achievement (Lagos & Kano). But

	place **2010 milestone:** Partners forum in place in all supported states	focus is on development partners & NGOs no talk of, or reference to, coordination with private for profit sector - *This indicator should be combined with indicator 3 above and a new 4th indicator be developed, on the capacity building process as capacity is mentioned in the wording of the output and capacity building is not just about helping establish plans and mechanisms, tangible outputs. What really matters is the approach(es) used*

Thinking on what is, and is not, useful to measure has changed:

Output 3: Improved population coverage of effective measures for the prevention of malaria

No.	Indicator and Milestone	Progress
5	% of sampled outlets selling nets that have at least one LLIN branded on sale **2010 milestone:** 80%	2010 baseline determined May 2010 & given as 79% & 2013 target is 90% - *This indicator does not reflect access to nets (i.e. number of outlets with LLINs) – since the number of outlets could remain unchanged until 2013. Possible rewording is: 'Number of shops with at least one LLIN brand on sale per 1,000 shops screened in the sampled SuNMaP states'.*

Output 5: Community awareness and demand for effective malaria treatment and prevention are improved

No.	Indicator and Milestone	Progress
2	Proportion of women in child bearing age in supported states who know the preventive benefits of LLIN **2010 milestone:** 70%	- No data available **-** *Is it enough that women 'know' about benefits? What about their use?*
4	Proportion of care givers in supported states who recognise need for treatment of malaria within 48 hours **2010 milestone:** 90%	- No data available - *Is it enough that need is recognised? It should also measure if some sort of action is taken e.g. taken to public or private health facility?*

4.2.3 SuNMaP's programme assumptions and risks

All the assumptions in the logframe remain appropriate. A new one could be added at the purpose level about the forthcoming elections e.g. something to the effect that 'Pre and post election activities do not disrupt the achievement of results'

In the DFID memorandum for this support to the national malaria programme[4] the following 15 risks and their probability and impact were identified as follows:

Risks	Probability	Impact
1. Competition from cheap monotherapies cannot be minimised	High	Low
2. Drug quality is not adequately assured	High	Medium
3. LLNs cannot be marketed in the face of competition from untreated nets and ITNs	Low	Medium
4. Import duties are not adjusted to allow cheap imports	Low	Low
5. Malaria parasites develop resistance to SP	Medium	Low
6. Other household members use the ITNs rather than target groups	Low	Medium
7. ACTs cannot be delivered in Nigeria at an affordable cost	Medium	High
8. Oil prices stabilise or fall	Medium	Medium
9. ITN demand cannot be met	Low	High
10. Women do not continue to attend ANC	Low	Medium
11. NEEDS is not effective at reducing poverty in Nigeria	Low	Medium
12. Prevention strategies do not continue to be effective	Medium	Low
13. FGN does not deliver health sector reform	Medium	Medium
14. Strengthened RBM secretariat weakens ownership by states	Low	High
15. Geographical coverage of project inputs is not sufficient to deliver national impact	Medium	High

Over the past year, 3 additional risks have emerged: (i) the forthcoming elections; (ii) the increasing reliance on grant funding from GFATM and from the World Bank loan; and (iii) the continued lack of sufficient government funds to cover operational costs and where some do exist, their inefficient disbursement. There is much rhetoric on pledges towards covering costs, but in reality any spend is mainly on salaries and buildings. This latter risk is

[4] DFID Project Memorandum, Nigeria National Malaria Project (NMP) November 2006

increasingly jeopardising the sustainability of health systems, services and public health interventions, more generally in the health system and, for the purpose of this review, in malaria control.

4.3 On the appropriateness of SuNMaP' approach, strategic direction and risk mitigation

Priority recommendations

- Start planning the development of the 2011 state operational plans. By end August SuNMaP with SMCPs
- Analyse how the estimated 70% of population living on less than $1 a day can own and use and replace nets and any implications for the strategic direction of SuNMaP. By end December by SuNMaP with NMCP

Other recommendations

- Produce a capacity building statement that is owned by all key stakeholders. By end August SuNMaP with NMCP/FMoH
- Develop and implement system with FMCP/FMoH to evaluate all TA provided through the programme. By end December, by SuNMaP
- Help revise the National Malaria Strategic Plan 2009-13 to be in line with the FMoH National Strategic Health Development Plan 2010 – 2015. By end December by SuNMaP and partners
- Analyse the need for additional funding for PIPs for; i) community mobilization/raising awareness activities especially on case management and on routine availability of free LLINs for pregnant women and U5s; and ii) ensuring greater emphasis on developing community engagement and ownership. By end October, by SuNMaP
- Develop closer operational research engagement with the states in terms of choice of topics and dissemination of findings. By end October, by SuNMaP
- Help develop a results culture and accountability among SuNMaP PIPs at State level through requiring the development of annual and monthly work plans. Ongoing by SuNMaP
- Consider where health facilities, boarding schools & prisons fit in – for BCC/IEC and (purchase of) nets. By end 2010 by SuNMaP with NMCP

4.3.1 The wider context

For malaria and indeed other health programmes in Nigeria, any success is very dependent on the wider context in the health system. On reading the 10th November 2009, Abuja, Presidential Summit Health Declaration,[5] this can only be described as challenging. For example, the declaration states that it recognises that:

[5] See the FMoH National Strategic Health Development Plan (national health plan) 2010 – 2015

'The key challenges for achieving national health objectives are related to the weak health system, characterized by constrained governance systems and structures, low levels of health care financing and poor predictability and release of funds with inadequate financial protection for the poor, a shortage and mal-distribution of human resources for health, poor quality service delivery, inadequate and untimely availability of quality health commodities, lack of routine health services data, low levels of research for health, weak partnership and coordination, as well as poor community participation and poor utilization of health services, particularly child and maternal services, to mention but a few'.

4.3.2 Appropriateness of SuNMaP's approach

SuNMaP is to be highly commended for adopting an approach that embraces the Paris commitments of ownership and alignment and to a certain extent that of managing for results[6]. This was not originally envisaged by DFID in the initial design of the project and goes beyond the scope of output 2 on harmonisation. SuNMaP is therefore addressing 4 of the 5 Paris commitments/principles and in doing so is bringing added value to the programme of support.

To help further determine whether SuNMaP's approach is appropriate, a SWOT exercise was done during the review by a mix of NMCP and SuNMaP staff (see annex G). This helped confirm that SuNMaP is working to the strengths and opportunities identified and helping address some of the weaknesses in malaria control.

SuNMaP has produced an impressive programme capacity building strategy (undated). Most other international support tends to just (help) develop policies, plans, coordinating mechanisms etc. without considering 'how' to best go about the work in order to ensure the institutional sustainability of the processes and changes in the thinking and work of individuals. The focus is almost always on 'what' needs to be done. That said, during discussions both in the SuNMaP office in Abuja and in field offices, and on reading SuNMaP documents, training is mentioned most of the time e.g. 'state training plans'. This is to the relative neglect of talking/reference to, about other important aspects of capacity building such as mentoring, coaching, institutional capacity strengthening and the strengthening of the systems crucial for effective and efficient malaria control. Such approaches may be happening but their lack of 'visibility' raises questions about the level of ownership and commitment to working on/talking about more than training.

[6] OECD, 2005, Paris Declaration on Aid Effectiveness. High Level Forum, Paris 28 February – 2 March

If SuNMaP focuses more on these other aspects of capacity building in the future it could have a real and lasting impact on the sustainability of processes and systems. Any impact would of course be strengthened if government was to effectively allocate and efficiently disburse adequate funds for operational costs. Additionally, if SuNMaP could work with a wider range of stakeholders e.g. the FMoH and SMoH (not just the malaria programme), in collaboration with other relevant DFID support in the health sector on some aspects of capacity building, it would be extremely beneficial. It would help avoid the trap of a national programme becoming 'an island of excellence', yet still unable to work effectively and efficiently because of the wider institutional context[7].

Examples of a wider strengthening of institutional capacity that could be supported include: helping develop FMoH and SMoH level capacity strengthening statements before the NMCP develops a malaria programme specific one; and helping establish a common system for monitoring and evaluating TA, not only for the NMCP.

There is no doubt that SuNMaP is working to its comparative strength - technical capacity in malaria control in the public sector in resource poor settings. This is a recognized area of excellence for the Malaria Consortium, the lead partner 'at the heart' of SuNMaP's work[8]. Working in the commercial and private for profit health sector does not play to the Consortium's strengths in the same way. This is reflected in many of the comments in section 4.4. However, it has demonstrated a willingness to learn from experience and it is taking steps to address the challenges it faces.

SuNMaP demonstrated innovative thinking and work in year 2 primarily by proposing and then implementing state support teams (SSTs). SuNMaP recognised that the NMCP could be totally distracted by the net campaigns and that it needed a coherent structure and strategy for the planning and implementation of the LLIN campaigns. SSTs were established as nationally coordinated, multi disciplinary expert TA teams to support their planning and implementation. They seem to be functioning well, but need additional logistical support for supervision and monitoring during the final 3 days of any campaign to be fully effective. This can be achieved through developing a better culture of sharing the resources that are available (vehicles etc.), and by encouraging greater integration and cooperation, and less verticality of programmes. This is a good example of where management creativity can help resolve problems strategically and cost-effectively rather than by simply throwing additional funds at a problem.

SuNMaP's relevant and effective approach is demonstrated by a number of achievements in year 2. In particular:

[7] Stephanie Simmonds 2008 Institutional factors and HIV/AIDS, TB and Malaria. International Journal of Health Planning and Manageent, 23:139-151

[8] Annual review document of the Malaria Consortium 2008-2009

- The bringing of institutions/organisations and people together to secure a common approach (e.g. operational plans, behaviour change strategy and net campaigns)
- A functioning and effective partnership between government, DFID & SuNMaP in terms of collaboration, harmonisation & alignment but not a partnership vis a vis actual government resources for operational costs – the rhetoric is common but the reality is salaries and buildings
- As stated earlier, while working well on output 2, the Paris commitment of harmonization, an unplanned consequence of SuNMaP's approach is that it is also addressing the commitments of ownership and alignment and to a certain extent that of managing for results

The 11 PIPs represent a wide variety of comparative advantages and are contributing in many ways (see annex H). Those PIPs with expertise and experience of working with communities are a very valuable, currently underused, resource. SuNMaP is working actively at the national, state and to a certain extent at the local government authority (LGA) levels. A limited amount of community level work is happening. A community approach that aims to build community engagement and ownership, not just awareness as users of commodities, can add value to the programme by contributing to sustainability.

4.3.2 Appropriateness of SuNMaP's strategic direction

The programme needs to better understand the commercial market and supply chain for nets as a basis for refining the incentives needed to encourage greater private sector engagement.

When aiming for universal coverage it is important to consider facilities other than households. Health facilities in particular need to change practice by example. The review concluded that at present there is an impression of 'do as I say, not as I do' as no examples of health centres or hospitals using nets on all beds could be found. Where health facilities, boarding schools and prisons fit in both for behaviour change communication (BCC) and information, education and communication (IEC) and the provision, and/or purchase, of nets emerged as an unknown. This is a minor but important aspect of strategic direction that NMCP and SUNMaP should consider.

At a practical level, SuNMaP was 'sucked' into net campaigns at the expense of some of its original priorities. Whilst there were real benefits from this – in terms of field experience and establishing trust and credibility – it also affected other important work in some field offices.

4.3.3 SuNMaP's risk mitigation strategies

SuNMaP has yet to design any strategies to mitigate the negative impact of the risks identified in section 4.2.3. Work on developing a risk register is underway. But this needs to be further developed into a risk mitigation and management plan that includes new risks (see 4.2).

4.4 SuNMaP's approach and management of its commercial sector work

This section is a summary of a more detailed consideration of the commercial sector work at annex J.

Priority recommendations

- Record and analyse in more detail the lessons learned from the first year's experience of working with the commercial sector. By end August 2010, SuNMaP
- Develop a deeper understanding of the market for nets (both nationally and in the supported states), of capacity to pay and of the supply chain. By end October 2010, SuNMaP
- In the light of the above, rework and cost the new engagement strategy. By end October 2010, SuNMaP
- Ensure that a senior member of the management team is able to dedicate adequate time to supporting and monitoring the commercial team and where necessary bring in experienced and expertise. Ongoing, SuNMaP

Other recommendations

- Assess the options for supporting the development of the retail market through states purchasing their routine net requirements through local suppliers. By SuNMaP by December 2010
- Establish a regular meeting with the Society for Family Health as a basis for better understanding of the LLIN market and for working together to support/develop the market. By SuNMaP by August 2010
- Address the relationship with Teta Pharmaceuticals (immediate)
- Require members of the commercial sector team to spend significant amounts of time in the supported states in order to better understand these markets and to monitor the performance of the commercial sector partners and the interventions funded by SuNMaP; as well as helping staff in state offices to better understand the CSP programme. By SuNMaP, September 2010
- Work only with financially sound companies, whose financial performance does not need to be monitored – allowing the focus of monitoring to be on performance in the market and how it is achieved. Ongoing by SuNMaP
- Keep the incentives as few and as simple as possible, for ease of implementation and monitoring, such simplicity to be reflected in the engagement contract. Ongoing by SuNMaP
- Identify ways of making a net purchase easier for those on limited resources – possibly through the promotion of susu-type schemes in small institutions that are trusted by their communities. Ongoing by SuNMaP
- Avoid trying to engage with too many suppliers/distributors. It only takes a few competitors to bring the price down and if too many are competing some will inevitably drop out and the money spent on supporting them will be wasted. Ongoing by SuNMaP

- SuNMaP to invest in building an understanding of the private providers of health care, both for-profit and non-profit – asking the questions noted in section 4.4.5[9]. By SuNMaP by December 2010
- SuNMaP to continue to monitor the situation re ACTs and modify and cost its current range of proposals (which include RDTs) ready for the time when the AMFm plans and strategies have been fully developed and finalized. Ongoing by SuNMaP

4.4.1 Why engage with, and seek to support, the LLIN commercial sector?

SuNMaP's engagement with the commercial sector reflects the focus of the NMCP's current strategic plan on the 'keep-up' phase being achieved through a 'mixed-model that is a blend of stand-alone campaigns, routine net distributions and support to the commercial sector'. However, the strategic plan does not address how this might be achieved, the role each component is expected to play in relation to people's capacity and willingness to pay for nets nor the potential size and nature of the (unsupported) retail market.

These roles can be crudely assessed through understanding the level of availability of free or subsidised nets for those who have a right to LLINs, the capacity/willingness of those who are not targeted for subsidy to pay the real cost of a net in the retail market; and the willingness of the commercial sector to invest in developing a retail market throughout the country. Without generating this information, it is difficult for SuNMaP to create a coherent strategy for developing the retail net market - that is currently focused on 3 of the supported states. If engagement in the market is to become a significant reality, there is a need to better understand both the current and potential unsupported market for fully priced LLINs and the supply chain – as these will determine private sector interest and help to understand what interventions are likely to be most cost-effective. This requires:

A clear understanding of the range of products – nets vary in terms of shape, size, material, weight, colour, fittings and packaging. To simplify demand projections at this stage a few of the most popular types should be selected.

Understanding the demand side – the current and projected size of the market - the market for LLINs was estimated by SuNMaP to be only 280,000 in 2008 and expected to increase as a result of the net campaigns. The Kano representative post-campaign net survey undertaken in October 2009 suggested that between 1-5% of households purchased a net from the

[9] The health facility assessment exercise being undertaken by SuNMaP will provide an initial interface with this sector that can be further developed to generate a deeper understanding of the sector, also building on the work and experience of the authors of the USAID report by Health Systems 2020 - – The Private Health Sector in Nigeria – an assessment of its workforce and service provision. Published June 2010

commercial market following the campaign. This translates into a national market of 280,000 – 1.4 million nets. Whether this can be further extrapolated to project national effective demand for LLINs at steady state depends upon an understanding of capacity and willingness to pay amongst the wider population in both urban and rural areas.

The same survey notes 'a higher rate (of purchase) in the wealthiest quintiles whilst not entirely excluding the two poorest quintiles'. Recognition of inability to pay, and a concern about an approach to malaria control that depends upon out-of-pocket contributions, is reflected in two recent papers[10] highlighting the reality that there is a significant proportion of the population (who will not be covered by routine distributions) for whom purchasing nets will be difficult if not impossible. This is a sector falling outside the commercial market that needs to be defined and assisted if 'keep-up' is to be maintained.

To some extent, capacity to pay can be increased if the cost can be broken down into smaller elements, like small denomination scratch cards, perhaps making use of local susu-type savings schemes that are common at community level. The size of the commercial market will also be influenced by whether or not state governments opt to purchase their nets for routine distribution from local suppliers or encourage those benefitting from routine distributions to purchase their nets on the local retail market (using coupons or vouchers). There is clearly a cost to this but there is also a cost (£10 million of programme support) associated with the current approach to developing the retail market. A further key factor determining the potential size of the unsupported commercial market is whether or not free or heavily subsidized nets (provided by GFATM or others) will continue to flow into the market - which would appear to be inevitable if 80% coverage is to be maintained.

Understanding the supply side – how the market works - Distributors and retailers are basically interested in shifting their stock as quickly as possible and will give preference to those fast-moving consumer goods (FMCG) that are most in demand, that generate the highest profit and which take up the least space. Nets are not a priority for many retailers – a relatively bulky product with currently limited and seasonal demand[11] and small retailing margins. Hence distributors, wholesalers and retailers may need to be encouraged to hold stock through some form of financial incentive. How much, where and when depends upon a detailed understanding of the supply chain and of how a LLIN compares with other products in the eyes of those within the chain. Some of this information appears to be available, but not in a standardised or readily accessible format. Such information, and its

[10] Kilian et al: Review of delivering strategies for insecticide treated mosquito nets – are we ready for the next phase of malaria control efforts: 2010. http://journal.tropika.net and Jimoh et al; Quantifying the economic burden of malaria in Nigeria using the willingness to pay approach: BioMed Journal; May 2007

[11] Nets are a considered purchase made very occasionally by householders compared with impulse purchases such as bread, cigarettes or tea bags

analysis, should be summarised in the new SuNMaP commercial sector engagement strategy.

4.4.2 SuNMaP's current management of its commercial sector programme

What has happened to date*?*

The situation that SuNMaP found itself in during the early periods of the project was not easy – and this is reflected in the quarterly reports of April 2008 to June 2009. The government's decision to seek universal coverage with free LLINs not only impacted on the retail market for LLINs but also required SuNMaP to focus on both implementing the campaigns and learning the lessons from them. As a result, it would appear that the initial attempts to engage with the commercial net distribution sector may have taken place during periods of intense field activity and without some of the required information being available.

Contracts have been signed with 3 net distributors. These have received financial incentives in advance, which puts SuNMaP in a weak position. The inception report raised a number of concerns and recommended that the current contracts be fulfilled but no further commitments made, more market research undertaken and a closer relationship be established with SFH – the latter important because it is the leading social marketing organization in Nigeria, with experience of retailing a range of products including LLINs. SFH has a marketing agreement with Vestergaard-Frandsen (the makers of Permanet – the most popular net in the retail market) and appears[12] to be selling around 250,000 a year in a small number of states with around one third sold in Lagos State alone. It also due to receive 1.26 million nets from GFATM for distribution into the retail market at US$0.65 each[13]. There does not appear to be a structured relationship between SuNMaP and SFH.

A report by the Mennonite Economic Development Association (MEDA) in November 2009 asked for greater control over the CSPs - especially linking payments to performance, obtaining detailed commercial information about the CSPs, building an M&E capacity that will feed back to the commercial sector (and to SuNMaP) and promoting the commercial sector as a source of nets rather than the public sector. It also proposed a very detailed contract to replace the existing one. SuNMaP has largely fulfilled the recommendations of MEDA[14]. However, it is questionable whether private companies[15] will share detailed commercial information with SuNMaP (that is information which

[12] Time did not permit a meeting with SFH so the information noted here is second-hand
[13] It is not clear what GFATM hopes to achieve through placing this small, one-off package of nets into the market at a heavily discounted price
[14] Excluding the requirement for a more detailed commercial contract, as the original contracts are still extant
[15] As distinct from publicly quoted corporations

reflects reality) and whether such information is necessary – particularly if payments are retrospective. SuNMaP should consider contracting only with those companies that are financially strong so that it will be their performance in selling nets (rather than their continuing financial performance) that will be of primary interest to SuNMaP. Further, whether a complex contract is necessary is questionable if the support to be provided by SuNMaP is less complex than at present. Contracts should be as simple and straightforward as possible, whilst ensuring that key issues are addressed and allowing for appropriate levels of monitoring.

The current situation is that there are currently 3 CSPs, of which one is a manufacturer and two are distributors (with one of these planning to move into the cut, make and trim business). As of March 2010, three quarters of the way through the first year's contracts, supported sales of 379,000 nets have been achieved out of a June 2010 target of 770,000 (49%) – distributed within 5 states. Of these, 65% were sold within 3 of the supported states. 45% of those sold were sold in Lagos State alone.

The progress of each company is noted in Annex J and more information on the sales performance of each company and of the subsidies received can be found in a separate document[16]. In brief, as at March 2010 (75% through the one year contract):

- Rosies had achieved 88% of its 12-month target and is likely to be a continuing, solid and competitive partner.
- Harvestfield had achieved 67% of its 12 month target and is also likely to be a continuing, solid and competitive – reinforced by its decision to invest US$800,000 in building a cut, make and trim capacity so that it can make WHOPES-approved nets to different shapes and sizes to meet the demands of the evolving market.
- Teta Pharmaceuticals had achieved only 8% of its 350,000 net target. It is a young company that distributes imported pharmaceutical products and has an agreement with Vestergaard-Frandsen (VF) to market Permanet – an agreement that restricts where it can sell, due to VF having a similar agreement with SFH. With over $600,000 advanced to the company that is not reflected in sales, a meeting needs to take place urgently to find a constructive way ahead – a meeting that involves SuNMaP, Teta, NMCP, SFH and VF.

The lessons learned from working with these three companies need to be formally written down and analysed, noting how each lesson learned will be reflected in the new engagement strategy.

[16] Note for the file: Documenting SuNMaP's LLIN commercial sector support approaches and activities May 2010

4.4.3 Where next with the commercial sector?

Earlier reports have highlighted the weaknesses of the current contractual arrangements and recommended that they should not be continued. In response, SuNMaP has produced a 'new engagement strategy for commercial sector partners[17]'. This is not an easy document to read as it assumes a significant level of understanding of what has happened to date – the section on 'Implementation so far' not linking past experience to future plans. The strategy focuses on the process of screening and how the several interventions will be made, but does not provide a comprehensive review of the lessons learned during the past 12 months and how these are reflected in the new strategy. As a result, even though the strategy seeks to place itself in the context of the NMCP strategy of developing the mixed model, it does not appear to build strategically upon past experience. A short summary of the current proposals is given in box 1 below.

Box 1. Key proposals of the new engagement strategy

1. **Importers and distributors.** SuNMaP intends to distinguish between the two, potentially offering incentives to both.
2. **Engagement with importers and distributors.** It wishes to engage with as many importers and distributors of WHOPES-approved and NAFDAC-registered nets as possible (there are 7 brands meeting this standard) in order to encourage competition and choice and bring the price down
3. ***Support to importers.*** This will include a guaranteed market for an agreed volume, *generic* marketing support, access to soft loans and possible underwriting of bank charges.
4. ***Support to distributors.*** This includes:

- Facilitating access to limited amounts of working capital – possibly through paying the finance charges.
- Price support. A figure of $2 per net is proposed.
- Distribution support – through subsidising part of the cost of employment of two sales reps per distributor (including training, paying them sales commissions etc) – to be allocated to specific zones.
- Generic promotional material – T-shirts, caps, point of sale materials etc.
- Limited branded promotional material

It is hard to comment in detail on the new engagement strategy without having access to the market information referred to above (size of market, willingness to pay, cost of sales and margins), without knowing what level of financial support will encourage distributors to enter into/expand the commercial net market and without knowing the cost of implementing the new strategy. As a general matter of principle, it is important to keep commercial transactions simple. Only the commercially strong should become CSPs and hence monitoring their commercial health routinely should not be necessary. In contrast, there should be a strong flow of information from the market as to

[17] Commercial sector approach as part of the mixed model for attaining universal coverage

the levels and distribution of sales that will help to assess the impact of the support to the CSPs.

4.4.4 A suggested way forward

In the absence of the kind of analysis referred to above, it is difficult to see how a new engagement strategy can further be developed. An investment of more than £10 million in supporting the development of the retail market requires a business plan. It needs a more thorough analysis of the market and of the supply chain – that starts with national policy in relation to maintaining cover, assesses the capacity of people to pay (which will determine the size of the retail market and the extent to which it can contribute to 'keep-up'), explains the supply chain, presents and analyses the lessons learned and how this is reflected in the new strategy, considers options/makes recommendations for intervention and puts the revised strategy back within the context of the national policy. Whilst not a formal part of the terms of reference, a separate paper has been drafted and made available to SuNMaP that suggests how this might look in practice.

4.4.5 Engaging the private providers of health care

Reflecting the project documents, SuNMaP is concerned only with those trading in nets[18] and not those producing goods or providing services. This could to be broadened to include a greater understanding of, and engagement with, the wider private health sector.

The private health sector: It is clear that malaria in Nigeria is treated in a variety of settings. Many Nigerians treat themselves at home using self-purchased products. Others prefer the institutional route, which includes both public and private health facilities. Private facilities can be divided into those that operate for profit (depending upon such profit to recover their costs of investment and reinvestment) and those (mainly faith-based) facilities that do not seek a profit, but whose investment and reinvestment costs are provided by third parties - either from within their own network or from external donors. SuNMaP currently works almost solely through the public sector, yet in some locations the majority of people use private facilities. If there is to be a coordinated and harmonised approach to malaria control, then all of these facilities could be productively involved.

As with intervening effectively in the LLIN market, in-depth knowledge of the market is essential. Who are these private providers (both for-profit and others)? What do they provide? At what cost? How are they funded? What is the quality of care? How open are they to new ideas? Who are their clients? What is the market segmentation? Do they sell nets? If not might they sell nets? What role could they play re. ACTs and RDTs? What role can they play in BCC/IEC?

[18] ACTs were part of the original focus but engagement in relation to this commodity has been put on hold pending finalising of the AMFM initiative.

A report produced for USAID by Health Systems 2020 on the private health sector[19] gives a first glimpse of this sector. It raises a number of issues and it comments: *"we need more data on characteristics of the clients of private health services in order to understand what out of pocket costs, such as consultation fees, represent in terms of a proportion of income (a measure of financial burden) to households"* – the same question that needs to be asked concerning LLINs. It would seem appropriate for SuNMaP to engage with Health Systems 2020 to understand its work more fully and how future cooperation could support this sector in becoming part of the 'mixed model'. This could contribute significantly to increasing the availability of both prevention (BCC and LLINs) and treatment (RDTs and ACTs).

Responding to the Affordable Medicines Facility - malaria (AMFm): This facility is in the last stages of development in Nigeria and exactly how it will operate is still not clear even to those charged with overseeing its implementation. SuNMaP is adopting a cautious position. It has undertaken a detailed review of the options for contributing to the scheme (the decision on which to implement depending upon how the scheme works out in practice) and has highlighted the importance of building the capacity within the health sector for diagnosis through RDTs. Proposals for the latter are still in preparation, but in principle have significant merit and – if the £3 million programme budget for price support to ACTs should not be needed for that purpose - potentially its utilisation to promote RDTs could have a significant impact on the capacity to treat malaria based on an accurate diagnosis.

4.5 Effectiveness of coordination between SuNMaP and others

Priority recommendation

- Active lobbying needed to ensure government operational costs are included in budgets and disbursed; and raise profile of sustainability issues within each of 6 SuNMaP supported states including determining the cost of a sustainable malaria control programme. Ongoing but to start immediately, NMCP and SMCPs with SuNMaP

Other recommendation

- Develop a short but comprehensive position paper on coordination

[19] Health Systems 2020. The Private Health Sector in Nigeria – An Assessment of Its Workforce and Service Provision. A report for USAID - dated June 2009 (to be published in June 2010)

4.5.1 Coordination between SUNMAP and other DFID health programmes

There is good collaboration between SuNMaP and other DFID health programmes both at Federal and State levels. However it is unclear if, at State level in particular, subjects such as governance and approaches to health systems strengthening are being adequately discussed.

4.5.2 Coordination between SUNMAP and other development partners working at the Federal level and in supported States

SuNMaP's coordination with other development partners seems to be working well at both Federal and State levels. "Other development partners" usually implies government, bilateral and multilateral organisations and not-for- profit NGOs. What is less clear, but what has not been asked for in this review, is the extent of SuNMaP's coordination with the private providers of health care sector. However indicator 2, output 2 (see section 4.1) should address this in year 3.

The extent of coordination, not just information sharing, and of follow-up action following any coordination meeting is unclear, especially at State level. Meetings need to be clearly minuted and the identification of individuals responsible for undertaking agreed actions clearly stated. This will help develop a culture of accountability. There needs to be an effective follow-up of agreed recommendations and actions in subsequent meetings. While SuNMaP has done important, useful work over the past year in bringing people and organizations together, it is doing so without stating what, in the context of the malaria programme, coordination is all about. It is unclear what it is trying to achieve Better clarification of the following issues is required:

- Who are the stakeholders being targeted and which should be targeted?
- What mechanisms are being used or proposed and which of those need refinement and/or development?
- How should coordination on malaria fit with the wider FMoH and SMoH existing coordination mechanisms?
- What needs to happen to enable a transition from information sharing to a more effective, results orientated model of coordination?

A short position paper on coordination would therefore be useful, ideally produced jointly with both the FMoH and SMoH levels. This would not be directed only at Federal and State NMCPs but would help to establish and clarify the context and purpose of coordination, not only for malaria but also for related health issues.

Deleted: clarifiy

Specifically in relation to malaria it would also be helpful to define the purpose of coordination in relation to specific groups of stakeholders such as the private-for-profit health sector and the commercial sector. A small but not

inconsequential point is that it would be good if SuNMaP would more judiciously use the term 'partner'. At present everyone is a partner.

4.6 Effectiveness of management arrangements and internal coordination

Priority recommendations

- Develop within the management team a formal process of recording, reviewing and applying the lessons learned. Ongoing, SuNMaP and NMCP
- Review and learn the lessons of the long term TA located in the NMCP. Ongoing, by SuNMaP

Other recommendations

- Revise and date the year 3 SuNMaP work plans at both Abuja and State levels based on observations in this review report. By SuNMaP by end September
- Develop a clearly written, precise memo or other document for PIPs that describes the SuNMaP purpose, outputs and its planned results. By SuNMap by end October
- Support each PIP to develop and implement a clear set of work and planned results against which they report monthly to SuNMaP. By PIPs with SuNMaP by end October
- Continue to brief senior officials at state level of the objectives and activities of the programme. Ongoing SuNMaP
- Consider upgrading the management skills within the SuNMaP by providing management support for technical staff. By SuNMaP by end October
- Explore and develop opportunity for SuNMaP to develop local champions who can advocate on its behalf at state level in order to overcome some of these concerns. Ongoing, by SuNMaP

4.6.1 With the exception of the commercial sector component, there are no major concerns with the management of the project. There is a good spirit amongst the team and, certainly within the Abuja office, a free flow of information. Such concerns as are raised here, relate primarily to the relationship with, and within, the state offices.

Whilst the Abuja office plays a vital role in bringing about effective coordination at Federal level, the real world is outside Abuja. The state SuNMaP offices are responsible for interfacing with the institutions and people in the field who are the key stakeholders for SuNMaP. These stakeholders are the public at large, and also service providers (government departments or private health providers). The SuNMaP state offices also link national policies/strategies with the states and their communities. They form the hub around which the relationships with the PIPs are built. The relationship between SuNMaP's Abuja office and its state/satellite offices is therefore vital and needs to be managed effectively.

4.6.2 It was not always clear at the state level exactly what role the PIPs were playing, nor that the PIPs had a clear understanding of the purpose and objectives of SuNMaP – which SuNMaP plans to address through its year 3 work plan. The former could be addressed by each PIP (operating at state level) having a clear set of objectives against which they report monthly – generating a culture of accountability and the latter by producing a simplified version of the log frame – or a summary of the project, its objectives and outputs - that is shared with all the PIPs at state level.

4.6.3 As the relationship has been in place for some time, it would also make sense to review the provision by SuNMaP of long term TA to NMCP. What lessons have been learned? Have the requirements changed? Is short term or long term TA most appropriate – or a mix of the two? If there is now no-one in the Office of the Federal Minister of Health would it be better to place a national there?

4.6.4 Earlier concerns that SuNMaP was not in a position to pay competitive salaries has been addressed through a contract amendment with DFID.

4.6.5 Relations with the state authorities are generally good – with two exceptions. In Ogun state the SMCP has been placed within the Primary Health Board, for political reasons. It was clear during the review that the Chairman of the Board was not fully aware of SuNMaP's role, and more specifically in relation to the net campaign. This is being addressed by arranging a focused briefing session for the Chairman. This is a relationship that needs to be nurtured in the medium term, as does the wider relationship with the SMoH. In Katsina, the Director of Public Health indicated that he did not understand how SuNMaP worked or what it had achieved. Again, this is to be addressed through a special briefing, followed by routine updates. More generally in each SuNMaP supported State, perhaps it would be useful to appoint local champions who can advocate on its behalf at state level in order to overcome some of these concerns.

4.6.6 It is important to recognize that technical people, in any institution, do not necessarily make good managers. This is something of which SuNMaP needs to be more aware of, and pro-active about, within its own organization as well as within the PIPs. It is also relevant within its public sector partners, where management weaknesses can significantly reduce the value of investments made in goods and services.

4.6.7 Finally, the SuNMaP year 3 work plan is comprehensive but it could be made even more useful. This review report suggests some changes. For example:

(i) Show a link to the logframe outputs, indicators and expected results for year 3.
(ii) Show support to help the NMCP develop a capacity building statement.
(iii) Include support to develop a definition and statement on coordination in the NMCP.

(iv) Give greater emphasis to strengthening the routine distribution of nets and creating capacity for regular demand.
(v) Refer to the development of a deeper understanding of the private health sector (all in section 4.1).

4.7 Efficiency of approach to value for money

Priority recommendations

- Consider delaying state net campaigns where the operational costs are not adequate to secure the required level of coverage
- Seek to link the routine distribution of commodities to undertakings by the benefitting states to fund future requirements.
- Engage more deeply in understanding how net coverage will be maintained, without which the current investment in achieving coverage up may not be sustained

Other recommendation

- Work with each of the states to understand, define and cost a sustainable approach to malaria control

4.7.1 The deployment of resources

How resources are used within in a project will be largely determined by its design. SuNMaP had a long gestation from conception to inception, which could have contributed to a disconnect between the original planning stage and the operating environment when the programme of support began. Within months of starting, the operating environment changed significantly – firstly with the Federal Government's decision to seek universal coverage of LLINs initially with the distribution of free nets, and secondly with the emergence of the AMFm initiative. Both of these factors could have contributed to a situation where the deployment of resources was not wholly appropriate to the new operating context.

The parties[20] involved have demonstrated a willingness to be flexible in response to these changed circumstances; for example in setting up the SSTs to coordinate the delivery of campaign nets, which were not on the agenda at inception, and successfully bringing the World Bank and USAID as co-funders alongside DFID. DFID has also agreed to a significant contract amendment to reflect the changed circumstances. Such flexibility is generally a hallmark of the programme support.

Questions could be raised about the appropriateness of SuNMaP supplying commodities (LLINs etc.), when global health programs such as the GFATM are bringing in very large quantities of commodities for both prevention (nets)

[20] SuNMaP, DFID and NMCP in particular but also other donors – notably the World Bank and USAID

and treatment (ACTs) – but in general the project has used the available resources sensibly.

The supply of nets to the campaigns in Kano and Anambra[21], gave SuNMaP profile and status in those States beyond that possible solely through the provision of TA. It also provided SuNMaP with firsthand experience of the distribution process, which it used to develop the SSTs. In the case of nets for routine distribution, again SuNMaP is using this experience to make current systems of routine net distribution more cost effective. Some concerns about how this is being implemented are noted in 4.7.3 below, but the principle of engagement in these systems is valid.

In the case of price support for ACTs, this has been put on hold until such time as the whole AMFm mechanism has been finalized and SuNMaP can identify where it could most effectively intervene. SuNMaP has undertaken a detailed analysis of the AMFm initiative (as currently planned) and has identified a number of options for intervention. The final choice will depend upon the design and structure that is finally agreed.

One area where concern has already been expressed is in relation to the development of the retail market and the subsidies for LLINs provided through the project. The need for change has been recognized, and options need to be developed based on a greater understanding of the demand for fully priced nets and of the supply chain (see section 4.4).

4.7.2 The efficiency of commodity procurement and distribution

SuNMaP has a procurement budget of £10.75 million (23% of the total project budget), of which 90% (£9.6 million or approximately $14.4 million) is for the procurement of nets to be fed into the routine distribution system. Of this, the Crown Agents has spent $9.5 million on the purchase of nets for routine distribution (equating to £7.073 million including the additional cost of clearing and in-country transport) within all the SuNMaP supported states. A further 2 million nets were purchased directly by DFID for the Kano and Anambra campaigns i.e. from outside the SuNMaP budget.

All procurement is contracted out to the Crown Agents, which is DFID's procurement agent in Nigeria. In the case of LLINs, Crown Agents (Nigeria) subcontracts the procurement to its office in Nairobi, which is generally recognized as a centre of excellence in net procurement – having cut its teeth on procuring nets for the Kenya ITN project between 2003 and 2008. One of the outcomes of this early experience was the need for nets to be inspected during the production process within the factory, and this is now standard practice – the cost of which is covered within the Crown Agent's contract.

[21] These nets were not part of the formal SuNMaP budget and were procured directly by DFID for SuNMaP to distribute

An LLIN is not a standard item, varying in terms of size, material, weight, fittings and packaging – the specification being clearly laid down in each order. One of the most common nets for general distribution is the 4 ft x 6ft net – often known as the standard net - although even this will vary in terms of material, hanging depth etc. All of these orders placed on behalf of SuNMaP were put out to tender according to the EC procurement directives, with the price of the lowest offer (accepted in each case) varying between only $4.36 and $4.37[22]. In response to local pressure, the Crown Agents also put out a local tender for a 'standard' net in order to assess whether Nigerian manufacturers or suppliers could make a competitive bid. Their price was not competitive (in excess of $5 per net), and therefore the order was placed with an international supplier at a price of $4.22 per net. As far as can be seen, the procurement process to date has been both fair and cost-effective.

A subsidiary issue relates to whether or not the programme support should promote local net manufacturers by purchasing nets locally at a price higher than can be achieved internationally. In the medium to long term it will be important for local manufacturers to be able to compete with their international counterparts. However, the reasons why they are not competitive[23] are not issues that can be addressed within the resources, or within the timescale or objectives, of SuNMaP support. The Crown Agents has set up a framework agreement with the existing 7 international manufacturers of WHOPES-approved nets for a period of 3 years, starting from February 2010. This agreement currently does not include any Nigerian manufacturers.

SuNMaP also asked the Crown Agents whether it could purchase the stock of one of its CSPs. Crown Agents responded by saying that it was constrained by EU regulations on all orders over £108,000 and that therefore this was not possible. In the same response, the Crown Agents also noted that local suppliers are likely to stock 'standard' nets and therefore not be able to meet the varying specifications of institutional orders or be price competitive. However, it did also note that it is possible that a single order valued at less than £108,000 could be placed with a local supplier, but that if it was not competitive on price (in relation to international suppliers) this would not represent value for money. The Crown Agents has supplied a value for money statement for the procurement of SP, as it has for LLINs, and there is no reason to believe that the purchases could have been made more cost-effectively.

Some concerns have been raised by SuNMaP about the quality of the service of the Crown Agents – in terms of quality, speed and price. Whilst there are always two sides to every case, that similar complaints have been made by other DFID-funded projects/programmes of support suggests that there is a case to answer – which DFID has taken up over recent months. A one year

[22] Delivered Lagos
[23] These reflect the poor operating environment for the private sector (which have been well defined in – and are being addressed by – other DFID-funded projects managed by its Growth Team)

contract extension has been signed between DFID and the Crown Agents that requires the Crown Agents to provide a value for money statement[24] with each major purchase and to physically inspect and approve all items that are procured (the cost of this chargeable to DFID). In addition, SuNMaP (and other projects) may directly purchase small items to a total of £108,000.

;There have also been some concerns raised about the delays in being able to reconcile the actual cost of items procured by Crown Agents against the programme budget. This may in part be due to DFID changing its own accounting system, which records large procurements by the Crown Agents in its East Kilbride office. The DFID country office is addressing this and arranging for a quarterly meeting between the Crown Agents and all DFID-funded support where all issues of concern about procurement and of budgetary reconciliation will be addressed. It would appear that the mechanisms are now largely in place to address the concerns raised by SuNMaP.

4.7.3 The cost-effectiveness of programme interventions delivered.

This element is sometimes referred to as 'value for money' and reflects a wider assessment than simply whether or not a given item was purchased as cheaply as possible. It requires a judgment as to whether or not the approach taken is the most appropriate for achieving an identified goal. In general, the review team has found that the approach being taken by the project is achieving the goal and purpose of the project. Also it should be noted that DFID has been flexible in responding to the changing circumstances on the ground – notably the decision to provide LLINs to 80% of the population by the end of 2010. However, there are a number of areas that require some attention – as follows:

The provision of support to the commercial sector partners: This component will consume 22% of the SuNMaP budget. A number of concerns have been raised (in the inception report, in the MEDA report and in this review) about the approach adopted by SuNMaP towards the development of a retail market as well as the nature of the contracts signed with the current partners. This was reviewed in section 4.4.

The efficiency and effectiveness of the 'catch-up' phase: Achieving 80% coverage with LLINs is fundamental to the campaigns currently under way. This was achieved in Kano and Anambra, reflecting a high degree of effort and determination and the direct participation of many of the international donors. Lessons learned from that experience have been fed into the establishment of the SSTs (originally 4 teams and now 6), which are guiding the campaigns in the other states. However, subsequent experience has

[24] The requirements of this statement are laid down by DFID and require the Crown Agents to document the process that was followed in inviting bids, the bids offered and the selection made.

been less successful – such as in Sokoto (not a supported state) where there was a conflict within the state about whether it wished to pursue IRS or LLINs as the primary mechanism and where an adequate operational budget was not provided, In Ogun the campaign occurred over the Christmas period. This, together with some local disturbances, resulted in 300,000 nets remaining undistributed. In Lagos State, with distribution due to start in September 2010, there was little sign of either preparation or allocation of budget for the operational costs. The shortage of operational costs reflects a decision by the GFATM not to provide them, as well as the timing of the national decision to institute the campaigns occurring after state budgets had been approved.

In some cases, donors have stepped in and in others there has been a shortfall of funds resulting in incomplete distribution and poor value for money being achieved. This will also have a negative impact on the achievement of the 80% coverage (catch-up) that is required. The need to consider delaying some of the campaigns beyond the December 2010 deadline was discussed with the Special Assistant to the UN Envoy on Malaria (Suprotik Bassu). It was agreed, albeit with some reluctance that, where circumstances required delaying the campaigns beyond December 2010, this should be allowed in order to ensure that the 80% level of coverage is achieved.

The need to balance 'catch-up' with 'keep-up': A target of the National Strategic Plan for Malaria Control is to 'secure 80% of households having two or more LLINs by 2010 and to sustain it at this level until 2013 (and presumably beyond)'. Whilst it is understandable that the focus of activity (not only of SuNMaP but also of the government, of donors and of the various implementing partners) is on achieving 80% coverage through the current campaigns (catch-up), efforts to reach that initial coverage level will be of limited value unless it can be sustained. The NMCP strategic plan gives an estimate of the numbers of nets needed for 'keep-up', and suggests channels through which they might be delivered (including through the private sector). But the plan is weak on actual mechanisms, volumes and costs and this will require more attention in the next 12 months[25].

The routine distribution of LLINs (and SP): 21% of the project budget is for the routine distribution of LLINs (20%) and SP (1%), both of which are distributed through ANC health services. The justification for this is that, apart from providing one-off preventative cover to a significant number of pregnant women and children <5, much will be learned about the various distribution systems – the lessons learned being fed back to NMCP (and to the SMCPs). Whilst there is real benefit for those who receive the nets, the long term benefit will be limited unless the states commit to future funding.

[25] This is addressed in the Note for the file: Documenting SuNMaP's LLIN commercial sector support approaches and activities May 2010 – but there is scope for more detail in terms of mechanisms, volumes and costs

The provision of nets by SuNMaP to the supported states provides the opportunity both for dialogue and for the development of an agreement in which the State undertakes to both act on the lessons learned and to provide funding for on-going requirements. If that is not done, the benefits of this distribution of nets in each supported state will be short-lived.

Understanding the wider health sector: Because the NMCP is a government organisation, SuNMaP has focused on working with and understanding the public sector. However, a significant proportion of the population does not use the public sector health services, preferring a range of private providers. Engaging with the non-government sector in terms of both prevention and treatment should significantly increase the value for money of the project in terms of the return (reflected in health benefits) on the investment (reflected in cash spent). SuNMaP is aware of this and is taking the first steps to define and understand the private providers of health care.

5. OPTIONS FOR POSSIBLE FUTURE SCALE UP

Priority recommendation

- Further explore the desirability, feasibility and mechanism(s) of the options. By DFID

5.1 Approach to determining possible options

Three brainstorming exercises were held to help determine possible options for scale up, 2 comprised a mix of NMCP and SuNMaP staff and the third was just of SuNMaP senior management staff (see table 9 below). For many of the possible scale up ideas in the table below success in scaling up is very dependent on the strength of various health systems. The review team did not have the time to adequately assess these for sound judgments to be made especially in terms of value for money. Some of the other possibilities that arose out of the brainstorming are issues that the review team feel should be being done as part of day-to-day work and should not require additional financial resources e.g. 'strengthening the implementation of the coordination frame work e.g. quarterly RBM programme management meetings instead of bi annually'.

When trying to determine possible options for scale up the key criteria used by the 2 independent review team members was 'bringing benefits to the poor'.

5.2 Options for possible scale up

Option 1. Do nothing

Option 2. Provide more commodities with the poor as the target - to be available at no cost by right

Option 3. Geographical extension of agreed national BCC

Option 4. Roll-out malaria diagnostic improvement at scale (policy first, QA, storage, communication etc. – in order to improve treatment (with focus on paediatric.
ACTs) in the private health care provider sector in line with WHO guidelines on malaria case management including RDT/ACT combination.

Option 5. ? Support the scale up of IRS where geographically the intervention is effective.

Option 6. Two or more of options 2-5.

Options 2, 3 and 4 were deemed by the 2 independent consultants, based on this brief review, to be the favoured options.

Table 9. Results of brainstorming on possible scale up of malaria interventions

No.	Scale up intervention	By whom
Group 1. Mix of NMCP and SuNMaP staff 11 June 2010		
1.	Commodities gap – RDTs, ACTs, LLIN – campaign and routine	WB/GFATM/DFID/NMCP
2.	Operational cost in delivering interventions	NMCP/SuNMaP
3.	Increase BCC efforts – communication and advocacy	NMCP/SuNMaP
4.	Additional operational research	SuNMaP/WB/WHO
5.	Forecasting and resource mobilisation for 2011 and beyond	NMCP/WHO
6.	IRS scale up where effective	NMCP/WB
7.	Capacity building for health workers	NMCP/SuNMaP/WHO/WB
8.	Support local manufacturers to meet prequalification	NMCP/SuNMaP
9.	Develop systems for scaling up routine distributions for LLIN	NMCP/SuNMaP/WB
10.	Scale up community level intervention for case management (including diagnosis)	NMCP/WHO/SuNMaP
11.	Expand routine SP distribution	NMCP/SuNMaP
	Develop system for integrated supportive supervision and scale up	SuNMaP/WB/NMCP/GFATM
12.	Increase IT	NMCP/SuNMaP/WHO/GFATM
13.	Capacity for collation and analysis from LGA to State and Federal level	NMCP
14.	Make sentinel sites sustainable	NMCP/WB/GFATM
Group 2. Mix of NMCP and SuNMaP staff 11 June 2010		
1.	Strengthening the implementation of the coordination frame work e.g. quarterly RBM programme management meetings instead of bi annually	
2.	Strengthening the National and State malaria team (training, mentoring, supportive supervision etc.)	
3.	Operational research to inform evidence based implementation of policy and interventions	
4.	Increased engagement with the private sector health care providers	

5.	Strengthen malaria HIS (generation, quality, analysis)
6.	Strengthen capacity to track to burden of the disease through surveys, operational research, sentinel sites
7.	Technology transfer to promote commercial as a channel for the availability of affordability malaria commodities
8.	Strengthen logistic management systems and capacity
9.	Investing malaria resources in opportunities for cost effective delivery of integrated packages that will positively impact on malaria
10.	More resources for behaviour change interventions across all areas
11.	Roll-out malaria diagnostic improvement at scale (policy first, QA, storage, communication etc)
12.	Support critical gaps in implementation of LLIN campaigns
13.	Scale-up routine LLIN distribution
SuNMaP team 14 June 2010 (in order of priority)	
1.	Improve access to malaria diagnosis (including QA) and treatment (with focus on paediatric ACTs) in the private health care sector in line with WHO guidelines on malaria case management including RDT/ACT combination
2.	Increase communication work, especially use of mass media (TV spots, soap opera, use of TV celebrities) and start as soon as possible high scale generic and brand marketing for LLINs and ACTs
3.	Deepening in existing states: State harmonization, scale up to cover management strengthening and other possible capacity building gaps to entire state and cross states experience sharing
4.	Demonstrate and scale up model for routine delivery
5.	Expanding geographical territory for commercial sector and market monitoring
6.	Dedicated staff in case of increase in OR studies
7.	Expand monitoring areas
8.	Malaria control planning in non-supported states to increase efficient use of malaria resources from other partners
9.	More states

Annex A. TERMS OF REFERENCE

1. Objective

The objective of this annual review is to assess progress with the implementation of the SUNMAP programme, to assess progress with recommendations made during the inception review and propose recommendations for future action.

2. Recipient

The recipients of the work are the Federal Government of Nigeria; State Governments in Kano, Katsina, Niger, Anambra, Ogun, Lagos; DFID Nigeria; and other Development Partners

3. Scope of Work

The Review Team will review progress made so far and make recommendations to enhance programme effectiveness. The review will focus in particular on the following:

(i) Quantitative and qualitative progress against the SUNMAP programme outputs and purpose. This will include a full assessment against the revised SUNMAP log-frame milestones and targets as well as progress against the work-plan.

(ii) The appropriateness of SuNMaP's monitoring and evaluation framework and logframe, including whether any assumptions or risks have changed.

(iii) The appropriateness of SuNMaP's approach, strategic direction, and risk mitigation strategies, including any strategies relating to the forthcoming period of political elections.

(iv) Review progress with SuNMaP's work with the commercial sector, including its strategic approach and the management of its commercial sector programme.

(v) Review effectiveness of coordination between SUNMAP, other DFID health programmes, and other development partners working at the Federal level and in supported States.

(vi) Review effectiveness of management arrangements and internal coordination within the programme.

(vii) Efficiency of SuNMaP's approach with respect to Value for Money, in terms of (I) the deployment of resources, (ii) the efficiency of commodity procurement/ distribution, and (iii) the cost-effectiveness of programme interventions delivered.

(viii) To explore options for possible future scale up of the project, or DFID's support for malaria control in Nigeria

4. Method

a. The SUNMAP review team will be made up of two independent consultants, a representative from the World Bank, a representative from the Federal Ministry of Health, and/or State Ministries of Health and DFID staff.
b. Review of relevant documentation and programme log frame (see list below for background reading requirements).
c. Briefing of team by DFID SUNMAP lead and by SuNMaP senior team
d. Visits to Kano, Katsina, Anambra, Niger, Ogun and Lagos, as well as work within Abuja
e. Interviews and meetings with SUNMAP staff and key stakeholders, such as Government Health officials, other DFID programmes, other development partners, the commercial sector, and civil society organisations.
f. Presentation of draft findings of review to Government, other partners, SUNMAP and DFID staff

5. Reporting and Outputs

The review team leader will be required to produce the following reports:

a) SUNMAP Annual Review Report
b) Completed DFID Annual Review form.

Deliverable	Timing
Initial presentation of key findings and recommendations of the review to Government, other partners, SUNMAP and DFID staff	Wednesday 16th June, 2010
Draft SUNMAP Annual Review Report and completed annual review form submitted to DFID	Wednesday 23rd June 2010
Final agreed review report submitted to DFID	Wednesday 30th June 2010

6. Timing

The review will take place in country from Thursday, 3rd June to Wednesday, 16th June 2010.

It is currently estimated that this consultancy will require a total of 21 days for both independent consultants. The tasks, their duration and timing are:

- 3 days prior to commencement of the assignment for examination and analysis of key documentation;

- 12 full working days in Nigeria for the main review mission (excl. Sunday);

- Days after completion of the mission to complete draft deliverables and follow up editing.

7. DFID Co-ordination

The overall co-ordinator for this review is Ebere Anyachukwu, Health Adviser, DFID Nigeria.

8. SUNMAP Inception Review Team Members

a) One International Consultant Team Leader: The team leader will have competencies in health systems, public health, and preferably some expertise in malaria control. S/he should have relevant experience working in Nigeria, and will have overall responsibility for delivery of the outputs of this review.

b) A second international consultant who will have competencies in private sector development and/or social marketing. S/he should have relevant experience working in Nigeria or Africa, and will have responsibility for reviewing SuNMaP's work with the commercial sector as well as any other tasks allocated by the team leader.

c) One or two representatives of the Federal or State Ministries of Health – TBC

d) One or two representatives of other development partners such as the World Bank and/or USAID -TBC

e) Ebere Anyachukwu, DFID Health Adviser

f) Gill Rogers, DFID Private Sector Development Adviser (p/t) - TBC

g) Carolyn Sunners, DFID Health Adviser (p/t)

h) Jane Miller, DFID Human Development team leader (p/t)

9. Logistics

Logistics and Planning for the review will be provided by SuNMaP, supported by David Ukagwu, Programme Officer, Human Development, DFID Nigeria, and Edward Idenu, Assistant Programme Officer

10. Background

a) The £50m DFID Support to National Malaria Programme (SUNMAP) was started in April 2008. Its purpose is to strengthen delivery of Nigeria's Roll Back Malaria Control Programme. It is scheduled to run for five years and is currently operating in six States – Lagos, Kano, Niger, Katsina, Ogun, and Anambra.

b) The programme approach includes: building capacity at Federal, State and local levels to develop and implement plans for effective malaria control; supporting FMOH to harmonize efforts of donors and funding agencies around national plans, policy and priorities; and direct support to the delivery of effective malaria prevention and treatment through the public and private sectors. This approach will require

engagement with Government partners at all levels, as well as extensive work with the commercial sector.

c) The purpose of the programme is "To strengthen delivery of Nigeria's National Malaria Control Effort". It has the following six outputs:

(i) National, State, and LGA capacity for policy development, planning and coordination are improved

(ii) All agencies' support for the malaria sub-sector at federal, state and local levels are effectively harmonized

(iii) Population coverage of effective measures for the prevention of malaria is increased

(iv) Access of the population to effective treatment for malaria is improved

(v) Community awareness and demand for effective malaria treatment and prevention are improved

(vi) Operational research into key areas of prevention and treatment provides the evidence base for more effective strategies

d) Nigeria has started an unprecedented effort, backed by DFID, USAID, the World Bank, The Global Fund, UNITAID/UNICEF and other partners, to distribute 2 insecticide treated bednets to each Nigerian household (totalling 63 million bednets) by 2010. SUNMAP is providing technical and coordination support; and has contributed an initial 2 million nets to this effort. As at April 2010, 19 million LLINs had been distributed in 11 Nigerian States.

Required background reading

(i) SUNMAP Quarterly reports and Year 2 report**.**
(ii) SUNMAP Updated Strategic approach papers for each output and cross-cutting themes
(iii) SUNMAP Programme Memorandum
(iv) SUNMAP Programme logframe in revised DFID format
(v) SUNMAP self assessment against logframe using DFID annual review format
(vi) Post inception phase review report of SUNMAP Commercial sector support interventions
(vii) SUNMAP 2009 inception review report
(viii) SUNMAP Monitoring and Evaluation framework' including baseline and progress report
(ix) Results of post bednet campaign surveys
(x) SUNMAP work plans for 09/10 and 10/11
(xi) National/State Malaria Control Programme Strategic Plan and operational plans

Annex B. REVIEW AGENDA

AGENDA		
Support to National Malaria Programme (SuNMaP) Annual Review **Date: Thursday, 3rd – Wednesday, 16th June 2010**		
Wednesday 2nd June	Arrival of Consultants in Abuja	
Thursday 3rd June	**09:00 AM** Presentations at SuNMaP office: * Objectives of annual review – DFID and Consultants **SuNMaP's Presentation:** * Overview of SuNMaP * Progress to date – discussion of log-frame * Key risks/challenges in for Malaria in the Nigerian Health Sector * Key risks/challenges in SuNMaP * Overview of key plans for year 3 of implementation **14:00 PM** Meeting with NMCP (National Malaria Control Programme) √ Meet with NMCP Senior Officials/Technical Team Leads **16:00 PM** Agreeing field visits tasks / itinerary and breaking into teams	
Friday 4th June	**09:00 AM** Meet at SuNMaP office **Meeting with Government partners at Federal level:** **10:00 AM** Visit Federal Ministry of Health (FMoH) for review meetings with Director of Public Health **12:00 Noon** Meeting with NMCP – SST (LLIN State Support Team)	
Review Team Field visits to SuNMaP States	**REVIEW TEAM ONE** To Visit: Kano, Katsina and Niger states	**REVIEW TEAM TWO** To Visit: Ogun, Lagos and Anambra

		States
Sunday 6th June	Team departs Abuja 14:30 PM to airport for 16:00 PM flight to Kano	Team departs Abuja 13:00 PM to airport for 15:20 PM flight to Lagos.
Monday 7th June	**KANO State** Hold review meetings in Kano with key stakeholders	**OGUN State** **AM 08:00** Travel by road to Ogun from Lagos **10:00 AM:** Hold review meetings in Ogun with SuNMaP and key stakeholders **16:00 PM:** Travel by road back to Lagos from Ogun state (overnight in Lagos / accommodation).
Tuesday 8th June	**A.M (07:00):** Travel by road from Kano to Katsina **KATSINA State** 11:00 A.M Hold review meetings with key stakeholders	**LAGOS** **08:00 AM** Meet with SuNMaP team in Lagos **09:00 AM** Hold review meetings with key stakeholders in Lagos
Wednesday 9th	**A.M: 08:00** Conclude meetings/Debrief in Katsina **12:00 Noon** Travel back by road to Kano State **15:00 PM** Review team meetings / wrap up in Kano.	**LAGOS** **09:00 AM** Concludes review meetings / visits in Lagos **12:00 PM** Travel by Air from Lagos to Owerri and by road from Owerri to Awka

	17:30 PM Review team fly to Abuja	**ANAMBRA State** **15:30 PM** Meet with SuNMaP team & Hold review meetings with some key stakeholders.
Thursday 10th June	**NIGER State**: **07:00 AM** Review team travel by road to Minna, Niger State **10:00 AM** Hold review meetings with key stakeholders **PM 16:00** Review team returns to Abuja by road	**ANAMBRA State** **08:00 AM** Hold review meetings with key stakeholders in Awka, Anambra State **13:00 PM** Travel back to Owerri from Awka, Anambra state to catch flight back to Abuja
Friday 11th June	**09:00 AM** Review team take stock of field visits **12:00 Noon** Meeting with Crown Agents Nigeria (CANL) to review procurement (VfM) **14:00 PM** Further discussions with SuNMaP / NMCP	
Monday 14th June	**10:00 – 13:00 AM/PM** Review SuNMaP's Programme management (Organisation/Administrative and Finance discussion)	
	14:00 – 16:30 PM Meeting Malaria Development Partners Group / Stakeholders (USAID, WB, SfH, Global Fund, YGC, PIPs and PRs).	
Tuesday 15th June	**AM/PM: 09:00- 13:00** Review Team write-up time	

	PM: 14:00 – 16:00 Debrief with SuNMaP team by Review Team
Wednesday 16th June	**11:00 – 13:00 AM/PM** Debrief with DFID and Stakeholders
	14:00 PM: Consultants Write up Notes/Reports **Late PM:** Consultants fly back to UK

Annex C. TEAM MEMBERS, FIELD VISITS

STATES TO BE VISITED	REVIEW TEAM	DESIGNATION	PHONE NO.	EMAIL ADDRESS
KANO; KATSINA & NIGER STATES	STEPHANIE SIMMONDS	CONSULTANT, REVIEW TEAM LEADER		sarajevohospice@yahoo.com
	JANE MILLER	HD TEAM LEADER	08036783798	J-Miller@dfid.gov.uk
	DR. ABBA UMAR ZAKARI	HEAD OF KANO OFFICE	08033423370	A-Umar@dfid.gov.uk
	DR. AUDU BALA	NMCP		
	SOLVI TARALDSEN	HEALTH ADVISER - KANO	08065079631	S-Taraldsen@dfid.gov.uk
	WORLD BANK REPRESENTATIVE			
	*REP. FROM DFID UK			
	MAXWELL KOLAWOLE	SUNMAP PROGRAMME DIRECTOR	08060077143	m.kolawole@malariaconsortium.org
ANAMBRA; LAGOS & OGUN STATES	JOHN MEADLEY	COMMERCIAL SECTOR REVIEW CONSULTANT		ryeford@phonecoop.coop
	EBERE ANYACHUKWU	HEALTH ADVISER, ABUJA	08033230612	E-Anyachukwu@dfid.gov.uk
	CAROLYN SUNNERS	DEP. HEAD/HEALTH ADVISER – DFID KANO	08034565126	C-Sunners@dfid.gov.uk
	DAVID UKAGWU	PROGRAMME OFFICER	08033498719	D-Ukagwu@dfid.gov.uk
	OLACHI CHUKS-RONNIE	REGIONAL COORDINATOR, DFID ENUGU	08033309817	O-Chuks-Ronnie@dfid.gov.uk

	EBENEZER SHESHI BABA	PUBLIC HEALTH SPECIALIST	08035955725	e.baba@malariaconsortium.org
	USAID REPRESENTATIVE			
	REP. FROM DFID UK			

LAST UPDATED: 20/05/2010

Annex D.

PEOPLE MET		
Federal Government		
Name	**Role**	**Institution/Organisation**
Dr Mike Anibueze	Director of Public Health	Federal Ministry of Health (FMoH)
HMEJ Bassey	Head of Coordination, Department of Public Health	FMoH
Dr Folake Ademola-Majekodunmi	Outgoing National Malaria Coordinator	National Malaria Control Programme (NMCP)
Dr Bala Audu	Branch Head, Case Management	NMCP
Mrs B I Jarmai	Member, ACSM Unit	NMCP
Mrs Ewoigbokhan	Branch Head, ACSM Unit	NMCP
Donald A Ordu	Member, IVM Branch	NMCP
Dr Babatnnde Ipaye	TA (SuNMaP)	NMCP
Kemi Tesfazghi	Coordinator, SST	NMCP
Godwin Aidenagbon	Technical Adviser, SST	NMCP
J K T Ajiboye	Demand Creation Adviser	NMCP
Dr David Durojaiye	Head, Programme Management	NMCP
Mrs. Glory Opusunju	Programme Officer	NMCP
Kano State Government		
Name	**Role**	**Institution/Organisation**
Tajudden Gambo	Permanent Secretary	SMoH, Kano State
Baffa Kademi	Malaria Project Manager	
Aliyu Magaji	Director, Planning, Research & Statistics	SMoH, Kano State
Aminu Idris	Director, Administration & General Services	SMoH, Kano State
Ashiru Rajab	Deputy Director, Disease Control	SMoH, Kano State

Sheshu Abdullahi	Community Directed Intervention Focal Person, PIU (World Bank)	SMoH, Kano State
Audu Bala	Deputy Director, Case Management	NMCP, SMoH, Kano State
Katsina State Government		
Name	**Role**	**Institution/Organisation**
Dr Kabasiyu	Executive Secretary, State Primary Health Care Agency and Acting Commissioner for Health	State Primary Health Care Agency, Katsina State
Idris Haliru	Director of Public Health	SMoH, Katsina State
Yusufu Banjuma	State RBM Programme Manager	
Zuwaira Abubaycar	M&E Officer	SMoH, Katsina State
Mamusa Adamu	Procurement/Logistics Officer	SMoH, Katsina State
Junaidu Murnai	Integrated Vector Control Officer	SMoH, Katsina State
Tanimu Babale	Case Management Officer	SMoH, Katsina State
Binta Hussaini	Advocacy, Planning & Mobilization Officer	SMoH, Katsina State
Niger State Government		
Name	**Role**	**Institution/Organisation**
Ibrahim Chindo	Permanent Secretary	SMoH, Niger State
Hajiya Rakiya	Deputy Director, Public Health	SMoH Niger State
Hajiya Bilikisu Ibrahim	Deputy State Roll Back Malaria Coordinator	Niger State
Amina Zimro	Staff, Malaria Unit	
Lagos State Government		
Name	**Role**	**Institution/Organisation**
Pharm Toyin Hamzat	Special Assistant to Gov. Health	Lagos State Ministry of Health (SMoH)
Dr. Mrs. Adetoun Davis	Permanent Secretary	SMoH
Dr. O. O Taiwo	Director of Disease Control	SMoH

Dr. K. E. Layeni Adeyemo	Deputy Director Occupational Health	SMoH
Dr. O. O. Bakare	Assistant Director, Disease Control/SMCPM	SMoH
Dr. O. Oyenuga	Assistant SMCPM	SMoH
G. O Jolaoso	BCC Focal Person Malaria Control	SMoH
Dr. Sikuade Jakun	Director	SMoH
Pharm. G.O. Balaogun	Director, Pharmaceutical Services	SMoH
Anambra State Government		
Name	**Role**	**Institution/Organisation**
Ike Edith A.	Logistics Officer	Malaria Control Booster Project, Awka
Dr. Joe Orawura	Programme Manager	State Malaria Control Programme (SMCP)
Prof. Amobi Ilika	Honorable Commissioner for Health	SMoH
Dr. Onurughelu N.B	Deputy Public Health Coordinator/DC	SMoH
Ogoegbunam A. C	Special Adviser to Hon. Commissioner for Health	SMoH
Ogun State Government		
Dr. Toye Alatishe	Executive Secretary/CEO	Ogun Primary Health Care & Development Board
Dr. Kafayat Lawal	Deputy Public Health Coordinator	Ogun Primary Health Care & Development Board
Mrs Toyin Oworu	Malaria Control Programme Manager	Ogun Primary Health Care & Development Board
Dr Olukayode Kusimo	Ag. Director, Public Health Care	SMoH
Dr. Isiaq Kunle Solako	Honorable Commissioner for Health	SMoH
Dr. Oyin Sodipe	Permanent Secretary	SMoH
SuNMaP, Malaria Consortium		
Name	**Role**	**Institution/Organisation**

Sunhil Mehra	Executive Director	Malaria Consortium headquarters, London
James Tibenderana	Director of Case Management	Malaria Consortium headquarters, London
Caroline Vanderick	Programmes Director, Africa	Malaria Consortium Office, Uganda
Kate Brownlow	Country Director	Malaria Consortium Office, Mozambique
Kolawole Maxwell	Programme Director, Nigeria	Abuja, Nigeria
Stephen Cooper	Deputy Programme Director	Abuja
Ebenezer Sheshi Baba	Programme Technical Director	Abuja
John Dada	Communications Specialist	Abuja
Ebere Chikwe	Acting Office Manager	Abuja
Essien Essienawan	Programme Assistant	Abuja
Gaji Aklali	State Technical Malaria manager	Kano
Tunde Oladimeji	Operations Officer	Kano
Basheer Yahya	Senior Technical Malaria Officer	Katsina
Kolo Yakubu	Senior Technical Malaria Officer	Niger
Tunde Adesoro	Senior Technical Malaria Officer	Ogun
Laja Odunuga	State Technical Malaria Manager	Lagos
Abidemi Okechukwu	Senior Technical Malaria Officer	Lagos
Bimbola Olutola	Operations Officer	Lagos
Gabriel Akuegbo	Commercial Sector Manager	Lagos
Oghenovo Ugbebor	Commercial Sector analyst	Lagos
Issac Adiele	Acting Operations Officer	Anambra
SuNMaP Partners		
Name	**Role**	**Institution/Organisation**
Ike Osakwe	Managing Director	GRID
Monday Egume	Director	GRID
Bryan Haddon	Chair	Health Partners International

		(HPI)
Babafunke Fagbemi	Executive Director	Centre for Communications Programs Nigeria (CCPN)
Saka Jimoh	Programme Manager	Health Reform Foundation of Nigeria (HERFON), Abuja
Jada Ayuk	A.M. Resource Centre	HERFON, Abuja
Nwankwo Ekene Inno	Programme Assistant (Projects)	HERFON, Abuja
Zainab Saraj	Representative	HERFON, Kano State
Halima Adanu	Member	HERFON, Katsina State
Dr. Dennis Aribodor	Prep HERFON PIP	HERFON, Anambra State
Dr. R. O. Nriagu	State Chairman	HERFON, Anambra State
Oguntolu E. A.	Secretary	HERFON, Ogun State
Idris Mohammed	Focal Person	HERFON, Niger State
Joseph Kolo	Member	HERFON, Niger State
Mairo Mandara	Chair, Health Board	Federation of Muslim Women's Associations of Nigeria (FOMWAN)
Sadiya Adamu	President	Kano State, FOMWAN
Amina Abdulkadir	Health Coordinator	FOMWAN, Niger State
Hajiya Aisha Lemu	Amirah	FOMWAN, Niger State
Ishola F.A.T (Mrs)	State Chairperson, Health Committee	FOMWAN, Ogun State
Akindele R. A. (Mrs)	State Chairperson, Health Committee	FOMWAN, Ogun State
Saeed S.A.O. (Mrs)	State Secretary, Health Committee	FOMWAN, Ogun State
Adegbite Badamus T.A. (Mrs)	Member	FOMWAN, Ogun State
Patrick Kwakfut	Secretary General	Christian Health Association of Nigeria (CHAN)
Christopher O. Ogunnupelu	State Chairperson	CHAN Ogun State
Dr. Douglas Nkemdilim	Chairman, State Advocacy Committee	CHAN, Anambra State
Mrs. Obadiah	Representative	CHAN, Niger State
Mathew O. Azoji	Managing Director	CHAN-Medipharm
Edward Egede	Head of Programmes & SCM	CHAN-Medipharm

Yemisi Ojo	Programme Manager	CHAN-Medipharm
Other Relevant DFID Supported Programmes		
Name	**Role**	**Institution/Organisation**
Abubakar Izge	State Team Leader	PATHS 2
Said Ahmad	Senior State Programme Officer	Katsina State, PRRINN – MNCH
Karina Lopez	Nutrition Adviser	PRRINN – MNCH/SCF UK
Amina Baba-Manu	Policy and Advocacy Specialist	Enhancing Nigeria's Response to HIV/AIDS (ENR)
Omokhudu Idogho	Programme Director	ENR
DFID		
Name	**Role**	**Institution/Organisation**
Jane Miller	Head, Human Development Team	Abuja
Ebere Anyachukwu	Health Adviser	Abuja
Gill Rogers	Private Sector Development Adviser, Growth Team	Abuja
David Ukagwu	Programme Officer	Abuja
Olatunji Ogunbanwo	Deputy Programme Manager, Human Development Team	Abuja
Abdulkareem Lawal	Social Development Adviser	Abuja
Justice Ogmoh	Asst. Facilities Manager	Abuja
Edward Idem	DFID Nigeria	Abuja
Carolyn Sunners	Deputy Head/Health Adviser, Kano	Kano State office
Abba Umar Zakari	Head of Office	Kano State office
Solvi Taraldsen	Health Adviser	Kano State office
Olachi Chuks-Ronnie	Regional Coordinator	Enugu
Other Development Partners		
Name	**Role**	**Institution/Organisation**

Wole Odutolu	Specialist	World Bank
Jinem Nan	World Bank	World Bank
John Quinley	Senior Health Adviser	USAID
Dr. Folake Olayinka	MCH Programme Manager	USAID
Sue Fry	Senior Procurement Manager	Crown Agents
Jiru Bako	Technical Manager (Health)	Crown Agents
Sarah Pasternak	Director of New Programmes	Clinton Health Access Initiative (AmFM)
Diden Gbofeyin	Consultant	UNICEF, Anambra
Dr. Akubue Augustin	National programme Officer – Malaria SEZ	WHO, South East Region
Dr. Arowolo Tolu	National Programme Officer – Malaria SWZ	WHO, South West Region
Dr. Onyibe R.I.	State Coordinator	WHO, Anambra
Dr Soyinka		WHO, Abuja
Ado Bwaka	State Coordinator	WHO, Katsina
Lynda Ozor	Malaria Zonal Officer	WHO, Niger
Oluwatosin Kuti	CSO- Malaria	FHI/AHNI
Ezeh Bishop	Zonal Manager (Anambra)	FHI/GHAIN
Nduka Ozor	Coordinator	ACOMIN, Lagos
Joshua Chu	Assistant Country Director	Clinton Foundation
Remi Sogunro		YGC
Dr E. Gemade		UNICEF
Nduka Ozor	Coordinator	ACOMIN, Lagos
Ernest Nwokolo	Global Fund Malaria Coordinator	Society for Family Health (SFH), Abuja
Balkisu Abubakar	Global Fund Malaria Coordinator	SFH, Kano
Amal Shelley	Regional Manager	SFH, Kano
Toyin Ogbondeminu	Regional Manager (Lagos)	SFH, Lagos
Yinka Goodman	Territorial Manager, Lagos	SFH, Lagos
Gbenga IOlorunipa	State Programme Officer (Niger)	Association for Reproductive &

		Family Health (ARFH)
Commercial Sector Partners		
Name	**Role**	**Institution/Organisation**
Martins Awofisayo	Managing Director	Harvestfield Industries
Taofeek Bankole	Head of accounts	Harvestfield Industries
Makinde Oludepo	National Sales Manager	Teta Pharmaceuticals
Clement Ogunleye	General Manager	Teta Pharmaceuticals
Idris Ibrahim	Public Health Development Manager	Vestergaard Frandsen
Conference call		
Name	**Role**	**Institution/Organisation**
Suprotik Bassu	Special Assistant to UN Envoy on Malaria	UN headquarters, New York

Annex E. LIST OF KEY DOCUMENTS REVIEWED

1) DFID project memorandum, Nigeria National Malaria Project (NMP) November 2006.
2) DFID SuNMaP inception review aries report 16 July 2009.
3) Inception DFID annual form, July 16th 2009 (by Bruce Mackay).
4) HLSP inception review of DFID support to National Malaria Programme (SuNMaP) Bruce Mackay July 15th 2009.
5) FMoH National Strategic Health Development Plan (national health plan) 2010 – 2015.
6) National Malaria Programme Strategic Plan 2009-2013 – a road map for malaria control in Nigeria.
7) NMCP 2010 Operational Plan reviewed 31 March 2010.
8) NMCP Advocacy, Communications and Social Mobilisation Strategic Framework and Implementation Plan, Draft 31 May 2010.
9) NMCP Nigeria LLINs campaign State Support Teams, concept note August 2009 and update (undated) ? June 2010.
10) NMCP Framework for the coordination of the Malaria Control Programme in Nigeria, Draft September 2009.
11) NMCP ROLL BACK MALARIA Partners Profile April 2010
12) NMCP Policy for the Implementation of Insecticide-Treated Mosquito Nets (ITNs/LLINs) in Nigeria, July 2009.
13) NMCP Guidelines for the Implementation of Insecticide-Treated Mosquito Nets in Nigeria, July 2009.
14) NMCP Spraymen manual November 2009.
15) Office of the Minister of Health, Minutes of the AIDS, TB and Malaria Technical Working Group (1st – 6th meetings).
16) Kano 2010 Malaria Programme Operational Plan.
17) Katsina 2010 Malaria Programme Operational Plan.
18) Niger 2010 Malaria Programme Operational Plan.
19) Lagos 2010 Malaria Programme Operational Plan.
20) Ogun 2010 Malaria Programme Operational Plan.
21) PRRINN brief for meeting to finalise equity and social strategy in Katsina State (undated ? 2009).
22) Prof Kio N Don Redro, Programme of action on malaria control and elimination in Nigeria, 22 January 2008.
23) Jimoh et al; Quantifying the economic burden of malaria in Nigeria using the willingness to pay approach: BioMed Journal; May 2007.
24) Health Systems 2020. The Private Health Sector in Nigeria – An Assessment of Its Workforce and Service Provision. A report for USAID - dated June 2009 (to be published in June 2010).
25) Kilian et al: Review of delivery strategy for ITNs – are we ready for the next phase of malaria control efforts. TropIKA.net http://journal.tropika net.

SuNMaP documents

26) A post inception phase review of SuNMaP commercial sector support interventions – November 2009 (MEDA)
27) SuNMaP monitoring and evaluation framework (undated)
28) SuNMaP revised logical framework (undated ? November 2009)
29) SuNMaP programme progress reports:
- April – September 2008
- October – December 2008
- January – March 2009
- April – June 2009
- July – September 2009
- October – December 2009
- January – March 2010

30) SuNMaP annual work plan for 2010
31) SuNMaP year 2 (April 2009 – March 2010) work plan and its budget
32) Niger State - SuNMaP presentation to review team, ppt 10 June 2010: second annual review of DFID support to National Malaria Programme
33) SuNMaP year 3 (April 2010 – March 2011) Work plan and its budget
34) DFID annual review form, SuNMaP self-assessment (undated) received 28 May 2010
35) Performance of year 2 plan (undated) received 01 June 2010
36) Indicator matrix (undated) received 01 June 2010
37) SuNMaP rapid baseline capacity needs assessment for malaria control at Federal level (undated) received 08 June 2010
38) SuNMaP Programme Capacity Building Strategy (undated) received 08 June 2010
39) Result of SuNMaP post campaign surveys - update on post campaign survey findings in Kano & Anambra states
40) SuNMaP Commercial Sector Approach as Part of the Mixed Model for Attaining Universal Coverage, May 2010
41) Update on SuNMaP progamme approaches – May 2010
42) Net market survey 2010 report draft 1.0
43) Final framework of new CSS strategy June 2010 for discussion
44) Note for the file – CSP LLIN – June 2010
45) Advocacy, Communication and Social Mobilisation Strategic Framework and Implementation Plan of 31 May 2010
46) SuNMaP Updated Programme Strategy June 2010
47) Terms of reference SuNMaP TA Coordination, NACP, 22 January 2009
48) Abuja - SuNMaP presentation to review team, ppt 02 June 2010: second annual review of DFID support to National Malaria Programme
49) Kano State - SuNMaP presentation to review team, ppt 07 June 2010: second annual review of DFID support to National Malaria Programme
50) Katsina State - SuNMaP presentation to review team, ppt 08 June 2010: second annual review of DFID support to National Malaria Programme
51) Niger State - SuNMaP presentation to review team, ppt 10 June 2010: second annual review of DFID support to National Malaria Programme
52) Ogun State - SuNMaP presentation to review team, ppt 07June 2010: second annual review of DFID support to National Malaria Programme
53) Lagos State - SuNMaP presentation to review team, ppt 08June 2010: second annual review of DFID support to National Malaria Programme
54) Anambra State - SuNMaP presentation to review team, ppt 10June 2010: second annual review of DFID support to National Malaria Programme

Annex F. SUMMARY OF NOTES FROM FIELD VISITS TO SIX STATES

Kano State:

Achievements

- Clear, comprehensive presentation focused on SuNMaP activities in has been undertaken
- Successes demonstrated and corroborated by stakeholders in supporting the net campaign
- Useful contribution observed in the development of the state health strategic plans
- Facilitate in coordination of stakeholders meeting
- Initiated support towards the provision of health commodities for malaria in pregnancy.
- Support to community mobilization activities in the state.
- Community 'nets culture' demonstrated in Kadawa village during the field trip

Coordination/harmonisation

- Some evidence of coordination with outside partners e.g. PATHS2 although most areas are at an early stage. Planning to collaborate on delivery of SPs to health facilities although still not clear which of PATHS2-supported 329 facilities will be involved. Some work together on planning, supervision, data management (HMIS), and training. No mention yet of community engagement/BCC, which may be an important area with PATHS2 and other development partners.
- Lack of knowledge by programme partners in the state (FOMWAN and HERFON) of SuNMaP work plans. Reportedly the fault of those organisations' headquarters but SuNMaP must also take responsibility. Need clarity on relationship between state FOMWAN and HERFON staff and SuNMaP state technical manager. There needs to be a clear work plan and expected outputs/results framework for their work.

BCC and capacity building

- In light of the difficulty in changing health workers behaviour on malaria (particularly prescribing etc), might be worth looking at BCC activities specifically for them i.e. not just training.
- FOMWAN and HERFON suggested there is a need to focus their community work more on women. There is a tendency for community meetings to be male-dominated. SuNMaP should monitor gender issues and adopt appropriate strategies as required.

Other

- Constructive meeting with SMoH. Permanent Secretary particularly engaged, as was malaria programme manager. Very supportive of SuNMaP. This is quite a transformation from the time of first engagement where relations with manager of state malaria programme was poor; this seems to have been turned around which is a credit to the programme.
- Some concern re capacity of state technical manager, shown also during the meeting. Some lack of ability to see the bigger picture and understand some concepts being discussed.
- In general, the pace of the programme needs to speed up. Some of this is due to their (good) attempts to harmonise activities, tools etc. Some due to the campaigns. However it is 9 months since the last campaign in Kano so can't still be used as an excuse. Still not clear how routine nets and drugs are going to be distributed. Also some risk to the

original concept linking free nets with commercial nets if the commercial side is not progressing.

Challenges

- Lack of clarity on capacity building approach underlying current work undertaken in the state
- A need for improvement in communication with programme implementing partners and programme partner specific work plans at state level
- High poverty indices in Kano state

Recommendations

- Capacity building statement to be developed
- Explore other alternative approaches of routine distribution of LLIN
- Discuss possibility of support for environmental sanitation
- Additional funding support for community mobilization activities By SuNMaP implementing partners

Katsina State:

Observations

- Any comments on Katsina have to be understood in the context of a State that feels very responsible for its people, has pride++ and considers itself different from, and ahead of, other States. It can be much more difficult for outsiders to get acceptance and the pace of getting things done can be slow. Until there is acceptance the reality on the situation on the ground is not freely talked about, everything is working well. Claims by SMoH staff that everything – drugs, intersectoral coordination etc are in place while there is no evidence on ground to support/suggest that
- The Director of Public Health, SMoH, critical of SuNMaP "SuNMaP has been here for over one year, baffling how it works, seen nothing to date'. He thought it should " build capacity, work on case management, do preventive work including environmental management and do mobilisation. He also said he had "not taken advantage of SuNMaP's resources and expertise to date" as he was waiting to see some tangible product produced with their assistance. Furthermore, he felt that "SuNMaP has a lot of bureaucracy' it had not helped with World Malaria Day, nor had its technical officer been allowed to accompany SMoH personnel on a visit to Kaduna State to look at issues of malaria there. Other comments by the Director included: on capacity building "bringing in TA does not help". The 'health system is working well". "The State can provide all drugs".
- The Chairman, SPHCDA by contrast was more positive. He said he had of heard of SuNMaP through various routes and subsequently had meetings with them. He felt they had raised awareness about their work in the State, worked on coordination, supported the development of the malaria strategic plan and work plan and got ITNs for routine distribution. He was however very critical of delays in the supply of nets for the campaign "We feel we are being left behind".
- SuNMaP could be said to (just) still be at the inception stage in Katsina, implemented needs to be speed. It has contributed to the resuscitation of the SMCP and assisted the state in the development of the State Strategic Health Development Plan
- Most of the achievements of SuNMaP are still ongoing activities
- The SMCP is situated within the SMoH but the roles of the SPHCDA and SHMB in malaria control is not clear and there seems to be rivalry between the agencies

Recommendations

1. SuNMaP should improve communication with SMCP, SMoH and other stakeholders on the purpose and output of the project
2. There is a need for a high advocacy groups to assist SuNMaP and the programme
3. Partnership should be broader beyond the DFID sister projects and like at the national level should take a lead in partner harmonisation
4. The gap in capacity is wide and the capacity building plan should go beyond training to include mentoring and coaching. SuNMaP should collaborate with professional groups in the state – to ensure this
5. Joint development of the 2011 operational plan and its implementation will help the relationship between SuNMaP and SMCP
6. SuNMaP should be more responsive to the demands of the state
7. Net campaign is an issue for the state; it is an opportunity for SuNMaP to take a leading role
8. The SuNMaP (technical malaria) manger for Kano and Katsina should spend more time in Katsina, addressing management issues as much as technical ones

Niger State:

Observations

- Niger State Government not spending on health, it tells the LGAs to pick up any costs; only about 20% of the health budget was disbursed in 2009
- There is a Niger State Association of Civil Society Organisations which focuses on malaria, immunization and nutrition
- There is also a State malaria work plan for 2010; it is planned to do a more comprehensive one for 2011
- Malaria related maternal and neo-natal mortality declining since 2002, mainly attributed to implementation of a midwifery service
- Priority health systems in need of reform/strengthening and that affect efficiency of malaria programme are logistics and supervision. Latter extremely difficult when the SMCP has no operational costs
- There is a State inter-sectoral committee, malaria discussed sometimes especially in relation to the environment
- There is no contact with, coordination of the private, commercial sector for malaria
- SMCP has one office for 4 staff, no budget, no computer and no vehicle
- Extent of counterfeit ACTs on the market is of increasing concern
- All capacity building to date by partners has been very technical, nothing on management or mentoring

SuNMaP achievements and findings

- Permanent Secretary for Health thought that the technical capacity of SuNMaP is its key strength. Also good at working as a partner
- One NGO said of its work with SuNMaP “A marriage which has been successful”
- Conducted rapid baselines assessment of the state’s capacity for malaria control
- Advocated for and ensured the strengthening of SMCP unit to align with the national guidelines
- Supported LLIN mass coverage campaign in the state; not seen or heard of any leakage of nets
- Conducted post campaign rapid survey to ascertain factors affecting LLIN use in the state
- Produced messages in four languages (English, Nupe, Hausa and Gbagyi) to counter factors associated with non use of LLIN

- Together with SMCP and partners visited health facilities to study the routine systems for distribution of commodities and explore ways to improve them
- Programme implementing partners not aware of planned outputs and their indicators
- SuNMaP office complex is large and undertilised, rent reasonable but cost not giving DFID value for money

Recommendations

1. Need for effective lobbying by SuNMaP, possibly with HERFON, of the State government for operational costs and their efficient disbursement
2. Extend collaboration and coordination to private health care sector and commercial sector
3. Increase work on strengthening routine distribution systems for commodities
4. There needs to be a clear work plan and expected outputs/results framework for the work of programme implementing partners
5. Explore with government, SuNMaP headquarters and WHO how to address the problem of counterfeit ACTs and chloroquine
6. Ensure value for money for office space, perhaps through inviting another organization to pay rent for the use of 1-2 rooms

Ogun State:

Achievements

Output 1- Improved capacity for policy development, planning and coordination

- In the limited time available to it, the local team has not been able to facilitate a state malaria control operational plan, but this will start in June and should be completed by August – producing a plan that will be owned by the State. The lack of such a plan has undoubtedly constrained what the local team has been able to achieve, including the level of coordination amongst technical partners and the performance of the overall campaign
- Stakeholder engagements have been achieved with the SMoH, Primary Health Care Board (PHC), the Bureau of Planning and the PIPs
- Capacity baseline assessment undertaken with the state, LGAs, public & private health facilities and communities
- SMCP framework reviewed

Output 3 – Improved population coverage of effective measures for prevention of malaria

- Support to LLIN distribution campaign
  - ✓ TA to LCCN (State level coordination)
  - ✓ Operational support to 2 LGAs
- Estimation of SP and LLIN (routine) needs for 2010
- Supply of 430,000 doses of SP for IPT

Output 5 – Increased community awareness and demand for effective malaria treatment and prevention

- Formative research
- TA and operational support to LLIN distribution campaign
- Capacity development for staff & PIPs
- Mapping of communication resources
- Specific activities to promote & sustain net use

- Media appearances
- Symposium on malaria case management

Observations

- Achieving a positive interface for engagement, when what SuNMaP can offer is not as tangible as most other projects, has not been easy and whilst considerable progress has been made in building the interface at the operational level there is some way to go at the political level. This is because malaria control is embedded within the State Primary Health Board (PHB) rather than the State Ministry of Health (for political reasons) and there is currently little if any dialogue between the two entities – even though the PHB should report to the SMoH. SuNMaP needs to build a stronger relationship with the PHB (de facto its formal partner within the State) at the political level. This will hopefully be achieved by increasing PHB's awareness of what SuNMaP offers (which can be provided by the local office but the presentations need to be much simpler than currently) with reinforcement if necessary by the SuNMaP Director and DFID.
- The LLIN campaign did not go as well as it should have[26]. The PHB Director was very critical of the campaign and of SuNMaP, although this reflected a misunderstanding of the role of SuNMaP. Later discussions with senior technical staff from PHB and RBM confirmed the limitations of the campaign but demonstrated clear appreciation of the contribution of SuNMaP and of the quality of the monitoring done by SuNMaP. Their view was that the problems reflected:

  - Weaknesses in the approach adopted by the state, NMCP and the various donors
  - Lack of coordination in approach
  - A wider group of local organisations should have been involved in the distribution process and have been trained accordingly
  - Confusion arising from SFH and SuNMaP arriving in the state almost simultaneously and the perception of their roles becoming blurred
  - The nets arriving at Christmas time
  - Lack of a local budget, so that even now some of those participating have not been paid for services provided.

- A short meeting was held with three of the PIPs, FOMWAN, HERFON and CHAN. All three of these organisations appeared committed to their allotted tasks and provide a vital interface for SuNMaP (and the wider malaria control initiative) with the jigsaw of communities in the state – an interface that SuNMaP needs to nurture. It is of concern that at present the local SuNMaP office does not receive any regular information from the three PIPs, even though they meet regularly and exchange information. The current arrangement is that each PIP sends a quarterly report to its national office, which is consolidated and sent to SuNMaP in Abuja. SuNMaP in Ogun is working with PIPs to develop a Communication Action Plan (CAP) that would be routinely updated.
- SuNMaP is in the process of supplying 190,000 LLINs to the public health network for ANC clients. This number is based upon NDHS data. There is currently no provision for the NGO or private sector clinics – although they may benefit if take-up in the public health sector is less than expected. Although it is national policy for ANC clients to receive such nets, in reality such provision is sporadic. SuNMaP advises that the justification for making this one-off supply of LLINs is to pioneer the process and learn the lessons so that the state can continue the practice. However, there is no

[26] The comments on the campaign are all anecdotal and there are currently no figures as to the numbers of nets still in store and how many people (and where) did not receive a net. Such information should be generated, at least in part, by the net retention survey that is due to start shortly.

commitment from the state government to supply LLINS thereafter and no formal written agreement between the state and SuNMaP specific to this transaction.
- The Commissioner for Health noted that few hospitals have nets in place and that this not only permits malaria to be contracted within the hospitals but also suggests to patients that using a LLIN is not important. SuNMaP should follow up on this.
- There are issues of chloroquine procurement and administration within the State health facilities. Though minimal, SuNMaP may need to work to influence the state/doctors on the need to move on to ACTs.
- The SMoH was unaware of the proposed operational research (OR), was presented with the current list and was asked to consider where its priorities lie and what other OR areas are not included in the list.

Recommendations

- SuNMaP needs to build a stronger relationship with the PHB (de facto its formal partner within the State) at the political level.
- Increase the awareness of the PIPs as to the wider objectives of the project
- Build a culture of accountability within the PIPs by producing an annual and monthly work plan at the state level with each local PIP sending a short report each month to the local SuNMaP office in which it summarises what it has been doing (with figures where possible – e.g. numbers of communities, people seen etc) and with clearly stated aims and targets for the next month. Not only does this strengthens the relationship but also allows SuNMaP to monitor progress and identify where additional assistance might be needed and offered.
- In relation to the routine supply of commodities, effect an agreement that clearly lays out the responsibilities and commitments of each party, the point at which ownership transfers from one party to the other and the undertaking of the state to fund such supplies thereafter.
- Work with the SMoH to encourage hospitals and clinics to provide nets for their patients.
- Address with the SMoH the continued use of chloroquine and other monotherapies
- The local office of SuNMaP should consider itself an integral part of the OR review process, engaging the SMoH on a continued basis by feeding back to it the results of the research, and should include output 6 in its future presentations.

Lagos State:

Observations on Lagos reflect the need to split the available time between reviewing activities in the state and in the commercial sector programme.

General:

Lagos State has some special characteristics – not least due to the density of population and history – its status as the commercial capital and the former national capital giving it a sense of independence and reluctance to listen to the experience of other states. The state also does not accept the population figures from the last census (11 million), believing it to be around 19 million and rising - with implications for the level of support from the Federal government and from donors.

Achievements

Output 1: Capacity Development

- Supported Development and dissemination of the State 2010 Operational Plan and resource mobilization strategy and provides continuing support through quarterly meetings and consensus building
- Supports and provides TA to the state monthly meeting of RBM managers in the state.

Output 2: Harmonization and Coordination

- Mapping of partners and civil society organizations in malaria control in the state.
- Supported State-driven technical review and consensus meeting of all partners for the state 2010 operational plan and supported quarterly meetings on monitoring implementation of the state work plan and coordination of other donor funded activities
- Supported State led quarterly activity plan extracted from the work plan

Output 3: Prevention

- Supported the demand estimation for LLINs and SP needed for routine distribution for year 2010, providing 1.01 million doses of SP for prevention of malaria in pregnancy through the state established routine system.
- Strengthening of the state routine system for distribution of commodities (SP and LLINs) for prevention of malaria.

Output 5: Demand creation

- Supported the setting up and enlargement of the state Advocacy Communications and Social Mobilization (ACSM) Committee, the development of the strategic technical report on ACSM for the state and capacity building for its members
- Training of PIPs on strategic communication
- Developed the State Communication Action Plan, Implementation plan as extract from the state operational plan.

Observations

- SuNMaP has done well to achieve a presence in this slightly hostile environment and has built professional relationships with key institutions in the state that are concerned with malaria control. The most prominent and tangible output from such relationships is the publication of the Lagos State 2010 Malaria Control Operational Plan and Resource Mobilisation Strategy, an official state document which was referred to by state officials with pride, seeing it as a powerful tool for coordination, mobilising of resources and monitoring of progress. A number of committees have evolved around the implementation of the plan including those concerned with resource mobilisation and with advocacy.
- State officials and the WHO representative spoke highly of the plan and of SuNMaP, replacing what had previously been an annual “cut and paste “ event, and of the need to start thinking about its updating for 2011. They also noted the need for activities to be prioritised within the N11.5 million budget, although around 60% of the funding has been identified from various donors.

- The SMoH has introduced a State Malaria Control Research Committee chaired by the Commissioner.
- SuNMaP's local staff indicated that if more funds were to be available, the local preference would be to increase the level of capacity building – first in case management and then in control
- One can only express concern about the upcoming net campaign due in September – even though this may be delayed by the arrival of the nets. Amongst those directly concerned with its implementation, within the SMOH and the sub-recipient (FHI) in particular, there was a remarkable lack of a sense of urgency. The SSTs have to date had no involvement in the state (possibly due to the change of Director of NMCP), and as SuNMaP has a direct role in the SSTs some action would seem appropriate. The 4.2 million nets currently being supplied are linked to the official population rather than the actual population (for which 6 million nets are needed), indicating an inevitable shortfall. Around N420 million is needed to fund the local distribution, responsibility for which the state government is passing on to the LGAs. There was little no evidence of lessons being learned from other campaigns, and SFH confirmed when asked that whatever lessons had been learned in Ogun state had not been passed on to FHI - something which the SSTs should have required of them

Recommendations

- Reassess whether the currently planned date for the net campaign of September 2010 is realistic and, if not, seek a delay. With a commodity investment of around US$30 million, inadequate resources for distribution could lead not only to a waste of funds but also to a failure to achieve the 80% coverage that is critical to the national programme's success.
- Further support is needed to build local government capacity and to provide information on the utilisation of nets
- Health workers need to be trained in the benefits of SP

Anambra State:

Comments are necessarily relatively superficial, based on only four working hours in the state.

Achievements

- The State Malaria Control Operational Plan has been completed – which is currently awaiting final approval. Partners confirmed that the plan had given a new focus to malaria control in the state and was increasing the level of coordination. Key funding partners are World Bank, WHO, UNESCO and GFATM (through FHI).
- Direct assistance in the planning and delivery of the LLIN campaign, as well as supplying 685,000 of the 1.8 million nets used.
- SUNMAP has assisted SMCP to harmonise all malaria-related training and capacity strengthening within the state.
- Successful post-campaign net-retention survey in December 2009
- The supply of 230,000 LLINs and 510,000 doses of SP for routine delivery
- Successful completion of net market survey
- Successful development, production and airing of media demand creation (DC) materials (jingles, talk shows etc)
- Formation of core state demand creation group

Observations

- A copy of the 46 OR projects was passed to the SMoH with a request for him to select the top 6 and also identify any areas not already covered. The SMoH asked that research workers should where possible be drawn from within the state.
- The SMoH advised that the demand for nets had increased significantly, although many could not afford them. He noted how people were able to pay for mobile phones and scratch cards because they could see their value and were able to purchase through a sequence of small payments, asking if the same could be achieved for nets. Some lessons can be learned from scratch cards, which for many are affordable only because they can be purchased for as little as N20. Rotating credit clubs focused on purchasing a net – whether operating independently or through a church or mosque - might achieve the same effect.
- Whereas the State appreciates the coordinating role that SuNMaP has played in the above activities, and appears actively involved in engaging with donors and partners to bring about such coordination, the state does not appear to be engaged in terms of its budget. The current allocation of malaria control is only N30 million, and even this has not been released. There is no commitment in the budget to purchase SP or LLINs once the current quantities supplied by SuNMaP have run out. This in part reflects a belief that the WB Booster project will provide. This is unacceptable from the perspective of building sustainability and the establishment of such a budget line should be encouraged. The SMCP admits that it is currently virtually synonymous with the Booster Project and recognises the need to separate itself and assert its own independence.
- The possibility of the state purchasing its own nets was discussed, but the view was that all nets are purchased by NMCP. This may not be the case if the states are purchasing using their own funds. Currently there appears to be no mechanism for projecting the demand for "routine" nets, nor awareness of when the currently supply will run out. This could become a priority for SuNMaP.
- In line with SuNMaP's strategy, partnership with the private sector is currently restricted to increasing the commercial supply of LLINS (and in due course perhaps of ACTs). The only CSP specifically focusing on Anambra state is Teta, which has achieved sales of only 500 in Anambra state. In terms of developing public-private partnerships there is an opportunity for much wider engagement of the private sector in health care, in particular the private practices, clinics and hospitals – which already play a significant role in malaria control, and whose role could be expanded or upgraded. What market segments do they serve? What interfaces exist for engagement with them – perhaps their professional associations? Perhaps they could also stock LLINs for private sale, since the segment of the population that they serve may have deeper pockets. The first requirement is to map the private health care sector and to understand what malaria control services it is currently providing, what constraints it is facing and what opportunities exist for engagement.
- Only 20 minutes was available to meet with the PIPs – including CHAN and HEFRON as well as RBM/WHO and UNICEF – all of whom spoke highly of SuNMaP. In terms of expansion, the need to focus on RDTs was raised.
- Nets are currently being distributed by the SMoH directly to government clinics and hospitals as routing through the LGAs have being found to be inefficient due to their lack of capacity for storage and transport. SuNMaP plans to research different routes of achieving routine distribution – e.g. through ANC, immunisation, communities, private health clinics etc
- The SMoH asked for a greater focus on:
  - Recording the lessons learned. He went further, to suggest the creation of archives to record the process of eliminating malaria;
  - Schools – both on their value as a means of education and BCC (with knock-on effect on their families and communities) and also in terms of helping to supply subsidised nets to all boarding schools.

Recommendations

Continue with dialogue with the SMoH re:

- Operational research, its focus and how the results will be disseminated
- The potential for breaking down the cost of a net into smaller elements so that those on limited resources can afford them
- Securing a written agreement relating to the supply of LLINs and SP for routine distribution – to include a commitment by the state to continue funding their purchase in future and the introduction of a system of estimating future requirements on a rolling basis
- The potential for purchasing the routine nets locally, in order to build up the local market
- Identifying how best to map the private health care sector in the state and identify how its role in malaria control can be enhanced
- Recording the lessons learned from the current experience, possibly establishing formal archives for the purpose
- Increasing the focus on schools in terms both of creating awareness and encouraging the purchase of nets.

Annex G. SWOT of the NMCP

SWOT of NMCP: collation of groups 1 and 2 (mix of NMCP and SuNMaP staff)

Strengths	Weaknesses
• Improved political will • Increased global attention on malaria • Increased resources from government and development partners • Increased technical assistance from partners – local and international • Improved tools for prevention, case management including diagnosis • Highly qualified and motivated NMCP staff • Increased awareness about malaria prevention and curative interventions • Strong partnership • Increased programme coverage (no more 'orphan' states) • Evidence based NMSP strategy in place for 2009-13 • Coordination framework in place • Universal scale up capacity demonstrated through LLIN campaigns • Improving human resource capacity • Increased public awareness on malaria • Improving policy environment	• Inconsistent political will • Capacity to absorb huge increase in resources • Inadequate supervision at all levels • Inadequately skilled health care providers • Lack of staff (quality and quantity) for M&E/Lack of good data • Frequent posting of leadership and staff by Ministry • Referral systems • No proper linkages between different levels (Federal, State, LGA) for implementation • Linkage with broader health systems • Lack of proper dissemination of evidence and using it to inform policies and strategies • State level malaria programmes not properly set up • Over dependence on external sources for funding • Lack of baseline data • Frequent posting of leadership and staff by Ministry • Suboptimal implementation of coordination framework • M&E (data generation/quality and management) • Wrong staff mix at all levels • Supply chain management • Donor dependency • Bureaucracy • Level of local technology & lack of pre-qualification of local manufacturers • Resources to maintain coverage • Demand and supply side interventions not synchronized
Opportunities	**Threats**
• General political stability and security • NMSP and Abuja targets now leading to political commitment • Government commitment through MDG funding • Increased partners committed to funding malaria • Formidable partnerships & work increasingly harmonised • AMFm and other funding mechanisms • New innovations/products for malaria control such as ACTs, RDTs, LLINs • NMCP as a PR • High scale of deploying interventions and high level of maintenance • Scale up of diagnostics for rational use of drugs	• Corruption • Political interference • Forthcoming political elections • Pockets of ethnic/religious crises • Lack of enforcement and transparency on how taxes are spent • Taxes and tariffs on commodities • Lack of government funding for operational costs • Frequent change in leadership at various levels (inc. State) • Poverty/illiteracy • Cultural beliefs and practices • Impact of AMFm on local manufacturers • Cross-border leakages of subsidised commodities • Delay in arrival of commodities (clearance

	at port) • Insecticide and drug resistance

Annex H. ROLE AND PERFORMANCE OF SuNMaP IMPLEMENTING PARTNERS

*Partner	Designated role	Up to 3 key achievements & 3 key challenges	Suggestions for year 3
*Malaria Consortium	• Contract holder and overall responsible for cost effective programme implementation and management • Member of the Managing Consortium's Core Partners Group • Liaise, through programme team, with Crown Agent on procurement management • Lead technical partner for Outputs 2, 3, 4 and M&E. • Agree on overall strategy for output 1, 5 and 6 and contribute to provide technical input as required.	**Achievements:** 1. Successfully set up the programme and built a strong core and extended partnership to successfully implement the project; rapid policy, planning and decision-making processes; and quality technical, management, operations and financial management support. 2. Built a good working relationship with stakeholders and UKAID demonstrating flexibility and responsiveness to fast changing environment and linkages with global harmonization agenda 3. Brought experience and expertise from other countries to inform context responsive innovative scale-up approaches (e.g. LLIN campaigns, mixed model and engagement with commercial sector with targets for Year 2 reached at satisfactory levels). 4. Development and implementation of a sound M&E project framework feeding into the national monitoring needs **Challenges:** 1. The changes in leadership at National Malaria Control Programme and rapid	• Strengthen state capacity in the State Ministry and SuNMaP to coordinate, harmonise implementation of ambitious national plans for malaria control • Strengthen technical support for further development of commercial sector given the current opportunities in the country • Strengthen consolidated oversight for the scale-up phase of SuNMaP starting in Year 3 by appointing as MC project manager for SuNMaP - the Africa Director of Programmes

		changes in Nigeria malaria landscape 2. Harmonization is hard work and has slowed some aspects of the projects – still worthwhile though 3. The slow roll out of AMFm influencing SuNMaP's initiation of it case management and commercial sector activities	
*Grid Consulting, Nigeria	• Member of the Managing Consortium's Core Partners Group • Programme set-up and management support. • Employment and payroll management of national staff. • Financial management set-up and internal audits • Funding agent for commercial sector interventions • Technical inputs in commodities management systems and budgeting	**Achievements** 1. Programme offices set-up (all operational procedures), staff employed and programme activities commenced in very good time 2. Legal framework developed for engaging with CSPs 3. Successful disbursement and monitoring of the utilisation of £1m+ as CS interventions **Challenges** 1. Following up the CSPs in order to establish sound financial management and verifiable sales	• Establishing (with DFID) a revised acceptable framework for conducting the commercial sector interventions • Supporting CS partners to achieve their sales targets in the next year
*Health Partners International	• Member of the Managing Consortium's Core Partners Group • Lead technical partner for Output1. • Provide technical input on social development issues across the outputs as the need arise. .	**Achievements** 1. State Operational Plans for Malaria Control prepared by Lagos (finalised), Anambra & Kano 2. Capacity building roll-out planning process agreed for all states and started in two states 3. Consensus achieved on content of national training materials and drafting largely complete **Challenges** 1. Engagement in State Malaria Control Teams 2. Ambitious state C-B roll-out plans to fulfill this year	• Focus on developing the systems and capacity of State Malaria Control Teams • Develop effective models for the practical capacity building roll-out from state to state and LGA to LGA • Coordinate and advocate with RBM, GF, WB, others, NMCP and SMCP to agree on a final national set of educational materials and approach befitting the Case Management and the Management of Malaria Control in Nigeria.

		3. Streamlined, completion of appropriate manuals	
Health Reform Foundation of Nigeria (HERFON)	• Implementing partner for Outputs 1 & 5 (for output 5 with a focus on advocacy to raise malaria profile in governmental and traditional leadership). .	• Capacity of HERFON members (in SuNMaP States) and staff developed on Advocacy and Strategy Communication through trainings and work shops • Involved in development of National Malaria Advocacy, Communication and Social mobilization Strategic Framework Implementation Plan. • Participated actively in Technical Support for the Development of the 2010 Malaria Control Operational Plan in SuNMaP States • Involved in the development of capacity building materials and planning for its roll-out • Participated in Net Distribution Campaign (Anambra, Kano SuNMaP) **Challenges** • Short notices of meetings and other engagements activities • Diminutive DSAs for HERFON participants in some States • Coordination of SuNMaP State Activities and	• Advance notices from SuNMaP on activities within the minimum of 2 weeks • Upward review of DSA and Transport allowances to conform with reality of different locations • Greater involvement of HERFON in implementation of all the outputs
Federation of Muslim Women's Associations of Nigeria (FOMWAN)	• Implementing partner for Output 5 with a focus on. Community Mobilisation on malaria, using their network of Muslim women to reach	**Achievement** • During the campaign FOMWAN was able t o mobilize and sensitize the women even those in Pudah to come out and obtain the LLINs • Pregnant women are now able to identify dangers of malaria to them and their unborn babies.	Looking forward to a more participatory year 3 where every one will play his or her parts

		• Pregnant women able to take two doses of IPTs during antenatal before delivery. **Challenges** • Inadequate of supply of IPT's in the interior clinics (rural areas) for the pregnant women • There is delay in communications and getting information from the (SuNMaP) office • DSA transportations of ten (₦10) per kilometre given to PIPs is inadequate	
Christian Health Association of Nigeria (CHAN	• Implementing partner for Output 5 with a focus on Community Mobilisation using their network of members to mobilise community on malaria	**Achievements** 1. Over 90% redemption rate of nets in Anambra state 2. Effective coordination of community mobilisation 3. Effective coordination of liaison officers and Town criers. **Challenges** 1. Lack of sufficient time was allowed for effective planning 2. Poor security situation of the environment due to the high crime rate. 3. The absence of a follow up review meeting	• The need for early and timely communication between SuNMaP and Implementing Partners. • Review meetings should be held between liaison officers, • Supervisors and SuNMaP team in order to evaluate • In critical areas of risk, adequate security personnel as police escorts to key project personnel
CHAN-Medi-Pharm	• Implementing partner for Outputs 3 & 4 as local logistic partner for commodities management and participate in capacity development of stakeholders in procurement and supply management.	**Achievements** 1. **Distribution of malaria prevention commodities**: • In Kano wave 1 distribution (May 2009); CMP delivered 3,362 bales (168,100) of LLINs to 2 LGAs in Kano State. • Anambra distribution (July 2009): CMP	• We should focus on the development of additional channels for LLIN distribution e.g. PMVs and Women support groups to increase coverage. • A flexible tracking system that is not limited to physical visits should be encouraged to

		delivered a total of 13,075 bales (653,750) of LLINs in 7 LGAs in Anambra State. • Kano wave 2 distribution (August 2009): CMP delivered 13,618 bales (680,900) of LLINs to 9 LGAs. • We delivered 270,000 and 230,000 LLINs from Lagos State to Kano and Anambra States respectively (November 2009). • We delivered 598,920 and 250,000 doses of SP from Abuja to Kano and Anambra States respectively (January 2010). **2.0 PSM Baseline Assessment (BLA):** • Pre-testing of Baseline Assessment (BLA) tools were carried out in Nassarawa State [August 2009] • The field survey spanned from 31st January -13th February 2010 and was carried out in the following states: Lagos, Ogun, Cross River, Anambra, Kano, Kastina, Sokoto, Niger and Bauchi States. **3.0 LMIS Systems Design:** As a follow-up to the PSM baseline assessment, CMP represented SuNMaP in the LMIS Systems for Malaria commodities in Kaduna State. **4.0 Challenges**: There were not many challenges in the course of providing PSM support to SuNMaP; however enough notice should given to CMP before the commencement of any PSM activity.	enhance the pooled system • The SMOH should be strengthened for an effective quantification process to enable each health facility determine what they need before resupply. • Post campaign survey should be carried out to determine the continuous impact of the LLINs distribution and check usage even through some women groups. • A single LMIS tool that captures the different commodities should be encouraged but specifically linked to source of each commodity received. • Capacity enhancement should be a continuous exercise considering the high attrition rates in most of the public health facilities.
John Hopkins Bloomberg School of Public Health –	• Lead technical partner for Output 5.	• Developed, revised and managing the Demand Creation strategy of SuNMaP • Worked successfully with other output 5 partners to develop a shared vision	• Work with SuNMaP National office to ensure improved internal coordination of other PIPs (as affects information

Centre for Communication Programs (Nigeria) (JHU-CCP)		and common understanding crucial to the success of output 5
		• Provided DC support for the mass LLIN campaigns
		  • Actively supported the ACSM subcommittee of the ATM TWG task force as inputs into harmonisation outputs of SuNMaP
		  • Communication Capacity has been built at various levels; formal, on the job, mentoring etc
		Challenges.
		• Managing partner expectations from other PIPs
		• Communication gap within PIPs at National and state level and lack of clarity especially with respect to financial obligations
		• Finding the right balance between building PIP capacity and expectations for implementation at the state level... so as not to compromise quality
			sharing, joint planning etc)
			• Communication activities will be intense this year. Work with PIPs to ensure consistency in personnel representation at planning and implementation of programmes. These people have received some training, will get some more and should by all means be available when needed

Centre for Communications Programs Nigeria	• Implementing partner for Output 5 with a focus on providing technical assistance for strategic communication and building communication skills of stakeholders and partners	• CCPN has recently received a subcontract from MC and has put in place staff with support from SuNMaP... • Under the subcontract supported NMCP to develop a comprehensive ACSM SF & IP which should serve as a blue print for development of state and context specific communication plans	• Contribute to improved articulation of roles of SuNMaP state key officers taking into cognisance communication expertise and skills required to play such roles • As communication activities increase, identify a focal communication officer/ Consultant for the states • As we look forward to rolling out communication activities, hold 'regular' meetings with all key players with National and state representatives to elicit feedback, improve coordination and share best practices

			• In collaboration with SuNMaP, provide continuous technical support as appropriate, to NMCP and SMCP on Malaria Communication in SuNMaP focal states.
London School of Hygiene and Tropical Medicine (LSHTM)	• Lead on Output 6.	**Achievements** 1. An operational research protocol to evaluate the usefulness of intermittent preventive treatment in pregnant women using sulphadoxine-pyrimethamins (IPTp-SP) was developed and the agreement between the implementation partners (Shu et al and Watila et al) has been completed 2. A concept paper for evaluating the capacity building activities of SuNMaP and other development partners have been developed 3. A research priority setting meeting of key stakeholders was facilitated **Challenges** 4. Logistical and human resources obstacles to initiate the operational research studies 5. Obtaining approvals from relevant ethics committees 6. Analytical complexity of research priority setting workshop data	• Complete year one data collection for the IPTp-SP study • Develop a full research protocol for evaluating capacity building activity and facilitate the initiation of this research • Complete analysis of research priority setting workshop data and assist in developing protocols to address the priority operational research questions identified
Pharmaceutical Manufacturers Group of the Manufacturers Association of Nigeria (PMG-MAN)	• Facilitate interface between pharmaceuticals commercial sector partners and public health interventions.	**Achievements** 1. Increase coverage for Intermittent Preventive Treatment (IPT) for Malaria in Pregnancy using locally manufactured anti-malarial medicines 2. Patronage of local manufacturers for IPT through procurement of doses of Sulphadoxine pyrimethamine tablets 3. Improved collaborations between	**Proposed interventions** • Increased Demand Creation, BCC & IEC for ACTs to emphasize change from monotherapies • Study in collaboration with PMGMAN to assess quality of anti-malaria medicines in Nigeria as EVIDENCE for further ADVOCACY for patronage of local

		private and public sectors in interventions towards malaria control in Nigeria **Challenges** 1. Disruption of ACTs roll out because of the expected interventions of AMFm 2. WHO Prequalification process for locally manufactured ACTs taking much time & resources without commensurate assurance of Patronage by Government and Partners 3. Communication gap between PMGMAN & SUNMAP	manufacturers • Parallel roll-out of subsidized ACTs to compliment AMFm using SAME pricing models in selected/designated SUNMAP states • Technical assistance to pharmaceutical manufacturers towards attaining WHO PREQUALIFICATION for ACTs • Appointment of a Deputy Executive Secretary in PMGMAN as focal person for malaria interventions and interface between the public and private sectors
University of Nigeria, Enugu Campus	• Implementing partner for Output 6 with a focus on quality assurance of national research agencies and research institutions capacity building	**Achievements** • Helped in developing calls for OR1 and OR2 research projects • Undertook site assessment of Damboa, Borno state and Enugu, Enugu state for OR1 work • Ensured increased visibility of SuNMaP OR work amongst researchers **Challenges** • Attracting many researchers to respond to calls for EOI • Limited funding for QA, which limits our level of engagement with researchers undertaking SuNMaP OR work • Slow OR process that may make the research findings redundant	• Increased engagement with researchers and programme managers • Faster OR process – from development of calls, advert, selection of research teams/proposal and undertaking the research • Developing approaches that will ensure that outputs from OR get into policies, strategies and practice. • Convening a mini-summit or conference where outputs from SuNMaP OR as well as research outputs from related work not funded by SuNMaP are presented and used to improve malaria control in Nigeria

* Core partner

Annex I. SUNMAP LOGFRAME AS OF MAY 2010

PROJECT TITLE	**Support to the National Malaria Programme, Nigeria**					
GOAL	**Indicator**	**Baseline 2007 (MICS) and 2008 (NDHS)**	**Milestone 2010**	**Milestone 2011**	**Target 2013**	
To achieve progress towards the health Millennium Development Goals in Nigeria	All cause under-five mortality	157/1000	100/1000	90/1000	80/1000	
		Source				
		NDHS				
		138/1000	100/1000	90/1000	80/1000	
		Source				
		MICS				
PURPOSE[27]	**Indicator National**	**Baseline 2007**	**Milestone 2010**	**Milestone 2012**	**Target 2013**	**Assumptions**

[27] Both national and supported states level indicators are used at purpose level. 'Nigeria' in the purpose implies a national level indicator. Although the programme will be supporting the national malaria control programme at federal level, it is likely that it will exert higher influence at State level, hence the rationale for monitoring both levels. Baseline, milestones and targets for Supported States here and elsewhere are obtained from weighted (with weight applied to population size) average between the six SuNMaP supported States, Kano, Katsina, Niger, Ogun, Lagos and Anambra. The project M&E framework will keep track of State specific database. For use in the logframe, state data are averaged.

To strengthen delivery of Nigeria's National Malaria Control Effort	Percentage of all children under 5 who slept under a ITN the night before the interview	4%	50%	60%	80%	Commitment to Nigeria's PRSP (Vision 20 2020) continues beyond the planning stage into effective implementation Sustained Commitment by NMCP to achieving targets in National Malaria Strategic Plan (2009 – 2013) ACTs and LLINs remain effective No large scale other disease epidemics
		Source				
		MICS				
	Indicator National	**Baseline 2007**	**Milestone 2010**	**Milestone 2012**	**Target 2013**	
	Proportion of all women with birth in last 2 years who received at least two doses of IPT	3%	10%	25%	40%	
		Source				
		MICS				
	Indicator National	**Baseline 2007**	**Milestone 2010**	**Milestone 2012**	**Target 2013**	
	Proportion of children age under 5 with a fever episode in last two weeks who received treatment with ACT	2%	20%	30%	35%	
		Source				
		MICS				

	Indicator Supported States	**Baseline 2007**	**Milestone 2010**	**Milestone 2012**	**Target 2013**
	Percentage of all children Under 5 in supported states that slept under a ITN the night before the interview	3%	50%	60%	80%
		Source			
		MICS 2007			
	Indicator Supported States	**Baseline 2007**	**Milestone 2010**	**Milestone 2012**	**Target 2013**
	Proportion of all women with birth in last 2 years in supported states who received at least two doses of IPT	2%	10%	25%	40%
		Source			
		MICS 2007			
	Indicator Supported States	**Baseline 2007**	**Milestone 2010**	**Milestone 2012**	**Target 2013**
	Proportion of children age under 5 with a fever episode in last two weeks in supported states who received treatment with ACT	3%	20%	30%	35%
		Source			
		MICS 2007			
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID share (%)**
	£ 46,775,568[28]				
INPUTS (HR)	**DFID (FTEs)**				

[28] The total budget is **£50,000,000** which as at October 2009 includes £36,030,048 for the service provider, £10,745,520 for procurement through the DFID procuring agent and a balance £3,224,432 used directly by DFID for Monitoring & Evaluation, External audits and other expenses. The budget used below to show contributions to each output exclude the budget directly managed by DFID, hence the sum of the budgets show against each outputs equals £46,775,568 and not £50,000,000. The budget split between the outputs was done using the following principles: each output budget include: 1) budget that is allocated in the contract against the output, 2) procurement that relates to the output, 3) a share of cross-cutting procurement and overheads costs calculated using the impact weighting.

OUTPUT 1	Indicator	Baseline 2008	Milestone 2010	Milestone 2011	Target 2013	Assumptions
National, State, and LGA capacity for policy development, planning and coordination are improved	NMCP annual operational planning process[29] in place	0	First comprehensive NMCP Annual Operational Plan developed and endorsed by key partners	Process to review NMCP Annual Operational Plan in place and showing up to 60% implementation	NMCP Annual Operational Plan showing up to 70% implementation	FGN continues to implement health system reforms and increases health spending Accountability mechanisms between National, State, LGA and community levels are strengthened Government and Partners are committed to NMCP Coordination Framework
		Source				
		NMCP documents, Annual Review Meeting Reports				
	Indicator	**Baseline 2008**	**Milestone 2010**	**Milestone 2011**	**Target 2013**	
	SMCP annual operational planning process in place in all supported states[30]	0	First comprehensive SMCP Annual Operational Plan developed and endorsed by key partners	Process to review SMCP Annual Operational Plan in place and showing up to 60% implementation	SMCP Annual Operational Plan showing up to 70% implementation	
		Source				
		State documents				
	Indicator	**Baseline 2008**	**Milestone 2010**	**Milestone 2011**	**Target 2013**	

[29] The operational planning process includes development of operational plan, mechanisms to reach agreements on stakeholders contribution to the plan, process of regular assessment of implementation progress and plan review.

[30] Same as previous footnote

	NMCP coordination mechanism in place[31]	Very irregular coordination meetings	NMCP coordination framework revised and endorsed by partners. Partners forum and sub-committees revitalized	NMCP branches heads, partners forum and sub-committees meeting taking place regularly	NMCP branches heads, partners forum and sub-committees meeting taking place regularly	
		Source				
		Coordination framework, Minutes of meeting of partners and sub-committees meetings				
IMPACT WEIGHTING	**Indicator**	**Baseline 2008**	**Milestone 2010**	**Milestone 2011**	**Target 2013**	
20%	SMCP coordination mechanism in place [32]	Available in 1 State	Partners forum for malaria control coordination in place in all supported states	Partners forum for malaria control coordination meetings taking place regularly in all supported states	Partners forum for malaria control coordination meetings taking place regularly in all supported states	
		Source				**RISK RATING**
		Coordination meeting minutes				Medium
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID share (%)**	

[31] NMCP coordination mechanism includes any means to ensure internal (between NMCP branches and with other federal institutions) and external (with States and partners) coordination of NMCP as agreed in the NMCP Coordination framework endorsed by partners.

[32] This indicator does not mean that coordination forum strictly looking at malaria issues need to be put in place. In states where a broader health coordination forum can adequately coordinate issues pertaining to malaria control it will be considered as achieving the targets under this indicator.

	£ 4,153,242				
INPUTS (HR)	**DFID (FTEs)**				

OUTPUT 2	Indicator	Baseline 2008	Milestone 2010	Milestone 2011	Target 2013	Assumptions
All agencies' support for the malaria sub-sector at federal, state and local levels are effectively harmonized	Cumulative number of strategic areas for which harmonized methodologies and tools are developed and used by partners[33]	0	2	4	5	FGN, State and donor agencies are willing and able to combine resources in support of NMSP NMCP provides leadership and stewardship to RBM Partnership
		Source				
		Annual NMCP review meeting reports				
	Indicator	**Baseline 2008**	**Milestone 2010**	**Milestone 2011**	**Target 2013**	
	Mechanism in place for public-private partnership coordination **Indicator**	0	Forum for interaction between NMCP, RBM partners and private sector partners in place	Forum for interaction between NMCP, RBM partners and private sector partners meetings taking place regularly	Forum for interaction between NMCP, RBM partners and private sector partners meetings taking place regularly	
		Source				
		Private sector forum meeting minutes				
IMPACT WEIGHTING						**RISK RATING**
15%						High

[33] These strategic areas are defined as included in the National Malaria Strategic Plan (NMSP) 2009-13 and could be around LLINs campaigns, LLINs routine distribution, IPT distribution, diagnostic, treatment, supervision, procurement and supply management, behavioral change communication and monitoring and evaluation

INPUTS (£)	DFID (£)	Govt (£)	Other (£)	Total (£)	DFID share (%)
	£ 1,930,656				
INPUTS (HR)	**DFID (FTEs)**				

OUTPUT 3	Indicator	Baseline 2008	Milestone 2010	Milestone 2011	Target 2013	Assumptions
Population coverage of effective measures for the prevention of malaria is increased	Proportion of households in supported states with at least one ITN	7%	60%	70%	90%	Sufficient LLIN for campaigns are available from other sources outside the project There is minimal leakage of free LLINs from donor programmes into the commercial market ANC attendance in supported states remains at weighted averaged NDHS 2008 rate of 62% There is no major competing price-support programme that undercuts
		Source				
		NDHS				
	Indicator	**Baseline**	**Target**			
	Proportion of nets received from the distribution campaign still in possession of the household 4-6 months after distribution	N/A[34]	90%			
		Source				
		Programme post campaign net retention and use surveys				
	Indicator	**Baseline 2008**	**Milestone 2010**	**Milestone 2011**	**Target 2013**	
	Cumulative number of SP doses distributed in supported states in public facilities	1,714,291[35]	7,300,000	10,200,000	13,300,000	
		Source				
		NMCP distribution and SMOH consumption reports				
IMPACT WEIGHTING	**Indicator**	**Baseline 2008**	**Milestone 2010**	**Milestone 2011**	**Target 2013**	
25%	Cumulative number of LLINs sold by supported	0	2,500,000	5,000,000	10,000,000	

25%	commercial sector partners on the retail market	0	2,500,000	5,000,000	10,000,000	commercial efforts
		Source				**RISK RATING**
		Commercial Sector Partners reports				Medium
	Indicator	**Baseline 2010**	**Milestone 2010**	**Milestone 2011**	**Target 2013**	
	Proportion of sampled outlets selling nets that have at least one LLIN brand on sale	79%	80%	80%	90%	
		Source				
		Programme net retail market surveys				
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID share (%)**	
	£ 26,910,403					
INPUTS (HR)	**DFID (FTEs)**					

[34] This indicator does not require baseline since distribution campaigns will only happen once and the indicator is expressed as a percentage of nets received. This indicator will only be measured for the States where SuNMaP programme had a substantial role in the campaign planning and coordination and where the programme contributed commodities and operational cost. The target has no associated period as it is dependent on when the campaigns takes place.

[35] Consumption data at facility level are not available as at 2008; this baseline figure represents the number of SP doses distributed to the supported states through NMCP and partners.

OUTPUT 4	Indicator	Baseline 2009	Milestone 2010	Milestone 2011	Target 2013	Assumptions
Access of the population to effective treatment for malaria is improved	Proportion of health facilities in supported states with adequate logistics compliance for ACTs[36]	TBD[37]	TBD	TBD	60%	Sufficient and consistent resources are provided from global sources for commercial sector ACTs distribution There is high acceptance of ACT amongst health workers in their treatment practices
		Source				
		Health Facility Assessment				
	Indicator	**Baseline 2009**	**Milestone 2010**	**Milestone 2011**	**Target 2013**	
	Proportion of U5 malaria cases that were reviewed in sampled health facilities in supported states and were treated with ACTs.	TBD[38]	TBD	TBD	60%	
		Source				
		Health Facility Assessment				
	Indicator	**Baseline 2008**	**Milestone 2010**	**Milestone 2011**	**Target 20113**	
	Cumulative number of	0	1,500,000	4,500,000	9,520,000	
		Source				

[36] As defined in Health Facility Assessment: # HF that have ordered ACTs in last 3 months, stock card agrees with hand count of ACTs; no ACTs have passed expiry date; and have appropriate plan for ACT disposal

[37] Health Facility Assessment was done with WB funding in 2 out of the 6 states by the end of 2009; the 4 other states will be covered before end of FY 09/10, once tools and methodologies are reviewed; once completed baseline and milestone will be available

[38] Same as previous footnote

	commercial sector ACTs sold by supported commercial sector partners	Commercial sector partners reports				
IMPACT WEIGHTING						
20%						
						RISK RATING
						Medium
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID share (%)**	
	£ 6,128,082					
INPUTS (HR)	**DFID (FTEs)**					

OUTPUT 5	Indicator	Baseline	Target			Assumptions
Community awareness and demand for effective malaria treatment and prevention are improved	Proportion of nets received from the distribution campaigns and retained by the household that were used by any household member the night before the survey	N/A[39]	80%			RBM partners harmonize malaria control communication messages
		Source				
		Programme post campaign net retention and use surveys				
	Indicator	**Baseline 2010**	**Milestone 2011**	**Milestone 2012**	**Target 2013**	
	Proportion of women in child bearing age in supported states who know the preventive benefits of LLIN	57%	70%	80%	80%	
		Source				
		Omnibus survey				
	Indicator	**Baseline 2010**	**Milestone 2011**	**Milestone 2012**	**Target 2013**	
	Proportion of women in child bearing age in supported states who	29%	40%	60%	80%	
		Source				
		Omnibus survey				

[39] This indicator does not require baseline since distribution campaigns will only happen once and the indicator is expressed as a percentage of nets received. This indicator will only be measured for the States where SuNMaP programme had a substantial role in the campaign planning and coordination and where the programme contributed commodities and operational cost. The target has no associated period as it is dependent on when the campaigns takes place.

	know the preventive benefits of IPT					
IMPACT WEIGHTING	**Indicator**	**Baseline 2010**	**Milestone 2011**	**Milestone 2012**	**Target 2013**	
15%	Proportion of care givers in supported states who recognize need for treatment of malaria within 24 hours	86%	90%	90%	90%	
		Source				**RISK RATING**
		Omnibus survey				Low
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID share (%)**	
	£ 5,206,071					
INPUTS (HR)	**DFID (FTEs)**					

OUTPUT 6	Indicator	Baseline 2008	Milestone 2010	Milestone 2011	Target 2013	Assumptions
Operational research into key areas of prevention and treatment provides the evidence base for more effective strategies	Cumulative number of OR studies completed and disseminated	0	2	6	10	Results of OR are accepted at policy development level
		Source				
		OR reports and documents				
IMPACT WEIGHTING	**Indicator**	**Baseline 2008**	**Milestone 2010**	**Milestone 2011**	**Target 2013**	
5%	Proportion of OR studies that have confirmed current malaria strategies and practices or contributed to changes in malaria strategies or practices	0	0	20%	50%	
		Source				**RISK RATING**
		Programme Report				Low
INPUTS (£)	**DFID (£)**	**Govt (£)**	**Other (£)**	**Total (£)**	**DFID share (%)**	
	£ 2,447,114					
INPUTS (HR)	**DFID (FTEs)**					

Annex J. ADDITIONAL DETAIL ON SUPPORT TO THE COMMERCIAL SECTOR

(Section 4.4 of the main report is a summary of this annex – and the same numbering is used as in section 4.4)

4.4 SuNMaP's approach and management of its commercial sector work.

The mission's terms of reference require 'a review of progress of SuNMaP's work with the commercial sector, including its strategic approach and the management of its commercial sector programme'. The depth of this review of the commercial sector is inevitably constrained by the amount of time available, and it has not been possible to look at all the documents, spreadsheets and results of field surveys that might be available to a review focusing solely on the commercial sector. However, a number of key issues have emerged from the field work and from reading the documents provided and these are reflected here. Some of the statements may be obvious to some readers, but in trying to assess progress on the limited information available, the author has endeavoured to adopt a step-by-step approach and work through the key issues.

The commercial sector with which SuNMaP is engaged is concerned only with 'the exchange of merchandise' or trade and does not include those business entities that manufacture goods or those that provide services. Whilst the manufacturing of nets within Nigeria is not (and should not be) an immediate priority for SuNMaP, the current project focus (in terms of budget allocation and effort) solely on the commercial sector (specifically those who distribute nets) does not reflect the wider contribution that the private sector (both for-profit and non-profit) could make in the field of malaria control – particularly through its involvement in the provision of health care. However, SuNMaP's focus on the commercial sector correctly reflects what is found in its' documents (project memorandum, log frame and budget) and hence SuNMaP is currently seeking to achieve that which has been asked of it. This needs to be broadened to include a greater understanding of, and engagement with, private providers of health care.

4.4.1 Strategic direction

Why engage with, and seek to support, the LLIN commercial sector?

The rationale for engaging with the commercial sector in relation to the supply and distribution of LLINs[40] is that the current National Malaria Control Programme Strategic Plan envisages the 'keep-up' phase being achieved through a 'mixed-model that is a blend of stand-alone campaigns, routine net distributions and support to the commercial sector[41]'. However, the plan does not address how this might be achieved, the role each component is expected to play in relation to people's capacity and willingness to pay for nets nor the potential size and nature of the (unsupported) retail market.

These roles, in relation to people's capacity and willingness to pay, can be crudely assessed by knowing:

a) The level of availability of free or subsidised nets for those who have a right to LLINs (currently women who are receiving ANC but potentially a much larger number of both women and men who have no ability to pay);
b) The capacity/willingness of those who are not targeted for subsidy (i.e. women who are not pregnant and all men) to pay the real cost of a net in the retail market; and
c) The willingness of the commercial sector to invest in developing a retail market throughout the country in response to perceived and real demand (understanding what factors determine their interest in making such investments).

Without generating this information, it is difficult for SuNMaP to create a coherent strategy for developing the retail net market that is focused initially on 3 of the supported states.

Understanding the LLIN market and the supply chain: If engagement in the market is to become a significant reality, there is a need to understand in greater depth both the market and the supply chain – as these will influence the willingness of the commercial sector to engage in developing the retail market. There are a further three factors that require more understanding. These include:

A clear understanding of the range product(s): An LLIN is not a standard item, varying in terms of shape42, size, material43, weight, fittings and packaging. For the purposes of estimating effective demand, at least in the early stages, it will be important to simplify these into 2-3 of the most popular types of nets so that comparisons can be made within and between markets.

Understanding the demand side - the current and projected size of the market: The current unsupported national retail market for nets is small. It

[40] ACTs were part of the original focus but engagement in relation to this commodity has been put on hold pending finalising of the AMFM initiative.
[41] (including through transfer of long lasting technology to local net manufacturers and importers, reduction in taxes and tariffs and price support to reduce the retail price of nets).
[42] square, rectangular or conical
[43] Polyester, polyethylene, polypropylene

was estimated by SuNMaP to be 280,000 in 2008) but is likely to increase as a result of the current campaigns - influenced by awareness of the benefits of nets and by increased brand awareness. However, the effective demand will be determined by both ability and willingness to pay – about which relatively little is known. Kilian[44] advises that "household surveys suggest that 1-5% of families are already procuring a net from the commercial market in the first 6 months after the campaign, translating into a real demand of 280,000 – 1.4 million nets nationwide". That is useful information, but without knowledge of the socio-economic quintiles that this small percentage represents, it is not possible to assess whether or not this can be extrapolated to estimate the potential size of the unsupported commercial market as most of those who have purchased immediately after the campaign will be those who can afford to pay. The same survey indicates, not surprisingly, 'a higher rate in the wealthiest quintile whilst not entirely excluding the two poorest quintiles[45]'. A deeper understanding of capacity to pay is critical.

Whilst capacity to pay can be determined by comparing the retail price of a net with household budgets in the different socio-economic quintiles, willingness to pay assumes not only the capacity to pay but also that it is considered by the household to be an investment worth making when compared with the many other competing calls on its budget[46]. In their 2007 paper on willingness to pay[47] in relation to malaria prevention and treatment, Jimoh et al suggest that 'on average households in Nigeria are willing to pay $9.30 per month for the treatment of malaria (they are currently paying only an average of $3.60) and $61 per month (currently $22.60) for the control of malaria[48].

It is beyond the capacity of this review to comment on these figures, which appear high when compared with the number of Nigerians living on less than $1/day. However, significantly, they also note[49] *'with concern the association between willingness to pay and socio-economic status and the greater price sensitivity of the lowest economic groups.....there is cause for concern about relying on strategies of malaria control that require out-of-pocket contributions from all segments of the population ....there is an urgent need for strategies to protect the very poor from user fees through carefully designed and targeted subsidies'*. This implies that whilst there is a proportion of the population that is able and willing to pay for malaria prevention (including the purchase of LLINs), there are significant segments of the population for whom the purchasing of a net will be difficult or impossible and who will not be covered

[44] Personal communication by email dated 21 June 2010
[45] Personal communication from Ebenezer Baba
[46] For the price of a net costing N1,000 – a household could purchase around 67 candles (@N15 each), 16 large bottles of coke (Oroboa size), 15 litres of fuel (@N65 each), 20 maize cobs (@N50 each), 2 plastic bowls of garri (@N500 each), 6 dericas of rice, 5 dericas of beans and 5 x N200 phone recharge cards.
[47] Jimoh et al; Quantifying the economic burden of malaria in Nigeria using the willingness to pay approach: BioMed Journal; May 2007
[48] Protection, treatment and indirect costs
[49] Page 7

by routine distribution – a sector that needs to be defined and assisted, since without their continuing to own and use nets the 'keep-up' phase of 80% cover will not be maintained.

Whilst willingness to pay is a notoriously difficult characteristic to measure, it does allow a first attempt at understanding what proportion of the population is likely to be willing to pay the full commercial cost of a net – which constitutes the potential retail market for nets. Finally, the capacity and willingness to pay can be significantly altered if the cost of a net can be broken down into smaller components, as is the case with the small denomination phone scratch cards or with the opportunity to purchase small packets of soap powder or individual cigarettes or tea bags. Whilst a net cannot be physically divided into smaller parts, its purchase can be staggered through the use of susu-type savings schemes organised through trusted institutions at the community level.

As knowledge of the market increases, it can be segmented further based on location (e.g. urban, peri-urban and rural), those with the right to free nets (ANC, other vulnerable groups and potentially the poorest members of society[50]), levels of interest in purchasing specific types of nets (texture, colour, shape etc) and different brands.

Another factor determining the size of the retail market will be whether nets are provided to those eligible for a free net through public sector channels (i.e. purchased by the state and distributed through all types of health facilities) or whether those who are eligible are provided with a coupon or voucher which they can redeem in the retail market – as happens in Tanzania. If institutional purchases for free routine distribution continue to be significant (as seems inevitable if the 80% cover is to be maintained), then requiring the beneficiaries to access their nets through the retail sector (e.g. through the use of vouchers or coupons) would increase the size of the retail market by an equivalent amount – which would in turn increase the level of interest of distributors in that market. There is clearly a cost associated with the introduction of vouchers (or similar) and SuNMaP has taken the considered view that vouchers are not appropriate in the Nigerian context – at least during the life of the project.

A key justification for spending £10 million[51] in supplying nets for routine distribution (currently primarily for ANC) is to identify the most cost-effective way of achieving routine distribution, and reconsidering the voucher approach in each state as part of that assessment could be instructive. SuNMaP does accept the underlying premise that institutional nets for routine purposes should be purchased locally - suggesting that "the better option is to convince the states to procure their LLINs needed for the routine ANC distribution from

[50] Identified within communities through the use of emerging social protection techniques
[51] That is in addition to the £10 million budgeted to be spent on supporting the commercial sector partners

the local LLIN distributors[52]". Inherent in all these observations is the conflict between providing nets as cheaply as possible in order to achieve and maintain coverage (which may well be achieved through continued institutional purchase and distribution – providing that public funds are available) and establishing a sustainable retail market for nets, in which not only the cost of the net but also the cost of its distribution, has to be paid for by the purchaser.

Finally, whether projections of the retail market for LLINs are realized in practice will be significantly influenced by whether or not there are further waves of free nets distributed throughout the country (in addition to those penciled in for ANC) – such waves inevitably reducing the number of nets sold in the retail market.

Understanding the supply side - how the market works: Distributors and retailers are basically interested in shifting their stock as quickly as possible and will give preference to those fast-moving consumer goods (FMCG) that are most in demand, that generate the highest profit and which take up the least space. Nets are not a priority for many retailers – a relatively bulky product with currently limited and seasonal demand[53] and small retailing margins. Hence distributors, wholesalers and retailers may need to be encouraged to hold stock. Questions that need to be asked include: What margins do distributors and retailers require? How does a net compare with soap powder or soft drinks in terms of frequency of stock turnover, shelf-space taken, seasonality of demand etc? What size of retail market within a state or region justifies investment in exploiting that market? Some of this information may be available but was not apparent during the review. Once such information is available, and recognising that (in crude terms) profit is made up of volume (number of nets sold) times margin (income less expenditure), there may well be a case for encouraging retailers to stock nets through raising consumer awareness of nets (branding) and through reducing the retail price and increasing the margins through subsidy – a case that should be argued within the new engagement strategy.

Consumer awareness can be increased through two types of intervention – behaviour change communication (BCC) that increases awareness of the generic benefits of a net (preventing malaria, absence of mosquitoes etc) and branded advertising that encourages consumers to purchase a particular brand. BCC is part of SuNMaP's brief – in terms of both harmonising the message[54] and delivering the message, the latter funded both by DFID[55] and by other donors. Branded advertising can be funded using the funds available for developing the retail market.

[52] Kilian - personal communication by email dated 21 June 2010
[53] Nets are a considered purchase made very occasionally by householders compared with impulse purchases such as bread, cigarettes or tea bags
[54] This has been achieved, reflected in the Advocacy, Communication and Social Mobilisation Strategic Framework and Implementation Plan of 31 May 2010.
[55] The budget allocation is £2.58 million of which only 15% has been spent to date

To establish an appropriate level of net subsidy requires a knowledge of the costs involved at each point in the supply chain – ex-factory price, costs of clearing, of distribution and of selling, of warehousing and of insuring, of retailers costs etc – costs that are likely to be broadly the same for all distributors and retailers[56]. Information is also needed about the range of potential commercial distributors and their products, distribution networks, financial strength etc[57] – as well as of those engaged in the social marketing of nets[58]. Some of this information appears to be available, but not in a standardised or readily accessible format. Such information, and its analysis, should be summarised in the new SuNMaP private sector engagement strategy.

4.4.2 SuNMaP's current management of its commercial sector programme

What has happened to date?

The situation that SuNMaP found itself in during the early periods of the project was not easy – and this is reflected in the quarterly reports of April 2008 to June 2009. The government's decision to seek universal coverage with free LLINs not only impacted on the retail market for LLINs but also required SuNMaP to focus on both implementing the campaigns and learning the lessons from them. As a result, it would appear that the initial attempts to engage with the commercial net distribution sector took place during periods of intense field activity and without some of the required information being available.

The current contracts provide 3 selected net distributors (one of which is also a manufacturer) with a range of incentives. These were made as a lump sum payment in advance against agreed targets, any shortfall in meeting the targets to result in SuNMaP being reimbursed. This puts SuNMaP in a weak position. The current arrangements are also complex and require detailed reporting and accounting, whilst in contrast the contractual arrangements are very basic.

The inception report recommended that the current contracts should continue until their expiry, but that SuNMaP should make no further commitments to these suppliers, should increase its market research and work more closely with the Society for Family Health (SFH). No further contractual commitments have been made. Information on the market – in terms of what nets are available and where – has grown following the net market survey of April

[56] Varying with location, distance, population density etc.
[57] Note for the file: Documenting SuNMaP's LLIN commercial sector support approaches and activities May 2010
[58] Currently SFH is the major social marketing organisation, although its current sales of its "cost-recovery" net appears to be modest (around 250,000 nets per annum) and in a limited number of states

2010. However, this data is insufficient to enable a detailed estimate of the potential size of the market, either nationally or in the supported states to be made. There does not appear to be a structured relationship between SuNMaP and SFH through which each can learn from the other and plan how best to contribute to the high level of coverage that is required.

It was not possible to schedule a meeting with SFH during the review so the information presented here is second hand. This suggests that, although SFH is the leading social marketing organisation (SMO) in Nigeria, it is struggling to sell even its 'cost-recovery' nets – with current annual sales of around 250,000 of which around one third are in Lagos State and the balance restricted to a small number of other states. SFH has an 'exclusive' agreement[59] with Vestergaard-Frandsen for the retailing of its Permanet, which is by far the best known brand in Nigeria, at a cost-recovery price and SFH is able to keep its retail price down through cross-subsidy with other SM products. SFH is also due to receive 1.26 million nets from the GFATM, to be sold in the retail market for $0.65 – at between 10-15% of the regular retail price. What happens thereafter is not clear.

A report by the Mennonite Economic Development Association (MEDA) in November 2009 asked for greater control over the commercial sector partners (CSPs), linking payments to performance, obtaining detailed commercial information about the CSPs, building an M & E capacity that will feed back to the commercial sector (and to SuNMaP) and promoting the commercial sector as a source of nets rather than the public sector. It also proposed a very detailed contract to replace the existing one. SuNMaP has largely fulfilled the recommendations of MEDA[60]. However, it is questionable whether private companies[61] will share detailed commercial information with SuNMaP (that is information which reflects reality) and whether such information is necessary – particularly if payments are retrospective. SuNMaP should contract only with those companies that are financially strong and it is their performance in selling nets (rather than their continuing financial performance) that should be of primary interest to SuNMaP. Further, whether a complex contract is necessary is questionable given that the support to be provided by SuNMaP should be basic in nature. Contracts should be as simple and straightforward as possible, whilst ensuring that key issues are addressed and allowing for appropriate levels of monitoring.

The current situation is that there are currently 3 CSPs, of which one is a manufacturer and two are distributors (with one of these planning to move into the cut, make and trim business). As of March 2010, three quarters of the way through the first year's contracts, supported sales of 379,000 nets have been achieved out of a June 2010 target of 770,000 (49%) – distributed within

[59] This is not entirely exclusive as Vestergaard also has a restricted marketing agreement with Teta Pharmaceuticals
[60] Excluding the requirement for a more detailed commercial contract, as the original contracts are still extant
[61] As distinct from publicly quoted corporations

five states as follows (see table 8). Of these, 65% were sold within 3 of the supported states. 45% of these were sold in Lagos State alone).

Table 8. Distribution of supported sales of LLINs within states

State	Rosies	Teta	Harvestfield	Sub-total	%
Abia	71,000			71,000	18.6
Anambra		500		500	0.1
Kano	75,000	500		75,500	20.0
Borno	61,000			61,000	16.1
Lagos	62,000	28,000	81,000	171,000	45.1
Total	**269,000**	**29,000**	**81,000**	**379,000**	**100.00**

Rosies is a textile company with a long history of producing (bundled) nets and it is currently supplying the Net Protect brand. Under a contract signed in June 2009, sales began a month later – with the sum of US$739,000 advanced, equivalent to $2.46 per net. By the end of March 2010 the company had achieved 88% of its 12-month target of 300,000 nets – with 22% sold through pharmacies and market stalls, 17% sold through direct sales to schools and hospitals and 61% through distributors/wholesalers – mainly in Lagos and Kano states. The company is likely to meet its target and would appear to be a solid and competitive partner with which SuNMaP should continue to engage. The positive lessons from working with this CSP need to be recorded, analysed and fed into future interventions.

Harvestfield is a fast-growing company that started in the field of agro-chemicals and has moved into the area of malaria control – projecting 2010 gross sales of US$26 million of which more than 75% is projected to come from malaria control, in particular the sale of chemicals for IRS and larvicides. It represents manufacturers of three different types of nets[62] and has warehouses in 9 states, each of which has a mobile sales team, with Kano having 10 distributors servicing a network of retailers. Seemingly financial strong, although no formal financial data has been seen, the company has had for some time a stock of 700,000 nets that were imported speculatively for the institutional market and which must be carrying a significant interest charge. Attempts to assist the company to find an institutional market have failed – due to their uncompetitive price.

Harvestfield signed an agreement with SuNMaP in March 2009 with sales starting in July 2009, to date exclusively in Lagos State and with funds advanced of $220,000 – or a subsidy of approximately US$1.83/net. As at the end of March 2010 it had achieved 67% of its 120,000 sales target. A sign of Harvestfield's commitment to the malaria control sector in general, and the net market in particular, is its $800,000 investment in a cut, make and trim (CMT) facility that will allow the company to import WHOPES-approved netting in bulk and to make up nets to the varying shapes and sizes required

[62] Dawanet, Duranet and Lifenet

by this evolving market. With Vestergaard-Frandsen considering a similar arrangement with a textile company in Kaduna, this suggests that there will be at least 3 Nigerian companies capable of producing WHOPES-approved nets of different shapes and sizes.

Teta Pharmaceuticals is a relatively young company (established in 2001) that is distributing imported pharmaceutical products. With sales of only US$3.33 million it is a relatively small company. Teta is also distributing the most commonly sold net (Permanet) in competition with SFH and with Vestergaard imposing restrictions on where both organizations can sell their nets. Teta signed its agreement with SuNMaP in March 2009, with an advance of over US$700,000 (or $2.00 per net) but with sales not starting until November 2009 – to be focused on Kano, Lagos and Anambra. As at March 2010, Teta had sold just 8% of its target of 350,000 nets. The agreement with Teta has significant weaknesses and requires attention. This will not be straightforward, due to the involvement with Vestergaard and the associated market restrictions, hence a meeting involving SuNMaP, NMCP, SFH, Vestergaard and Teta might be required. The outcome of these discussions will be critical not only in determining the future relationship with Teta (if any) but also the amount of funds available in the CSP budget (with over US$600,000 having been advanced to the company not yet reflected in sales – a significant sum of money for a company to repay that has annual sales of only US$3.3 million).

Expressions of interest have been received from other companies, including C-Zard – which was previously part of the group supported by NetMark.

4.4.3 Where next with the commercial sector?

Earlier reviews (the inception report and the MEDA report) have highlighted the weaknesses of the current contractual arrangements and recommended that they should not be continued and that a new strategy should be developed. In response, SuNMaP has produced a 'new engagement strategy for commercial sector partners'[63]. This is not an easy document to read since it assumes a significant level of understanding by the reader of what has happened to date. The strategy focuses on the process of screening and how the several interventions will be made. Whilst a separate document[64] summarises the performance of the three CSPs and the funds disbursed, it does not provide a comprehensive review of the lessons learned during the past 12 months and how these are reflected in the new strategy. As a result, even though the strategy seeks to place itself in the context of the NMCP strategy of developing the mixed model, it does not appear to build strategically upon past experience. Ideally, such a strategy document would:

[63] Dated June 2010
[64] Note for the file: Documenting SuNMaP's LLIN commercial sector support approaches and activities May 2010

- Analyse the effect of the subsidies provided to date
- Assess whether or not supporting the price by around $2 has had any material effect on eventual prices, consumer demand and trader interest
- Describe the nature of the media support provided and what has been its impact
- Note the lessons learned, using them as part of the context within which to place the new proposals
- Provide an analysis of the keep-up market (including the impact of continuing supplies of subsidised nets and of the grey/leaked market) within which the retail market is to be developed – either nationally or in the supported state
- Comment on whether this is the best time to be providing support
- Estimate the cost of implementing the new strategy – without which it is difficult to assess cost-effectiveness
- Identify how the impact of the continuing support will be measured.
- Include some analysis of the attractiveness of the net distribution business[65]

A short summary of the current proposals is given in the box 2. Significantly, it gives limited priority to branded media advertising. It is hard to comment in detail on the new engagement strategy without having access to the market information referred to above (size of market, willingness to pay, cost of sales and margins), without knowing what level of financial support will encourage distributors to enter into/expand the commercial net market and without knowing the cost of implementing the new strategy.

The programme budget for price support to commercial LLIN sales is £10.25 million of which £1.31 million has already been spent in relation to a target of 770,000 nets – at a theoretical cost of £1.71 per net if the target is achieved. This leaves a balance of £8.94 million – more if the currently unspent balances are returned (by Teta in particular). The number of net sales that can be achieved through price support (both media promotion and direct price support) will depend upon the level of subsidy provided. At £1 per net this would be 8.94 million nets and at £2 would be 4.97 million nets. However, the objective is not to sell subsidised nets but to establish a sustainable commercial market – and that may be achieved by securing higher sales over a shorter period at a lower price to secure brand awareness and a presence in the market.

A number of questions arise from this strategy document:

- What impact is each of these interventions likely to have in practice and how can it be measured?
- What is the role for SuNMaP's state offices in promoting and monitoring their local retail markets?
- How to measure the impact – what is the baseline?
- Are there other ways of intervening – credit, susu, use of private health care sector, churches etc
- How to pull the nets to the states rather than push them from Lagos
- What is the justification for trying to engage with all manufacturers of nets[66]

[65] Porter's Five Forces matrix may provide a useful starting point for this

- Why are proposals not costed – making it difficult to see what level of penetration into the market can be achieved with the funds available?

Box 2. Key proposals of the new engagement strategy

1) **Importers and distributors.** SuNMaP intends to distinguish between the two, potentially offering incentives to both.
2) **Engagement with importers and distributors.** It wishes to engage with as many importers and distributors of WHOPES approved and NAFDAC-registered nets as possible (there are 7 brands meeting this standard) in order to encourage competition and choice and bring the price down
3) **Support to importers.** This will include a guaranteed market for an agreed volume, *generic* marketing support, access to soft loans and possible underwriting of bank charges.
4) **Support to distributors.** This includes:

- Facilitating access to limited amounts of working capital – possibly through paying the finance charges.
- Price support. A figure of $2 per net is proposed. Distribution support – through subsidising part of the cost of employment of two sales reps per distributor (including training, paying them sales commissions etc) – to be allocated to specific zones.
- Generic promotional material – T-shirts, caps, point of sale materials etc.
- Limited branded promotional material

As a general matter of principle, it is important to keep commercial transactions simple. SuNMaP accepts that all incentive payments should be made based on performance i.e. after the event. If possible there should be a single and standard payment reflecting each sale, the size of that payment based on the level of support found to be necessary in order to generate interest in the retail market. Only the commercially strong should become CSPs (based on their capitalisation and audited accounts) and hence monitoring their commercial health routinely should not be necessary. In contrast, there should be a strong flow of information from the market as to the levels and distribution of sales. This will help to assess the impact of the support and provide valuable information to the CSPs.

4.4.4 A suggested way forward

In the absence of the kind of analysis referred to above, it is difficult to see how a new engagement strategy can be developed. An investment of more than £10 million in supporting the development of the retail market requires a business plan. It needs a more thorough analysis of the market and of the supply chain. This should start with national policy in relation to maintaining

[66] Bearing in mind that prices do not fall exponentially as the number of competitors increase and that there is a point below which retail distribution of nets is no longer economic. It only needs a few competitors to push the price down.

cover, assess the capacity of people to pay (which will determine the size of the retail market and the extent to which it can contribute to 'keep-up'), explain the supply chain, present and analyse the lessons learned and how this is reflected in the new strategy, consider options/make recommendations for intervention and puts the revised strategy back within the context of the national policy. Whilst not a formal part of the terms of reference, a separate paper has been drafted and made available to SuNMaP that suggests how this might look in practice.

The priority recommendations regarding commercial sector engagement are:

1. Formally note and analyse the lessons learned (both positive and negative) from the first year of working with the CSPs, in each case noting how any future relationship should be amended – and include this in the new engagement strategy
2. Further define the retail market (i.e. who can and is willing to pay) and how it can be addressed – identifying not only those whose needs can potentially be met by the retail market but also those whose economic circumstances prevent this
3. In the light of this re-work and cost the new engagement strategy
4. Ensure that a senior member of the management team is able to dedicate adequate time to supporting and monitoring the commercial team and where necessary bring in experienced technical support

Other recommendations relating to operational issues are:

- Assess the options for supporting the development of the retail market through states purchasing their routine net requirements through local suppliers. By SuNMaP by December 2010
- DFID to formally request SFH and SuNMaP (both significantly funded by DFID) to meet regularly in order to discuss how 80% coverage can be maintained, what activities each is undertaking in order to address that need, what lessons are being learned, how best the need in the rural areas can be met and how each can assist the other to meet a demand which – even together – neither can fulfill. Minutes of these meetings should be copied to DFID.
- Address the relationship with Teta as a matter of urgency, any continued relationship to reflect (if possible, since SuNMaP has little power over this) a willingness by the company to refund monies advanced for sales not achieved.
- Work only with financially sound companies, whose financial performance does not need to be monitored – allowing the focus of monitoring to be on performance in the market and how it is achieved.
- Keep the incentives as few and as simple as possible, for ease of implementation and monitoring, such simplicity to be reflected in the engagement contract.
- Identify ways of making a net purchase easier for those on limited resources – possibly through the promotion of susu-type schemes in small institutions that are trusted by their communities.
- Avoid trying to engage with too many suppliers/distributors. It only takes a few competitors to bring the price down and if too many are competing some will inevitably drop out.

- In the short term the commercial sector staff should spend a significant proportion of their time in the supported states. They should build their knowledge of the local markets (including capacity to pay), meet the CSPs' local distributors and retailers (to identify their interests, constraints and potential incentives), assess the rogue elements in the market (grey nets, subsidised nets etc) and identify the links between the urban and rural markets and how the latter can be addressed. They should also discuss with the SMoHs, the potential for purchasing their routine distribution nets through the local suppliers, identify what forms of media are most likely to increase awareness (both generically and as branded products), and help the staff in the local SuNMaP offices to understand the CSP programme (as well as learning from their local knowledge and agreeing on what formal role they can play in both opening up the markets and monitoring the progress of the CSPs). This should enable detailed market reports for each of the supported states to be developed that will provide a solid foundation for discussions and negotiations with the CSPs.
- SuNMaP to continue to monitor the situation re ACTs and modify and cost its current range of proposals (which include RDTs) ready for the time when the AMFm plans and strategies have been fully developed and finalized. Ongoing by SuNMaP

If commercial sector staff are required to spend significant amounts of time in the field collecting market intelligence this should allow SuNMaP to develop relatively quickly, a workable and costed revised engagement strategy. During the coming months, there will still be a number of rogue elements in the market (including grey nets leaked from free distribution and heavily subsidized nets from GFATM) and it may be wise to let their influence diminish before making a major push into the market.

4.4.5 Engaging with private providers of health care

The private health sector

It is clear that malaria in Nigeria is treated in a variety of settings. Many Nigerians treat themselves at home using self-purchased products; their actions are influenced by generic BCC or through the places where they purchase their products – through pharmacies and Private Medicine Vendors (PMVs). Others prefer the institutional route, which includes both public and private health facilities. Private facilities can be divided into those that operate for profit (depending upon such profit to recover their costs of investment and reinvestment) and those (mainly faith-based) facilities that do not seek a profit, but whose investment and reinvestment costs are provided by third parties either from within their own network or from external donors. SuNMaP currently works almost solely through the public sector, yet in some locations, the majority of people use private facilities. If there is to be a coordinated and harmonised approach to malaria control, then all of these facilities must be involved.

As with intervening effectively in the LLIN market, in-depth knowledge of the market is essential. Who are these private providers (both for-profit and others)? What do they provide? At what cost? How are they funded? What is

the quality of care? How open are they to new ideas? Who are their clients? What is the market segmentation? Do they sell nets? If not might they sell nets? What role could they play re ACTs and RDTs? What role can they play in BCC/IEC?

A report produced for USAID by Health Systems 2020 on the private health sector[67] gives a first glimpse of this sector. It notes that:

- Although it employs the same number of doctors as the public sector, the private health sector has fewer support staff (nurses, laboratory staff etc);
- Salaries are comparable with the public sector;
- Private doctors are concentrated in the urban areas (80%) and in the south (62%),
- The major burden of service provision for malaria provision remains in the public sector (80%).

The report raises a number of issues about the higher productivity of the private sector, questioning whether this is due to actual higher productivity or to lower standards of care; and comments *"we need more data on characteristics of the clients of private health services in order to understand what out of pocket costs, such as consultation fees, represent in terms of a proportion of income (a measure of financial burden) to household*s*"* – the same question that needs to be asked concerning LLINs. It would seem appropriate for SuNMaP to engage with Health Systems 2020 to understand its work more fully and how future cooperation could support this sector in becoming part of the 'mixed model'. This could contribute significantly to increasing the availability of both prevention (BCC and LLINs) and treatment (RDTs and ACTs).

Recommendation

SuNMaP to invest in building an understanding of the private health sector, both for-profit and non-profit – asking the questions noted in section 4.4.5[68]. By SuNMaP by December 2010

Responding to the Affordable Medicines Facility for Malaria (AMFm)

This facility, which will make ACTs available at nominal cost (5% of the normal retail price) is in the last stages of development and exactly how it will operate in Nigeria is still not clear even to those charged with overseeing its implementation. Many issues are being raised, including the potential for overuse, given the current limited capacity for diagnosis, the long term impact

[67] Health Systems 2020. The Private Health Sector in Nigeria – An Assessment of Its Workforce and Service Provision. A report for USAID - dated June 2009 (to be published in June 2010)

[68] The health facility assessment exercise being undertaken by SuNMaP will provide an initial interface with this sector that can be further developed to generate a deeper understanding of the sector, also building on the work and experience of the authors of the USAID report (see previous footnote).

on developing a sustainable retail market, how to secure buy-in from medicine sellers, the potential role of local manufacturers etc. SuNMaP is adopting a cautious position, has undertaken a detailed review of the options for contributing to the scheme (the decision on which to implement depending upon how the scheme works out in practice) and has highlighted the importance of building the capacity within the healthcare sector for diagnosis through RDTs. Proposals for the latter are still in preparation, but in principle have significant merit and – if the £3 million programme budget for price support to ACTs should not be needed for that purpose - potentially its utilisation to promote RDTs could have a significant impact on the capacity to treat malaria based on an accurate diagnosis.

Recommendation

Continue to monitor the situation re ACTs and further refine and cost the proposals currently being developed by SuNMaP (which include RDTs) ready for the time when the AMfM plans and strategies have been fully developed and finalised.

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