NATIONAL MALARIA STRATEGIC PLAN,

2021 – 2025

NATIONAL MALARIA ELIMINATION PROGRAMME

FEDERAL MINISTRY OF HEALTH
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National Malaria Strategic Plan, 2021 - 2025
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Foreword

Malaria is still a major public health challenge but we are determined as a nation to reduce the burden to an insignificant level and to finally eliminate it from Nigeria. The National Malaria Strategic Plan (2014 - 2020) presented a very determined plan to commence in earnest a transition from malaria control to malaria elimination. It signified the efforts at ensuring a reduction in ill-health and death caused by malaria and a drive towards the eventual elimination of the disease.

The implementation of the plan resulted in further reductions in prevalence from 27% in 2015 (NMIS) to 23% in 2018 (NDHS). A total of 130.42 million LLINs were distributed through campaigns in 33 states while over 16.3 million LLINs were distributed through the routine system. The percentage of pregnant women who slept under LLINs increased from 49% in 2015 to 58% in 2018 and for children under five years, from 44% in 2015 to 52% in 2018. Similarly, the cumulative number of children reached with the intervention from 2015 – 2019 was 12,583,379. A total of 48,329,983 SMC treatments were provided in 101 LGAs.

The access to ACTs improved significantly to 52% (2018 NDHS) from 18% in 2013, while testing with either microscopy or RDT from both public and private health facilities increased slightly from 13% in 2015 (NMIS) to 14% in 2018 (NDHS) and facility report completeness on the DHIS increased from 53.2% in 2014 to 79.2% in 2018. The development of this Malaria Strategic Plan is therefore anchored on lessons learnt over the years.

The vision of the NMSP, 20121-2025 is to achieve a malaria-free Nigeria while the goal is to achieve a parasite prevalence of less than 10% and reduce mortality attributable to malaria to less than 50 deaths per 1,000 live births by 2025. Our priority is to ensure the delivery of robust multi-stakeholder, multisectoral and appropriate strategy mixes based on the stratification of Nigeria into low, medium, high and very high epidemiological areas to achieve a rapid reduction in malaria burden and deaths while maintaining consistency with the key principles and pillars of the National Strategic Health Development Plan.

The implementation of the prioritized strategies and key activities will be rested on the High Burden High Impact (HBHI) approach of high political will; strategic information to drive impact; better guidance for policies and strategies with a coordinated national malaria response. We will continue to work with all our partners such as WHO, the Global Fund, World Bank, UK-DFID, USAID, UNICEF, AFRICARE and other RBM partners towards the achievement of global and national malaria targets. We are committed to ensuring improved local resources and effective coordination of both the public and the private sectors.

We are also set to provide the leadership required for the achievement of the objectives of this plan to ensure the improvement in the quality of life of Nigerians despite the pressure on the health system brought about by the COVID-19 pandemic. I wish to thank all our partners and other stakeholders who supported the development of this plan.

Thank you.

Dr Osagie Ehanire, MD, FWACS

Honourable Minister of Health

Acknowledgements

The new National Malaria Strategic Plan, 2020 – 2025 was developed through a series of virtual and face to face meetings, technical sessions and reviews in line with the National Centre for Disease Control's guideline on Covid-19 pandemic. The pandemic brought out the creative skills and the determination of the national programme and the malaria partners in Nigeria to ensure that the gains of the recent past are not reversed.

We wish to express our gratitude to the Honourable Minister of Health, Dr Osagie Ehanire, who approved and guided the development of the plan. We are grateful to the Honourable Minister of State, Dr Olorunninbe Mamora for his firm support for the process. Similarly, our thanks go to the Permanent Secretary, Alhaji Abdullahi Mashi as well as the Director of Public Health, Dr Umo Mildred Ene-Obong for their leadership and commitment to the development of this plan.

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I also want to thank the Malaria Partnership in Nigeria who supported the development of the plan, particular thanks go to the Global Fund to Fight Aids Tuberculosis and Malaria, UK-DFID /SuNMaP 2, USAID /PMI, ACOMIN, Catholic Relief Service (CRS), Clinton Health Access Initiative (CHAI), Society for Family Health (SFH), Management Science for Health (MSH), Jhpiego, Malaria Consortium (MC), Breakthrough Action- Nigeria (BA-N), UNICEF, AFRICARE, CAMA, University of Ibadan, Malaria Technical Director- GF and the World Health Organization for providing both technical and funding support for the Malaria Strategic Plan development process.

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I sincerely thank all the members of the Technical Working Group (TWG), the subcommittees of the TWG, the NMEP heads of Branches and Staff of the National Malaria Elimination Programme for their priceless contributions.

Dr Audu Bala Mohammed

National Coordinator, NMEP.

List of Acronyms

ACSM	Advocacy Communication Social Mobilisation
ACTs	Artemisinin-based Combination Therapy
AGPMPN	Association of General & Private Medical Practitioners of Nigeria
ANC	Ante-Natal Care
AOP	Annual Operational Plan
ATM	AIDS, Tuberculosis and Malaria
BCC	Behaviour Change Communication
BFSR	Bimonthly Facility Stock Report
BHCPF	Basic Health Care Provision Fund
BMGF	Bill & Melinda Gates Foundation
BOD	Burden of Disease
CAMA	Corporate Alliance on Malaria in Africa
CBHCs	Community Based Health Care Services
CEFPs	Community Engagement Focal Persons
CHAI	Clinton Health Access Initiative
CHE	Current Health Expenditure
CHEW	Community Health Extension Workers
CHIPS	Community Health influences
CHWs	Community Health Workers
cIPTp	community Intermittent Preventive Treatment in Pregnancy
CM	Case Management
CORPS	Community-Oriented Research Persons
CRF	Consolidated Revenue Fund
CRS	Corporate Social Responsibility
CSOs	Civil Society Organizations
DF	Dangote Foundation
DFH	Department of Family Health
DFID	Department for International Development (UK)
DHIS	District Health Information System
DPRS	Department for Planning, Research and Statistics
DQA	Data Quality Assurance
DRF	Drug Revolving Fund
DTET	Drug Therapeutic Efficacy Test
EIR	Entomological Inoculation Rate
EQA	External Quality Assurance
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, TB Malaria
GMP	Global Malaria Programme
GoN	Government of Nigeria
GTS	Global Technical Strategy
HBHI	High Burden to High Impact
HDCC	Health Data Consultative Committee
HDGC	Health Data Governance Council
HDI	Human Development Index

HF	Health Facility
HIS	Health Information System
HMB	Hospital Management Board
HMIS	Health Management Information System
HW	Health Workers
iCCM	integrated Community Case Management
ICT	Information Communication Technology
IDPs	Internally Displaced Persons
iMSV	integrated Monitoring and Supervision
IPC	Inter-Personal Communication
IPs	Implementing Partners
IPTi	Intermittent Prevent Treatment in Infants
IPTp	Intermittent Preventive Treatment in Pregnancy
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Net
IVM	Integrated Vector Management
LBW	Low Birth Weight
LGA	Local Government Area
LLIN	Long-lasting Insecticides Net
LMCU	Logistics Management Coordinating Unit
LMD	Last-Mile Delivery
LMIS	Logistics Management Information System
LSM	Larva Source Management
M&E	Monitoring and Evaluation
MDA	Ministry, Department and Agencies
MDGs	Millennium Development Goals
MFO	Mixed Function Oxidase
MHPLMIS	Malaria Health Products Logistics Management Information Systems
MICS	Multiple Indicator Cluster Survey
MiP	Malaria in Pregnancy
MIS	Malaria Indicator Survey
MPR	Malaria Program Performance Review
MSP	Malaria Strategic Plan
MTEF/FSP	Medium Term Expenditure Framework and Fiscal Strategy Paper
NAFDAC	National Agency for Food and Drug Administration and Control
NAPPMED	Nigeria Association of Patent and Proprietary Medicine Dealers
NASCP	National AIDS and STDs Control Programme
NC	National Coordinator
NCD	Non-Communicable Disease
NCDC	Nigeria Centre for Disease Control
NDHS	Nigeria Demographic and Health Survey
NEMA	National Emergency Management Agency
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
NHLMIS	National Health Logistics Management Information System
NHMIS	National Health Management Information System
NIMR	Nigerian Institute for Medical Research
NLSS	Nigerian Living Standard Survey
NMEP	National Malaria Elimination Programme

NMICS	Nigeria Multiple Indicator Cluster Survey
NMIS	Nigeria Malaria Indicator Survey
NMORA	National Malaria Operations Research Agenda
NMSP	National Malaria Strategic Plan
NPHCDA	National Primary Health Care Development Agency
NPSCMP	National Products Supply Chain Management Programme
NSHDP II	National Strategic Health Development Plan 2
NTLCP	National Tuberculosis and Leprosy Control Programme
OCA	Organisational Capacity Assessment
OOPE	Out-of-Pocket Expenditure
OR	Operational Research
PBO	Piperonyl butoxide
PCR	Polymerase Chain Reaction
PHC	Primary Health Centre
PM	Programme Management
PMI	President's Malaria Initiative (US)
PMIS	Pharmaceutical Management Information System
POD	Proof of Delivery
PPEs	Personal Protective Equipment
PPMV	Patent and Proprietary Medicine Vendors
PPP	Public-Private Partnership
PSM	Procurement and Supply Management
QA	Quality Assurance
QC	Quality control
RAS	Rectal Artesunate
RBM	Roll Back Malaria
RDT	Rapid Diagnostic Test
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
SBC	Strategic Behavioral Communication
SDGs	Sustainable Development Goals
SEMA	State Emergency Management Agency
SHIS	State Health Insurance Scheme
SMC	Seasonal Malaria Chemoprevention
SMEOR	Surveillance, Monitoring, Evaluation and Operation Research
SMEP	State Malaria Elimination Programme
SMOH	State Ministry of Health
SOML	Saving One Million Lives
SOP	Standard Operating Procedure
SP	Sulphadoxine/Pyrimethamine
SPHCDA	State Primary Health Care Development Agency
SUFI	Scale-Up for Intervention
SuNMaP	Support for Nigeria Malaria Control Programme
TA	Technical Assistance
TWG	Technical Working Group
U5MR	Under 5 Mortality Rate
UHC	Universal Health Coverage
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United National Children's Fund

USAID	United States Agency for International Development
USD	US-Dollar
VHWs	Volunteer Health Workers
WB	World Bank
WDCs	Ward Development Committees
WHC	Ward Health Committee
WHO	World Health Organization
WMR	World Malaria Report

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Executive Summary

In the last two decades, Nigeria and her partners have committed significant human, financial and material resources to reduce the malaria burden and to work towards achieving a malaria-free status. The overall objective of many of the earlier plans was to rapidly scale up interventions to achieve the reduction of the burden of disease or mortality due to malaria by agreed percentages. The goal of the National Malaria Strategic Plan (NMSP) 2014-2020 was to reduce the malaria burden to under 5% and malaria-related mortality to zero. Although the goal was not achieved, there was a substantial reduction in the prevalence of malaria from 42% in 2010 (NMIS,2010) to 23% in 2018 (NDHS, 2018).

Vision, Mission, Goal and Objectives of NMSP 2021 – 2025.

The Vision - A MALARIA free Nigeria

The Mission - To provide equitable, comprehensive, cost-effective, efficient and impactful malaria control interventions through transparent, accountable, client-oriented, community-owned and multisectoral approaches that contribute to a strengthened health system

The Goal - To achieve a parasite prevalence of less than 10% and reduce mortality attributable to malaria to less than 50 deaths per 1,000 live births by 2025.

The Objectives

1. Improve access and utilization of vector control interventions to at least 80% of the targeted population by 2025.
2. Ensure provision of chemoprevention, diagnosis and appropriate treatment for 80% of the target populations at risk by 2025
3. Improve generation of evidence for decision making and impact through reporting of quality malaria data and information from at least 80% of health facilities (public and private) and other data sources including surveillance, surveys and operations research by 2025.
4. Strengthen coordination, collaboration, and strategic partnership to promote efficiency and effectiveness of malaria control activities towards achieving at least 75% improvement from baseline using a standardized OCA tool.
5. Improve funding for malaria control by at least 25% annually through predictable and innovative sources to ensure sustainability at federal and sub-national levels

NMSP Implementation

This Malaria Strategic Plan (NMSP, 2021 – 2025) will be implemented through the existing health system structures at the facility and community levels and regarding the guiding principles and the priorities of the National Health Strategic Development Plan, 2018 – 2022, the High Burden, High Impact (HBHI) approach and the evidence from epidemiological stratification conducted. The need for multi-stakeholder and multisectoral coordination and collaboration at the Federal, State, LGA, Community and Household levels to deliver on the priorities of this plan has been highlighted at every stage of the plan development process.

The implementation of the Plan will be guided by the following principles:

- **Multi-stakeholder and Multisectoral Approach**: Successful implementation of the MSP Strategies and priority actions will most times require the involvement of actors from

different branches of NMEP, departments of FMOH and other line Ministries and Agencies e.g., Family Health, NPHCDA, SPHCDA, NHIS, SHIS, NPSCMP, NCDC, NEMA, SEMA, Private Sector, etc

- **Human Rights, Gender, and Equity**: High priority must be given to the vulnerable populations including the rural poor, women, children under 5, mobile populations, refugees, etc. Gender and Human rights issues should also be considered at all times.
- **Efficiency:** The use of available and prospective resources must reflect efficiency in allocation and at programmatic levels to ensure value for money.
- **Appropriate Interventions Mixes**: Deployment of strategies and intervention mixes across epidemiological zones should be based on epidemiological, entomological and socio-economical stratification of Nigeria.
- **Mechanisms for Performance Tracking;** NMEP and Partners should of necessity establish and operationalise mechanisms for tracking implementation progress, expenditure, commodities, etc.
- **Leveraging the Community Health Service**: Sub-national level implementation of malaria-related activities may not require creating different tiers of workstream. Existing structures and social infrastructure can be leveraged upon – Civil Society, CHIPs, WHC, etc
- **Risk Management**: The risks and assumptions around malaria programme implementation should be predicted and mitigated. These include issues around standards, internal control, external audit, quality issues, etc
- **Aid Effectiveness:** Malaria Partners in Nigeria must of necessity align their support to the country's priorities, ensure harmonisation and joint management for results. There should also be mutual accountability

NMSP Budget

The NMSP budget is **estimated at N1.89 trillion ($4.98 billion) for the five-year duration**. The mean cost per capita is estimated at N1,825 ($5.0) and the average annual cost is estimated at N378 billion (approx. $1bilion).

Resource Mobilisation

Beyond donors' support, NMEP and Partners will develop a Malaria Resource Mobilisation Strategy and Implementation Plan to operationalize and help achieve the targets set in Objective 5 of this Plan.

Mobilisation of resources through innovative methods, private sector support, expansion of social health insurance schemes and increased budgetary allocation to malaria control activities will help reduce the funding gap identified in table 5 of this Plan and ensure the sustainability of malaria programming in Nigeria.

Chapter 1. Introduction

1.1. Policy and programming environment:

The National Health Policy 2016, is the overall guiding policy for health care delivery in Nigeria; it stipulates that Primary Health Care (PHC) is the bedrock of Nigeria's health care delivery system. Nigeria also enacted the National Health Act 2014, which prescribes the Basic Health Care Provision Fund, designed to provide sub-national level resources to fund the delivery of the Basic Minimum Package of Health Services including malaria, basic emergency obstetric and new-born care.[1]

The National Health Policy and the Health Act guided the development of the second National Strategic Health Development Plan (NSHDP II) which articulates the position of Nigeria's health sector stakeholders in terms of the national health systems gaps, priorities and investment plan.

NSHDP II also articulates the strategies for health systems improvement at the community level with the support of Ward Development Committees (WDCs), comprising selected community leaders and members to ensure community participation, monitoring and accountability. Also, Community-Based Health Care Services (CBHCS) will be guided by the recently launched Community Health Influencers, Promoters and Services (CHIPS) initiative which aims to harmonise Community Health Workers (CHWs) and to better define their roles and coordination, with Community Health Extension Workers (CHEWs) expected to spend at least 60% of their time on CBHCS delivery.

The WHO Global Technical Strategy for Malaria 2016–2030 (GTS), adopted by the World Health Assembly in May 2015, provides a technical framework for all malaria-endemic countries. It is intended to guide and support regional and country programmes as they work towards malaria control and elimination[2]. The Strategy sets ambitious but achievable goals that include (i) reducing malaria case incidence by at least 90%, (ii) reducing malaria mortality rates by at least 90%, (iii) eliminating malaria in at least 35 countries and (iv) preventing the resurgence of malaria in all countries that are malaria-free by the end of 2030.

The "**High burden to high impact**" (HBHI) approach, launched alongside the World Malaria Report, 2018 is founded upon 4 pillars: political will to reduce malaria deaths; strategic information to drive impact; better guidance, policies and strategies; and a coordinated national malaria response. This new approach aims to intensify support for countries that carry the highest burden of disease.

Malaria control is also included under Goal 3 Target 3.3 of the Sustainable Development Goals (SDGs), which aims to "end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases" by the year 2030.

Nigeria's current strategy for malaria elimination is based on the NMSP 2014 - 2020. The Strategic Plan states the Government's goal to achieve pre-elimination status and articulates its priority thrusts for vector control, disease prevention for those at high risk and malaria case management. The Malaria Programme Review, 2019, highlighted the gaps and weaknesses related to the implementation of the previous MSP and provided future direction in terms of strategy mixes and the implementation approaches.

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[1] Minimum standard for primary health care in Nigeria,

[2] https://www.who.int/malaria/areas/global_targets/en/

1.2. MSP and the national planning cycle:

Nigeria's Ministry of Finance, Budget and Planning leads in national planning and the preparation of an annual budget for all sectors of the economy. This process ensures that resource allocation is prioritized in a manner that allows funds to reach where they are most required.

Section 81 of the Constitution of the Federal Republic of Nigeria, 1999 allows the President and the Governors to prepare and lay before the National and State Legislatures at any time in each financial year estimates of the revenues and expenditure of the Federation for the following financial year using the Medium-Term Expenditure Framework and Fiscal Strategy Paper (MTEF/FSP). The MTEF/FSP provides estimates and projections that guide annual budget planning and fiscal management over three years[3].

In Nigeria, crude oil output continues to have important implications for government revenues. In the first quarter of 2020, crude oil production accounted for 9.5% of Nigeria's real GDP. However, crude oil receipts constituted about 50% of the Federal government's revenues during the same period and about 90% of Nigeria's foreign exchange earnings[3].

The annual planning and financing for Health are guided by the priority areas of the National Strategic Health Development Plan, 2018 - 2022 (NSHDP II). It is noteworthy that malaria control occupies a major part of this plan under Priority Area 5 of the Strategic Pillar Two. The NSHDP II and the National Malaria Strategic Plan, 2014-2020 are operationalised through the respective annual operational plans.

The current NSHDP II 2018 -2022 serves as the key guiding document for the development of the new NMSP. It outlines specific predetermined objectives and interventions for the control of endemic diseases including malaria and sets clear targets for the National Malaria Programme.

Objective 14 of the NSHDP II seeks to "reduce significantly morbidity and mortality due to Malaria and move towards pre-elimination levels". This represents a significant alignment with the strategies outlined in the current NMSP and provides the direction for the Nigeria Malaria Strategic Plan, 2021 - 2025.

1.3. The Process of developing the NMSP, 2021 - 2025.

The National Malaria Elimination Programme and RBM Partnership to End Malaria in Nigeria commissioned a Malaria Programme Review (MPR) in November 2019. The findings and recommendations of the MPR set the tone for the development of the National Malaria Strategic Plan, 2021 – 2025.

Following the approval of the Hon. Minister of Health, the process of development started with the setting up of the Steering Committee and the Secretariat in July 2020. With support from the Technical Working Group (TWG) Malaria, the Steering Committee supported NMEP to develop a detailed work-plan for the planning process and supported the recruitment of the consultants that will support the planning process.

The MSP development process was categorised into 7 phases:

1. Organizing and preparing the planning process

[3] 2012 – 2023 Medium Term Expenditure Framework and Fiscal Strategy Paper.

2. Situation analysis – Programme review and validation

3. Developing a Strategic Framework

4. Developing an implementation framework

5. Developing an M&E framework

6. Finalizing and adopting the strategic plan

7. Strategic plan dissemination and resource mobilization

The challenge of Covid-19 pandemic necessitated the adoption of a mixed approach to the development process – (i) virtual stakeholder meetings/workshops and (ii) restricted physical meetings in line with the guidelines from Nigeria's Centre for Disease Control (NCDC).

The inception and orientation meeting held on August 3, 2020, with the presentation of the MPR findings and the finalisation of the MSP detailed work-plan. This was followed by one week of remote desk reviews and virtual meetings.

A three-week restricted physical workshop held at Kini Resort, Akwanga, Nasarawa State with strict compliance with the NCDC regulations. This workshop was supported by daily virtual participation (via zoom) of lead representatives of RBM Partners in Nigeria. The workshop produced the Strategic Framework, the Implementation Framework and the M&E Framework.

The costing of the MSP and the finalization were done with the support of the MSP development consultants, the TAs supporting the Malaria Programme in Nigeria and the sub-committees of the TWG Malaria.

Chapter 2. Country profile

2.1. Overview

Nigeria, the most populated country in Africa lies between latitudes 4° and 14°N and longitudes 2° and 15°E on the West coast of the continent with a total surface area of 923,708 sq. km. It borders Cameroon in the East, Benin to the West, Chad to the North- East, Niger to the North and on the south by the Atlantic Ocean (see figure 1 below).

The topography of its landmass is diverse with its terrain consisting of lowlands in the South, plateaus and hills towards the Centre, mountains in the South East and plains in the North. The highest point is Chappal Waddi at 2,419m in Taraba State in the North Eastern Region of the Country. The Rivers Niger and Benue run from the North-Western and North-Eastern parts of the Country respectively with their confluence in Lokoja from which it runs to the Delta region in the South where it communicates with the Atlantic Ocean.

Figure 1: Map of Nigeria showing the States, Regions and the borders

2.2. Socio-political system

Administratively, Nigeria operates a three-tiered federal system of governance comprising Federal, the 36 States and the FCT, and 774 Local Government Areas (LGAs). The LGAs are further divided into 9,565 political wards, which are the focus of PHC revitalisation to achieve UHC. For political and administrative purposes, the country is divided into 6 geopolitical zones (North East, North West, North Central, South East, South West and South

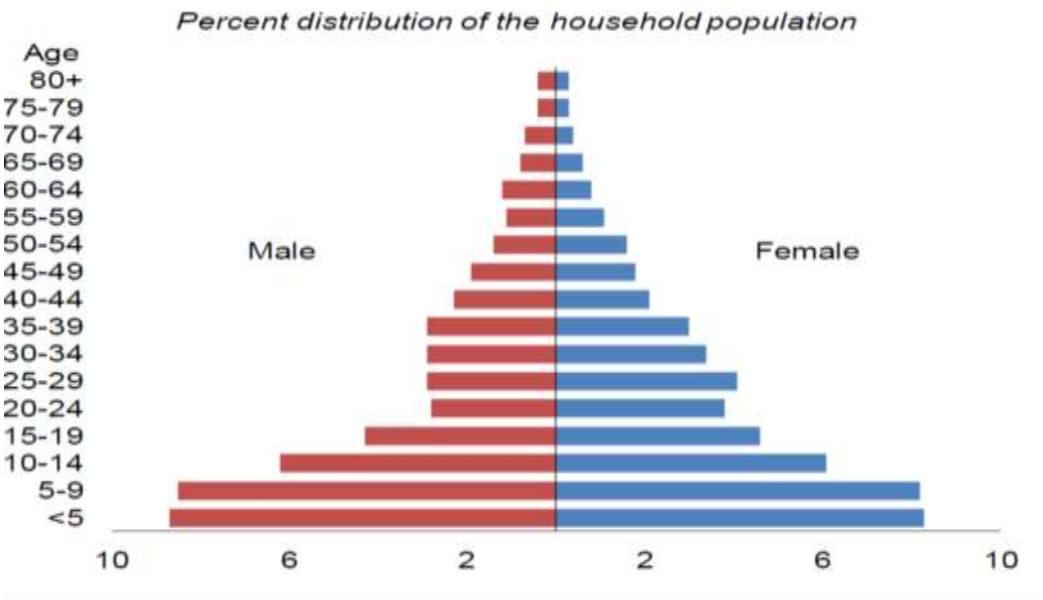
South). These geopolitical zones comprise states with a similar culture, ethnic groups, and common history.

Nigeria's return to democracy in 1999 till date remains the longest period of civilian rule since independence. In 2015, there was a peaceful transition of power to an opposition political party despite the political tension of that moment. Currently, the country is experiencing tense political rivalry, criminality and conflicts, particularly in the Northern part. Insurgency in the Northeast has displaced almost 2 million people in recent years. The conflict has had different impacts on women, men, boys and girls, and women and girls have been marginalized in the post-conflict peace-building process.

2.3. Demographic data

With a population of 203,081,567[4], the largest in Africa, Nigeria has about 374 ethnic groups that are broadly divided into ethnic "majorities" and ethnic "minorities". The major ethnic groups are the Hausa-Fulani of the north, the Yoruba of the southwest, and the Igbo of the southeast[5]. These ethnic groups speak over 500 different native languages and are identified with a wide variety of cultures. The dependent age groups constitute 50% of the population (disaggregated into 46% for children aged 0-14 years and 4% for adults ≥65 years)[6]. Also, children aged 0-17 constitute more than half (52%) of the population. The broad base of the population pyramid (figure 2) shows that Nigeria's population is typical of countries with a low life expectancy and high fertility rates. The average household size is 4.7 persons (disaggregated into 5.0 persons for rural and 4.3 persons for urban households respectively). The majority (82%) of the households are headed by men[3].

Figure 2: Population distribution by age group and sex (NDHS, 2018)



The segments of the population most affected by malaria are the children under-5 and pregnant women who constitute 20% and 5% of the population respectively. The under-5 mortality rate and maternal mortality ratio are 132 per 1,000 live births and 556 per 100,000

[4] World Population Review, November, 2019: http://worldpopulationreview.com/countries/nigeria-population/

[5] Abdul Rufus Mustapha. Ethnic Structure, Inequality and Governance of the Public Sector in Nigeria - Democracy, Governance and Human Rights Programme, Paper Number 24, November 2006. Page iv.

[6] NDHS, 2018

live births respectively[6]. Almost one-quarter (24%) of all malaria deaths globally are accounted for by Nigeria with children aged under 5 years being the most vulnerable group affected, accounting for 67%.[7]

2.4. Ecosystem, environment and climate

Nigeria has various ecological zones with vegetation changing from Sahel savannah in the far north followed by Sudan savannah merging into Guinea savannah in the middle belt, then Rain forest in the south and Mangrove forest in the coastal areas. In the northern part of the country, the transmission is highly intense during the short-wet season as compared with the low transmission during the long dry season. In the central and southern parts of the country, the transmission is intense, stable and uniform throughout the year.

The climate varies from arid in the North, with annual rains of 600-1,000 mm lasting for 3-4 months to predominantly humid weather in the South with an annual average of 1,300-1,800 mm (and in some coastal areas up to 2,500 mm) lasting for 9-12 months. Rainfall is highest in the Northern parts of the country between June and September and from March to November in the Southern parts, which usually coincides with the peak transmission of malaria. The geographic location of Nigeria makes the climate suitable for malaria transmission throughout the country. It is estimated that up to 97 per cent of the country's population risk of getting the disease. The remaining 3 per cent of the population who live in the mountains in southern Jos (the Plateau State) at an altitude ranging from 1,200 to 1,400 metres are at relatively low risk for malaria.

2.5. Socioeconomic situation

According to the Nigerian Living Standards Survey (NLSS) report released by the National Bureau of Statistics covering the year 2019, 40.1% of Nigerians estimated to be 82.9 million people are classified as poor by national standards.

Life expectancy is an important health indicator and a key component of the global Human Development Index (HDI) which ranks the social and economic development of nations. In Nigeria, life expectancy at birth in 2016 was 54.5 years, an increase of 7.5 years from 2007, but remaining below the national target of 70 years by 2015 and the global average of 71 years. According to the 2016 Global Burden of Disease Study, while Nigeria is undergoing an epidemiological transition, communicable diseases remain the major health challenge.

There are wide variations in heath and malaria services coverage, the burden of diseases and health outcomes across Nigeria's different regions and States.[8] For example, the U5MR range from 30 deaths per 1,000 live births in Ogun State to 252 deaths per 1,000 live births in Kebbi State (NDHS, 2018; the proportion of pregnant women who received ANC from a skilled provider ranged from 15% in Kebbi State to 97% in Imo State; the 33.8% malaria prevalence rate in children in the North-West region is more than double the prevalence of 15.6% in the South-South region.

A recent national survey showed a mother's low level of education and belonging to the lowest wealth quintile were associated with higher malaria prevalence among children under five. The prevalence was more than twice in rural than urban areas, and the upper economic quintile was least likely to have malaria (NDHS, 2018).

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[7] World Malaria Report, 2019

[8] See Table 4, page 35 of Annex 5, *Nigeria Health Programmes and Situation Analysis – February 2020.*

There has been a progressive spread of insecurity across Nigeria[9] including increased cases of the abduction of health workers. These insecurities have led to continued displacements of individuals and communities. The epicentre of North East insurgency in Nigeria are Adamawa, Borno and Yobe states, but IDPs are spread across all six North-East States to include Bauchi, Gombe and Taraba. Banditry and other forms of insecurities have also become frequent in the North West and the North Central regions of Nigeria. Women and children constitute the majority of IDPs and refugee populations, and their vulnerability to malaria and other health challenges is significantly aggravated by displacement

2.6. Health system analysis

2.6.1. Leadership and Administration

Nigeria has a pluralistic health care system with public and private health providers, with both modern and traditional health care systems. According to the Nigerian Constitution, 1999 (as amended), health care provision is the concurrent responsibility of the three tiers of the Government. The Federal Government is responsible for tertiary health care and also formulates health policies through the FMOH.

The FMOH coordinates and leads the implementation of specific public health programmes, e.g. the National Malaria Elimination Programme, the National AIDS and STDs Control Programme (NASCP), the National Tuberculosis and Leprosy Control Programme (NTLCP), the National Immunisation Programme, etc.

The State Governments provide largely secondary health care through the state General Hospitals and occasionally tertiary care through the State-owned Teaching Hospitals. They also coordinate PHC implementation at the LGA level through the State Primary Health Care Development Agency (SPHCDA).

The LGAs implement primary health care and manage the ward health committees, village health committees, private care providers, and traditional and alternative health care providers that enhance service delivery and community mobilisation.

With full fiscal decentralisation, each State Governor, the Parliament and State level ministries that echo the Federal-level set-up determine its budget and fund same despite being dependent on the consolidated income transfers from the Federation account. It is therefore advisable that Nigeria is treated like the Federal Government and 36 different entities each with their peculiar context.

2.6.2. Organisational Structure

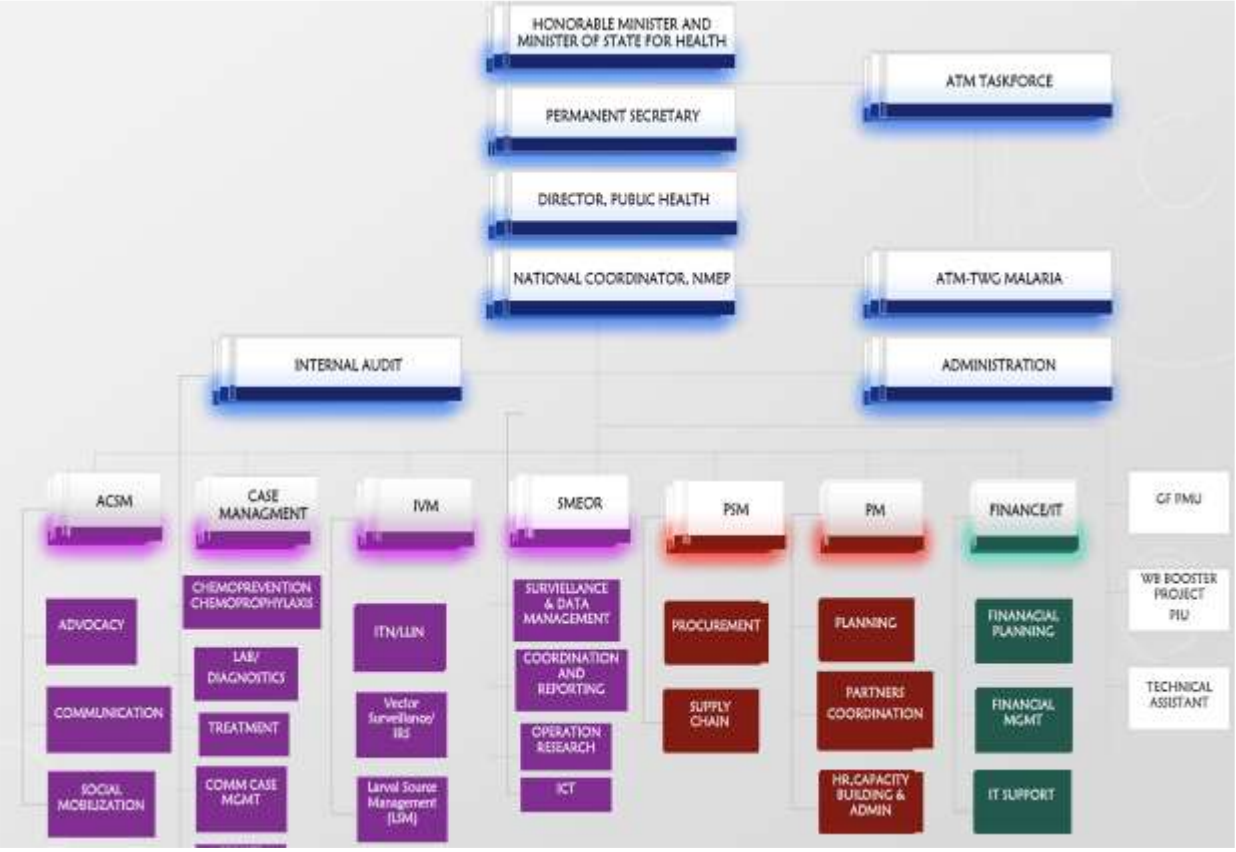
The Ministries of Health, are headed at the Federal and State levels by the Honourable Minister for Health and Honourable Commissioner of Health respectively. At the LGA level, the supervisory councillor for health leads the medical officer of health or the PHC coordinator to deliver primary health care services.

The NMEP is a division of the Department of Public Health of the Federal Ministry of Health responsible for policy formulation, coordination and regulatory roles on all matters that concern Malaria control and elimination in Nigeria. It has seven branches representing the programmes core task units, they include Programme Management; Integrated Vector Management; Case Management; Procurement and Supply Management; Monitoring and

[9] https://dtm.iom.int/reports/nigeria-%E2%80%94-emergency-tracking-tool-report-155-20-26-january-2020

Evaluation; Advocacy, Communication, and Social Mobilization and Finance. See Organogram below:

Figure 3: Organogram of NMEP



2.6.3. Policy and Legislative Framework

The National Health Policy and National Health Act, 2014 prioritize the provision of a comprehensive health care package that is based on Primary Health Care (PHC) to achieve universal health coverage (UHC). The FMOH has launched a 'Reach Every Ward' strategy which aims to have at least one functional PHC in each political ward for the delivery of the Basic Minimum Package of Health Services including malaria. The strategy also advocates community participation to facilitate ownership and accountability through the establishment of the Ward Development Committee (WDC) comprising of selected community members.

2.6.4. Health Work Force

Skilled health workers; doctors, nurses and midwives mostly provide care at the tertiary, secondary and PHC levels. Community-based health care services are provided by Community Health Extension Workers (CHEWs) who are expected to spend at least 60% of their time within the community and various cadre of Volunteer Health Workers (VHWs) who are engaged by different public health programmes through inconsistent standards and incentives

The NPHCDA recently launched the Community Health Influencers and Promoters of Services (CHIPS) initiative aims to facilitate task sharing and improve coordination of community health services.

The CHIPS strategy seeks to transition all current community-based workers from programmes that are phasing out into a single national programme. Both the training programmes and health workers will be integrated, so that there are one training programme, one curriculum and one category of community-based workers – the CHIPS Personnel, made up of CHIPS Agents and Community Engagement Focal Persons. A minimum of 10 CHIPS Agents, preferably females will be trained in each political ward. They will be responsible for working at the household level, to provide counselling, create demand and refer household members to PHC facilities for the uptake of needed services.

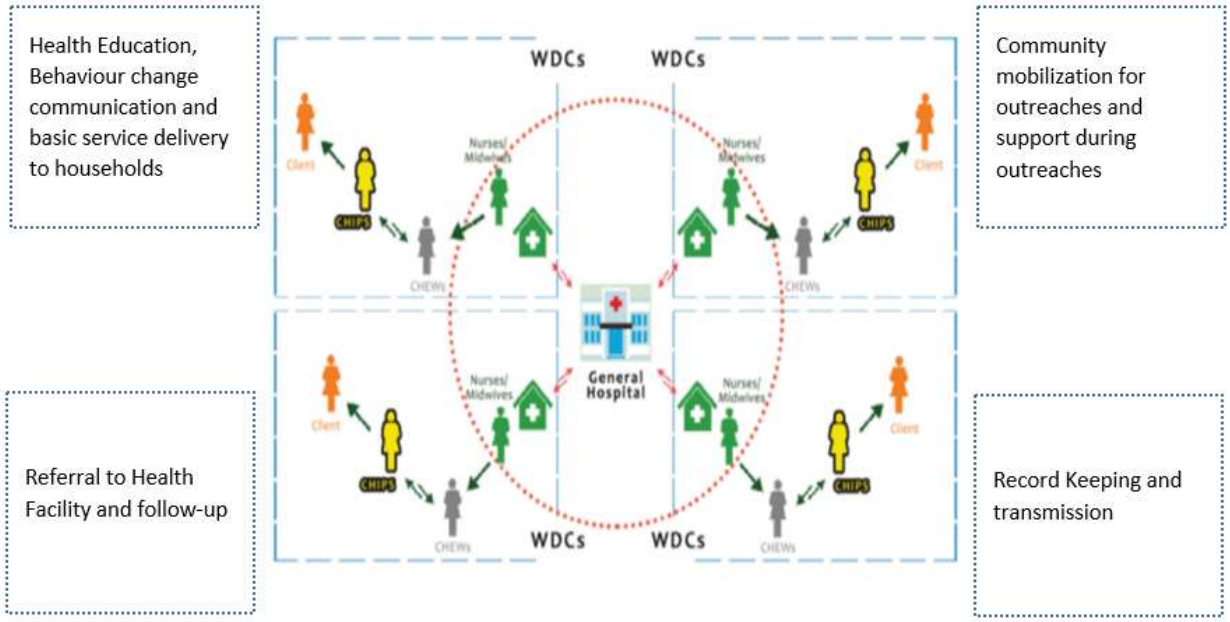
Also, they will provide basic preventive services, case management of fever, cough and diarrhoea in children under five years and first aid services. These will lead to an expansion of access to services, bringing health care as close as possible to where people live and work, and increase uptake of PHC services at the community and PHC facility levels.

The Community Engagement Focal Persons (CEFPs), preferably males, will be recruited to support the work of CHIPS Agents. Two CEFPs will be recruited per ward and trained. They will support the work of the CHIPS Agent by fostering male participation, promoting community engagement and participation through strategic participatory community communication interventions e.g. community dialogues, town hall meetings, community workshops, etc. targeting key stakeholders.

Critical to the success of the programme is ensuring the availability of a functional PHC in the ward that will serve as the site for referrals. The PHC facility serves as the anchor point for CHIPS management, supervision, and data collation. It also serves as an operational logistics hub for the distribution of commodities, which CHIPS Agents need for service delivery and to stimulate demand for services at the health facility.

For the deployment of CHIPS in the malaria programmatic environment, please refer to the **CHIPS Operational Manual**

Figure 4: Conceptual framework for the CHIPS Programme



2.6.5. Health Products Management

There are many policies, guidelines and institutions that facilitate a sustainable supply of high quality, safe and affordable medicines, vaccines and other health products. One of such institution is the National Agency for Food and Drugs Administration and Control (NAFDAC) which regulates and controls the manufacture, importation, exportation, distribution, advertisement, sale and use of Food, Drugs, Cosmetics, Medical Devices, Packaged Water, Chemicals and Detergents (collectively known as regulated products).

The Government of Nigeria with support from the Global Fund, established the National Products Supply Chain Management Programme (NPSCMP) to facilitate the integration of supply chain systems across all public health interventions/programs and ensure, effective logistics and supply of medicines and other health products to service delivery points. The NPSCMP coordinates the quantification, distribution and warehousing with oversight from the Department of Food and Drug Services of the FMoH. At the state level, the NPSCMP is coordinated through the State Logistics Management Coordination Units.

2.6.6. Health Information System

The revised Health Information System (HIS) policy and the HIS Strategic Plan 2014-2018 provide the framework for the collection, collation, analysis, storage, dissemination and use of health and health-related data. In line with this policy, the DHIS 2 is the platform for routine health facility data collection from public and private primary and secondary facilities at national and sub-national levels. The department of Planning Research and Statistics is responsible for overseeing and building capacity for data management within the Ministry of Health.

The Health Data Governance Council (HDGC), chaired by the Honourable Minister of Health, serves as the coordinating body that provides oversight and governance for health information and to foster the use of data for decision making. The Health Data Consultative Committee (HDCC) is the operational arm of the HDGC. Both the HDGC and HDCC are replicated at the State and LGA levels.

2.6.7. Health Care and Malaria Financing

Budgetary allocation to health at Federal and States levels has remained consistently low especially when compared to the recommendation of the Abuja Declaration. At the federal level, the annual budget in the last five years has been less than 5% of the total budget. The allocation to the National Malaria Elimination Programme for programmatic support (exclusive of salaries) within the Federal Health budget continues to decline from 2016. The proportion of Malaria budget as a component of the Federal budget reduced from 0.003% in 2016 to 0.0003% in 2019 representing a 10-fold decrease.

Out-of-pocket expenditure (OOPE), estimated at 76.6% of the Current Health Expenditure (CHE) in 2017 poses a huge barrier to accessing health services, worsening inequities in health outcomes and exposes the poor to impoverishment as a result of catastrophic health spending.

The National Health Account, 2017, estimated total expenditure on malaria at N1.9 trillion ($5.3 billion) with out-of-pocket (households) payment accounting for 78.4% of all malaria spending[10]. Government contribution to Malaria prevention and treatment totalled 17.8%,

[10] Federal Republic of Nigeria – National Health Account, 2017

with the Federal government contributing 12.2%, state government 4.5% and the local government 1.1%. Contribution from donor partners to Malaria control spending in 2017 was estimated at 3.6%[10].

To improve funding for the health sector, the National Health Act of 2014 provides for the allocation of 1% of the consolidated revenue fund (CRF) to fund selected priority health services under the Basic Health Care Provision Fund. Other sources for financing include the National and State Health Insurance Schemes, Private Sector Funds, Philanthropists, etc.

Chapter 3. Malaria situation analysis

3.1. Historical perspective of malaria control and elimination

In 2000, malaria was identified as one of the biggest impediments to global development and selected as a critical global target of the Millennium Development Goals (MDGs). The target set in the MDG (Target 6c) was to halt and begin to reverse the incidence of malaria by 2015.

A joint WHO-UNICEF report of September 2015 shows that the malaria MDG target was significantly met[11]. The number of malaria cases fell from an estimated 262 million in 2000 to 214 million and the annual deaths from malaria plunged from 839,000 to 438,000. Despite those achievements, more than 3 billion people mostly in sub-Saharan Africa remained at risk for malaria with significant funding gaps.

Domestic investments within malaria-affected countries as well as global bi-lateral and multi-lateral funding for malaria increased 20-fold between 2000 and 2015. This surge in funding led to an unprecedented expansion in the delivery of core interventions across sub-Saharan Africa with approximately 1 billion insecticide-treated bed nets (ITNs) distributed[11].

In the last two decades, Nigeria and her partners have committed significant human, financial and material resources to reduce malaria burden and to work towards achieving a malaria-free status. Ambitious targets were set in the National Malaria Control Plans, 2001-2005, 2006-2010, 2009-2013 and 2014 - 2020.

The overall objective of many of the earlier plans was to scale up for intervention (SUFI) package(s) of interventions to achieve a reduction of the burden of disease or mortality due to malaria by agreed percentages. The goal of the National Malaria Strategic Plan (NMSP) 2014-2020 was to reduce the malaria burden to under 5% and malaria-related mortality to zero.

In May 2015, the Global Technical Strategy for Malaria 2016–2030 was adopted by the World Health Organisation (WHO) and its member States. The strategy sets the target of reducing global malaria incidence and mortality rates by at least 90% by 2030, with near-term milestones of reductions in malaria case incidence and death rates of at least 40%, and the elimination of malaria in at least 10 countries for 2020. The report notes that these targets can only be achieved with political will, country leadership and significantly increased investment

Progression towards malaria-free status is a continuous process, and not a set of independent stages. Countries, subnational areas and communities are situated at different points on the path towards malaria elimination, and their rate of progress will differ and depend on the level of investment, biological determinants (related to the affected populations, the parasites and the vectors), environmental factors, the strength of health systems as well as social, demographic, political, and economic realities.

3.2. Epidemiology

3.2.1. Malaria parasites distribution

Five parasite species of Plasmodium have been documented to cause malaria disease in humans. These include *Plasmodium falciparum* (P.f), *Plasmodium vivax* (P.v), *Plasmodium*

[11] https://data.unicef.org/resources/achieving-malaria-mdg-target/

ovale (P.o), *Plasmodium malariae* (P.m), *Plasmodium knowlesi* (P.k). Malaria in Nigeria is principally due to *Plasmodium falciparum* and, a lesser extent to *Plasmodium malariae* and *Plasmodium ovale*. However, there are reports of P. vivax infection in Duffy negative individuals in the country.[12] *Plasmodium falciparum* accounts for 94% - 98% of infections, *Plasmodium malariae* accounts for almost 2% of infections, while Plasmodium ovale is rare, accounting for approximately 0.2% of all infections. The mixed infections account for 4%.[12.]

Plasmodium falciparum is the most virulent of the malaria parasites species and responsible for most reported severe cases[13]. It also causes heavy parasitisation of the placenta in pregnancy affecting the pregnant woman and the outcome of the pregnancy.

3.2.2. Malaria vectors distribution

Historically, thirty Anopheles species have been reported in Nigeria. Current data emanating from longitudinal surveillance sites supported by PMI and Global Fund across the five geo-ecological zones in Nigeria have recorded eleven Anopheline species. These are *An. gambiae, An. coluzzii, An. arabiensis. An. funestus, An. nili, An. moucheti, An. pharoensis, An. coustani, An. squamosus, An. pretoriensis* and *An. longipalpis.* Ten of these have been implicated in malaria transmission. *An. coluzzii, An. gambiae*, and *An. arabiensis and An. funestus* are the predominant vectors across all ecozones of the country. The composition of each of these vector species varies across the states and ecological zones in Nigeria.

Vector surveillance and insecticide resistance monitoring activities conducted with support from PMI across the five ecological zones in Nigeria from November 2018 to September 2019, to determine the species composition, behaviour, seasonality, biting rates, infectivity rates, blood meal sources, and entomological inoculation rates (EIRs) of malaria vectors across sentinel sites, showed that *Anopheles gambiae* s.l. was the most abundant species across the sites, ranging from 81.1% in Plateau to 98.2% in Akwa Ibom.

Other *Anopheles* species identified with limited distribution were *An. funestus*, *An. coustani*, *An. moucheti*, *An. nili*, *An. pharoensis*, *An. squamosus*, *An. maculipalpis*, *An. longipalpis*, *An. rufipes*, and *An. pretoriensis. An. gambiae*, a member of the *An. gambiae* s.l. complex, was found to be the dominant species both indoors and outdoors in Bauchi, Nasarawa, Oyo, and Plateau, while in Akwa Ibom, Ebonyi, and Sokoto, its predominance was limited to indoors (in Akwa Ibom, *An. coluzzii* predominated outdoors, while in Ebonyi and Sokoto, *An. arabiensis* predominated outdoors).

The highest proportion of *An. coluzzii* indoors was recorded in Ebonyi (39.4%), while the highest outdoor collections of *An. coluzzii* were in Akwa Ibom (40%). Hybrid forms were recorded indoors only in Akwa Ibom (2.0%), Ebonyi (1.2%), Nasarawa, (0.8%), Plateau (2.9%), and Sokoto (1.9%). *An. arabiensis* was found in all sites, with the highest indoor occurrence in Sokoto (43.5%) and the lowest in Ebonyi (3.6%)[14].

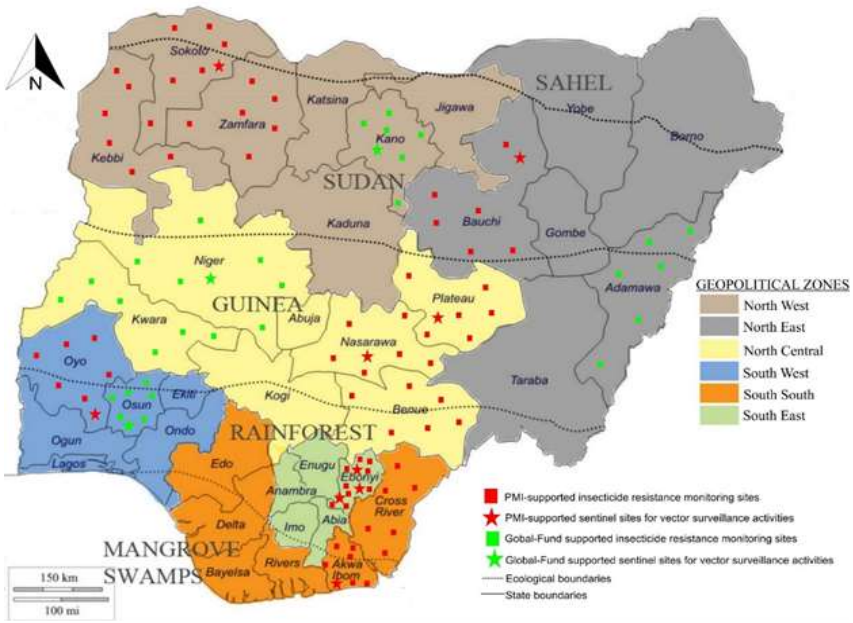
Figure 5: Map showing sentinel sites and sampling stations at the end 2019

[12] Oboh MA, Badiane AS, Ntadom G, Ndiaye YD, Diongue K MA Diallo, Ndiaye D. Molecular identification of Plasmodium species responsible for malaria reveals Plasmodium vivax isolates in Duffy negative individuals from southwestern Nigeria. Malar J (2018) 17:439.

[13] White NJ (2004) Antimalarial drug resistance. *J Clin Invest*.; 113(8): 1084 - 1092

[14] The PMI VectorLink Project. (2019). The PMI Vectorlink Nigeria Annual Entomological Report. November 2018 – September, 2019. Rockville, MD. VectorLink, Abt Associates Inc

Entomological Inoculation Rates varied by month, vector species, and location (indoor/outdoor). Indoor EIRs for *An. gambiae* ranged from 7.9 infective bites/person/year to 60.2 infective bites/person/year, while outdoor EIRs ranged from 10.3 infective bites/person/year to 134.9 infective bites/person/year. Indoor EIRs for *An. coluzzii* ranged from 20.4 infective bites/person/year in Nasarawa to 48.2 infective bites/person/year in Plateau. No outdoor EIR for *An. coluzzii* was recorded at any of the sites. Also, there was no record of indoor EIR for *An. arabiensis* across all sites. However, outdoor EIRs for *An. arabiensis* ranged from 2.7 infective bites/person/year in Plateau to 22.2 infective bites/person/year in Nasarawa[9].



Insecticide susceptibility test results indicated that pyrethroid resistance was widespread in *An. gambiae* s.l. mosquitoes at all sentinel sites across all ecozones. Some levels of resistance of *An. gambiae* to deltamethrin has been recorded in Akwa Ibom, Bauchi, Nasarawa, Sokoto, Zamfara. Ebonyi, and Plateau. In Plateau, low resistance intensity was observed in *An. gambiae* s.l. populations exposed to permethrin. Other outcomes showed that high permethrin resistance intensity exists in mosquito populations in Benue, Akwa Ibom and Ebonyi states.

The National Malaria Elimination Programme (NMEP) has gradually scaled up the establishment of entomological sentinel sites across the country where longitudinal mosquito collections and insecticide resistance monitoring would be conducted periodically. More recently, the emphasis has leaned towards insecticide resistance monitoring to inform programme decision on the deployment of insecticide-treated nets.

3.2.3. Dynamics of malaria transmission

Evidence shows that malaria transmission is high across the country, with higher transmission occurring in the rural communities and communities situated by the banks of major rivers and other bodies of water such as irrigation dams in the northern parts of the country.

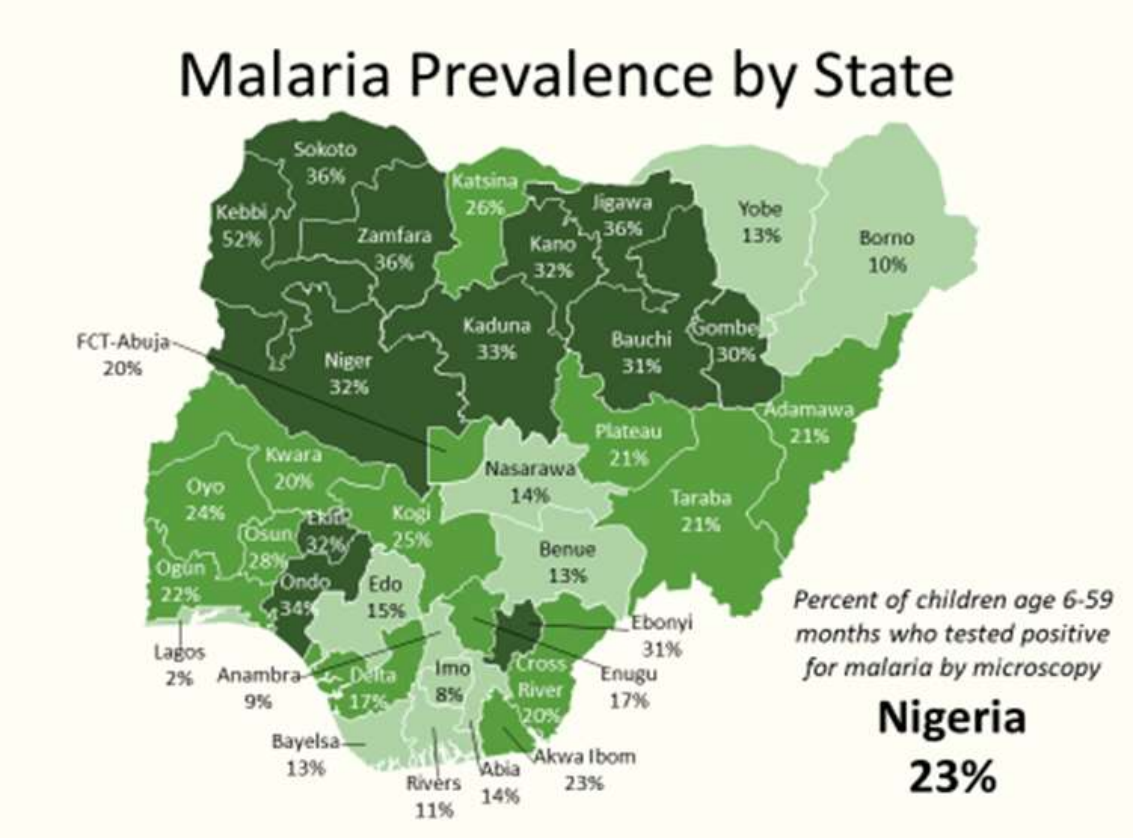
Rainfall occurs throughout the year in the Mangrove and Rainforest, there are 2 rainfall peaks in Guinea and Sudan savannah, usually commencing from March or April with a break in August, then continuing till October. Rainfall in the Sahel savannah commences around June or July and lasts for about three to four months. In most cases, malaria transmission seasons coincide with the rainfall pattern.

3.2.4. Morbidity and mortality

Nigeria recorded a significant reduction in malaria burden between 2010 and 2018 with parasite prevalence in children under-5 decreasing from 42% to 23%. Pregnant women and children are the most at-risk populations, with the highest prevalence in children age 6-59

months recorded in Kebbi State (52%) and the lowest in Lagos State (1.8%). State-level variation in malaria burden across different states in Nigeria is shown in figure 6 below. Regional variations do exist,

Figure 6: Malaria Parasite Prevalence across the states of Nigeria, NDHS, 2018



with the North West region having the highest prevalence of 33.8%, North East -- 19.9%, North Central – 21.2%, South West – 18.4%, South East – 15.7% and the lowest being South-South region with a prevalence of 15.6%.

Estimates of malaria deaths globally fell from about 400 000 in 2010 to about 260 000 in 2018, the most substantial reduction being in Nigeria, from almost 153 000 deaths in 2010 to about 95 000 in 2018 (WMR, 2019).

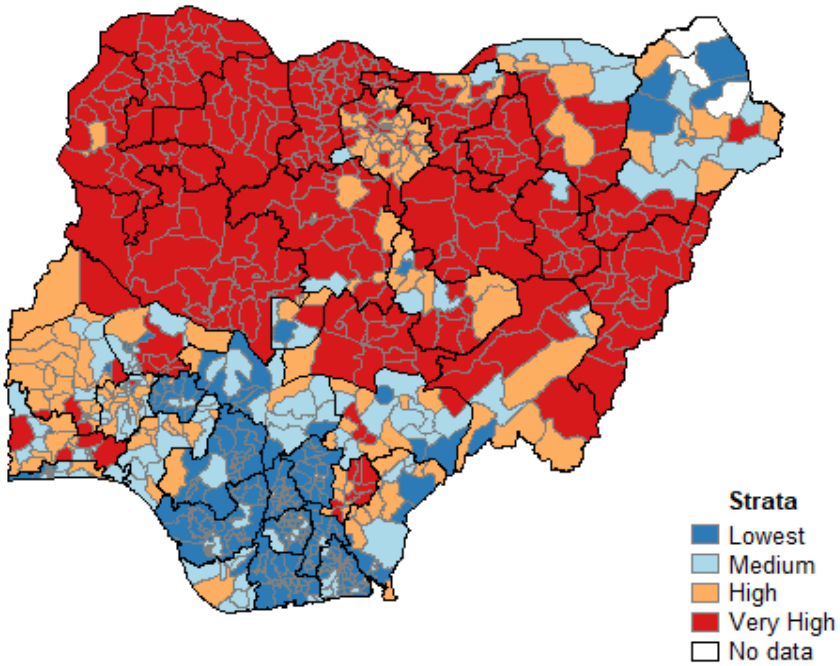
Malaria case incidence decreased from 450 per 1,000 in 2000 to 300 per 1,000 in 2018 and, over the same period, malaria-specific mortality fell from over 140 per 100,000 to below 50 per 100,000 (WMR, 2019).

3.2.5. Malaria stratification, mapping and intervention mixes

Nigeria recently undertook a comprehensive stratification of the malaria context to provide strategic information to guide a targeted approach to the deployment of malaria interventions. The new Nigeria's malaria map shows the distribution of malaria burden of disease (BOD) based on the combination of prevalence, incidence, under-five mortality, ecological, entomological, levels of urbanisation and access to HFs.

The stratification study combined the reported cases, prevalence and mortality due to malaria as a composite measure of malaria burden, thereby dividing the country into four strata: low, medium, high and very high burden areas (see figure 7).

Figure 7: Stratification and analysis for optimizing the mix of interventions and resource prioritization - Nigeria (Source: WHO GMP, 2019)



The stratification exercise also provided empirical analysis for targeting interventions at various subnational populations based on their respective epidemiological, ecological and health system contexts. Several states in the Sahel and Savannah areas have high seasonality (more than 60% of rainfall occurring in four consecutive months) and high transmission rates, therefore under-five children in these States were considered eligible for SMC implementation as shown in figure 8 below. This implies that 10 other states may be targeted for SMC in addition to the nine states that are currently targeted. Nigeria is working on a detailed micro-stratification in large urban areas and this will inform further targeting of nets in urban areas.

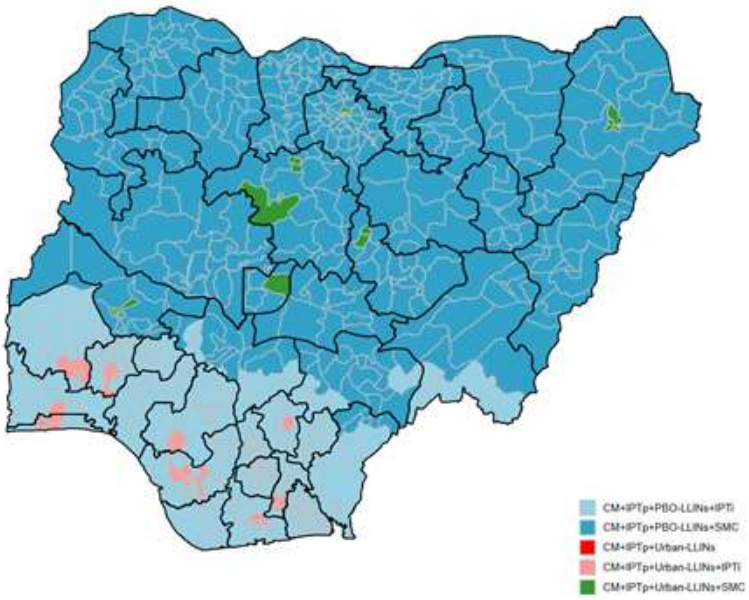


Figure 8: Map of Nigeria showing the stratification of Interventions based on epi-analysis

Epidemiological Analysis of Proposed Interventions

LLINS: All rural areas and small urban areas (<1,000,000 population) would continue to be targeted with LLINs. For urban areas with population >1,000,000 people, microstratification would be

implemented to decide if and where to target LLINS.

PBO LLINs: Within areas targeted for LLIN, where states have data on Mixed Function Oxidase (MFO) type resistance, this would be considered for the decision on PBO LLINs scale up. Urgent investments in resistance monitoring across states are important for evidence and decisions.

IRS: This is not proposed for resistance mitigation but as an alternative to LLINs. Although there were no resources available imminently for IRS scale-up in Nigeria through existing funding channels, the Strategy is proposed for high burdened states to rapidly reduce BOD or to take the lowest burden states closer to elimination (as an acceleration tool). Issues around the sustainability of resources and risk of a rebound if IRS was interrupted should be carefully considered and a clear transition plan should be in place.

LSM: Given the principles of few, fixed and findable, LSM is best suited to urban areas and the decision to scale up should be preceded by good entomological and geospatial surveillance.

SMC: Currently, Nigeria has identified the 9 sub-Sahelian states for SMC. However, the analysis identified additional states in the savannah area with seasonality and transmission profile and would be eligible for SMC.

IPTi: The NMSP proposes an IPTi **evaluation pilot** in some carefully selected set of LGAs in the non-SMC states in the first 3 years of the Plan to explore the SP resistance profile as well as the impact to inform further decisions.

iCCM: Access to care is defined by several factors outside of NMEP control. iCCM deployment is premised on the collaboration with key actors of the health system and the possible engagement with the private sector. The CHIPs programme of NPHCDA provides a new opportunity for iCCM implementation.

IPTp and Case Management: This NMSP has emphasised malaria activities integration with the broader health sector to improve ANC coverage as well as ensuring quality clinical case management in health facilities – in particular, health worker adherence to diagnostic results.

3.2.6. Impact Projections

The Goal, Objectives and Targets of NMSP 2021-2025 were based on key assumptions that the implementation of broad activities prioritized in this Plan will align with the scenarios modelled with the technical assistance of WHO.

These assumptions include: (1) Maintaining and sustaining current coverages and gains through 2025 – Business As Usual (BAU); (ii) Ensuring high effective coverage (>80%) across all core interventions; (iii) Increase from baseline by 10%; (iv) Increase from baseline by 20%; (v) Increase from baseline by 30%; (vi) Funded scenario with SMC LGAs: Increased SMC and ITN to 80% and IPTp was kept at BAU (this will impact mainly LBW and stillbirths) and (vii) Funded scenario without SMC LGAs

Figure 9: Projections of parasite prevalence in U5s based on different scenarios

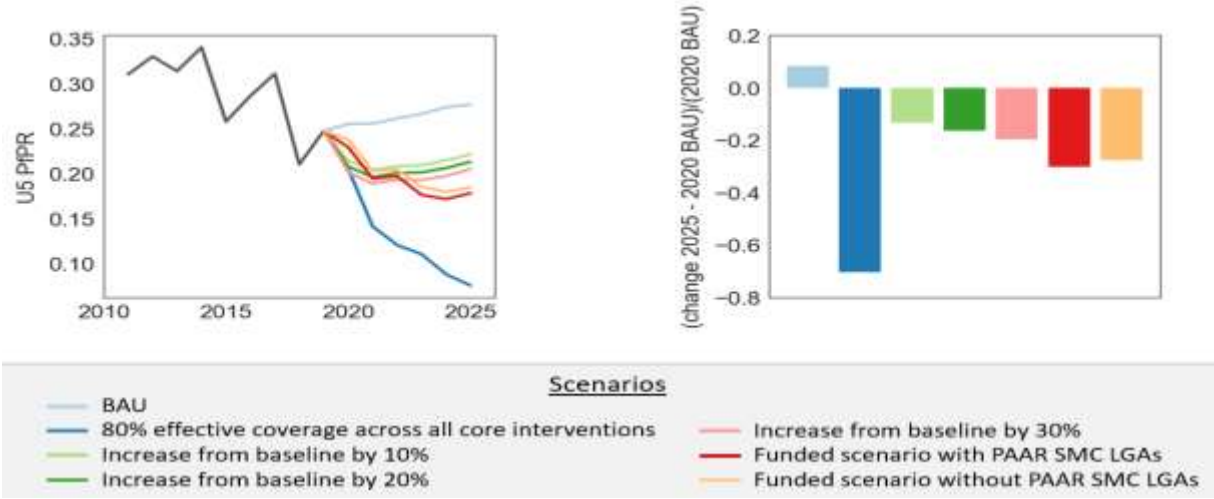
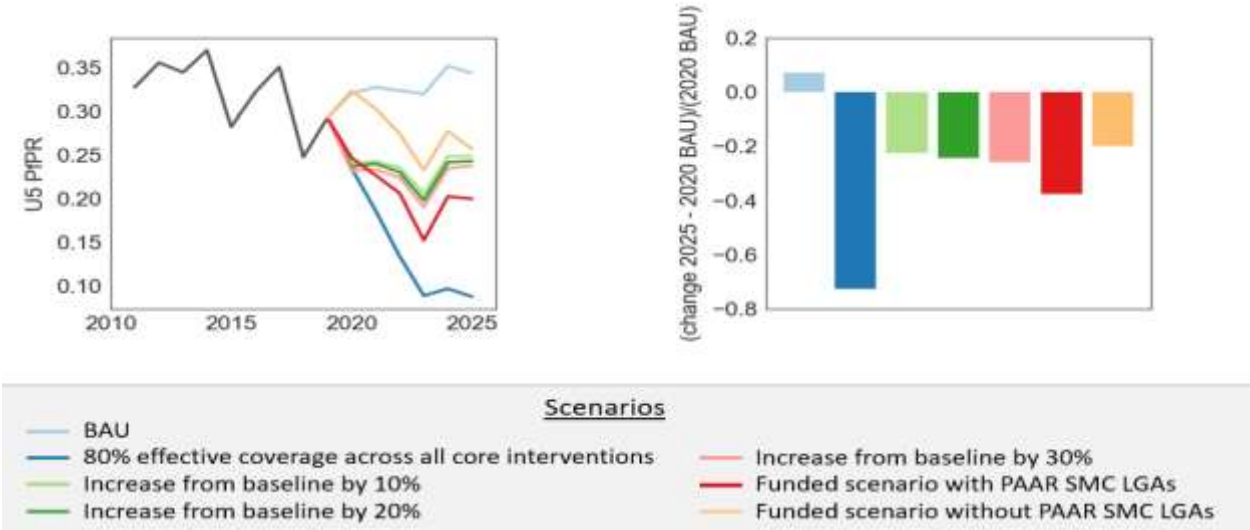


Figure 10: Projections of parasite prevalence in children under 5 years based on different scenarios and the additional impact of SMC implementation in eligible states



3.3. Review of the previous MSP

NMEP in collaboration with RBM Partnership to End Malaria in Nigeria commissioned an MPR with an inception meeting on Monday, 18th November 2019 to assess the progress made towards the implementation of the National Malaria Strategic Plan 2014 – 2020,

The purpose of the MPR was to ascertain the malaria epidemiology and response with regards to the burden, trends and efforts invested; carry out a revised stratification and create a framework for strategic revision to attain the relevant global and national targets in the light of the changing environment, new trends and other developments in malaria control and elimination space globally.

The 2019 Nigeria MPR had five objectives built around the five MPR questions:

- To assess the progress of the NMCP towards the epidemiological and entomological impact targets of the MSP during the period under review and make appropriate recommendations towards enhanced impact

- To review the level of financing of the NMCP during the period under review and make appropriate recommendations towards optimal financing
- To review the capacity of the NMCP to implement planned activities during the period under review and make appropriate recommendations towards the optimal capacity for programme implementation
- To review the attainment of programme outcome targets during the period under review and make appropriate recommendations for optimal delivery of malaria services
- To define the programming implications of the lessons learned in the implementation of the NMSP, 2014-2020.

Key findings of the MPR, 2019 are presented below:

3.3.1. Goal level achievement

The goal of the National Malaria Strategic Plan, 2014-2020 was to reduce the malaria burden to pre-elimination levels and bring malaria-related death to zero. While this goal was not achieved, a substantial decline in malaria prevalence from 2010 value was achieved (42% in 2010 to 23% in 2018).

3.3.2. Financing the MSP

The percentage budgetary allocation for health by Governments (Federal and States) as a percentage of overall investments have remained low (average of 5-7%) and consistently below the 15% recommended by African Heads of State during the Abuja Declaration of 2001.

Domestic Financing for Malaria Elimination has declined, and the proportion of the budget allocated to NMEP as a component of the FMoH budget reduced from 0.003% in 2016 to 0.0003% in 2019 representing a 10-fold decrease, widening the funding gap for the Malaria Strategic Plan.[15]

3.3.3. Objective level achievements and capacity to implement planned activities

Using an Excel-based 'Nigeria MPR 2019 Technical Performance Tool', the assessment of the capacity of NMEP to implement planned activities under each strategy was conducted to determine the overall performance rate by activity based on both quantitative and qualitative dimensions. The seven strategic objectives of NMSP 2014-2020 were implemented to varying degrees with an overall implementation rate of 53%.

The highest level of implementation was recorded on Objective 3 which deals with the treatment of all confirmed cases by 2020 with a score of 70%. The lowest level of implementation was recorded in Objective 7 which seeks "To strengthen governance and coordination of all stakeholders for effective programme implementation towards an 'A' rating by 2017 that is sustained through to 2020 on a standardized scorecard" with an implementation rate of 37%. Performance across the seven objectives is presented in the table below:

Table 1: Implementation rate of NMSP, 2014-2020 by strategic objectives

Strategic Objective	***%***

[15] Nigeria Malaria Programme Review Report, December, 2019 – page 47.

	implementation
Objective 1: To provide at least 80% of targeted population with appropriate preventive measures by 2020	*40*
Objective 2: To test all care-seeking persons with suspected malaria using RDT or microscopy by 2020	*46*
Objective 3: To treat all individuals with confirmed malaria seen in private or public facilities with an effective anti-malarial drug by 2020	*70*
Objective 4: To provide adequate information to all Nigerians such that at least 80% of the populace habitually takes appropriate malaria preventive and treatment measures as necessary by 2020	*60*
Objective 5: To ensure the timely availability of appropriate antimalarial medicines and commodities required for the prevention and treatment of malaria in Nigeria wherever they are needed by 2018.	*51*
Objective 6: At least 80% of health facilities in all LGAs report routinely on malaria by 2020, progress is measured, and evidence is used for programme improvement	*68*
Objective 7: To strengthen governance and coordination of all stakeholders for effective programme implementation towards an 'A' rating by 2017 that is sustained through to 2020 on a standardized scorecard	*37*
Overall average	***53***

3.3.4. Key Achievements on the Delivery of Malaria Services

Vector Control

- A total of 127.9 million LLINs were distributed through 45 campaigns in 32 states. In addition, 16.3 million LLINs were distributed through the routine system. LLINs durability monitoring shows an estimated median of 5.3 years in Zamfara and 3.2 years in Oyo State, the difference attributable to the difference in net use environment and net handling.
- The use of ITNs among children under age 5 has increased over the past 7 years, from 16% in 2013 to 52% in 2018. Similarly, the use of ITNs by pregnant women has increased from 17% in 2013 to 58% in 2018. However, the target of 80% set for both indicators in the NMSP, 2014 – 2020 was not met.

Chemoprevention

- The proportion of pregnant women who received **two or more doses** of SP rose from 14.6% in 2013 (NDHS, 2013) to 40.4% in 2018 (NDHS, 2018).
- Although, SMC strategy was not well reflected in NMSP, 2014-2020. and no indicator or target mentioned, a total of **12,583,379** children were reached and 48,329,983 SMC treatments provided in 101 LGAs.

Diagnosis and Treatment

- The use of ACTs for the treatment of uncomplicated malaria progressively increased from **12% in 2010 to 52% in 2018.**
- Efficacy Tests/Trials of ACTs showed a PCR-corrected efficacy of 100% and 97.8% for AA in Kano and Plateau states respectively whereas the PCR-corrected ACPR values for AL in Enugu, Kano and Plateau states were 98.9%, 97.9% and 97.8% respectively. Efficacy for DHP (PCR-corrected) was 100% (FMoH, 2018).

Products Supply Management

- Availability of zonal pharma-grade warehouses and coordination of PSM Stakeholders through the National Products Supply Chain Management Program (NPSMCP) improved visibility of antimalaria medicines and commodities at the sub-national level.
- Significant work in the area of Quality Assurance took place within the period under review producing guidelines, protocols and several policies for QA and QC of both malarial medicines, RDTs and other malarial commodities
- NAFDAC conducts post-marketing surveillance to ensure malaria medicines and other commodities remain efficacious at points of use.

Social and Behaviour Change Communication

- Knowledge of ways to avoid malaria was 97%, a few percentages from the MSP target of 100% for 2015. The knowledge however did not translate to corresponding action(s).
- The use of the internet daily was a major source of Malaria information at 51%. This reveals the importance of the inclusion of digital/modern media in channels of communication for malaria.

Monitoring and Evaluation (including surveillance and OR)

- Strengthened collaboration with DPRS and other MDAs on the HMIS and monthly HMIS/DHIS data analysis and feedback to states
- The timeliness and completeness of reporting steadily increased over the five years of NMSP. Virtually all the LGAs in the country are currently reporting malaria data through the DHIS 2.0.
- Use of ICT for improving data quality and establishment of Nigeria Malaria Data Repository to improve data use for decision making.
- Nigeria conducted nationally representative, population-based household surveys in the period under review. These surveys include Nigeria Malaria Indicator Survey (NMIS) 2015, Nigeria Multiple Indicator Cluster Survey (NMICS) 2016/2017 and Nigeria Demographic and Health Survey (NDHS) 2018.
- Poor government funding of Surveillance, Monitoring, Evaluation and Operation Research (SMEOR) activities at all levels including delayed conduct of DQA and iMSV at the states, especially in the 13 non-partners supported states.

Programme Management

- NMEP operationalises a Coordination Framework that ensures effective coordination of Malaria Partners through the Technical Working Group – Malaria and the thematic area sub-committees at the federal level.
- The development of annual Operational Plans at the Federal and State levels has provided a platform for the harmonization of government and donor resources (inputs) and achievement of service outputs in line with the objectives of the NMSP.

3.3.5. Key Challenges and Weaknesses

Vector Control

- Low coverage of LLINs in states not supported by Partners. Funding for LLINs distribution was largely donor-driven; states without donor support have not been able to conduct LLINs distribution in the last seven years.
- IRS and LSM as complementary strategies for vector control were not funded and sparsely implemented

Chemoprevention

- The outcome level indicator of IPTp in the NMSP, 2014-2020 is the proportion of pregnant women accessing **three or more doses** of SP. The value of 16.6% achieved in 2018 is not only lower compared to the 2015 value of 19.0% (MIS, 2015) but a far cry from the targets of NMSP (100%).
- Indicators for evaluating SMC outcome were not identified in the NMSP 2014 – 2020

Diagnosis and Treatment

- The proportion of suspected malaria cases who received a diagnostic test - RDT and/or microscopy - was abysmally low at 13.8% compared to the milestone target of 80%.
- The NMEP forecast shows that 0.3% of children having uncomplicated malaria may develop severe malaria, but the HMIS tools do not record severe malaria and there is no data on patients developing severe malaria to inform decisions.

Products Supply Management

- The MPR observed during the engagement with the State Malaria Programmes that Last Mile Distribution is being subjected to the varying degree of controversial practices including dumping and proxy delivery
- Weak data generation and management in LMIS platforms and poor development of the Operational Research component for the PSM branch.
- Poor storage conditions at the state and LGA levels

Social and Behaviour Change Communication

- The listed 4 ACSM outcome indicators for the NMSP 2014-2020 had no baseline figures, progress made was therefore difficult to ascertain. Only 2 of the 4 indicators were appropriately stated as an outcome, while the last 2 indicators listed were output indicators.
- There was a significant mismatch between the ACSM indicators of the NMSP, ACSM Guidelines and Surveys.

Malaria in Humanitarian Emergency

- NMSP, 2014- 2020 did not reflect the intention of national stakeholders on Malaria in Humanitarian Emergency. Therefore, progress was not measurable during this MPR as there were no documented indicators, baselines and targets.

Monitoring and Evaluation (including surveillance and OR)

- Private-sector data reporting remained a major challenge and reporting on the national instance is very low
- Most of the prioritised OR questions set by NMEP and its partners were not implemented during the period under review. Only 12% (4 out of 33) of the prioritised questions in the National Malaria Operations Research Agenda (NMORA) have been answered between 2014 to 2019 as reported to NMEP.

Programme Management

- Weak internal coordination of NMEP and the hierarchical orientation of most of the senior staff based on civil service culture
- Staff attritions and out-of-programme management of Human Resources.
- Uncoordinated approach to private sector engagement

3.3.6. Lessons Learnt

Substantial domestic financing and adequate capacity to implement planned activities are central to the achievement of the goal and the strategic objectives of the MSP. Significant donor funding as observed in the period under review was helpful, it was however not enough to achieve any of the targets set across all the outcome level objectives of the NMSP, 2014 2020.

- The huge numbers of LLINs distributed in supported states did not translate to increase use in some states across Nigeria. Additional efforts are required to improve the net use culture.
- The low coverage of IPTp is attributable to poor access to ANC services and limited engagement of poor pregnant women with RMNCAH service. The Malaria Control Programme should engage with the Family Health Department, NPHCDA and other entities with a mandate for ANC services to leverage on their platforms.
- Providers' behavior on RDT testing and rational use of ACT remains a big concern looking at the data generated from the facilities despite the declining prevalence of Malaria. The need to ensure adherence to treatment guidelines at the facility level will improve the efficient deployment of Malaria medicines.
- There were inadequate engagement and monitoring of Malaria treatment by the private care providers. There is a need for a private sector implementation plan to guide training and mentorship, quality assurance for antimalarials and diagnostics, and monitoring of the quality of care provided in the private sector.
- Decentralization of PSM functions to sub-national levels through establishment and operationalisation of State Logistics Management Coordinating Unit (LMCUs improved availability of Malaria products at the facility level.
- Despite the steady increase in the completeness of reporting over five years with virtually all the LGAs in the country currently reporting malaria data through the DHIS 2.0, data quality and reporting from the private sector remain a major challenge. This makes HMIS information difficult to use as national data.
- There is a need to strengthen advocacy at the federal and state levels for policy, resource mobilisation, and increased use of interventions.
- Many of the strategic priorities of NMEP require a strong health system and integration into the activities of other departments and agencies who work in silos. Achieving targets set in MSP became a major challenge,
- Mobilising private-sector resources requires a higher level of commitment and a well-coordinated strategy. Mandate allocation and expectation management should be a priority going forward

3.3.7. Future Strategic Direction

- Increase domestic financing of malaria programme activities at federal and state levels, with investments into areas the improve system resilience and promote sustainability of gains achieved.

- Strengthen evidence base for operational and strategic decision making; The evidence base should drive strategic direction in terms of strategy mix of strategies especially at sub-national levels
- Significant capacity strengthening of the NMEP, along with defining structures and pathways for better internal coordination with relevant departments or agencies of the FMoH.
- Leveraging on domestic homegrown flagship initiatives aimed at improving universal access to care such as the Basic Healthcare Provision Fund (BHCPF) through enhanced collaboration with NPHCDA/SPHCDA
- Urgent need to further strengthening existing platforms for Federal-State interface and collaboration. The efficient functioning of these platforms would be especially critical to ensure improved leverage of capacities of SMOH and SMEPs.
- GoN Strategic catalytic investments to provide active participation of the private sector participation such as deliberate country investment and regulatory concessions toward the development of local institutional production capacities and transfer of technology
- To address local variations in the mix of capacity needs at the sub-national level, a review of the current structure and function of the NMEP at the federal levels is needed to ensure a progressive shift in focus to building the capacity of states to adopt and implement national strategies to their context informed by best practice.
- Development of a holistic national TA plan incorporating all partner TA support rather than partner-specific plans.
- Prioritizing collaboration with the research community to urgently generate evidence (including exploring the use factors) to guide the deployment and uptake of appropriate intervention or a mix of interventions as part of Integrated Vector Management in the immediate term and all subsequent operational research needs of the programme

Chapter 4. Strategic framework

4.1. Vision

A MALARIA free Nigeria

4.2. Mission

To provide equitable, comprehensive, cost-effective, efficient and impactful malaria control interventions through transparent, accountable, client-oriented, community-owned and multisectoral approaches that contribute to a strengthened health system

4.3. Strategic directions and policy priorities

Building on the vision of a malaria-free Nigeria, ensure the delivery of robust multi-stakeholder, multisectoral and appropriate strategy mixes based on the stratification of Nigeria into low, medium, high and very high epidemiological zones to achieve a rapid reduction in malaria burden and deaths while maintaining consistency with the key principles and pillars of the National Strategic Health Development Plan.

The implementation of the prioritized strategies and key activities will be rested on the High Burden High Impact (HBHI) approach – High political will; Strategic information to drive impact; Better guidance for policies and strategies; and A coordinated national malaria response.

4.4. Goal and objectives

4.4.1. Goal

To achieve a parasite prevalence of less than 10% and reduce mortality attributable to malaria to less than 50 deaths per 1,000 livebirths by 2025.

4.4.2. Objectives of NMSP, 2021-2025

Objective 1:	Improve access and utilization of vector control interventions to at least 80% of the targeted population by 2025.
Objective 2:	Ensure provision of chemoprevention, diagnosis and appropriate treatment for 80% of the target populations at risk by 2025
Objective 3:	Improve generation of evidence for decision making and impact through reporting of quality malaria data and information from at least 80% of health facilities (public and private) and other data sources including surveillance, surveys and operations research by 2025.
Objective 4:	Strengthen coordination, collaboration, and strategic partnership to promote efficiency and effectiveness of malaria control activities towards achieving at least 75% improvement from baseline using a standardized OCA tool.
Objective 5:	Improve funding for malaria control by at least 25% annually through predictable and innovative sources to ensure sustainability at federal and sub-national levels

4.4.3. Supportive Cross-cutting Strategies

Advocacy, Communication and Social Mobilisation (ACSM)

Advocacy, Communication and Social Mobilisation remains a very important strategy towards the accomplishment of the objectives of NMEP Strategic Plan. It cuts across all objectives by ensuring the promotion of the desired change or positive behaviour for the prevention and control of Malaria at all levels.

In keeping malaria high on the political agenda, the strategy also focuses on the advocacy for political commitments of the different arms of governments at all levels in line with Pillar 1 of the High Burden High Impact (HBHI) approach

The Malaria Programme Review, 2019 revealed that 'the mixed results in the reduction of the burden of disease at sub-national levels despite substantial efforts are likely to be the result of a combination of factors". The factors include coverage on planned interventions, access to care, health-seeking behaviour, economic indices and climate change.

To achieve the desired behaviour change at all levels, SBC interventions will need to be data-driven and tailored towards localities, peculiarities, and target populations. The ACSM strategies of this MSP will focus on the behaviours of people at 4 different levels or domains.

These are – Policy; Services or Systems; Community; Household and Individual. The expected behaviour change at each level or domains include:

1) Policy – Increased political commitment through budget allocation and improved release of funds for malaria as well as policy reviews/adoption based on evidence. Advocacy will drive these expected results through the provision of facts on malaria control interventions and funding, including scorecards. More collaboration and commitment of the private sector – through consistent and outcome/result-driven advocacy.

2) Services or Systems – Improved providers' knowledge, attitude and behaviors; service communication; relevant stakeholders' engagement; buy-in and enabling environment (including accessibility affordability and availability). Improved demand for testing and ANC for IPTp.

3) Community – Increased commitment and ownership through community groups and associations, Community Health Workers. Promotion of SMC and positive norms for malaria control

4) Household and Individual – Increased knowledge, change in social norms or and beliefs and increased demand and use for products and services

For Objectives 1& 2, the communication and behavioural interventions will address the knowledge and practice gap as reflected in the reports of several surveys and noted in the MPR report, especially in the states where the respondents felt there was no need for net use despite high levels of ownership. Likewise, there is a need to intensify the promotion of early ANC attendance among pregnant women, which should result in an increased uptake of 3 or more doses of IPTp.

The support for Objectives 3-5 is focused on the need to strengthen the capacity of the ACSM drivers on coordination, planning, networking, data management, resource mobilization and alliance building for effective delivery of SBC interventions at the national and sub-national levels. ACSM will also support the development of advocacy tools for improved funding as well as those to increase coordination between service delivery and SBC to align demand and supply factors and efforts.

Procurement and Supply-Chain Management (PSM)

The availability and access to medicines and health products for the prevention, diagnosis and treatment of malaria is pivotal to the realisation of the Goal and Objectives of the Malaria Strategic Plan. To achieve this, it is critical to emphasise a pro-active and responsive malaria supply management, with well-designed and strengthened systems, processes, and partnerships.

The focus in the current plan is to improve the quantification, procurement, and last-mile distribution processes, through the evolution of a Pharmaceutical Management Information System (PMIS) that impact the objectives of the Malaria Strategic Plan for 2021-2025; this transcends the assembly of data without attention to their usage for real-time and long-term management decision making, The strategies developed to achieve this are a combination of robust Capacity Building activities, and a heightened focus on data quality, accented by new

inroads into integrated Supportive Supervision, Operational Research and Knowledge Management.

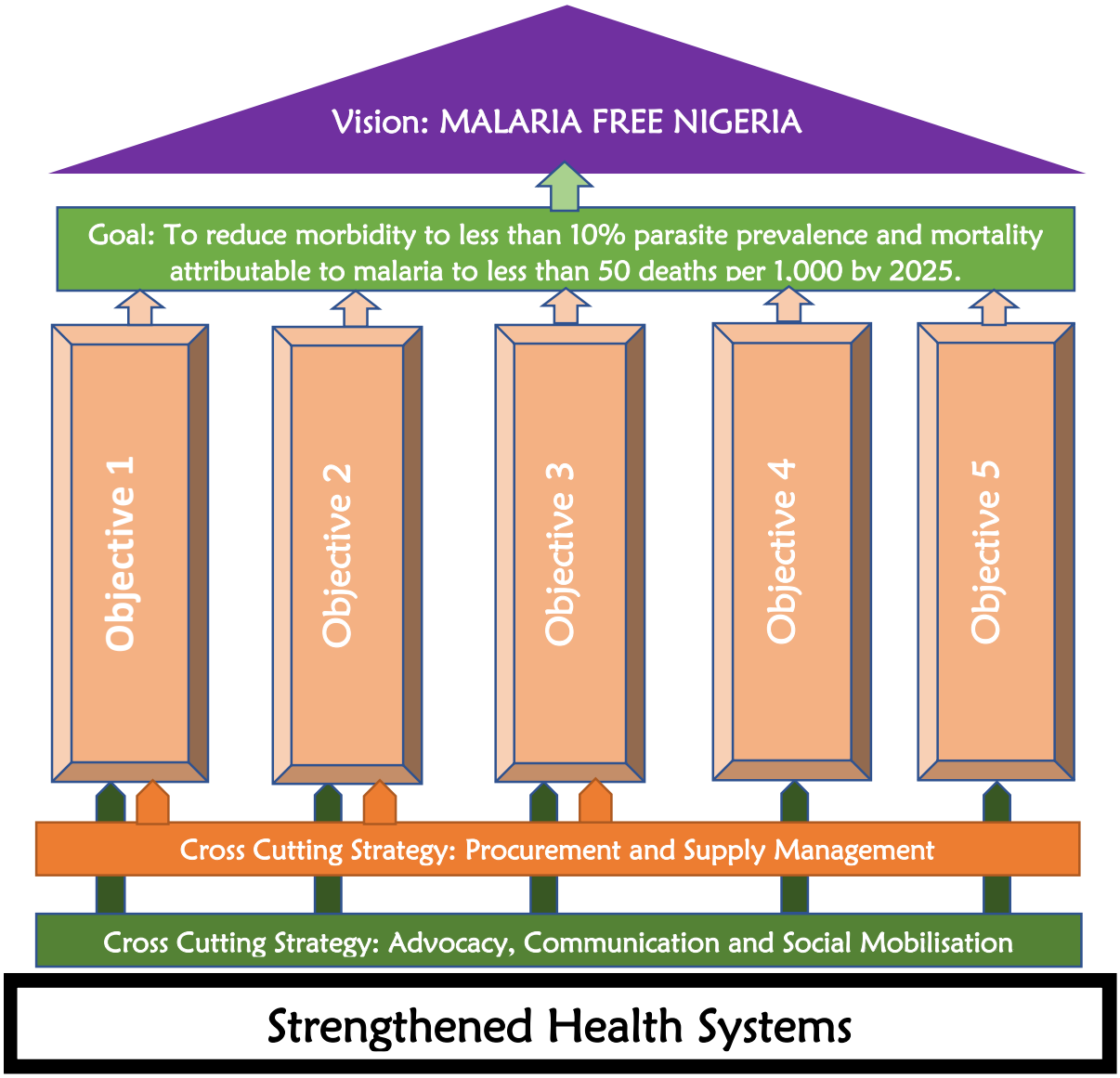
The gaps in resources for the procurement and last mile distribution of medicines and health commodities for malaria prevention, diagnosis and treatment will be addressed through more intensive efforts at high-level advocacy to the Government of Nigeria (at national and subnational levels) and amplified engagements with donors, to inform further partnerships and funding re-arrangements.

While availability and access are paramount in supply chain expectations, these are undergirded by the quality of the medicines and commodities; hence an intensified approach to tracking the post-market quality of products in circulation has been developed in this strategic plan, whereby collaboration with the National Agency for Food and Drug Administration (NAFDAC) will promote Quality Assurance outcomes for malaria medicines and commodities.

The supportive characteristics of the procurement and supply management component in malaria control and elimination will be made more significant through the strengthening power of collaborative systems, and emerging strategies and plans such as the Africa Strategy for Supply Chain Traceability and the National Supply Chain Strategic Plan within and beyond PSM functions. These should move the broad scope of the supply chain of malaria medicines and health products-procurement, quality, warehousing, distribution, use and data management towards a coordinated and all-inclusive impact on malaria control and elimination.

4.4.4. The Conceptual Framework of NMSP, 2021 - 2025

Figure 11: NMSP Conceptual Framework



4.5. Strategies and Broad Activities.

4.5.1. Objective 1: Improve access and utilization of vector control interventions to at least 80% of targeted population by 2025

This objective will focus on scaling up vector control interventions based on the epidemiological stratification map and vector surveillance information generated from time to time. The three vector control strategies to be deployed are (i) ITNs (ii) Targeted IRS, and (iii) Targeted LSM. The deployment of these strategies at the operational planning level will be guided by the LGA level strategies mixes indicated in the stratification table in annex 1 of this document. The list of the states being considered for IRS based on the epidemiological profile and availability of required resources is provided in annex 2.

New innovations, especially those that address the emerging threat of insecticide resistance, and modern, effective malaria vector control methods will be considered as they become available. All vector control interventions will be deployed in the context of integrated vector management (IVM).

This objective will be implemented through the following strategies:

Strategy	Broad Activities
Strategy 1.1: Deploy safe and effective integrated vector control interventions based on malaria epidemiological stratification.	1.1.1. Implement mass campaigns and continuous distribution in 36 states and the FCT of appropriate ITNs in targeted areas to achieve universal access 1.1.2. Implement IRS in targeted areas to accelerate progress towards elimination 1.1.3. Deploy Larval Source Management (LSM) as a complementary strategy to IRS and ITN to reduce malaria vector density in targeted areas 1.1.4. Institutionalize Quality Assurance/Quality Control (QA/QC) for vector control commodities in collaboration with relevant government agencies and the private sector 1.1.5. Update policy and operational guidance for malaria vector control interventions 1.1.6. Conduct appropriate vector control interventions in urban settings
Strategy 1.2: Institutionalize decision making for IVM deployment based on evidence from insecticide resistance monitoring and vector surveillance	1.2.1. Establish and scale-up vector sentinel surveillance and insecticide resistance monitoring as part of evidence generation to inform vector control decision-making 1.2.2. Strengthen capacity of NMEP, IVM Branch and relevant stakeholders for planning, implementation and monitoring and evaluation of vector control interventions 1.2.3. Collaborate with private sector and academia to introduce, pilot and adopt new technologies for malaria vector control
Strategy 1.3: Collaborate and coordinate effective integrated vector management through the involvement of relevant sectors and stakeholders in Nigeria	1.3.1. Strengthen inter-sectoral collaboration and private sector participation in vector control interventions through Public-Private Partnership (PPP) 1.3.2. Strengthen collaboration with relevant institutions and agencies to carryout operations research on vector control

Supportive PSM Strategy

Strategy	Broad Activities
Strategy 1.4: Strengthen systems for continuous availability of health products for the prevention of malaria through vector control	1.4.1: Strengthen the systems and processes to continuously provide credible estimates of malaria commodities for the prevention of malaria through vector control interventions 1.4.2: Deploy a Unified Framework for Procurement to improve availability of malaria commodities for the prevention of malaria 1.4.3: Institute equitable and realistic costing and resource allocation, to achieve effective and efficient last-mile distribution of commodities for malaria prevention

Supportive ACSM Strategies

Strategy	Broad Activities
Strategy 1.5: Sustain and expand high knowledge of malaria prevention for improved access and utilization of vector control interventions.	1.5.1. Promote actionable, audience-specific, pretested messages on effective malaria prevention behaviors using multi- media approaches 1.5.2. Promote access to, and utilization of malaria prevention interventions including through identified malaria ambassadors/champions/brand influencers
Strategy 1.6: Promote multi-sectoral and multi-level stakeholders' engagement for improved access and use of vector control interventions.	1.6.1. Engage community actors including leaders, members, and community-based organizations to support utilization of LLINs and other preventive services 1.6.2. Strengthen social mobilization efforts through existing relevant national, sub-national and community structures

4.5.2. Objective 2: Ensure provision of chemoprevention, diagnosis and appropriate treatment for 80% of the target populations at risk by 2025

Chemoprevention will be deployed to all at-risk population through Intermittent Preventive Treatment for all pregnant women (IPTp), Seasonal Malaria Chemoprevention (SMC) for eligible children and pilot study on Intermittent Preventive Treatment for children less than 12 months (IPTi) based on the epidemiological information available. The deployment of IPTp will be extended to delivery at the community level as community Intermittent Preventive Treatment of malaria in pregnancy (cIPTp) that is actively linked to ANC services.

The NMEP has established the MIP Technical Working Group comprising of Reproductive Health Unit, NPHCDA and other stakeholders. The TWG is headed by the Reproductive Health Focal Officer and supported by NMEP-MIP Focal point. The MIP-TWG meet monthly to share experience and strategize on scheduled activities.

The community Intermittent Preventive Treatment in Pregnancy (cIPTp) strategy is to address the challenge of poor ANC attendance and allow the use the of communities as one of the service delivery points for those who do not attend ANC as well as create awareness and sensitize the pregnant women on the need to attend ANC.

Prompt diagnosis and effective treatment of malaria is crucial towards achieving the goal of this strategy. This objective will focus on updating and disseminating relevant documents, enhancing the skills of healthcare providers, and ensuring access to diagnosis and treatment commodities. The target defined under this objective will be achieved through implementation of the following strategies.

Strategy	Broad Activities
Strategy 2.1: Deploy Chemo-preventive Interventions to eligible populations	2.1.1. Provide Intermittent Preventive Treatment in Pregnancy to all pregnant women across the country at ANC facilities and at community levels. 2.1.2. Scale-up Seasonal Malaria Chemoprevention services to all LGAs where more than 60% of rainfall occurs within four consecutive months. 2.1.3. Pilot Intermittent Preventive Treatment in infants (IPTi) in states not targeted for SMC and malaria vaccine in selected areas.

	2.1.4. Provide Chemoprophylaxis for Special groups, especially in individuals with Sickle Cell Anaemia and non-immune travelers
Strategy 2.2: Deployment of parasitological based diagnosis for care-seeking persons with suspected malaria	2.2.1. Build capacity of personnel in public health facilities and at community level for parasitological confirmation of malaria 2.2.2. Build capacity of personnel in private health facilities at all levels (tertiary, secondary, primary health facilities, Community pharmacies and PPMVs) for parasitological confirmation of malaria 2.2.3. Provide rapid diagnostic testing and microscopy for parasitological confirmation of malaria in public and private health facilities and the community level 2.2.4. Scale up for quality assurance and quality control systems for malaria diagnosis and update External Quality Assurance (EQA) guidelines, SOPs and Job Aids for malaria diagnosis 2.2.5. Conduct operational research on the deployment and acceptability of existing and emerging parasitological confirmation tests including Urine Malaria Test
Strategy 2.3: Ensure appropriate treatment for individuals with confirmed malaria with effective antimalarial medicines	2.3.1. Provision of treatment services for uncomplicated malaria in public and private health facilities and the community level 2.3.2. Strengthen capacity of public and private facilities for management of severe malaria 2.3.3. Scale-up community case management of malaria as a component of integrated community case management (iCCM) through the CHIPS programme, especially in hard-to-reach areas 2.3.4. Ensure compliance to National Malaria Treatment Guidelines and the National Quality of Care Guideline on malaria case management. 2.3.5. Strengthen delivery of prompt treatment of malaria for special groups (pregnant women, children under 5 years and vulnerable populations, including internally displaced populations) 2.3.6. Strengthen malaria surveillance activities (Antimalarial drug therapeutic efficacy test DTET) 2.3.7. Strengthen Pharmacovigilance activities

Supportive PSM Strategy

Strategy	Broad Activities
Strategy 2.4: Strengthen systems for continuous availability of medicines and health products for the chemoprevention, diagnosis and treatment of malaria	2.4.1. Improve systems for quantification of anti- malaria drugs and commodities for chemoprevention, diagnosis and treatment of malaria 2.4.2. Strengthen the coordination of procurement and delivery of medicines and commodities for chemoprevention, diagnosis and treatment 2.4.3. Strengthen the tracking systems (people, processes, tools and management) for last-mile distribution of malaria medicines and health commodities

Supportive ACSM Strategies

Strategy	Broad Activities
Strategy 2.5: Intensify appropriate information on malaria treatment practices for increased access to and demand for malaria chemoprevention, treatment, and management services	2.5.1. Undertake activities to improve demand for and use of diagnostic and treatment commodities among health workers 2.5.5. Reinforce multimedia approaches to reach target audiences with appropriate information on malaria diagnosis and treatment practices
Strategy 2.6: Scale-up provider-behaviour improvement interventions for improved quality of care in the management of fever and malaria cases for improved access to treatment services	2.6.1. Build capacity of Health Care Service Providers on Inter-Personal Communication (IPC) skills 2.6.2. Scale-up promising behavioral science interventions to improve trust in, and use of malaria diagnostic products.

4.5.3. Objective 3: To improve generation of evidence for decision making and impact through reporting of quality malaria data and information from at least 80% of health facilities (public and private) and other data sources including surveillance, surveys and operations research by 2025.

The SMEOR objective seeks to provide evidence for decision making through the flow of reliable, timely and complete malaria data from at least 80% of health facilities (public and private), strengthen generation and reporting of malaria data from Community health providers, including CORPS and CHIPs, PPMVs and Community Pharmacists, surveillance, surveys, evaluations and operation research. Greater efforts will be channeled towards direct reporting from the health facilities, especially, secondary, tertiary and private health facilities, into the DHIS 2 through the use of mobile technology. The use of mobile technology for reporting has been piloted by DPRS and HIV programme and was found effective in improving timeliness and completeness of reporting. It is currently being deployed in Lagos and Kaduna States to cover some health facilities. This technology will be scaled-up to more states and to cover more health facilities in the state where is it currently been used.

Strategy	Broad Activities
Strategy 3.1: Strengthen generation and reporting of quality malaria data through routine and non-routine sources.	3.1.1. Improve data flow from public health facilities (primary, secondary and tertiary) 3.1.2. Strengthen data flow from private health facilities 3.1.3. Strengthen data flow from community health providers (PPMVs, Community Pharmacists and CORPs) 3.1.4. Strengthen Data Quality Assurance (DQA) and broader surveillance systems assessments.
Strategy 3.2: Improve generation of evidence from evaluations, therapeutic efficacy and entomological surveillance studies for strategic deployment of interventions.	3.2.1. Strengthen data generation from evaluations, sharing and use 3.2.2. Improve generation of evidence through programme reviews at the different levels of the programme 3.2.3. Improve integration of malaria data and surveillance systems
Strategy 3.3: Strengthen human resource for SMEOR.	3.3.1. Build capacity of M&E and malaria programme officers at all levels on SMEOR

	3.3.2. Advocacy for M&E staff recruitment and deployment 3.3.3. Leverage on current M&E human resources of other public health programmes (e.g. EPI, HIV, MAL-RMNCH) for SMEOR activities 3.3.4. Strengthen human resources in collaboration with DPRS and other partners for integrated surveillance, monitoring and evaluation across programmes
Strategy 3.4: Harness innovation in technology and expand research for Malaria Programme.	3.4.1. Scale-up use of innovative approaches such as mobile technology for reporting onto the NHMIS/DHIS 3.4.2. Strengthen Operations Research (OR) 3.4.3. Strengthen data demand and use 3.4.4. Scale-up use of technology for data collection during non-routine malaria programme interventions
Strategy 3.5: Integrate and coordinate SMEOR interventions.	3.5.1. Strengthen SMEOR coordination at national and sub-national levels 3.5.2. Strengthen integrated routine monitoring and supervision (iMSV) 3.5.3. Improve coordination with DPRS to improve malaria data quality 3.5.4. Strengthen the existing linkages for data sharing and use 3.5.5. Improve linkages with health stakeholders for resource mobilization for SMEOR

Supportive PSM Strategy

Strategy	Broad Activities
Strategy 3.6: Develop a functional Pharmaceutical Management Information System (PMIS) to strengthen evidence-based decision making for malaria programming,	3.6.1. Revise the tools and processes used for data capturing: Malaria Health Products Logistics Management Information Systems (MHPLMIS), SOPs and others 3.6.2. Build capacity of staff at National, State, LGA and facility levels on Integrated NHLMIS -DHIS Operations 3.6.3. Institute annual malaria LMIS Data Quality Assurance (DQA) for public and private health facilities across all levels
Strategy 3.7: Collaborate with NPSCMP and NAFDAC for integrated supportive supervision activities and promote Quality Assurance for malaria medicines/commodities across all facilities (public and private) respectively.	3.7.1. Institute quarterly supportive supervision activities for integrated malaria LMIS-DHIS at all levels 3.7.2. Institute coordinated activities for routine testing and post-market surveillance to track storage, distribution and use of malaria drugs and commodities, at all levels, and in public and private facilities

Supportive ACSM Strategies

Strategy	Broad Activities
Strategy 3.8: Reinforce and enhance advocacy approaches targeting private sector stakeholders to improve timely, appropriate and reliable malaria data reporting	3.8.1. Engage with the private sector (private health facilities/SDPs) on malaria data reporting 3.8.1. Strengthen the use of appropriate evidence of effectiveness of SBC strategies 3.8.3. Conduct periodic supervision and monitoring of SBC activities at sub-national levels

4.5.4. Objective 4: Strengthen coordination, collaboration, and strategic partnership to promote efficiency and effectiveness of malaria control activities towards achieving at least 75% improvement from baseline using a standardized OCA tool.

Leadership responsibilities of the NMEP and the SMEPs require strong partnerships, collaboration and coordination with other MDAs such as NPHCDA/SPHCDA, Family Health Department, NPSCMP, NCDC, NEMA/SEMA, Hospital Management Boards, Research Institutions, Private Sector, etc., at all levels to provide a conducive strategy implementation environment. To achieve this objective, the following strategies will be implemented:

Strategy	Broad Activities
Strategy 4.1: Develop, review or domesticate malaria policies, strategies frameworks and plans.	4.1.1. Review and disseminate national malaria policy. 4.1.2. Establish consultative meetings to review existing mechanisms and status of compliance to National Drug Policies, Strategies and Regulatory framework 4.1.3. Support operationalization of the National Coordination framework at federal and in 36 states 4.1.4. Develop/support annual operational plan for malaria programme at Federal and in 36 States 4.1.5. Scale-up mechanisms for periodic malaria program progress and performance review at Federal and in 36 States 4.1.6. Periodic review of the NMSP and Develop next NMSP
Strategy 4.2: Improve NMEP capacity for coordination of malaria stakeholders in Nigeria	4.2.1. Map malaria partners to improve visibility and role of key actors in both public and private sector. 4.2.2. Operationalize external coordination platforms at Federal level and 36 states 4.2.3. Strengthen Internal coordination platforms at federal and in 36 states
Strategy 4.3: Improve collaboration with relevant MDAs to enhance efficiency and effectiveness of malaria program delivery	4.3.1. Engage line ministries and agencies for integrated delivery of malaria services. 4.3.2. Provide technical guidance for the implementation of malaria interventions in humanitarian emergencies 4,3,3, Strengthen inter-agency coordination and improve capacity for effective delivery of ACSM interventions at the National and sub-national level
Strategy 4.4: Strengthen private sector collaboration and participation for delivery of quality	4.4.1. Engage private sector organisations including manufactures and healthcare providers 4.4.2. Facilitate private sector Coordination mechanisms 4.4.3. Provide an enabling environment for private sector participation

malaria services.	4.4.4. Facilitate the use of a harmonized capacity-building curriculum for malaria control strategies at Federal and in 36 states
Strategy 4.5. Strengthen capacity of NMEP and SMEPs to harmonise capacity development processes	4.5.1. Conduct regular OCA to periodically ascertain the capacity of NMEP and SMEPs to deliver planned activities 4.5.2. Coordinate the implementation of capacity improvement plan

Supportive ACSM Strategies

Strategy	Broad Activities
Strategy 4.6: Strengthen coordination between SBC and service delivery actors to align supply (service provision) and demand (patient demand) efforts to increase alignment and impact of interventions.	4.6.1. Convene periodic SBC and service delivery coordination meetings or forums to promote data sharing, analysis and use and real-time strategy (re)alignment e.g., message harmonization.

4.5.5. Objective 5: Improve funding for malaria control by at least 25% annually through predictable and innovative sources to ensure sustainability at federal and sub-national levels

Inadequate funding remains a perennial challenge to MSP implementation in Nigeria. The MPR 2019 reported that inadequate financing of all the seven objectives of the NMSP, 2014-2020 affected the capacity of NMEP and Partners to implement planned activities. Presently, the Malaria control interventions have been largely donor-driven.

Apart from the need to increase budgetary allocation to health and malaria, the NMSP, 2021-2025 seeks to leverage on other financing opportunities that are available within the Nigeria fiscal space. The opportunities include the Basic Health Care Provision Fund (BHCPF) of the National Health Act, 2014, the National Health Insurance Scheme (NHIS) and the State Schemes, Drug Revolving Fund (DRF), the RMNCAH week, Saving One Million Lives (SOML) Project and funding of other PHC activities.

All the above funding streams and other innovative sources will be leveraged on in the course of implementing this MSP.

Strategy	Broad Activities
Strategy 5.1: Strengthen capacity for budget tracking, internal controls and financial reporting at national and sub-national	5.1.1. Promote and build capacity for budget tracking and risk management at Federal and 36 states 5.1.2. Establish systems for malaria financing evidence generation, expenditure tracking and management at National and subnational level (federal and 36 states) 5.1.3. Institute transparency and accountability in planning, budgeting, procurement and implementation processes for malaria procurement and supply chain management

levels	
Strategy 5.2: Scale-up DRM (Domestic resource mobilization)	5.2.1. Promote resource mobilization initiatives targeting philanthropic organisations and individuals 5.2.2. Engage with relevant MDAs to leverage on Government funding mechanism through policy integration and harmonization e.g. Health insurance, BHCPF and SOML 5.2.3. Identify innovative financing methods for malaria

Supportive ACSM Strategies

Strategy	Broad Activities
Strategy 5.3: Reinforce policy-makers and legislature engagement for increased funding allocation and release for malaria management at all levels	5.3.1 Deploy advocacy intervention tools and packages targeted at public policy makers and legislature at the national and state levels
Strategy 5.4: Strengthen proven-to-work stakeholders advocacy for improved resources for malaria interventions	5.4.1. Engage private sector actors, including the Media, to support malaria interventions (e.g. procurement & distribution of consumables, airing of jingles and printing of tools as part of their Corporate Social Responsibility

Chapter 5. Implementation framework

5.1. MSP work plan

To achieve the goal and objectives of the NMSP, the work plan below articulates the relevant strategies, broad activities, implementation timelines and responsible entities.

Table 2: Objectives, Strategies, Broad Activities, Implementation timelines and Key Responsible

Objective 1: Improve access and utilization of vector control interventions to at least 80% of targeted population by 2025							
Strategy	Broad Activity	Implementation Timeline					Key Responsible
		2021	2022	2023	2024	2025	
1.1. Deploy safe and effective integrated vector control interventions based on malaria epidemiological stratification	1.1.1 Quantify and procure ITNs and other materials using triangulated population data for 36 states and the FCT	x	x	x	x	x	NMEP; IVM; PSM; Partners
	1.1.2. Distribute ITNs through mass campaign in all states and FCT to achieve universal access	x	x	x	x	x	NMEP IVM; Partners
	1.1.3. Distribute ITNs through continuous distribution channels (HFs and schools)	x	x	x	x	x	NMEP IVM; Partners
	1.1.4. Quantify and procure insecticides, spray pumps, accessories and PPEs for IRS in targeted areas	x	x	x	x	x	NMEP; IVM; PSM; Partners
	1.1.5. Implement IRS in targeted areas.	x	x	x	x	x	NMEP IVM; Partners
	1.1.6. Quantify and procure LSM materials, PPEs and larvicides	x	x	x	x	x	NMEP; IVM; PSM; Partners
	1.1.7. Conduct Larval Source Management (LSM) activities in targeted areas.	x	x	x	x	x	NMEP IVM; Partners
	1.1.8 Ensure assurance and control for vector control commodities in collaboration with relevant agencies	x	x				NMEP; IVM; PSM; Partners
	1.1.9. Update policy and operational guidelines through periodic reviews.	x	x	x	x	x	NMEP IVM; Partners

1.2. Improve utilization of ITNs/IRS/LSM and other personal protective measures	1.2.1. Promote consistent use of ITNs/IRS/LSM and personal protective measures through strategic communication	x	x	x	x	x	NMEP ACSM; IVM; Partners
1.3. Institutionalise regular insecticide resistance monitoring and vector surveillance	1.3.1. Establish and/or strengthen vector sentinel surveillance and insecticide resistance monitoring in 36 states and FCT.	x	x	x	x	x	NMEP IVM; M&E; NIMR; Partners
	1.3.2. Strengthen capacity of NMEP and relevant stakeholders for implementation of vector control interventions.	x	x	x	x	x	NMEP IVM; PM; NIMR; Partners
	1.3.3. Collaborate with private sector and academia on innovate tools and strategies.	x	x	x	x	x	NMEP; Private Sector; Academia
PSM Supportive Strategy and Activities							
Strategy 1.4: Strengthen systems for continuous availability of medicines and health products for the prevention of malaria through vector control	1.4.1: Strengthen the systems and processes to continuously provide credible estimates of malaria commodities for the prevention of malaria through vector control interventions	X	X	X	X	X	NMEP/ IPs/ SMoH/LGA
	1.4.2: Deploy a Unified Framework for Procurement to improve availability of malaria commodities for the prevention of malaria	X	X	X	X	X	NMEP/ IPs /DONORS
	1.4.3: Institute equitable and realistic costing and resource allocation, to achieve effective and efficient last mile distribution of commodities for malaria prevention	X	X	X	X	X	NMEP/IPs
ACSM Supportive Strategies and Activities							
Strategy 1.5: Sustain and expand high knowledge of malaria prevention for improved access and utilization of vector control interventions.	1.5.1. Promote actionable, audience-specific, pretested messages on malaria prevention behaviors using multi- media approaches	X	X	X	X	X	NMEP ACSM Partners
	1.5.2. Promote access and utilization of malaria prevention interventions including through identified	X	X	X	X	X	NMEP ACSM Partners CSO Networks

	malaria ambassadors/champions/brand influencers						
Strategy 1.6: Promote multi-sectoral and multi-level stakeholders' engagement for improved access and use of vector control interventions.	1.6.1. Engage community actors including leaders, members, and community-based organizations to support utilization of LLINs and other preventive services	X	X	X	X	X	NMEP ACSM Partners CSO Networks
	1.6.2. Strengthen social mobilization efforts through existing relevant national, sub-national and community structures	X	X	X	X	X	NMEP ACSM Partners CSO Networks

Objective 2: Ensure provision of chemoprevention, diagnosis and appropriate treatment for 80% of the target populations at risk by 2025							
Strategy	Broad Activity	Implementation Timeline					Responsible
		2021	2022	2023	2024	2025	
2.1. Deploy Chemo-preventive Treatments to eligible populations	2.1.1. Provide Intermittent Preventive Treatment in Pregnancy to all pregnant women during ANC and at the community.	X	X	X	X	X	NMEP CM; Family Health; NPHCDA; Partners
	2.1.2. Scale up Seasonal Malaria Chemoprevention services to all eligible states and LGAs.	X	X	X	X	X	NMEP CM; Partners
	2.1.3. Pilot Intermittent Preventive Treatment in infants (IPTi) in states not targeted for SMC and malaria vaccine in selected areas.	X	X	X	X	X	NMEP CM; Family Health; NPHCDA; Partners
	2.1.4. Provide Chemoprophylaxis for special groups - Sickle Cell Anaemia and non-immune travellers	X	X	X	X	X	NMEP CM; NCD; Partners
2.2: Deploy parasitological based diagnosis for care-seeking persons with suspected malaria	2.2.1: Improve access to parasitological confirmation of malaria in public, private and community service delivery points	X	X	X	X	X	NMEP CM; Partners; Private sector
	2.2.2: Build capacity of personnel in health facilities (public and private) and at the community level.	X	X	X	X	X	NMEP; Partners

	2.2.5. Scale-up for quality assurance and quality control systems for malaria diagnostic and update External Quality Assurance (EQA) guidelines, SOPs and Job Aids for malaria diagnosis	X	X	X	X	X	NMEP CM; Reference Centres
	2.2.6: Create demand for utilization of parasitological confirmation of malaria in public and private sectors as well as community levels	X	X	X	X	X	NMEP ACSM; CM; Partners
	2.2.7: Conduct operational research on parasitological confirmation of malaria	X	X	X	X	X	NMEP M&E; CM; Partners
2.3: Ensure appropriate treatment for individuals with confirmed malaria with effective antimalarial medicines	2.3.1: Improve access to appropriate antimalaria medicines for treatment of uncomplicated and severe malaria.	X	X	X	X	X	NMEP; Partners; Private Sector
	2.3.3. Strengthen capacity of public and private facilities for management of severe malaria	X	X	X	X	X	NMEP; Partners
	2.3.4: Scale-up community case management through iCCM through the CHIPS programme in hard-to-reach areas	X	X	X	X	X	NMEP; NPHCDA; Family Health; Partners
	2.3.5. Ensure compliance to National Malaria Treatment Guidelines and the National Quality of Care Guideline on malaria case management	X	X	X	X	X	NMEP; Partners; Private Sector
	2.3.6. Strengthen delivery of prompt treatment of malaria for special groups (pregnant women, children under 5 years and vulnerable populations, including internally displaced populations)	X	X	X	X	X	NMEP; NPHCDA; Partners; Private Sector; NEMA; SEMA
	2.3.7: Strengthen surveillance of malaria medicines - *DTET*	X	X	X	X	X	NMEP; Partners; Academia
	2.3.8: Strengthen artemicinin resistance activities	X	X	X	X	X	NAFDAC; NPSCMP; NMEP
PSM Supportive Strategy and Activities							
Strategy 2.4: Strengthen systems for	2.4.1. Improve systems for quantification of anti- malaria drugs and commodities for	X	X	X	X	X	NMEP/IPs/ NPSCMP-LMCUs

continuous availability of medicines and health products for the chemoprevention, diagnosis and treatment of malaria	chemoprevention, diagnosis and treatment of malaria						
	2.4.2. Strengthen the coordination of procurement and delivery of medicines and commodities for chemoprevention, diagnosis and treatment	X	X	X	X	X	NMEP/IPs/ DONORS
	2.4.3. Strengthen the tracking systems (people, processes, tools and management) for last-mile distribution of malaria medicines and health commodities	X	X	X	X	X	NMEP/NPS CMP/ 3PLs
ACSM Supportive Strategies and Activities							
Strategy 2.5: Intensify appropriate information on malaria treatment practices for increased access to and demand for malaria chemoprevention, treatment, and management services	2.5.1. Undertake activities to improve demand for and use of diagnostic and treatment commodities among health workers	X	X	X	X	X	NMEP ACSM &CM, Partners
	2.5.5. Reinforce multimedia approaches to reach target audiences with appropriate information on malaria diagnosis and treatment practices	X	X	X	X	X	NMEP ACSM &CM, Partners
Strategy 2.6: Scale-up provider-behaviour improvement interventions for improved quality of care in the management of fever and malaria cases for improved access to treatment services	2.6.1. Build capacity of Health Care Service Providers on IPC skills and Behaviour Change	X		X		X	NMEP ACSM &CM, Partners
	2.6.2. Scale-up promising behavioural science interventions to improve trust in, and use of malaria diagnostic products	X	X	X	X	X	NMEP ACSM &CM, Partners

Objective 3: To improve generation of evidence for decision making and impact through reporting of quality malaria data and information from at least 80% of health facilities (public and private) and other data sources including surveillance, surveys and operations research by 2025							
Strategy	Broad Activity	Implementation Timeline					Key Responsible
		2021	2022	2023	2024	2025	
3.1. Strengthen generation and reporting of quality malaria data through routine and non-routine sources	3.1.1: Improve data flow from public health facilities (primary, secondary and tertiary)	x	x	x	x	x	NMEP SMEOR; DHPRS
	3.1.2: Strengthen data flow from private health facilities	x	x	x	x	x	NMEP SMEOR; DHPRS; Private Sector
	3.1.3: Strengthen data flow from community health providers (PPMVs, Community Pharmacists and CORPs)	x	x	x	x	x	NMEP SMEOR; DHPRS; NPHCDA
	3.1.4: Strengthen Data Quality Assurance (DQA)	x	x	x	x	x	NMEP SMEOR; DHPRS
3.2: Improve generation of evidence from evaluations, therapeutic efficacy and entomological surveillance studies to guide interventions	3.2.1: Strengthen data generation from evaluations, and sharing and use	x	x	x	x	x	NMEP SMEOR; DHPRS; Partners
	3.2.2: Improve generation of evidence through programme reviews	x	x	x	x	x	NMEP SMEOR; DHPRS; Partners
	3.2.3: Improve integration of malaria surveillance systems	x	x	x	x	x	NMEP SMEOR; DHPRS; Partners
3.3: Strengthen human resource for Surveillance, Monitoring, Evaluation and Operations Research	3.3.1: Build capacity of M&E and malaria programme officers on SMEOR	x	x	x	x	x	NMEP SMEOR; DHPRS; Partners
	3.3.4: Strengthen human resources in collaboration with DHPRS, NCDC and other partners for integrated surveillance, monitoring and evaluation across programmes	x	x	x	x	x	NMEP SMEOR; DHPRS; NCDC; WHO; Partners
3.4: Harness innovation in technology and expand research for	3.4.1: Scale-up use of innovative approaches such as mobile technology for reporting onto the NHMIS	x	x	x	x	x	NMEP SMEOR; DHPRS; Partners

Malaria Programme	3.4.2: Strengthen Operations Research (OR)	x	x	x	x	x	NMEP SMEOR; Partners
	3.4.3: Strengthen data demand and use	x	x	x	x	x	NMEP NC
3.5: Integrate and coordinate Surveillance, Monitoring, Evaluation and Operations Research interventions	3.5.2: Strengthen integrated routine monitoring and supervision	x	x	x	x	x	NMEP SMEOR; DHPRS; Partners
	3.5.3: Improve coordination with DHPRS to improve malaria data quality	x	x	x	x	x	NMEP SMEOR; DHPRS
	3.5.4: Strengthen the existing linkages for data sharing and use	x	x	x	x	x	NMEP SMEOR; DHPRS; Partners
PSM Supportive Strategy and Activities							
3.6: Develop a functional Pharmaceutical Management Information System (PMIS) to strengthen evidence-based decision making for malaria programming	3.6.1. Revise the tools and processes used for data capturing: Malaria Health Products Logistics Management Information Systems (MHPLMIS), SOPs and others	x	x	x	x	x	NMEP, SMEOR, PSM, IPs, NPSCMP, LMCUs, 3PLs
	3.6.2. Build capacity of staff at National, State, LGA and facility levels on Integrated NHLMIS -DHIS Operations	x	x	x	x	x	NMEP, SMEOR, PSM, IPs, NPSCMP
	3.6.3. Institute annual malaria LMIS Data Quality Assurance (DQA) for public and private health facilities across all levels	x	x	x	x	x	NMEP, PSM, SMEOR, IPs, NPSCMP
3.7: Collaborate with NPSCMP and NAFDAC for integrated supportive supervision activities and promote Quality Assurance for malaria medicines/commodities across all facilities (public and private) respectively.	3.7.1. Institute quarterly supportive supervision activities for integrated malaria LMIS-DHIS at all levels	x	x	x	x	x	NMEP, SMEOR, PSM, LMCUs
	3.7.2. Institute coordinated activities for routine testing and post-market surveillance to track storage, distribution and use of malaria drugs and commodities, at all levels, and in public and private facilities	x	x	x	x	x	NMEP, NAFDAC, IPs NPSCMP, LMCUs
ACSM Supportive Strategies and Activities							

3.8: Reinforce and enhance advocacy approaches targeting private sector stakeholders to improve timely, appropriate and reliable malaria data reporting	3.8.1. Engage with the private sector (private health facilities/SDPs) on malaria data reporting	X	X	X	X	X	NMEP, SMEOR, ACSM, Partners
	3.8.1. Strengthen the use of appropriate evidence of effectiveness of SBC strategies	X	X	X	X	X	NMEP, SMEOR, ACSM, Partners
	3.8.3. Conduct periodic supervision and monitoring of SBC activities at sub-national levels	X	X	X	X	X	NMEP, SMEOR, ACSM, Partners

Objective 4: Strengthen coordination, collaboration, and strategic partnership to promote efficiency and effectiveness of malaria control activities towards achieving at least 75% improvement from baseline using a standardized OCA tool							
Strategy	Broad Activity	Implementation Timeline					Key Responsible
		2021	2022	2023	2024	2025	
4.1. Develop, review or domesticate malaria policies, strategies frameworks and plans.	4.1.1. Review and disseminate national malaria policy.	X					NMEP PM
	4.1.2. Develop/support annual operational plan for malaria programme at Federal and in 36 States	X	X	X	X	X	NMEP PM; Partners
	4.1.3. Scale-up mechanisms for periodic malaria program performance review in 36 states and FCT	X	X	X	X	X	NMEP PM; Partners
	4.1.4. Periodic review of the MSP and Develop next MSP			X		X	NMEP PM; Partners
4.2. Improve NMEP capacity for coordination of malaria stakeholders in Nigeria	4.2.1. Map malaria partners to improve visibility and role of key actors in both public and private sector	X	X	X	X	X	NMEP PM; Partners
	4.2.2. Strengthen Internal coordination platforms at federal and in 36 states	X	X	X	X	X	NMEP; SMEPs
	4.2.3. Strengthen external coordination platforms at Federal level and 36 states	X	X	X	X	X	NMEP; Partners
4.3. Improve collaboration with relevant MDAs to enhance	4.3.1. Collaborate with key line ministries and agencies (NPHCDA, DFH, NHIS, Academia, etc) for integrated delivery of malaria services.	X	X	X	X	X	NMEP; NPHCDA; FDFH: NHIS; etc

efficiency and effectiveness of malaria program delivery	4.3.2. Support delivery of Malaria interventions in humanitarian emergencies	X	X	X	X	X	NMEP; NEMA
4.4. Strengthen private sector collaboration and participation for delivery of quality malaria services.	4.4.1. Establish the Private sector unit and map key stakeholders including manufactures and healthcare providers	X	X	X	X	X	NMEP; Partners; Private sector
	4.4.2. Establish and operationalise a coordination mechanism for private sector	X	X	X	X	X	NMEP PM
	4.4.3. Provide an enabling environment and incentives for private sector	X	X	X	X	X	NMEP; Partners; Private sector
4.5. Strengthen capacity of NMEP and SMEPs to harmonise capacity development processes	4.5.1. Conduct regular OCA to periodically ascertain the capacity of NMEP and SMEPs to deliver planned activities	X		X		X	NMEP PM; Partners
	4.5.2. Coordinate the implementation of capacity improvement plan	X	X	X	X	X	NMEP/SMEP PM
ACSM Supportive Strategies and Activities							
4.6: Strengthen coordination between SBC and service delivery actors to align supply (service provision) and demand (patient demand) efforts to increase alignment and impact of interventions.	4.6.1. Convene periodic SBC and service delivery coordination meetings or forums to promote data sharing, analysis and use and real-time strategy (re)alignment e.g., message harmonization.	X			X		NMEP ACSM &CM, Partners

Objective 5: Improve funding for malaria control by at least 25% annually through predictable and innovative sources to ensure sustainability at federal and sub-national levels							
Strategy	Broad Activity	Implementation Timeline					Responsible
		2021	2022	2023	2024	2025	
5.1. Strengthen capacity for budget tracking, internal controls	5.1.1. Build capacity of NMEP/SMEPs for budget tracking and risk management	X	X	X	X	X	NMEP; SMEPs

and financial reporting at national and sub-national levels	5.1.2. Establish systems for malaria expenditure tracking and financial reporting - federal and 36 states	X	X	X	X	X	NMEP; SMEPs
5.2. Scale-up DRM (Domestic resource mobilization)	Promote resource mobilization initiatives targeting philanthropic organisations and individuals	X	X	X	X	X	NC NMEP; Partners
	Engage legislators and executives towards evidence-driven budgetary allocation for malaria interventions	X	X	X	X	X	NC/Head Program Management
	Ensure malaria activities financing are prioritised in emerging sources - NHIS, SHIS, BHCPF and SOML	X	X	X	X	X	Head Program Management
	Identify and operationalise innovative financing methods for malaria	X					NC/Head Program Management
ACSM Strategies and Activities							
Strategy 5.3: Reinforce policy-makers and legislature engagement for increased funding allocation and release for malaria management at all levels	5.3.1 Develop Advocacy intervention tools and packages targeted at public policy makers and legislature at the national and state levels	X			X		NMEP ACSM; NMEP PM; Partners
Strategy 5.4: Strengthen proven-to-work stakeholders advocacy for improved resources for malaria interventions	5.4.1. Engage private sector actors, including the Media, to support malaria interventions (e.g. procurement & distribution of consumables, airing of jingles and printing of tools (CSR))	X	X	X	X	X	NMEP ACSM; NMEP PM; Partners

5.2. Implementation arrangements

This Malaria Strategic Plan (NMSP, 2021 – 2025) will be implemented through the existing health system structures at the facility and community levels and regarding the guiding principles and the priorities of the National Health Strategic Development Plan, 2018 – 2022,

the High Burden, High Impact (HBHI) approach and the evidence from epidemiological stratification conducted.

The need for multi-stakeholder and multisectoral coordination and collaboration at the Federal, State, LGA, Community and Household levels to deliver on the priorities of this plan has been highlighted at every stage of the plan development process. Many of the strategies and the broad activities of this MSP can only be achieved through mandate alignment with Ministries, Departments and Agencies with the responsibility and requirements to provide such services or create an enabling environment to do same.

The bilateral and multilateral agencies, Implementing Partners, Civil Society groups, Research Institutions, Academia and the private sector must align their support to the strategies and priority activities of this plan and contribute to the achievement of the goal and objectives of the MSP.

While NMEP and Federal MDAs provide policy and guidelines for key malaria control strategies, implementation will be integrated and decentralised to the States and the LGAs, managed by the State Malaria Elimination Programmes (SMEPs), the State Primary Health Care Development Agencies (SPHCDAs), Hospital Management Boards (HMBs), State Logistic Management Coordination Units (LMCUs), State Health Insurance Schemes, LGA focal persons, PHC facilities, private health facilities, community health workers and the newly initiated CHIPs initiative.

The implementation of this MSP should be guided by the following:

Guiding Principles

- **Multi-stakeholder and Multisectoral Approach**: Successful implementation of the MSP strategies and priority actions will most times require the involvement of actors from different branches of NMEP, departments of FMOH and other line Ministries and Agencies e.g., Family Health, NPHCDA, SPHCDA, NHIS, SHIS, NPSCMP, NCDC, NEMA, SEMA, Private Sector, etc
- **Human Rights, Gender, and Equity**: High priority must be given to the vulnerable populations including the rural poor, women, children under 5, mobile populations, refuges, etc. Gender and Human rights issues should be considered at all times.
- **Efficiency:** The use of available and prospective resources should reflect efficiency in allocation and at programmatic levels to ensure value for money.
- **Appropriate Interventions Mixes**: Deployment of strategies and intervention mixes across epidemiological zones should be based on epidemiological, entomological and socio-economical stratification of Nigeria
- **Mechanisms for Performance Tracking;** NMEP and Partners should of necessity establish and operationalise mechanisms for tracking implementation progress, expenditure, commodities, etc.
- **Strengthened Integration and Collaboration**: Busines processes should be clearly defined and responsibility allocated based on the mandate rating (Primary, Secondary or Remote mandates)
- **Leveraging the Community Health Service**: Sub-national level implementation of malaria-related activities may not require creating different tiers of workstream. Existing structures and social infrastructure can be leveraged upon – Civil Society, CHIPs, WHC, etc
- **Risk Management**: The risks and assumptions around malaria programme implementation should be predicted and mitigated. These include issues around

standards, internal control, external audit, quality issues, etc

- **Aid Effectiveness:** Malaria Partners in Nigeria must of necessity align their support to country's priorities, ensure harmonisation and joint management for results. There should also be mutual accountability

5.2.1. Planning;

Guided by the practice directive from the Federal Ministry of Finance, Budget and National Planning, the FMoH and its departments/agencies develop an annual operational plan from the multi-years NSHDP 2. The planning cycle aligns with the fiscal policy and budget cycle of January to December each year.

NMEP and Partners will therefore develop annual an operational plan that will provide needed input into the national and sub-national budgets for malaria and articulate the investments of malaria partners within the fiscal year that are consistent with the priorities set in this NMSP.

5.2.2. Partnership coordination system

The Coordination Framework for NMEP and Partners is being reviewed to reflect emerging issues and evidence from recent assessments. This Framework provides the general guide for internal and external coordination of Roll Back Malaria Partners to End Malaria in Nigeria at both Federal and sub-national levels. The State Government were expected to domesticate the Framework based on the local realities.

The major malaria partner coordination platforms at the federal level is the TWG-Malaria which is a sub-component of the HIV/AIDS Tuberculosis Malaria Task Force (ATM). The ATM Task Force has TWG for HIV&AIDS, Tuberculosis and Malaria. The Malaria-TWG) apart from providing broad support to FMoH and NMEP has six thematic area sub-committees that provides in-depth support to the technical areas of the Malaria Elimination Strategies. It is proposed that a sub-committee on Private Sector Stakeholders should also be established and operationalised.

The coordination arrangements at the state level is largely through the Partners forum and more specifically the Malaria Control Advisory Committees. Although most states have established Malaria Control Advisory Committees, it is uncertain the committees are fully functional.

It is expected that the Malaria-TWG and the sub-committees will continue to provide needed technical, financial and material assistance to NMEP and the SMEPs towards the implementation of this MSP.

5.2.3. Procurement and supply management system

The National Supply Chain system for the malaria program is coordinated by the Procurement and Supply Chain Management (PSM) branch of NMEP, which coordinates the forecast and quantification of malaria health product needs of the country. The procurement of malaria health products by Government and donors/implementing partners, is based on the national quantification outcome and donor commitment to the specific State(s) being supported.

The gaps between the forecast and the donor commitment for each State is filled by the Government of Nigeria (GoN). The malaria supply chain has three (3) storage levels: National

warehouses (Lagos and Abuja), Axial or Zonal warehouses (Lagos -South West; Gombe-North East; Sokoto-North West; Abuja-North central; Cross River-South south and Anambra-South East) and the State warehouses.

Presently, all malaria health products imported into the country go through the national warehouses in Abuja and Lagos. Thereafter, the products are long-hauled based on state-aggregated needs to the respective zonal warehouses. The health products need for each health facility obtained from the Bimonthly Facility Stock Report (BFSR) generated at the facility-level are aggregated by the State LMCU. The aggregated needs are used to generate the Last Mile Delivery (LMD) Plan for each health facility. The LMD plan is reviewed by the program at the national level and sent back to LMCU for approval by the relevant authority. The approved LMD plan is sent to the axial warehouse for Last Mile delivery to the health facilities.

At the HF, the health products are received and the Proof of Delivery (POD) signed off confirming receipt of quantities issued from the axial warehouses. Each health facility has LMIS tools for reporting and recording transaction. The Bimonthly facility Stock report is used to generate logistics report at the health facility every two (2) months. The report is collected by the LGA LMCU and transmitted to the state LMCU for entering into the National Health Logistics Management Information System (NHLMIS) to generate the malaria logistics dashboard and the LMD plan. The LMD plan drives the bimonthly re-supply of malaria health products to the facilities.

The MPR observed during the engagement with the State Malaria Programmes that Last Mile Distribution has been subjected to varying degree of controversial practices including dumping and proxy delivery. The warehouses and DRF offer additional opportunity to improve the logistics systems and ensure sustainability.

5.2.4. Financial resource management

Nigeria's main source of revenue remains crude oil and global politics determine the price based on market forces beyond the control of the Nigerian Government. The funds accrued which determine the annual budgetary allocation for the Ministries, Departments and Agencies (MDAs) thus vary from year to year. Budgetary allocation to Health and Malaria has remained low.

Apart from the government, other sources of funding for Malaria include, the Global Fund, US President's Malaria Initiative, UK Department for International Develop, The World Bank, World Health Organization, UNITAID, Clinton Health Access Initiative (CHAI), Bill and Melinda Gates Foundation (BMGF), Dangote Foundation (DF), Mobil Oil, other members of the Corporate Alliance on Malaria in Africa (CAMA), etc.

Partners' funding for Malaria interventions is usually managed by the Implementing Agencies with occasional financing through government-approved Project Management Units with in-built internal and external control mechanisms.

The government supports malaria elimination through an allocation from the budget both at the national and states levels as well as through special funding streams or specific programmes including the Basic Health Care Provision Fund (BHCPF) of the National Health Act, 2014, the National Health Insurance Scheme (NHIS) and the State Schemes, Drug Revolving Fund (DRF), the RMNCAH week, Saving One Million Lives (SOML) Project and funding of other PHC activities.

National Health Insurance Scheme: This is Nigeria's health financing strategy to attain UHC. Established over two decades ago, it currently supports only about 3% of the population especially those in the formal sector. The agency is undergoing structural reforms to reposition it for more efficient services and NMEP and Partners should leverage on this. Similarly, social health insurance schemes have been introduced at the State level to provide financial protection to the majority of citizens at the point of accessing health care.

BHCPF: States have commenced to draw down the 1% Consolidated Revenue Fund allocated to the BHCPF each year in accordance with the provisions of the National Health Act 2014. This will aid the implementation of the Basic Minimum Package of Health Services which includes Malaria.

Drug Revolving Fund (DRF) Schemes: The State and LGA DRF initiatives are opportunities for financing Malaria medicines and other commodities at the sub-national levels. This also holds the key to the sustainability strategy of the NMEP.

Saving One Million Lives (SOML): Funded by the World Bank, SOML provides periodic grants to the states based on certain performance indicators including use of LLINs. Malaria control is one of the six pillars of the project.

RMNCHAH Week: The bi-annual implementation of integrated reproductive, maternal, neonatal, child and adolescent health provides the opportunity for scaling up priority health services particularly in hard to reach areas with support from the State Governments, UNICEF, UNDP, WHO, etc, Malaria interventions remain a major component and beneficiary of the week.

Public-Private Partnership (PPP): Leveraging the corporate social responsibility (CSR) of private companies and organisations to fund malaria-related interventions and galvanising private-sector support for malaria through CAMA. Private sector engagement will be guided by the direction provided in the second National Strategic Health Development Plan (NSHDP II) – *Priority Area 3, Objective 7.*

Specifically, NMEP will In line with the objectives of the NSHDP 11 and National Malaria PPP strategy:

- Establish stronger PPP coordination platforms; development of a PPP framework and facilitating its adoption at all levels (through funding and technical support, see objective 4 of the MSP).

- Leverage on sector-specific platforms e.g., CAMA, NAPPMED, AGPMPN etc. and provide incentives for the adoption of policies, enforcement of regulations and participation in malaria programme delivery.

- Mobilize domestic resources for malaria through PPP and build capacity of the private care providers for programme implementation including service delivery, monitoring and evaluation.

- Foster growth of local markets e.g. facilitate the retailing of malaria commodities and support prequalification processes for the local manufacture of malaria commodities.

5.2.5. Risk management and mitigation.

The risks likely to be associated with the implementation of this Plan and the mitigating actions are presented in the table below:

Table 3: Risk categories and mitigation actions

Risk Category	Key Risk	Mitigation Actions
Inadequate Funding	• Poor allocation of resources to Health and Malaria • The delayed release of budgeted funds • Mis-application of released funds	• Advocacy to Government for increase allocation to Health and Malaria. • Early release and tracking of budget. • Establish appropriate internal control mechanisms and ensure timely financial reporting.
Capacity for Plan Implementation	• Re-assignment of competent and trained manpower • Inadequate Infrastructure, Tools and Equipment • Sub-Optimal Human Resource Management	• Civil Service Advocated retaining competent staff • Provision of appropriate tools and equipment • Institutional mechanisms for reward and sanctions
Coordination and collaboration	• Weak Federal level collaboration and State level coordination	• Ensure mandate alignment and collaboration • Implement the Coordination Framework
Malaria Commodities Security	• Delayed procurement and weak logistic management system • Suboptimal warehousing/storage at the State level • Commodity Theft	• Proactive pulled procurement and effective LMS. • Targeted improvements in storage Infrastructure and inventory management capacity and practices • Commodities Pipeline Monitoring and strengthened LMIS.
Monitoring and Supervision	• Vertical uncoordinated monitoring and supervision	• Develop Integrated Supportive Supervision Plan with IPs • Strengthen and support state-level stakeholders to conduct periodic ISS and reporting. • Period Plan Reviews
Private Sector	• Private sector buy-in and participation • Private Sector Data	• Establish a PPP unit and implement a robust PPP strategy. • Include private sector HFs in M&E plan implementation

5.3. Budget of the MSP

5.3.1. Budget summary

The budget of the National Malaria Strategic Plan, 2021-2025 was estimated using the Excel-based National Malaria Programme Strategic and Operational Plan Costing Tool (developed with support of WHO). The broad activities of each objective and the related strategies were costed through a bottom-up process and the cost of all inputs required per activity were estimated based on historic values and reasonable inflationary, demographic and epidemiological projections.

The MSP budget is **estimated at N1.89 trillion ($4.98 billion) for the five-year duration**. The mean cost per Capita is estimated at N1,825 ($5.0) and the average annual cost is estimated at N378 billion (approx. $1bilion).

Objective 2 of the NMSP, 2021-2025 that deals with all forms of malaria chemoprevention, diagnosis of all fever cases and appropriate treatment accounted for the largest share of the budget with 63.1%, this is followed by Objective 1 of the plan that deals with vector control and accounts for 35.9% of the Total Cost of the plan.

The budget provided for each Objective has embedded in it the cost of the supportive strategies of the procurement and supply chain management and the ACSM. This was done provide the full spectrum of the service delivery and prevent silos costing of the systems that provide a particular intervention.

Objectives 3, 4 and 5 accounted for 0.7%, 0.3% and 0.1% of the total budget of the NMSP respectively. These three Objectives are also expected to benefit from the broader health system financing and technical assistance. **The annual budget breakdown is presented in table 4 below; the breakdown of the budget by intervention areas and by prioritised strategies of the MSP are presented in annexes 4 and 5 respectively.**

Figure 12: Proportion of the budget of NMSP, 2021-2025 by Objectives

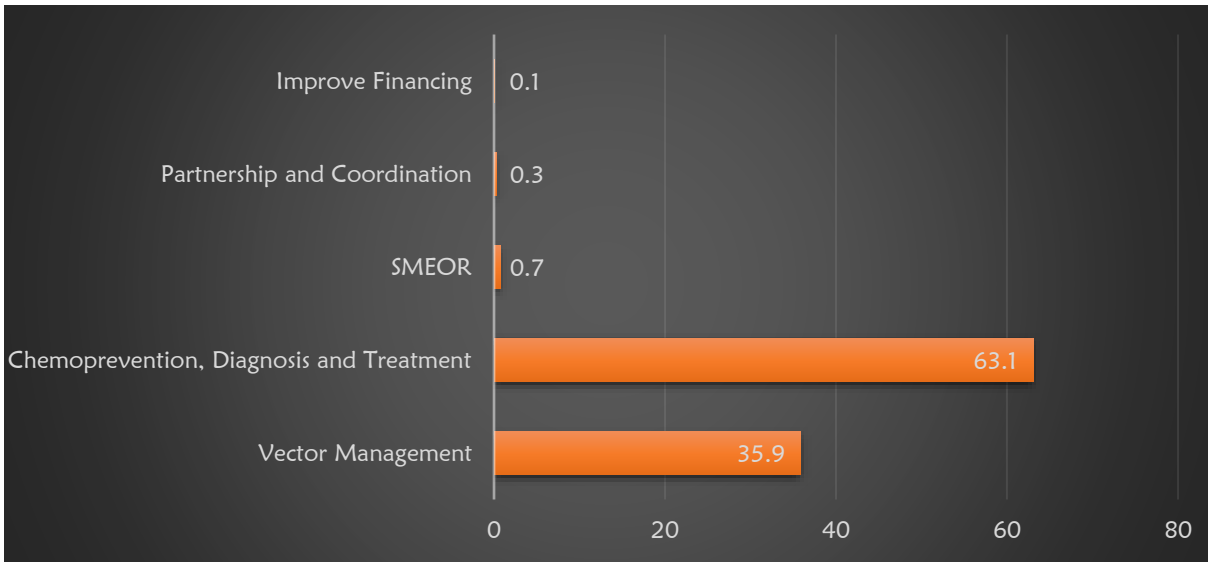


Table 4: Annual and Total Budget of the NMSP, 2012-2025 by Objectives

MSP Objectives and Strategies	2021	2022	2023	2024	2025	2021-2025 Total	% Total cost
Objective 1: Improve access and utilization of vector control interventions to at least 80% of targeted population by 2025	106,582,470,268	140,446,627,081	107,427,520,512	146,874,783,632	177,445,031,840	678,776,433,334	35.9%
Objective 2: Ensure provision of chemoprevention, diagnostic and appropriate treatment services for 80% eligible individuals in both public and private facilities by 2025	240,789,558,633	229,372,588,799	231,413,497,759	247,467,755,167	245,513,947,939	1,194,557,348,297	63.1%
Objective 3: Improve evidence-based decision making through the provision of timely, appropriate and reliable malaria and health information by at least 80% of facilities (public and private) providing malaria services by 2025	3,152,296,986	3,100,026,958	1,343,984,558	4,005,588,922	1,313,525,958	12,915,423,382	0.7%
Objective 4: Strengthen coordination, collaboration and strategic partnerships to promote efficiency and effectiveness of malaria control activities towards achieving at least 75% improvement from baseline using a standardized OCA tool	1,285,549,640	695,361,840	1,063,992,680	559,591,680	1,133,087,280	4,737,583,120	0.3%
Objective 5: Improve funding for malaria control by at least 25% annually through predictable and innovative sources to ensure sustainability at federal and sub-national levels	276,469,600	301,489,865	305,375,040	297,721,840	216,969,040	1,398,025,385	0.1%
Grand Total in Local Currency	352,328,881,126	373,845,142,542	341,628,010,549	399,134,825,240	425,851,728,058	1,892,788,587,517	MSP mean Cost per Capita: 1,825
Grand Total in $US (exchange: N380)	$927,181,266.12	$ 983,803,006.69	$ 899,021,080.39	$ 1,050,354,803.27	$ 1,120,662,442.26	$4,981,022,598.73	MSP mean Cost per Capita: $5.0

5.3.2. Resource Mobilisation

Financing for healthcare including malaria in Nigeria comes from many sources. These sources include the Government budgets (federal, state and LGA), donor partners, private sector contributions, health insurance and out-of-pocket payments.

The National Health Account has shown repeatedly that over 70% of malaria spending is out-of-pocket. Similarly, the poor coverage of insurance schemes at the national and sub-national levels is also responsible for the lack of financial protection for the vulnerable populations at service points.

Table 5 below shows the malaria funding opportunities presently available or committed during the period of this NMSP and the sources of such financing. It also shows the gap that exist between the projected budget required to achieve the goal of the MSP and the available resources. This therefore provides a reasonable estimate of the funding gap that does exist and the target that should drive the resource mobilization efforts of the government and malaria partners in Nigeria.

Table 5: Malaria Funding Landscape and the Gaps in the NMSP, 2021-2025 in millions

Resources	2021	2022	2023	2024	2025	2021-2025 Total Cost	Funding Gap
A. Total national strategic plan budget	352,329	373,845	341,628	399,135	425,852	1,892,789	
B. Current and expected domestic resources	158,960	165,525	165,525	172,418	172,418	834,845	
C. Current and expected external resources	39,351	37,760	36,444	272	-	113,826	
D. Total current and planned resources (B+C)	198,311	203,284	201,968	172,690	172,418	948,672	
E. Financial gap = A–D	154,018	170,561	139,660	226,445	253,434	944,117	50%
Financial Gap in $US (N380 to 1$)	$ 405	$ 449	$ 368	$ 596	$ 667	$ 2,485	

Governments financing for malaria have been inadequate, budgets have not been fully implemented and the funds released are sometimes not managed efficiently (Malaria Programme Review Report). The major sources of external support include the Global Fund, PMI, World Bank and UK-DFID.

One of the Objectives of the MSP is to improve financing through different strategies and to ensure sustainability of malaria programming beyond donor support. To ensure the implementation of these strategies, NMEP and Partners are expected to develop and operationalize a Resource Mobilisation Strategy and Implementation Plan that will articulate the methods and the expected results.

It is also expected that beyond the innovative financing strategies suggested in this plan and that may be included in the Resource Mobilisation Strategy and Implementation Plan, Governments at all levels need to urgently improve budgetary allocation to health and malaria and also support malaria programming though the emerging funding platforms like the BHCPF, Social Health Insurance Schemes and private sector CSRs.

5.3.3. Programme Needs

The estimates of key programmatic commodities required for the achievement of the objectives of the MSP in the next five years are indicated in table 5 below. It is noteworthy that quantification of these commodities should remain a dynamic process and the quantities presented in this plan should be reviewed from time to time.

Table 6: NMSP, 2021 – 2025 commodities need

Commodities	2021	2022	2023	2024	2025	2021-2025
ACT doses (Public)	64,849,457	65,655,361	66,449,473	67,230,270	67,996,136	**332,180,698**
ACT doses (Private)	88,070,204	89,111,234	90,132,723	91,132,413	92,107,909	**450,554,483**
RDT units (Public)	52,854,809	54,594,638	56,396,337	58,262,499	60,195,862	**282,304,146**
RDT units (Private)	70,787,046	73,117,153	75,530,120	78,029,422	80,618,724	**378,082,466**
Microscopy Needs (Public)	14,117,417	14,582,122	15,063,352	15,561,800	16,078,198	**75,402,889**
Microscopy Needs (Private Sector)	22,859,747	23,612,224	24,391,460	25,198,577	26,034,758	**122,096,766**
LLIN units Mass Campaign)	63,905,941	31,550,685	17,377,636	87,140,011	32,906,917	**232,880,740**
LLIN units (Routine)	8,291,544	9,161,238	10,080,096	11,050,654	12,075,592	**50,659,124**
Artesunate inj. Doses (Public)	6,282,291	6,360,363	6,437,293	6,512,932	6,587,126	**32,180,005**
RAS Need (Public)	502,583	508,829	514,983	521,035	526,970	**2,574,400**
SPAQs Need	90,063,576	93,155,977	96,367,293	99,703,176	103,169,628	**482,459,650**
SP Need (Public)	7,549,024	8,236,480	8,961,801	9,726,926	10,533,900	**45,008,131**
SP Need (Private)	3,277,096	3,575,526	3,890,394	4,222,541	4,572,856	**19,538,414**

Chapter 6. Monitoring and evaluation framework

This Monitoring and Evaluation Framework provides a road map to the successful implementation of NMSP, 2021-2025 activities. It comprises three parts, which are the performance framework, the data management system and the M&E coordination mechanisms. The Surveillance, Monitoring, Evaluation and Operations Research (SMEOR) Branch of NMEP is saddled with responsibilities of monitoring and evaluating the NMSP activities.

6.1. Performance framework

The framework helps to track implementation and output systematically and measure the effectiveness of the plan (table 7). It helps determine exactly when the plan is on track and when changes will be needed. The operational definition of the indicators, sources, frequency of measure, level of measurement and the responsible entities are listed in annex 3.

Table 7: NMSP, 2021-2025 Performance Framework

ITEM	INDICATOR		BASELINE			ANNUAL TARGETS				
			VALUE	YEAR	SOURCE	2021	2022	2023	2024	2025
GOAL										
To achieve a parasite prevalence of less than 10% and reduce mortality attributable to malaria to less than 50 deaths per 1,000 livebirths by 2025	1	Annual Parasite Incidence per 1000 population	473	2019	WHO	400	371	353	314	272
	2	All cause under-5 mortality rate per 1000 live birth	132	2018	Household Surveys	124	117	112	108	105
	3	% children aged 6–59 months with hemoglobin measurement of <8g/dl)	8%	2018	Household Surveys	7.4	7.1	6.9	6.8	6
	4	Malaria Parasite Prevalence in children U5 (Slide)	23 %	2018	Household Surveys	20.8	18.1	15.0	12.3	9.9
	5	Entomological Inoculation Rate (Indoor)	0 - 1.37	2019	Vector Surveillance Reports					
OBJECTIVE 1										
Improve access and utilization of vector control interventions to at least 80% of targeted population by 2025	1.1	% of households with at least 1 ITN	60 %	2018	Household Surveys	66 %	72 %	77 %	82 %	86 %
	1.2	% of households with at least 1 ITN for every two persons	30 %	2018	Household Surveys	40 %	46 %	52 %	60 %	70 %
	1.3	% of population with access to an ITN in the household*	47 %	2018	Household Surveys	54 %	60 %	66 %	74 %	80 %
	1.4	% of household residents who slept under an ITN the previous night	43 %	2018	Household Surveys	44 %	50 %	56 %	62 %	68 %
	1.5	% of under-5 Children who slept under an ITN	74 %	2018	Household Surveys	76 %	78 %	79 %	82 %	84 %

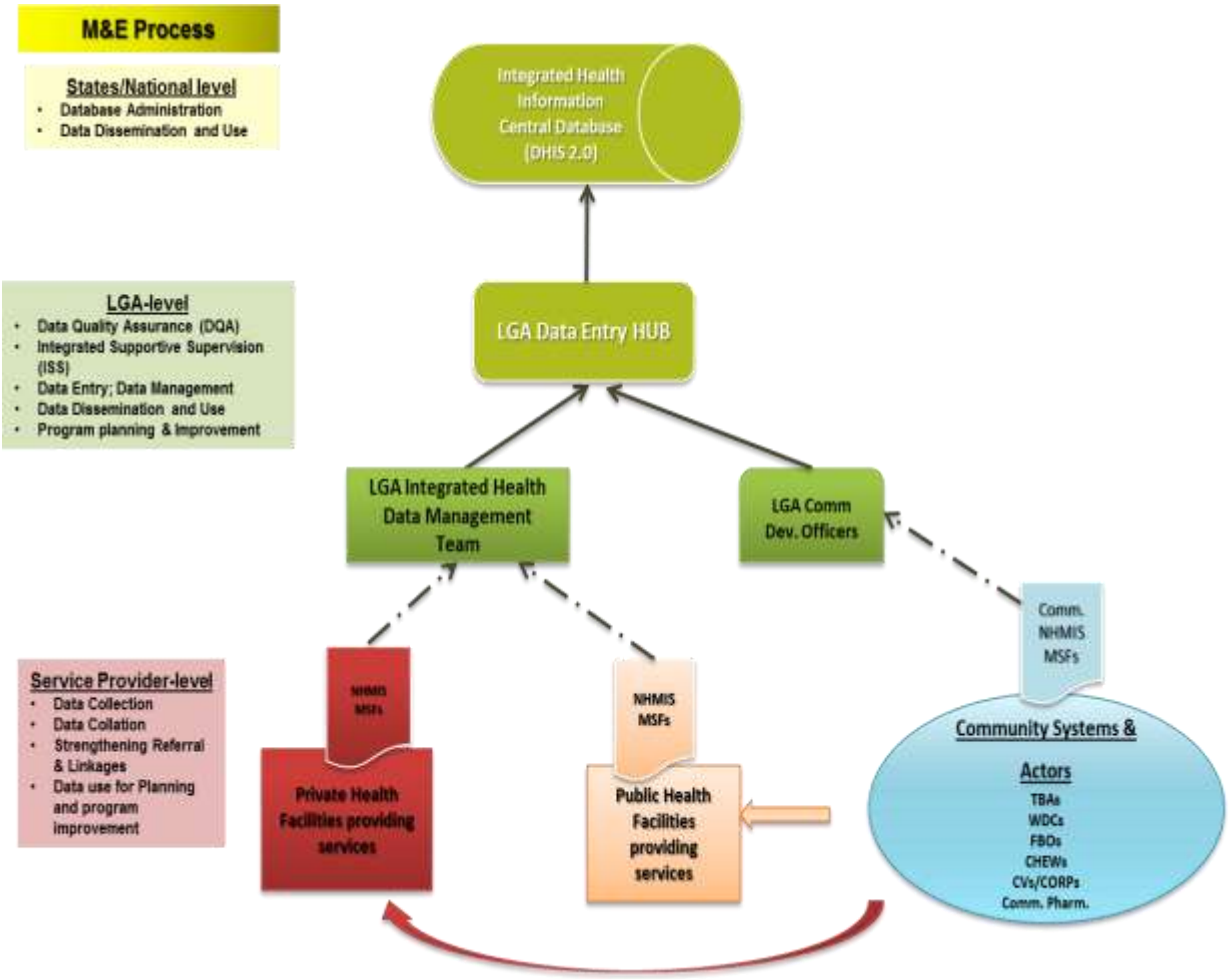
		the previous night**								
	1.6	% of pregnant women who slept under an ITN the previous night**	82 %	2018	Household Surveys	84 %	86 %	88 %	88 %	90 %
	1.7	% of targeted population protected by IRS within the last 12 months	TB D	2018	Programme records	90 %	90 %	90 %	90 %	90 %
	1.8	% of persons who agree with specified statements regarding malaria behaviours and products.	92 %	2018	Household Surveys	92 %	94 %	94 %	95 %	95 %
OBJECTIVE 2	OUTCOME INDICATORS									
Ensure provision of chemoprevention, diagnostic and appropriate treatment services for 80% eligible individuals in both public and private facilities by 25	2.1	% of women who received 3 or more doses of IPTp for malaria during their last pregnancy	17 %	2018	Household Surveys	38 %	44 %	52 %	63 %	76 %
	2.2	% of targeted children that have received all SMC cycles	TB D	2020	Coverage survey	70 %	75 %	80 %	85 %	90 %
	2.3	% of persons with suspected malaria receiving a diagnostic test (RDT and/or microscopy)	91 %	2019	HMIS	92 %	93 %	95 %	96 %	97 %
	2.4	% of confirmed malaria cases who received first line antimalarial treatment	94 %	2019	HMIS	95 %	96 %	97 %	98 %	98 %
	2.5	% of under-5 children with fever in the last two weeks for whom advice was sought within 24hours of the onset of fever	70 %	2018	Household Surveys	77 %	82 %	87 %	90 %	95 %
	2.6	% receiving ACT, among of under-5 children with fever in the last two weeks who received any antimalarial drug	28 %	2018	Household Surveys	37 %	42 %	48 %	54 %	62 %
	2.7	% of health facilities without stock out of ACTs for 7 consecutive days in a month		2019	NHLMIS					
	2.8	% of persons who agree with specified statements regarding malaria consequences	70 %	2018	Household Surveys	72 %	76 %	78 %	78 %	80 %
OBJECTIVE 3	OUTCOME INDICATORS									
To improve generation of evidence for decision making and impact through reporting of quality malaria data and information from at least 80% of health facilities	3.1	% of expected health facility reports received and complete (with core indicators)	68 %	2019	NHMIS	70 %	76 %	80 %	88 %	90 %
	3.2	% of health facilities reporting malaria data without variance >5% between NHMIS and NHLMIS	TB D	2019	NHMIS/ NHLMIS					

(public and private) and other data sources including surveillance, surveys and operations research by 2025	3.3	% of malaria medicines and health products that met quality specifications during post marketing surveillance visits	TBD	2019	NHLMIS					
OBJECTIVE 4										
Strengthen coordination, collaboration and strategic partnerships to promote efficiency and effectiveness of malaria control activities towards achieving at least 75% improvement from baseline using a standardized OCA tool	4.1	Organizational Capacity Assessment (OCA) score at federal level	46 %	2019	Report of OCA assessment	51 %	56 %	61 %	65 %	75 %
	4.2	Proportion of States with ≥75% OCA score	TBD		Report of OCA assessment	7 %	15 %	30 %	40 %	50 %
OBJECTIVE 5										
Improve funding for malaria control by at least 25% annually through predictable and innovative sources to ensure sustainability at national and sub-national levels	5.1	Proportion of States with at least 50% increase in malaria funding from government sources over 5 years	TBD	2019	Programme reports	45 %	65 %	70 %	80 %	85 %
	5.2	Proportion of total expenditure on malaria contributed by the Government (federal and states including FCT)	17.8%	2017	National health account	25 %	35 %	42 %	47 %	50 %

6.2. Data management system

The SMEOR policy/system consist of the National Malaria Operations Research Agenda; NMEP M&E Plan; Standard Operating Procedures for Data Management; Guidelines for Supportive Supervisory visit and Data Quality Assurance (DQA) and M&E Training manuals. At State level, there are dedicated malaria M&E officers who are responsible for the SMEOR activities. The state malaria M&E officers also work with the state HMIS officers in the Department of Health Planning Research and Statistics (DHPRS). At the Local Government Area (LGA) level, the LGA malaria focal persons and the LGA M&E and HMIS officers are responsible for malaria data quality. The LGA HMIS officers upload all data (including malaria programme data into the DHIS 2. The data flow from the health facility level to national level is depicted in the figure 14 below.

Figure 13: National data flow



6.3. M&E Coordination Mechanisms

These include coordination of SMEOR activities at the national and sub-national levels. The integrated routine monitoring and supervision is conducted in collaboration with the DPRS to improve malaria data quality. The SMEOR also utilises the existing linkages with health stakeholders for resource mobilization and data sharing and use.

7. Annexes

Annex 1: LGA Level Intervention Mixes based on Epidemiological Stratification.

DEMOGRAPHICS			MIX OF INTERVENTIONS	
STATE	LGA	city	iccm	mix
Abia	Aba North	Aba	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Abia	Aba South	Aba	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Abia	Arochukwu		No iCCM	CM+IPTp+LLINs+IPTi
Abia	Bende		No iCCM	CM+IPTp+LLINs+IPTi
Abia	Ikwuano		No iCCM	CM+IPTp+LLINs+IPTi
Abia	Isiala-Ngwa North		No iCCM	CM+IPTp+LLINs+IPTi
Abia	Isiala-Ngwa South		No iCCM	CM+IPTp+LLINs+IPTi
Abia	Isuikwato		No iCCM	CM+IPTp+LLINs+IPTi
Abia	Obi Nwa	Aba	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Abia	Ohafia		No iCCM	CM+IPTp+LLINs+IPTi
Abia	Osisioma Ngwa	Aba	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Abia	Ugwunagbo	Aba	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Abia	Ukwa East		No iCCM	CM+IPTp+LLINs+IPTi
Abia	Ukwa West		No iCCM	CM+IPTp+LLINs+IPTi
Abia	Umu-Neochi		No iCCM	CM+IPTp+LLINs+IPTi
Abia	Umuahia North		No iCCM	CM+IPTp+LLINs+IPTi
Abia	Umuahia South		No iCCM	CM+IPTp+LLINs+IPTi
Adamawa	Demsa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Adamawa	Fufore		No iCCM	CM+IPTp+PBO-LLINs+SMC
Adamawa	Ganaye		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Adamawa	Gireri		No iCCM	CM+IPTp+PBO-LLINs+SMC
Adamawa	Gombi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Adamawa	Guyuk		No iCCM	CM+IPTp+PBO-LLINs+SMC
Adamawa	Hong		No iCCM	CM+IPTp+PBO-LLINs+SMC
Adamawa	Jada		No iCCM	CM+IPTp+PBO-LLINs+SMC
Adamawa	Lamurde		No iCCM	CM+IPTp+PBO-LLINs+SMC
Adamawa	Madagali		No iCCM	CM+IPTp+PBO-LLINs+SMC
Adamawa	Maiha		No iCCM	CM+IPTp+PBO-LLINs+SMC
Adamawa	Mayo-Belwa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Adamawa	Michika		No iCCM	CM+IPTp+PBO-LLINs+SMC
Adamawa	Mubi North		No iCCM	CM+IPTp+PBO-LLINs+SMC
Adamawa	Mubi South		No iCCM	CM+IPTp+PBO-LLINs+SMC
Adamawa	Numan		No iCCM	CM+IPTp+PBO-LLINs+SMC
Adamawa	Shelleng		No iCCM	CM+IPTp+PBO-LLINs+SMC
Adamawa	Song		No iCCM	CM+IPTp+PBO-LLINs+SMC
Adamawa	Toungo		iCCM	CM+IPTp+PBO-LLINs+IPTi
Adamawa	Yola North		No iCCM	CM+IPTp+PBO-LLINs+SMC
Adamawa	Yola South		No iCCM	CM+IPTp+PBO-LLINs+SMC
Akwa Ibom	Abak		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Eastern Obolo		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Eket		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Esit Eket		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Essien Udim		No iCCM	CM+IPTp+LLINs+IPTi

DEMOGRAPHICS			MIX OF INTERVENTIONS	
STATE	LGA	city	iccm	mix
Akwa Ibom	Etim Ekpo		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Etinan		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Ibeno		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Ibesikpo Asutan		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Ibiono Ibom		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Ika		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Ikono		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Ikot Abasi		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Ikot Ekpene		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Ini		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Itu		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Mbo		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Mkpat Enin		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Nsit Atai		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Nsit Ibom		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Nsit Ubium		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Obot Akara		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Okobo		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Onna		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Oron		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Oruk Anam		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Udung Uko		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Ukanafun		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Uruan		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Urue-Offong/Oruko		No iCCM	CM+IPTp+LLINs+IPTi
Akwa Ibom	Uyo		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Aguata		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Anambra East		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Anambra West		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Anaocha		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Awka North		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Awka South		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Ayamelum		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Dunukofia		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Ekwusigo		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Idemili North		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Idemili South		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Ihiala		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Njikoka		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Nnewi North		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Nnewi South		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Ogbaru		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Onitsha North		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Onitsha South		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Orumba North		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Orumba South		No iCCM	CM+IPTp+LLINs+IPTi
Anambra	Oyi		No iCCM	CM+IPTp+LLINs+IPTi
Bauchi	Alkaleri		No iCCM	CM+IPTp+PBO-LLINs+SMC
Bauchi	Bauchi		No iCCM	CM+IPTp+PBO-LLINs+SMC

DEMOGRAPHICS			MIX OF INTERVENTIONS	
STATE	LGA	city	iccm	mix
Bauchi	Bogoro		No iCCM	CM+IPTp+PBO-LLINs+SMC
Bauchi	Damban		No iCCM	CM+IPTp+PBO-LLINs+SMC
Bauchi	Darazo		No iCCM	CM+IPTp+PBO-LLINs+SMC
Bauchi	Dass		No iCCM	CM+IPTp+PBO-LLINs+SMC
Bauchi	Gamawa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Bauchi	Ganjuwa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Bauchi	Giade		No iCCM	CM+IPTp+PBO-LLINs+SMC
Bauchi	Itas/Gadau		No iCCM	CM+IPTp+PBO-LLINs+SMC
Bauchi	Jama'are		No iCCM	CM+IPTp+PBO-LLINs+SMC
Bauchi	Katagum		No iCCM	CM+IPTp+PBO-LLINs+SMC
Bauchi	Kirfi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Bauchi	Misau		No iCCM	CM+IPTp+PBO-LLINs+SMC
Bauchi	Ningi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Bauchi	Shira		No iCCM	CM+IPTp+PBO-LLINs+SMC
Bauchi	Tafawa-Balewa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Bauchi	Toro		No iCCM	CM+IPTp+PBO-LLINs+SMC
Bauchi	Warji		No iCCM	CM+IPTp+PBO-LLINs+SMC
Bauchi	Zaki		No iCCM	CM+IPTp+PBO-LLINs+SMC
Bayelsa	Brass		No iCCM	CM+IPTp+LLINs+IPTi
Bayelsa	Ekeremor		No iCCM	CM+IPTp+LLINs+IPTi
Bayelsa	Kolokuma/Opokuma		No iCCM	CM+IPTp+LLINs+IPTi
Bayelsa	Nembe		No iCCM	CM+IPTp+LLINs+IPTi
Bayelsa	Ogbia		No iCCM	CM+IPTp+LLINs+IPTi
Bayelsa	Sagbama		No iCCM	CM+IPTp+LLINs+IPTi
Bayelsa	Southern Ijaw		No iCCM	CM+IPTp+LLINs+IPTi
Bayelsa	Yenegoa		No iCCM	CM+IPTp+LLINs+IPTi
Benue	Ado		No iCCM	CM+IPTp+LLINs+IPTi
Benue	Agatu		No iCCM	CM+IPTp+LLINs+SMC
Benue	Apa		No iCCM	CM+IPTp+LLINs+SMC
Benue	Buruku		No iCCM	CM+IPTp+LLINs+IPTi
Benue	Gboko		No iCCM	CM+IPTp+LLINs+IPTi
Benue	Guma		No iCCM	CM+IPTp+LLINs+SMC
Benue	Gwer East		No iCCM	CM+IPTp+LLINs+IPTi
Benue	Gwer West		No iCCM	CM+IPTp+LLINs+SMC
Benue	Katsina-Ala		No iCCM	CM+IPTp+LLINs+IPTi
Benue	Konshisha		No iCCM	CM+IPTp+LLINs+IPTi
Benue	Kwande		No iCCM	CM+IPTp+LLINs+IPTi
Benue	Logo		No iCCM	CM+IPTp+LLINs+SMC
Benue	Makurdi		No iCCM	CM+IPTp+LLINs+SMC
Benue	Obi1		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Benue	Ogbadibo		No iCCM	CM+IPTp+LLINs+IPTi
Benue	Ohimini		No iCCM	CM+IPTp+LLINs+IPTi
Benue	Oju		No iCCM	CM+IPTp+LLINs+IPTi
Benue	Okpokwu		No iCCM	CM+IPTp+LLINs+IPTi
Benue	Oturkpo		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Benue	Tarka		No iCCM	CM+IPTp+LLINs+SMC
Benue	Ukum		No iCCM	CM+IPTp+PBO-LLINs+SMC
Benue	Ushongo		No iCCM	CM+IPTp+LLINs+IPTi
Benue	Vandeikya		No iCCM	CM+IPTp+LLINs+IPTi

DEMOGRAPHICS			MIX OF INTERVENTIONS	
STATE	LGA	city	iccm	mix
Borno	Abadam		ICCM	CM+IPTp+LLINs+SMC
Borno	Askira/Uba		No iCCM	CM+IPTp+PBO-LLINs+SMC
Borno	Bama		ICCM	CM+IPTp+LLINs+SMC
Borno	Bayo		No iCCM	CM+IPTp+PBO-LLINs+SMC
Borno	Biu		No iCCM	CM+IPTp+PBO-LLINs+SMC
Borno	Chibok		No iCCM	CM+IPTp+PBO-LLINs+SMC
Borno	Damboa		No iCCM	CM+IPTp+LLINs+SMC
Borno	Dikwa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Borno	Gubio		ICCM	CM+IPTp+LLINs+SMC
Borno	Guzamala		No iCCM	CM+IPTp+LLINs+SMC
Borno	Gwoza		No iCCM	CM+IPTp+LLINs+SMC
Borno	Hawul		No iCCM	CM+IPTp+PBO-LLINs+SMC
Borno	Jere	Maiduguri	No iCCM	CM+IPTp+UrbanLLINs+SMC
Borno	Kaga		ICCM	CM+IPTp+LLINs+SMC
Borno	Kala/Balge		No iCCM	CM+IPTp+LLINs+SMC
Borno	Konduga		No iCCM	CM+IPTp+LLINs+SMC
Borno	Kukawa		ICCM	CM+IPTp+LLINs+SMC
Borno	Kwaya Kusar		No iCCM	CM+IPTp+PBO-LLINs+SMC
Borno	Mafa		No iCCM	CM+IPTp+LLINs+SMC
Borno	Magumeri		ICCM	CM+IPTp+LLINs+SMC
Borno	Maiduguri	Maiduguri	No iCCM	CM+IPTp+UrbanLLINs+SMC
Borno	Marte		No iCCM	CM+IPTp+LLINs+SMC
Borno	Mobbar		No iCCM	CM+IPTp+LLINs+SMC
Borno	Monguno		No iCCM	CM+IPTp+LLINs+SMC
Borno	Ngala		No iCCM	CM+IPTp+LLINs+SMC
Borno	Nganzai		No iCCM	CM+IPTp+LLINs+SMC
Borno	Shani		No iCCM	CM+IPTp+PBO-LLINs+SMC
Cross River	Abi		No iCCM	CM+IPTp+LLINs+IPTi
Cross River	Akamkpa		No iCCM	CM+IPTp+LLINs+IPTi
Cross River	Akpabuyo		No iCCM	CM+IPTp+LLINs+IPTi
Cross River	Bakassi		No iCCM	CM+IPTp+LLINs+IPTi
Cross River	Bekwara		No iCCM	CM+IPTp+LLINs+IPTi
Cross River	Biase		No iCCM	CM+IPTp+LLINs+IPTi
Cross River	Boki		No iCCM	CM+IPTp+LLINs+IPTi
Cross River	Calabar South		No iCCM	CM+IPTp+LLINs+IPTi
Cross River	Calabar-Municipal		No iCCM	CM+IPTp+LLINs+IPTi
Cross River	Etung		No iCCM	CM+IPTp+LLINs+IPTi
Cross River	Ikom		No iCCM	CM+IPTp+LLINs+IPTi
Cross River	Obanliku		No iCCM	CM+IPTp+LLINs+IPTi
Cross River	Obubra		No iCCM	CM+IPTp+LLINs+IPTi
Cross River	Obudu		No iCCM	CM+IPTp+LLINs+IPTi
Cross River	Odukpani		No iCCM	CM+IPTp+LLINs+IPTi
Cross River	Ogoja		No iCCM	CM+IPTp+LLINs+IPTi
Cross River	Yakurr		No iCCM	CM+IPTp+LLINs+IPTi
Cross River	Yala		No iCCM	CM+IPTp+LLINs+IPTi
Delta	Aniocha North		No iCCM	CM+IPTp+LLINs+IPTi
Delta	Aniocha South		No iCCM	CM+IPTp+LLINs+IPTi
Delta	Bomadi		No iCCM	CM+IPTp+LLINs+IPTi
Delta	Burutu		No iCCM	CM+IPTp+LLINs+IPTi

DEMOGRAPHICS			MIX OF INTERVENTIONS	
STATE	LGA	city	iccm	mix
Delta	Ethiope East		No iCCM	CM+IPTp+LLINs+IPTi
Delta	Ethiope West		No iCCM	CM+IPTp+LLINs+IPTi
Delta	Ika North East		No iCCM	CM+IPTp+LLINs+IPTi
Delta	Ika South		No iCCM	CM+IPTp+LLINs+IPTi
Delta	Isoko North		No iCCM	CM+IPTp+LLINs+IPTi
Delta	Isoko South		No iCCM	CM+IPTp+LLINs+IPTi
Delta	Ndokwa East		No iCCM	CM+IPTp+LLINs+IPTi
Delta	Ndokwa West		No iCCM	CM+IPTp+LLINs+IPTi
Delta	Okpe	Warri	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Delta	Oshimili North		No iCCM	CM+IPTp+LLINs+IPTi
Delta	Oshimili South		No iCCM	CM+IPTp+LLINs+IPTi
Delta	Patani		No iCCM	CM+IPTp+LLINs+IPTi
Delta	Sapele		No iCCM	CM+IPTp+LLINs+IPTi
Delta	Udu	Warri	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Delta	Ughelli North	Warri	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Delta	Ughelli South		No iCCM	CM+IPTp+LLINs+IPTi
Delta	Ukwuani		No iCCM	CM+IPTp+LLINs+IPTi
Delta	Uvwie	Warri	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Delta	Warri North		No iCCM	CM+IPTp+LLINs+IPTi
Delta	Warri South	Warri	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Delta	Warri South West		No iCCM	CM+IPTp+LLINs+IPTi
Ebonyi	Abakaliki		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Ebonyi	Afikpo North		No iCCM	CM+IPTp+LLINs+IPTi
Ebonyi	Afikpo South		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Ebonyi	Ebonyi		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Ebonyi	Ezza North		No iCCM	CM+IPTp+LLINs+IPTi
Ebonyi	Ezza South		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Ebonyi	Ikwo		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Ebonyi	Ishielu		No iCCM	CM+IPTp+LLINs+IPTi
Ebonyi	Ivo		No iCCM	CM+IPTp+LLINs+IPTi
Ebonyi	Izzi		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Ebonyi	Ohaozara		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Ebonyi	Ohaukwu		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Ebonyi	Onicha		No iCCM	CM+IPTp+LLINs+IPTi
Edo	Akoko-Edo		No iCCM	CM+IPTp+LLINs+IPTi
Edo	Egor	Benin City	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Edo	Esan Central		No iCCM	CM+IPTp+LLINs+IPTi
Edo	Esan North East		No iCCM	CM+IPTp+LLINs+IPTi
Edo	Esan South East		No iCCM	CM+IPTp+LLINs+IPTi
Edo	Esan West		No iCCM	CM+IPTp+LLINs+IPTi
Edo	Etsako Central		No iCCM	CM+IPTp+LLINs+IPTi
Edo	Etsako East		No iCCM	CM+IPTp+LLINs+IPTi
Edo	Etsako West		No iCCM	CM+IPTp+LLINs+IPTi
Edo	Igueben		No iCCM	CM+IPTp+LLINs+IPTi
Edo	Ikpoba-Okha	Benin City	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Edo	Oredo	Benin City	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Edo	Orhionmwon		No iCCM	CM+IPTp+LLINs+IPTi
Edo	Ovia North East		No iCCM	CM+IPTp+LLINs+IPTi
Edo	Ovia South West		No iCCM	CM+IPTp+LLINs+IPTi

DEMOGRAPHICS			MIX OF INTERVENTIONS	
STATE	LGA	city	iccm	mix
Edo	Owan East		No iCCM	CM+IPTp+LLINs+IPTi
Edo	Owan West		No iCCM	CM+IPTp+LLINs+IPTi
Edo	Uhunmwonde		No iCCM	CM+IPTp+LLINs+IPTi
Ekiti	Ado Ekiti		No iCCM	CM+IPTp+LLINs+IPTi
Ekiti	Efon-Alayee		No iCCM	CM+IPTp+LLINs+IPTi
Ekiti	Ekiti East		No iCCM	CM+IPTp+LLINs+IPTi
Ekiti	Ekiti South West		No iCCM	CM+IPTp+LLINs+IPTi
Ekiti	Ekiti West		No iCCM	CM+IPTp+LLINs+IPTi
Ekiti	Emure		No iCCM	CM+IPTp+LLINs+IPTi
Ekiti	Gboyin		No iCCM	CM+IPTp+LLINs+IPTi
Ekiti	Idosi-Osi		No iCCM	CM+IPTp+LLINs+IPTi
Ekiti	Ijero		No iCCM	CM+IPTp+LLINs+IPTi
Ekiti	Ikere		No iCCM	CM+IPTp+LLINs+IPTi
Ekiti	Ikole		No iCCM	CM+IPTp+LLINs+IPTi
Ekiti	Ilemeji		No iCCM	CM+IPTp+LLINs+IPTi
Ekiti	Irepodun/Ifelodun		No iCCM	CM+IPTp+LLINs+IPTi
Ekiti	Ise/Orun		No iCCM	CM+IPTp+LLINs+IPTi
Ekiti	Moba		No iCCM	CM+IPTp+LLINs+IPTi
Ekiti	Oye		No iCCM	CM+IPTp+LLINs+IPTi
Enugu	Aninri		No iCCM	CM+IPTp+LLINs+IPTi
Enugu	Awgu		No iCCM	CM+IPTp+LLINs+IPTi
Enugu	Enugu East	Enugu	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Enugu	Enugu North	Enugu	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Enugu	Enugu South	Enugu	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Enugu	Ezeagu		No iCCM	CM+IPTp+LLINs+IPTi
Enugu	Igbo-Etiti		No iCCM	CM+IPTp+LLINs+IPTi
Enugu	Igbo-Eze North		No iCCM	CM+IPTp+LLINs+IPTi
Enugu	Igbo-Eze South		No iCCM	CM+IPTp+LLINs+IPTi
Enugu	Isi-Uzo		No iCCM	CM+IPTp+LLINs+IPTi
Enugu	Nkanu East		No iCCM	CM+IPTp+LLINs+IPTi
Enugu	Nkanu West		No iCCM	CM+IPTp+LLINs+IPTi
Enugu	Nsukka		No iCCM	CM+IPTp+LLINs+IPTi
Enugu	Oji-River		No iCCM	CM+IPTp+LLINs+IPTi
Enugu	Udenu		No iCCM	CM+IPTp+LLINs+IPTi
Enugu	Udi		No iCCM	CM+IPTp+LLINs+IPTi
Enugu	Uzo-Uwani		No iCCM	CM+IPTp+LLINs+IPTi
Federal Capital Territory	Abaji		No iCCM	CM+IPTp+LLINs+SMC
Federal Capital Territory	Abuja Municipal	Abuja	No iCCM	CM+IPTp+UrbanLLINs+SMC
Federal Capital Territory	Bwari		No iCCM	CM+IPTp+LLINs+SMC
Federal Capital Territory	Gwagwalada		No iCCM	CM+IPTp+LLINs+SMC
Federal Capital Territory	Kuje		No iCCM	CM+IPTp+LLINs+SMC
Federal Capital Territory	Kwali		No iCCM	CM+IPTp+LLINs+SMC
Gombe	Akko		No iCCM	CM+IPTp+PBO-LLINs+SMC
Gombe	Balanga		No iCCM	CM+IPTp+PBO-LLINs+SMC
Gombe	Billiri		No iCCM	CM+IPTp+PBO-LLINs+SMC
Gombe	Dukku		No iCCM	CM+IPTp+PBO-LLINs+SMC
Gombe	Funakaye		No iCCM	CM+IPTp+PBO-LLINs+SMC
Gombe	Gombe		No iCCM	CM+IPTp+PBO-LLINs+SMC
Gombe	Kaltungo		No iCCM	CM+IPTp+PBO-LLINs+SMC

DEMOGRAPHICS			MIX OF INTERVENTIONS	
STATE	LGA	city	iccm	mix
Gombe	Kwami		No iCCM	CM+IPTp+PBO-LLINs+SMC
Gombe	Nafada		No iCCM	CM+IPTp+LLINs+SMC
Gombe	Shomgom		No iCCM	CM+IPTp+PBO-LLINs+SMC
Gombe	Yamaltu/Deba		No iCCM	CM+IPTp+PBO-LLINs+SMC
Imo	Aboh-Mbaise		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Ahiazu-Mbaise		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Ehime-Mbano		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Ezinihitte		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Ideato North		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Ideato South		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Ihitte/Uboma		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Ikeduru		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Isiala Mbano		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Isu		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Mbaitoli		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Ngor-Okpala		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Njaba		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Nkwerre		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Nwangele		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Obowo		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Oguta		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Ohaji/Egbema		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Okigwe		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Orlu		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Orsu		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Oru East		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Oru West		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Owerri North		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Owerri West		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Owerri-Municipal		No iCCM	CM+IPTp+LLINs+IPTi
Imo	Unuimo		No iCCM	CM+IPTp+LLINs+IPTi
Jigawa	Auyo		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Babura		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Biriniwa		No iCCM	CM+IPTp+LLINs+SMC
Jigawa	Birni Kudu		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Buji		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Dutse		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Gagarawa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Garki		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Gumel		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Guri		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Gwaram		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Gwiwa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Hadejia		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Jahun		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Kafin Hausa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Kaugama		No iCCM	CM+IPTp+LLINs+SMC
Jigawa	Kazaure		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Kiri Kasamma		No iCCM	CM+IPTp+LLINs+SMC

DEMOGRAPHICS			MIX OF INTERVENTIONS	
STATE	LGA	city	iccm	mix
Jigawa	Maigatari		No iCCM	CM+IPTp+LLINs+SMC
Jigawa	Malam Madori		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Miga		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Ringim		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Roni		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Sule-Tankarkar		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Taura		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	Yankwashi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Jigawa	kiyawa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kaduna	Birnin-Gwari		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kaduna	Chikun	Kaduna	No iCCM	CM+IPTp+UrbanLLINs+SMC
Kaduna	Giwa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kaduna	Igabi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kaduna	Ikara		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kaduna	Jaba		No iCCM	CM+IPTp+LLINs+SMC
Kaduna	Jema'a		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kaduna	Kachia		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kaduna	Kaduna North	Kaduna	No iCCM	CM+IPTp+UrbanLLINs+SMC
Kaduna	Kaduna South	Kaduna	No iCCM	CM+IPTp+UrbanLLINs+SMC
Kaduna	Kagarko		No iCCM	CM+IPTp+LLINs+SMC
Kaduna	Kajuru		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kaduna	Kaura		No iCCM	CM+IPTp+LLINs+SMC
Kaduna	Kauru		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kaduna	Kubau		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kaduna	Kudan		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kaduna	Lere		No iCCM	CM+IPTp+LLINs+SMC
Kaduna	Markafi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kaduna	Sabon-Gari	Zaria	No iCCM	CM+IPTp+UrbanLLINs+SMC
Kaduna	Sanga		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kaduna	Soba		No iCCM	CM+IPTp+LLINs+SMC
Kaduna	Zango-Kataf		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kaduna	Zaria	Zaria	No iCCM	CM+IPTp+UrbanLLINs+SMC
Kano	Ajingi		No iCCM	CM+IPTp+LLINs+SMC
Kano	Albasu		No iCCM	CM+IPTp+LLINs+SMC
Kano	Bagwai		No iCCM	CM+IPTp+LLINs+SMC
Kano	Bebeji		No iCCM	CM+IPTp+LLINs+SMC
Kano	Bichi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kano	Bunkure		No iCCM	CM+IPTp+LLINs+SMC
Kano	Dala	Kano	No iCCM	CM+IPTp+UrbanLLINs+SMC
Kano	Dambatta		No iCCM	CM+IPTp+LLINs+SMC
Kano	Dawakin Kudu		No iCCM	CM+IPTp+LLINs+SMC
Kano	Dawakin Tofa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kano	Doguwa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kano	Fagge	Kano	No iCCM	CM+IPTp+UrbanLLINs+SMC
Kano	Gabasawa		No iCCM	CM+IPTp+LLINs+SMC
Kano	Garko		No iCCM	CM+IPTp+LLINs+SMC
Kano	Garum Mallam		No iCCM	CM+IPTp+LLINs+SMC
Kano	Gaya		No iCCM	CM+IPTp+LLINs+SMC
Kano	Gezawa		No iCCM	CM+IPTp+LLINs+SMC

DEMOGRAPHICS			MIX OF INTERVENTIONS	
STATE	LGA	city	iccm	mix
Kano	Gwale	Kano	No iCCM	CM+IPTp+UrbanLLINs+SMC
Kano	Gwarzo		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kano	Kabo		No iCCM	CM+IPTp+LLINs+SMC
Kano	Kano Municipal	Kano	No iCCM	CM+IPTp+UrbanLLINs+SMC
Kano	Karaye		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kano	Kibiya		No iCCM	CM+IPTp+LLINs+SMC
Kano	Kiru		No iCCM	CM+IPTp+LLINs+SMC
Kano	Kumbotso		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kano	Kunchi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kano	Kura		No iCCM	CM+IPTp+LLINs+SMC
Kano	Madobi		No iCCM	CM+IPTp+LLINs+SMC
Kano	Makoda		No iCCM	CM+IPTp+LLINs+SMC
Kano	Minjibir		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kano	Nasarawa1	Kano	No iCCM	CM+IPTp+UrbanLLINs+SMC
Kano	Rano		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kano	Rimin Gado		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kano	Rogo		No iCCM	CM+IPTp+LLINs+SMC
Kano	Shanono		No iCCM	CM+IPTp+LLINs+SMC
Kano	Sumaila		No iCCM	CM+IPTp+LLINs+SMC
Kano	Takali		No iCCM	CM+IPTp+LLINs+SMC
Kano	Tarauni	Kano	No iCCM	CM+IPTp+UrbanLLINs+SMC
Kano	Tofa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kano	Tsanyawa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kano	Tudun Wada		No iCCM	CM+IPTp+LLINs+SMC
Kano	Ungogo	Kano	No iCCM	CM+IPTp+UrbanLLINs+SMC
Kano	Warawa		No iCCM	CM+IPTp+LLINs+SMC
Kano	Wudil		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Bakori		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Batagarawa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Batsari		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Baure		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Bindawa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Charanchi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Dan Musa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Dandume		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Danja		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Daura		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Dutsi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Dutsin-Ma		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Faskari		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Funtua		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Ingawa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Jibia		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Kafur		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Kankara		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Kankia		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Katsina		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Kurfi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Kusada		No iCCM	CM+IPTp+PBO-LLINs+SMC

DEMOGRAPHICS			MIX OF INTERVENTIONS	
STATE	LGA	city	iccm	mix
Katsina	Mai'Adua		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Malumfashi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Mani		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Mashi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Matazuu		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Musawa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Rimi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Sabuwa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Safana		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Sandamu		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	Zango		No iCCM	CM+IPTp+PBO-LLINs+SMC
Katsina	kaita		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kebbi	Aleiro		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kebbi	Arewa-Dandi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kebbi	Argungu		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kebbi	Augie		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kebbi	Bagudo		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kebbi	Birnin Kebbi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kebbi	Bunza		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kebbi	Dandi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kebbi	Fakai		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kebbi	Gwandu		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kebbi	Jega		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kebbi	Kalgo		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kebbi	Koko/Besse		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kebbi	Maiyama		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kebbi	Ngaski		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kebbi	Sakaba		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kebbi	Shanga		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kebbi	Suru		No iCCM	CM+IPTp+LLINs+SMC
Kebbi	Wasagu/Danko		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kebbi	Yauri		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kebbi	Zuru		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kogi	Adavi		No iCCM	CM+IPTp+LLINs+SMC
Kogi	Ajaokuta		No iCCM	CM+IPTp+LLINs+SMC
Kogi	Ankpa		No iCCM	CM+IPTp+LLINs+IPTi
Kogi	Bassa1		No iCCM	CM+IPTp+LLINs+SMC
Kogi	Dekina		No iCCM	CM+IPTp+LLINs+IPTi
Kogi	Ibaji		No iCCM	CM+IPTp+LLINs+IPTi
Kogi	Idah		No iCCM	CM+IPTp+LLINs+IPTi
Kogi	Igalamela-Odolu		No iCCM	CM+IPTp+LLINs+IPTi
Kogi	Ijumu		No iCCM	CM+IPTp+LLINs+IPTi
Kogi	Kabba/Bunu		No iCCM	CM+IPTp+LLINs+IPTi
Kogi	Kogi		No iCCM	CM+IPTp+LLINs+SMC
Kogi	Lokoja		No iCCM	CM+IPTp+LLINs+SMC
Kogi	Mopa-Muro		No iCCM	CM+IPTp+LLINs+IPTi
Kogi	Ofu		No iCCM	CM+IPTp+LLINs+IPTi
Kogi	Ogori/Mangongo		No iCCM	CM+IPTp+LLINs+IPTi
Kogi	Okehi		No iCCM	CM+IPTp+LLINs+SMC

DEMOGRAPHICS			MIX OF INTERVENTIONS	
STATE	LGA	city	iccm	mix
Kogi	Okene		No iCCM	CM+IPTp+LLINs+IPTi
Kogi	Olamabolo		No iCCM	CM+IPTp+LLINs+IPTi
Kogi	Omala		No iCCM	CM+IPTp+LLINs+SMC
Kogi	Yagba East		No iCCM	CM+IPTp+LLINs+SMC
Kogi	Yagba West		No iCCM	CM+IPTp+LLINs+SMC
Kwara	Asa		No iCCM	CM+IPTp+LLINs+SMC
Kwara	Baruten		No iCCM	CM+IPTp+LLINs+SMC
Kwara	Edu		No iCCM	CM+IPTp+LLINs+SMC
Kwara	Ekiti		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Kwara	Ifelodun1		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kwara	Ilorin East	Iilorin	No iCCM	CM+IPTp+UrbanLLINs+SMC
Kwara	Ilorin South		No iCCM	CM+IPTp+LLINs+SMC
Kwara	Ilorin West	Iilorin	No iCCM	CM+IPTp+UrbanLLINs+SMC
Kwara	Irepodun1		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Kwara	Isin		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Kwara	Kaiama		iCCM	CM+IPTp+PBO-LLINs+SMC
Kwara	Moro		No iCCM	CM+IPTp+LLINs+SMC
Kwara	Offa		No iCCM	CM+IPTp+LLINs+IPTi
Kwara	Oke-Ero		No iCCM	CM+IPTp+PBO-LLINs+SMC
Kwara	Oyun		No iCCM	CM+IPTp+LLINs+IPTi
Kwara	Pategi		No iCCM	CM+IPTp+LLINs+SMC
Lagos	Agege	Lagos	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Lagos	Ajeromi-Ifelodun	Lagos	No iCCM	CM+IPTp+UrbanLLINs
Lagos	Alimosho	Lagos	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Lagos	Amuwo-Odofin	Lagos	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Lagos	Apapa	Lagos	No iCCM	CM+IPTp+UrbanLLINs
Lagos	Badagry		No iCCM	CM+IPTp+LLINs+IPTi
Lagos	Epe		No iCCM	CM+IPTp+LLINs+IPTi
Lagos	Eti-Osa	Ikorodu	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Lagos	Ibeju/Lekki		No iCCM	CM+IPTp+LLINs+IPTi
Lagos	Ifako-Ijaye		No iCCM	CM+IPTp+LLINs+IPTi
Lagos	Ikeja	Lagos	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Lagos	Ikorodu	Ikorodu	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Lagos	Kosofe	Lagos	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Lagos	Lagos Island	Lagos	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Lagos	Lagos Mainland	Lagos	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Lagos	Mushin	Lagos	No iCCM	CM+IPTp+UrbanLLINs
Lagos	Ojo		No iCCM	CM+IPTp+LLINs+IPTi
Lagos	Oshodi-Isolo	Lagos	No iCCM	CM+IPTp+UrbanLLINs
Lagos	Shomolu	Lagos	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Lagos	Surulere1	Lagos	No iCCM	CM+IPTp+UrbanLLINs
Nasarawa	Akwanga		No iCCM	CM+IPTp+PBO-LLINs+SMC
Nasarawa	Awe		No iCCM	CM+IPTp+PBO-LLINs+SMC
Nasarawa	Doma		No iCCM	CM+IPTp+PBO-LLINs+SMC
Nasarawa	Karu		No iCCM	CM+IPTp+PBO-LLINs+SMC
Nasarawa	Keana		No iCCM	CM+IPTp+PBO-LLINs+SMC
Nasarawa	Keffi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Nasarawa	Kokona		No iCCM	CM+IPTp+PBO-LLINs+SMC
Nasarawa	Lafia		No iCCM	CM+IPTp+PBO-LLINs+SMC

DEMOGRAPHICS			MIX OF INTERVENTIONS	
STATE	LGA	city	iccm	mix
Nasarawa	Nasarawa-Eggon		No iCCM	CM+IPTp+PBO-LLINs+SMC
Nasarawa	Nasarawa2		No iCCM	CM+IPTp+PBO-LLINs+SMC
Nasarawa	Obi2		No iCCM	CM+IPTp+PBO-LLINs+SMC
Nasarawa	Toto		No iCCM	CM+IPTp+LLINs+SMC
Nasarawa	Wamba		No iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Agaie		No iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Agwara		No iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Bida		No iCCM	CM+IPTp+LLINs+SMC
Niger	Borgu		iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Bosso		No iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Chanchaga		No iCCM	CM+IPTp+LLINs+SMC
Niger	Edati		No iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Gbako		No iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Gurara		No iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Katcha		No iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Kontagora		No iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Lapai		No iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Lavun		No iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Magama		No iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Mariga		No iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Mashegu		No iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Mokwa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Muya		No iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Pailoro		No iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Rafi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Rijau		No iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Shiroro		No iCCM	CM+IPTp+PBO-LLINs+SMC
Niger	Suleja		No iCCM	CM+IPTp+LLINs+SMC
Niger	Tafa		No iCCM	CM+IPTp+LLINs+SMC
Niger	Wushishi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Ogun	Abeokuta North		No iCCM	CM+IPTp+LLINs+IPTi
Ogun	Abeokuta South		No iCCM	CM+IPTp+LLINs+IPTi
Ogun	Ado-Odo/Ota		No iCCM	CM+IPTp+LLINs+IPTi
Ogun	Egbado North		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Ogun	Egbado South		No iCCM	CM+IPTp+LLINs+IPTi
Ogun	Ewekoro		No iCCM	CM+IPTp+LLINs+IPTi
Ogun	Ifo		No iCCM	CM+IPTp+LLINs+IPTi
Ogun	Ijebu East		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Ogun	Ijebu North		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Ogun	Ijebu North East		No iCCM	CM+IPTp+LLINs+IPTi
Ogun	Ijebu ode		No iCCM	CM+IPTp+LLINs+IPTi
Ogun	Ikenne		No iCCM	CM+IPTp+LLINs+IPTi
Ogun	Imeko-Afon		No iCCM	CM+IPTp+LLINs+IPTi
Ogun	Ipokia		No iCCM	CM+IPTp+LLINs+IPTi
Ogun	Obafemi-Owode		No iCCM	CM+IPTp+LLINs+IPTi
Ogun	Odeda		No iCCM	CM+IPTp+LLINs+IPTi
Ogun	Odogbolu		No iCCM	CM+IPTp+LLINs+IPTi
Ogun	Ogun waterside		No iCCM	CM+IPTp+LLINs+IPTi
Ogun	Remo North		No iCCM	CM+IPTp+LLINs+IPTi

DEMOGRAPHICS			MIX OF INTERVENTIONS	
STATE	LGA	city	iccm	mix
Ogun	Shagamu	Ikorodu	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Ondo	Akoko North East		No iCCM	CM+IPTp+LLINs+IPTi
Ondo	Akoko North West		No iCCM	CM+IPTp+LLINs+IPTi
Ondo	Akoko South East		No iCCM	CM+IPTp+LLINs+IPTi
Ondo	Akoko South West		No iCCM	CM+IPTp+LLINs+IPTi
Ondo	Akure North		No iCCM	CM+IPTp+LLINs+IPTi
Ondo	Akure South		No iCCM	CM+IPTp+LLINs+IPTi
Ondo	Ese-Odo		No iCCM	CM+IPTp+LLINs+IPTi
Ondo	Idanre		No iCCM	CM+IPTp+LLINs+IPTi
Ondo	Ifedore		No iCCM	CM+IPTp+LLINs+IPTi
Ondo	Ilaje		No iCCM	CM+IPTp+LLINs+IPTi
Ondo	Ile-Oluji-Okeigbo		No iCCM	CM+IPTp+LLINs+IPTi
Ondo	Irele		No iCCM	CM+IPTp+LLINs+IPTi
Ondo	Odigbo		No iCCM	CM+IPTp+LLINs+IPTi
Ondo	Okitipupa		No iCCM	CM+IPTp+LLINs+IPTi
Ondo	Ondo East		No iCCM	CM+IPTp+LLINs+IPTi
Ondo	Ondo West		No iCCM	CM+IPTp+LLINs+IPTi
Ondo	Ose		No iCCM	CM+IPTp+LLINs+IPTi
Ondo	Owo		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Aiyedade		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Aiyedire		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Atakumosa East		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Atakumosa West		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Boluwaduro		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Boripe		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Ede North		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Ede South		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Egbedore		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Ejigbo		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Ife Central	Ife	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Osun	Ife East	Ife	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Osun	Ife North	Ife	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Osun	Ife South		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Ifedayo		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Ifelodun2		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Osun	Ila		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Ilesha East		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Ilesha West		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Irepodun2		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Osun	Irewole		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Isokan		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Iwo		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Obokun		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Odo-Otin		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Ola-oluwa		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Olorunda		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Oriade		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Orolu		No iCCM	CM+IPTp+LLINs+IPTi
Osun	Osogbo		No iCCM	CM+IPTp+LLINs+IPTi

DEMOGRAPHICS			MIX OF INTERVENTIONS	
STATE	LGA	city	iccm	mix
Oyo	Afijio		No iCCM	CM+IPTp+LLINs+IPTi
Oyo	Akinyele	Ibadan	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Oyo	Atiba		No iCCM	CM+IPTp+LLINs+IPTi
Oyo	Atigbo		No iCCM	CM+IPTp+LLINs+IPTi
Oyo	Egbeda	Ibadan	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Oyo	Ibadan North	Ibadan	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Oyo	Ibadan North East	Ibadan	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Oyo	Ibadan North West	Ibadan	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Oyo	Ibadan South East	Ibadan	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Oyo	Ibadan South West	Ibadan	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Oyo	Ibarapa Central		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Oyo	Ibarapa East		No iCCM	CM+IPTp+LLINs+IPTi
Oyo	Ibarapa North		No iCCM	CM+IPTp+LLINs+IPTi
Oyo	Ido	Ibadan	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Oyo	Irepo		No iCCM	CM+IPTp+LLINs+SMC
Oyo	Iseyin		No iCCM	CM+IPTp+LLINs+IPTi
Oyo	Itesiwaju		No iCCM	CM+IPTp+LLINs+IPTi
Oyo	Iwajowa		No iCCM	CM+IPTp+LLINs+IPTi
Oyo	Kajola		No iCCM	CM+IPTp+LLINs+IPTi
Oyo	Lagelu	Ibadan	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Oyo	Ogbomosho North		No iCCM	CM+IPTp+LLINs+SMC
Oyo	Ogbomosho South		No iCCM	CM+IPTp+LLINs+IPTi
Oyo	Ogo Oluwa		No iCCM	CM+IPTp+LLINs+IPTi
Oyo	Olorunsogo		No iCCM	CM+IPTp+LLINs+SMC
Oyo	Oluyole		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Oyo	Ona-Ara	Ibadan	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Oyo	Orelope		No iCCM	CM+IPTp+LLINs+IPTi
Oyo	Ori Ire		No iCCM	CM+IPTp+LLINs+IPTi
Oyo	Oyo East		No iCCM	CM+IPTp+LLINs+IPTi
Oyo	Oyo West		No iCCM	CM+IPTp+LLINs+IPTi
Oyo	Saki East		No iCCM	CM+IPTp+LLINs+SMC
Oyo	Saki West		iCCM	CM+IPTp+LLINs+SMC
Oyo	Surulere2		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Plateau	Barikin Ladi		No iCCM	CM+IPTp+LLINs+SMC
Plateau	Bassa2		No iCCM	CM+IPTp+LLINs+SMC
Plateau	Bokkos		No iCCM	CM+IPTp+LLINs+SMC
Plateau	Jos East		No iCCM	CM+IPTp+PBO-LLINs+SMC
Plateau	Jos North	Jos	No iCCM	CM+IPTp+UrbanLLINs+SMC
Plateau	Jos South	Jos	No iCCM	CM+IPTp+UrbanLLINs+SMC
Plateau	Kanam		No iCCM	CM+IPTp+LLINs+SMC
Plateau	Kanke		No iCCM	CM+IPTp+PBO-LLINs+SMC
Plateau	Langtang North		No iCCM	CM+IPTp+PBO-LLINs+SMC
Plateau	Langtang South		No iCCM	CM+IPTp+PBO-LLINs+SMC
Plateau	Mangu		No iCCM	CM+IPTp+LLINs+SMC
Plateau	Mikang		No iCCM	CM+IPTp+PBO-LLINs+SMC
Plateau	Pankshin		No iCCM	CM+IPTp+LLINs+SMC
Plateau	Qua'an Pan		No iCCM	CM+IPTp+PBO-LLINs+SMC
Plateau	Riyom		No iCCM	CM+IPTp+LLINs+SMC
Plateau	Shendam		No iCCM	CM+IPTp+PBO-LLINs+SMC

DEMOGRAPHICS			MIX OF INTERVENTIONS	
STATE	LGA	city	iccm	mix
Plateau	Wase		No iCCM	CM+IPTp+LLINs+SMC
Rivers	Abua/Odual		No iCCM	CM+IPTp+LLINs+IPTi
Rivers	Ahoada East		No iCCM	CM+IPTp+LLINs+IPTi
Rivers	Ahoada West		No iCCM	CM+IPTp+LLINs+IPTi
Rivers	Akuku Toru		No iCCM	CM+IPTp+LLINs+IPTi
Rivers	Andoni		No iCCM	CM+IPTp+LLINs+IPTi
Rivers	Asari-Toru		No iCCM	CM+IPTp+LLINs+IPTi
Rivers	Bonny		No iCCM	CM+IPTp+LLINs+IPTi
Rivers	Degema		No iCCM	CM+IPTp+LLINs+IPTi
Rivers	Eleme	Port Harcourt	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Rivers	Emohua		No iCCM	CM+IPTp+LLINs+IPTi
Rivers	Etche		No iCCM	CM+IPTp+LLINs+IPTi
Rivers	Gokana		No iCCM	CM+IPTp+LLINs+IPTi
Rivers	Ikwerre		No iCCM	CM+IPTp+LLINs+IPTi
Rivers	Khana		No iCCM	CM+IPTp+LLINs+IPTi
Rivers	Obia/Akpor	Port Harcourt	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Rivers	Ogba/Egbema/Ndoni		No iCCM	CM+IPTp+LLINs+IPTi
Rivers	Ogu/Bolo		No iCCM	CM+IPTp+LLINs+IPTi
Rivers	Okrika		No iCCM	CM+IPTp+LLINs+IPTi
Rivers	Omumma		No iCCM	CM+IPTp+LLINs+IPTi
Rivers	Opobo/Nkoro		No iCCM	CM+IPTp+LLINs+IPTi
Rivers	Oyigbo		No iCCM	CM+IPTp+LLINs+IPTi
Rivers	Port-Harcourt	Port Harcourt	No iCCM	CM+IPTp+UrbanLLINs+IPTi
Rivers	Tai		No iCCM	CM+IPTp+LLINs+IPTi
Sokoto	Binji		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Bodinga		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Dange-Shnsi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Gada		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Gawabawa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Goronyo		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Gudu		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Illela		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Isa		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Kebbe		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Kware		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Rabah		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Sabon Birni		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Shagari		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Silame		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Sokoto North		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Sokoto South		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Tambuwal		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Tangaza		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Tureta		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Wamako		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Wurno		No iCCM	CM+IPTp+PBO-LLINs+SMC
Sokoto	Yabo		No iCCM	CM+IPTp+PBO-LLINs+SMC
Taraba	Ardo-Kola		No iCCM	CM+IPTp+PBO-LLINs+SMC
Taraba	Bali		No iCCM	CM+IPTp+LLINs+IPTi

DEMOGRAPHICS			MIX OF INTERVENTIONS	
STATE	LGA	city	iccm	mix
Taraba	Donga		No iCCM	CM+IPTp+LLINs+IPTi
Taraba	Gashaka		No iCCM	CM+IPTp+PBO-LLINs+IPTi
Taraba	Gassol		No iCCM	CM+IPTp+PBO-LLINs+SMC
Taraba	Ibi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Taraba	Jalingo		No iCCM	CM+IPTp+PBO-LLINs+SMC
Taraba	Karin-Lamido		No iCCM	CM+IPTp+PBO-LLINs+SMC
Taraba	Kurmi		No iCCM	CM+IPTp+LLINs+IPTi
Taraba	Lau		No iCCM	CM+IPTp+PBO-LLINs+SMC
Taraba	Sardauna		No iCCM	CM+IPTp+LLINs+IPTi
Taraba	Takum		No iCCM	CM+IPTp+LLINs+IPTi
Taraba	Ussa		No iCCM	CM+IPTp+LLINs+IPTi
Taraba	Wukari		No iCCM	CM+IPTp+PBO-LLINs+SMC
Taraba	Yorro		No iCCM	CM+IPTp+LLINs+SMC
Taraba	Zing		No iCCM	CM+IPTp+LLINs+SMC
Yobe	Bade		No iCCM	CM+IPTp+PBO-LLINs+SMC
Yobe	Bursari		No iCCM	CM+IPTp+LLINs+SMC
Yobe	Damaturu		No iCCM	CM+IPTp+PBO-LLINs+SMC
Yobe	Fika		No iCCM	CM+IPTp+PBO-LLINs+SMC
Yobe	Fune		No iCCM	CM+IPTp+LLINs+SMC
Yobe	Geidam		iCCM	CM+IPTp+LLINs+SMC
Yobe	Gujba		No iCCM	CM+IPTp+PBO-LLINs+SMC
Yobe	Gulani		No iCCM	CM+IPTp+PBO-LLINs+SMC
Yobe	Jakusko		No iCCM	CM+IPTp+PBO-LLINs+SMC
Yobe	Karasuwa		No iCCM	CM+IPTp+LLINs+SMC
Yobe	Machina		No iCCM	CM+IPTp+PBO-LLINs+SMC
Yobe	Nangere		No iCCM	CM+IPTp+PBO-LLINs+SMC
Yobe	Nguru		No iCCM	CM+IPTp+LLINs+SMC
Yobe	Potiskum		No iCCM	CM+IPTp+PBO-LLINs+SMC
Yobe	Tarmua		No iCCM	CM+IPTp+PBO-LLINs+SMC
Yobe	Yunusari		No iCCM	CM+IPTp+LLINs+SMC
Yobe	Yusufari		iCCM	CM+IPTp+LLINs+SMC
Zamfara	Anka		No iCCM	CM+IPTp+PBO-LLINs+SMC
Zamfara	Bakura		No iCCM	CM+IPTp+PBO-LLINs+SMC
Zamfara	Birnin Magaji		No iCCM	CM+IPTp+PBO-LLINs+SMC
Zamfara	Bukkuyum		No iCCM	CM+IPTp+PBO-LLINs+SMC
Zamfara	Bungudu		No iCCM	CM+IPTp+PBO-LLINs+SMC
Zamfara	Gummi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Zamfara	Gusau		No iCCM	CM+IPTp+PBO-LLINs+SMC
Zamfara	Kaura-Namoda		No iCCM	CM+IPTp+PBO-LLINs+SMC
Zamfara	Maradun		No iCCM	CM+IPTp+PBO-LLINs+SMC
Zamfara	Maru		No iCCM	CM+IPTp+PBO-LLINs+SMC
Zamfara	Shinkafi		No iCCM	CM+IPTp+PBO-LLINs+SMC
Zamfara	Talata Mafara		No iCCM	CM+IPTp+PBO-LLINs+SMC
Zamfara	Tsafe		No iCCM	CM+IPTp+PBO-LLINs+SMC
Zamfara	Zurmi		No iCCM	CM+IPTp+PBO-LLINs+SMC

Annex 2: List of States targeted for IRS based on epidemiological attributes.

S/N	State	Population	Malaria Prevalence		Status
			MIS, 2015	DHS, 2018	
1	Bayelsa	2,550,338	31.4	12.5	Significant change, could be further improved upon with IRS
2	Kogi	5,033,267	5.4	25.4	High burden, reversal of gains
3	Anambra	6,155,892	10.2	8.8	No significant change
4	Ondo	5,242,007	21.3	33.5	High burden, reversal of gains
5	Rivers	8,596,747	7.3	11.2	Reversal of gains
6	Imo	6,096,067	5.1	7.8	Reversal of gains
7	Ekiti	3,683,269	28.2	32.3	High burden, reversal of gains
8	Abia	4,171,279	8.2	14	Reversal of gains
9	Gombe	3,775,545	28.6	30	High burden, reversal of gains
10	Jigawa	6,677,055	27.9	36	High burden, reversal of gains
11	Kaduna	9,735,051	36.7	33	High burden
12	Kano	15,775,329	27.7	32	High burden, reversal of gains
13	Katsina	9,295,387	27.8	26	No significant change
14	Niger	6,744,552	33.5	32	High burden
15	Osun	5,848,301	33.4	28	High burden
16	Zamfara	5,568,676	62.6	36	High burden
17	Benue	6,976,767	44.5	13	Significant change, could be further improved upon with IRS
18	Oyo	9,871,528	19.2	24	High burden, reversal of gains
19	Sokoto	5,759,804	46.6	36	High burden
20	Kebbi	5,119,659	63.6	52	High burden
21	Nasarawa	2,990,009	35.9	14	Significant change, could be further improved upon with IRS
22	Bauchi	8,255,946	35.8	31	High burden
23	Ebonyi	3,475,704	30	31	High burden,
24	Lagos	15,397,491	0	2	Low burden – targeted locations

Annex 3: Core Malaria Indicators

Indicator		Operation Definition	Source	Frequency	Level of Measurement	Responsible
Impact						
1	Annual Parasite Incidence per 1000 population	Numerator: Confirmed malaria cases adjusted for reporting from all sectors Denominator: Population	WHO	Annually	National	NMEP
2	All cause under-5 mortality rate per 1000 population	Probability of dying between birth and the fifth birthday	Household Surveys	Every 5years	National	SMEOR Branch Head
3	% children aged 6–59 months with hemoglobin measurement of <8g/dl)	Numerator: Number of children aged 6–59 months with hemoglobin measurement of <8g/dl) Denominator: Total number children aged 6–59 months surveyed	Household Surveys	Every 3years	National	SMEOR Branch Head
4	Malaria Parasite Prevalence in under-5 children (Slide)	Numerator: Number of microscopy positive results Denominator: Number of under-5 children tested for malaria with microscopy	Household Surveys	Every 3years	National	Case Management Branch Head
5	Entomological inoculation rate	Numerator: Number infective mosquito bites per person per night Denominator: Total number of mosquito bites per person per night	Vector Surveillance Reports	Annually	National	IVM Branch Head
Outcomes: Objective 1						
1.1	% of households with at least 1 ITN	Numerator: Number of households with at least 1 ITN Denominator: Total number of households surveyed	Household Surveys	Every 3years	National	IVM Branch Head
1.2	% of households with at least 1 ITN for every two persons	Numerator: Number of households with at least 1 ITN for every two persons Denominator: Total number of households surveyed	Household Surveys	Every 3years	National	IVM Branch Head

Indicator		Operation Definition	Source	Frequency	Level of Measurement	Responsible
1.3	% of population with access to an ITN in the household*	Numerator: Number of populations with access to an ITN in the household Denominator: Total number of persons in the households surveyed	Household Surveys	Every 3years	National	IVM Branch Head
1.4	% of household residents who slept under an ITN the previous night	Numerator: Number of household residents who slept under an ITN the previous night Denominator: Total number of persons (De facto population)	Household Surveys		National	ACSM Branch Head
1.5	% of under-5 Children who slept under an ITN the previous night*	Numerator: % of under-5 Children who slept under an ITN the previous night Denominator: Total number of under-5 children among HH with at least 1 ITN	Household Surveys		National	ACSM Branch Head
1.6	% of pregnant women who slept under an ITN the previous night*	Numerator: Number of pregnant women who slept under an ITN the previous night Denominator: Total number of pregnant women among HH with at least 1 ITN	Household Surveys		National	ACSM Branch Head
1.7	% of targeted population protected by IRS within the last 12 months	Numerator: Population protected by IRS within the last 12 months Denominator: Total population in the HH sprayed	Programme report	Annually	National State LGA	IVM Branch Head
1.8	% of persons who agree with specified statements regarding malaria behaviours and products.	Numerator: Number of persons (men & women) who agree with specified statements regarding malaria behaviours and products. Denominator: Total number of persons (men & women) surveyed	Household Surveys		National	ACSM Branch Head
Outcomes: Objective 2						
2.1	% of women who received 3 or more doses of	Numerator: Number of women who received 3 or more doses of IPTp	Household Surveys			

Indicator		Operation Definition	Source	Frequency	Level of Measurement	Responsible
	IPTp for malaria during their last pregnancy	for malaria during their last pregnancy Denominator: Total number of women with live birth in the last 2 years			National	Case Management Branch Head
2.2	% of targeted children that have received all SMC cycles	Numerator: Number of targeted children that have received all SMC cycles Denominator: Total number of targeted children for SMC	Coverage survey		National	Case Management Branch Head
2.3	% of persons with suspected malaria receiving a diagnostic test (RDT and/or microscopy)	Numerator: Number of persons with suspected malaria receiving a diagnostic test (RDT and/or microscopy) Denominator: Total number of persons with suspected malaria (Fever or history)	NHMIS	Annually	National State LGA	Case Management Branch Head
2.4	% of confirmed malaria cases who received ACT	Numerator: Number of confirmed malaria cases who received first line antimalarial treatment Denominator: Total number of confirmed malaria cases	NHMIS	Annually	National State LGA	Case Management Branch Head
2.5	% of under-5 children with fever in the last two weeks for whom advice was sought within 24hours of the onset of fever	Numerator: Number of under-5 children with fever in the last two weeks for whom advice was sought within 24hours of the onset of fever Denominator: Total number of under-5 children with fever in the last two weeks	Household Surveys		National	ACSM Branch Head
2.6	% receiving ACT, among of under-5 children with fever in the last two weeks who received any antimalarial drug	Numerator: Number receiving ACT, among of under-5 children with fever in the last two weeks who received any antimalarial drug Denominator: Total number receiving ACT, among of under-5	Household Surveys		National	Case Management Branch Head

Indicator		Operation Definition	Source	Frequency	Level of Measurement	Responsible
		children with fever in the last two weeks				
2.7	% of health facilities without stock out of ACTs for 7 consecutive days in a month	Numerator: Number of health facilities without stock out of ACTs (1&4) for 7 consecutive days in a month Denominator: Total number of health facilities reporting	NHLMIS	Annually	National State LGA	PSM Branch Head
2.8	% of persons who agree with specified statements regarding malaria consequences	Numerator: Number of persons (men & women) who agree with specified statements regarding malaria consequences Denominator: Total number of persons surveyed	Household Surveys	3 years	National	ACSM Branch Head
Outcomes: Objective 3						
3.1	% of health facilities using the revised data collection tools	Numerator: Number of health facilities using the revised data collection tools Denominator: Total number of health facilities	NHMIS	Annually	National State LGA	SMEOR Branch Head
2	% of expected health facility reports received and complete (with core indicators)	Numerator: Number of expected health facility reports received and complete (with core indicators) Denominator: Total number of expected health facility reports	NHMIS	Annually	National State LGA	SMEOR Branch Head
3.3	% of health facilities reporting malaria data without variance >5% between NHMIS and NHLMIS	Numerator: Number of health facilities reporting malaria data without variance >5% between NHMIS and NHLMIS Denominator: Total number of health facilities reporting malaria data	NHMIS	Annually	National State LGA	SMEOR Branch Head
4	% of malaria medicines and health products that met quality specifications during post marketing	Numerator: Number of malaria medicines and health products that met quality specifications during post marketing surveillance visits	Programme report	Annually	National	PSM Branch Head

Indicator		Operation Definition	Source	Frequency	Level of Measurement	Responsible
	surveillance visits	Denominator: Total number of malaria medicines and health products surveyed				
Outcome: Objective 4						
4.1	OCA score at federal level	Organisational Capacity Assessment score	Report of OCA assessment	Annually	National	PM Branch Head
4.2	% of States with ≥75% OCA score	Numerator: Number of States with ≥75% OCA score Denominator: 37 states	Report of OCA assessment	Annually	National State	PM Branch Head
Outcome: Objective 5						
5.1	% of States with at least 50% increase in malaria funding from government sources over 5 years	Numerator: Number of States with at least 50% increase in malaria funding from government sources over 5 years Denominator: 37 states	Programme reports	Five yearly	National State	PM Branch Head
5.2	% of total expenditure on malaria contributed by the government (federal and states including FCT)	Numerator: Expenditure on malaria contributed by the Government (federal and states including FCT) Denominator: Total expenditure on malaria	National Health Account	Annually	National State	PM Branch Head

Annex 4: Summary of NMSP Budget by Intervention Areas

Budget sub-item	2021 Cost	2022 Cost	2023 Cost	2024 Cost	2025 Cost	2021-2025 Total Cost	% Distribution of Total Cost
Vector Control: LLIN	90,323,331,573	119,123,120,606	81,022,885,058	110,314,437,097	131,188,062,306	531,971,836,641	**28.1%**
Vector Control: IRS	10,190,557,180	15,172,822,580	20,174,822,580	30,172,822,580	40,172,822,580	115,883,847,500	**6.1%**
Vector Control: Entomological monitoring	701,942,535	774,946,115	898,107,195	990,236,675	981,875,075	4,347,107,593	**0.2%**
Vector Control: LSM	2,131,806,280	2,130,114,080	2,131,114,080	2,130,114,080	2,130,114,080	10,653,262,600	**0.6%**
Other vector control measures:	78,668,000	55,621,000	58,450,500	49,384,400	37,070,700	279,194,600	**0.0%**
Specific prevention interventions (SPI)	35,605,173,100	25,646,698,300	23,022,976,700	32,746,266,400	28,144,764,700	145,165,879,200	**7.7%**
Case management - Diagnosis	65,908,279,479	67,420,877,337	69,678,546,602	71,787,014,287	73,739,413,640	348,534,131,345	**18.4%**
Case management - Treatment	69,202,346,776	65,535,591,234	66,119,500,461	67,200,914,297	67,566,183,836	335,624,536,605	**17.7%**
Specific prevention intervention: Intermittent preventive treatment in pregnancy (IPTp)	2,689,256,800	2,538,868,400	2,480,610,000	2,576,240,000	2,480,610,000	12,765,585,200	**0.7%**
Specific prevention intervention: Seasonal malaria chemoprophylaxis (SMC)	71,231,252,577	71,625,798,828	73,742,497,296	76,627,199,583	77,173,057,063	370,399,805,347	**19.6%**
RSSH - PSM	669,733,800	249,910,200	589,561,200	301,727,800	583,639,200	2,394,572,200	**0.1%**
RSSH- SMEOR	2,816,817,986	2,893,652,158	1,018,506,758	3,790,786,122	988,048,158	11,507,811,182	**0.6%**
Program Management	779,715,040	677,121,705	690,432,120	447,681,920	666,066,720	3,261,017,505	**0.2%**
Grand Total in Local Currency	**352,328,881,126**	**373,845,142,542**	**341,628,010,549**	**399,134,825,240**	**425,851,728,058**	**1,892,788,587,517**	**MSP mean Cost per Capita: 1,825**
Grand Total in $US	**$927,181,266**	**$ 983,803,006**	**$ 899,021,080**	**$ 1,050,354,803**	**$ 1,120,662,442**	**$4,981,022,598.73**	**MSP mean Cost per Capita: $5.0**

Annex 5: Summary of budget by Objectives and Strategies

MSP Objectives and Strategies	'2021 Cost	'2022 Cost	'2023 Cost	'2024 Cost	'2025 Cost	2021-2025 Total Cost	% of Cost per Obj & MSP Total cost
Objective 1: Improve access and utilization of vector control interventions by at least 80% of targeted population by 2025	**106,582,470,268**	**140,446,627,081**	**107,427,520,512**	**146,874,783,632**	**177,445,031,840**	**678,776,433,334**	**35.9% of MSP**
Strategy 1.1: Sustain and expand high knowledge of malaria prevention for improved access and utilization of vector control interventions.	441,223,500	370,019,500	309,904,500	400,349,500	309,904,500	1,521,497,000	0.2% of Obj-1
Strategy 1.2: Promote multi-sectoral and multi-level stakeholders' engagement to address key ideational factors towards the access and use of vector control interventions.	495,659,000	1,661,633,000	1,661,633,000	1,661,633,000	1,494,504,000	5,480,558,000	0.8% of Obj-1
Strategy 1.3: Promotion of preventive, and curative services by the private sector	-	-	-	-	-	-	0.0% of Obj-1
Strategy 1.4: Strengthen the systems and processes to continuously provide credible estimates of malaria commodities for the prevention of malaria through vector control interventions	21,939,200	15,115,200	21,939,200	15,115,200	21,939,200	74,108,800	0.0% of Obj-1
Strategy 1.5: Establish systems and processes to ensure availability of malaria commodities for the prevention of malaria infection through supplemental and routine services	67,987,800	36,824,000	36,824,000	67,987,800	36,824,000	209,623,600	0.0% of Obj-1
Strategy 1.6: Improve availability of and access to malaria commodities for the prevention of malaria	57,903,200	22,924,000	28,353,400	28,953,800	28,353,400	138,134,400	0.0% of Obj-1
Strategy 1.7: Comprehensive deployment of safe and effective	102,709,118,033	136,478,093,266	103,410,907,718	142,698,819,757	173,572,444,966	485,296,938,775	71.5% of Obj-1

MSP Objectives and Strategies	'2021 Cost	'2022 Cost	'2023 Cost	'2024 Cost	'2025 Cost	2021-2025 Total Cost	% of Cost per Obj & MSP Total cost
integrated vector control interventions based on malaria epidemiological stratification							
Strategy 1.8: Mobilize resources and improve utilization of ITNs/IRS/LSM and other personal protective measures	2,071,352,000	1,083,487,000	1,083,487,000	1,043,749,500	1,043,562,000	5,282,075,500	0.8% of Obj-1
Strategy 1.9: To institutionalize decision making for IVM deployment based on evidence from insecticide resistance monitoring and vector surveillance	673,516,035	734,759,615	830,700,195	914,403,575	912,150,275	3,153,379,418	0.5% of Obj-1
Strategy 1.10: Effective collaboration and coordination of integrated vector management involving relevant sectors in Nigeria	43,771,500	43,771,500	43,771,500	43,771,500	25,349,500	175,086,000	0.0% of Obj-1
Objective 2: Ensure provision of chemo-prevention, diagnostic and appropriate treatment services for 80% eligible individuals in both public and private facilities by 2025	**240,789,558,633**	**229,372,588,799**	**231,413,497,759**	**247,467,755,167**	**245,513,947,939**	**1,194,557,348,297**	**63.1% of MSP**
Strategy 2.1: Intensify the delivery of appropriate information on malaria treatment practices for increased access to malaria treatment and management services	29,429,216,000	22,160,740,000	17,081,148,400	29,171,050,000	22,244,688,400	97,842,154,400	8.2% of Obj-2
Strategy 2.2: Scale up provider-behaviour improvement interventions for improved quality of care in the management of fever and malaria cases for improved access to treatment services	2,198,218,000	-	2,194,830,000	-	2,194,830,000	4,393,048,000	0.4% of Obj-2
Strategy 2.3: Promotion of diagnosis and curative services by the private sector	-	-	-	-	-	-	0.0% of Obj-2
Strategy 2.4: Improve availability and affordability of malaria medicines and commodities in the private health facilities through	-	-	-	-	-	-	0.0% of Obj-2

MSP Objectives and Strategies	'2021 Cost	'2022 Cost	'2023 Cost	'2024 Cost	'2025 Cost	2021-2025 Total Cost	% of Cost per Obj & MSP Total cost
improved links for commodity access							
Strategy 2.5: Improve Quality of Care and commodity quality for malaria prevention, diagnosis and treatment in the private health sector.	-	-	-	-	-	-	0.0% of Obj-2
Strategy 2.6: Expand the capacity of the private sector to provide quality assured antimalarial products in a sustainable way	-	-	-	-	-	-	0.0% of Obj-2
Strategy 2.7: Strengthen system for quantification and procurement of anti- malaria drugs and commodities as part of integrated logistics supply chain management	32,054,000	-	30,069,000	1,985,000	28,869,000	64,108,000	0.0% of Obj-2
Strategy 2.8: Strengthen the coordination of pricing, procurement, and distribution of medicines and commodities for chemoprevention, diagnosis and treatment	25,424,000	12,785,000	12,785,000	25,424,000	12,785,000	76,418,000	0.0% of Obj-2
Strategy 2.9: Institute equitable and realistic costing and resource allocation, to achieve effective and efficient last mile distribution of commodities for malaria prevention	-	-	-	-	-	-	0.0% of Obj-2
Strategy 2.10: Strengthen the tracking system-processes, tools and management for monitoring and reporting the pipelines of malaria medicines and health commodities	69,264,000	69,264,000	69,264,000	69,264,000	69,264,000	277,056,000	0.0% of Obj-2
Strategy 2.11: Promote robust Quality Assurance mechanisms and adoption of applicable models for the procurement, storage, distribution and usage of malaria medicines and commodities	704,400	704,400	704,400	704,400	704,400	2,817,600	0.0% of Obj-2

MSP Objectives and Strategies	'2021 Cost	'2022 Cost	'2023 Cost	'2024 Cost	'2025 Cost	2021-2025 Total Cost	% of Cost per Obj & MSP Total cost
Strategy 2.12: Respond to the complexity of the malaria commodities supply chain – (both free and medicines and those procured as part of DRFs, both circulating in the same space)	7,959,600	7,959,600	7,959,600	7,959,600	7,959,600	31,838,400	0.0% of Obj-2
Strategy 2.13: Establish systems and processes to ensure availability of quality assured chemo-prevention, diagnostic and appropriate treatment services in both public and private facilities by 2025	-	-	-	-	-	-	0.0% of Obj-2
Strategy 2.14: Deployment of Chemo-preventive Treatments to eligible population	73,916,092,377	74,164,667,228	76,218,690,296	79,203,439,583	79,649,250,063	303,502,889,484	25.4% of Obj-2
Strategy 2.15: Ensure all care-seeking persons with suspected malaria use RDT or microscopy	65,908,279,479	67,420,877,337	69,678,546,602	71,787,014,287	73,739,413,640	274,794,717,705	23.0% of Obj-2
Strategy 2.16: Treat all individuals with confirmed malaria seen in private or public facilities with effective anti-malarial drugs	69,202,346,776	65,535,591,234	66,119,500,461	67,200,914,297	67,566,183,836	268,058,352,768	22.4% of Obj-2
Objective 3: Improve evidence-based decision making through the provision of timely, appropriate and reliable malaria and health information by at least 80% of facilities (public and private) providing malaria services by 2025	**3,152,296,986**	**3,100,026,958**	**1,343,984,558**	**4,005,588,922**	**1,313,525,958**	**12,915,423,382**	**0.7% of MSP**
Strategy 3.1: Reinforce and enhance advocacy approaches targeting private sector stakeholders to improve on data reporting	93,909,000	8,760,000	93,909,000	8,760,000	93,909,000	205,338,000	1.6% of Obj-3
Strategy 3.2: Strengthen the use of appropriate data-informed SBC strategies to suite localities and vulnerable populations	146,322,000	161,424,800	137,320,800	169,852,800	137,320,800	614,920,400	4.8% of Obj-3

MSP Objectives and Strategies	'2021 Cost	'2022 Cost	'2023 Cost	'2024 Cost	'2025 Cost	2021-2025 Total Cost	% of Cost per Obj & MSP Total cost
Strategy 3.3: Strengthen the contribution of the private sector to the overall malaria programme components of the Health Management Information System	-	-	-	-	-	-	0.0% of Obj-3
Strategy 3.4: Improve surveillance at the in private health facilities	-	-	-	-	-	-	0.0% of Obj-3
Strategy 3.5: Contribute to the overall strengthening of evidence-based decision making for malaria programming, by evolving a Pharmaceutical Management Information System (PMIS)	101,822,000	36,190,000	100,822,000	36,190,000	100,822,000	275,024,000	2.1% of Obj-3
Strategy 3.6: Strengthen collaboration with NAFDAC for routine testing and control of the quality of malaria medicines and commodities	-	-	-	-	-	-	0.0% of Obj-3
Strategy 3.7: Strengthen generation and reporting of quality malaria data through routine and non-routine sources.	1,550,804,262	601,789,272	601,789,272	1,193,936,512	601,789,272	3,948,319,318	30.6% of Obj-3
Strategy 3.8: Improve generation of evidence from evaluations, therapeutic efficacy and entomological surveillance studies for strategic deployment of interventions. (SMEOR)	837,367,724	-	9,330,000	697,591,724	-	1,544,289,448	12.0% of Obj-3
Strategy 3.9: Strengthen human resource for Surveillance, Monitoring, Evaluation and Operations Research	-	1,619,288,000	21,128,600	1,519,573,000	-	3,159,989,600	24.5% of Obj-3
Strategy 3.10: Harness innovation in technology and expand research for Malaria Programme	36,616,000	296,730,000	8,000,000	8,000,000	8,000,000	349,346,000	2.7% of Obj-3
Strategy 3.11: Integrate and coordinate SMEOR interventions.	385,456,000	375,844,886	371,684,886	371,684,886	371,684,886	1,504,670,658	11.7% of Obj-3
Objective 4: Strengthen coordination, collaboration and strategic partnerships to promote	**1,528,085,640**	**624,409,840**	**1,137,632,680**	**488,975,680**	**1,362,253,280**	**5,141,357,120**	**0.3% of MSP**

MSP Objectives and Strategies	'2021 Cost	'2022 Cost	'2023 Cost	'2024 Cost	'2025 Cost	2021-2025 Total Cost	% of Cost per Obj & MSP Total cost
efficiency and effectiveness of malaria control activities towards achieving at least 75% improvement from baseline using a standardized OCA tool							
Strategy 4.1: Strengthen ACSM Coordination, networking and alliance building at national and sub-national levels for effective delivery of SBC interventions	386,810,000	119,988,000	217,214,000	122,168,000	382,530,000	846,180,000	16.5% of Obj-4
Strategy 4.2: Enhance enabling environment and strengthen PPP for malaria control	190,076,000	26,080,000	190,076,000	26,080,000	190,076,000	432,312,000	8.4% of Obj-4
Strategy 4.3: Improve the Policy/Regulatory environment and practices in the private sector	-	-	-	-	-	-	0.0% of Obj-4
Strategy 4.4: Strengthen the PPP subunit at NMEP to provide for an efficient coordinating mechanism that warehouses the heterogeneous private sector response, in view of the multi-faceted strata of the private health sector.	-	-	-	-	-	-	0.0% of Obj-4
Strategy 4.5: Strengthen the alignment to/ compliance with national policies, plans and regulatory frameworks by malaria	9,139,000	-	9,139,000	-	4,417,000	18,278,000	0.4% of Obj-4
Strategy 4.6: Strengthen mechanisms for coordination of malaria PSM partner resource in States	31,367,800	-	27,532,800	-	27,532,800	58,900,600	1.1% of Obj-4
Strategy 4.7: Harness accessible coordination, collaborative mechanisms and partnerships to institute standard processes, and plans for overall management of malaria medicines and health commodities	205,387,600	9,987,600	205,387,600	9,987,600	205,387,600	430,750,400	8.4% of Obj-4
Strategy 4.8: Strengthen transparency and accountability in planning, budgeting, procurement	23,779,000	18,099,000	18,099,000	18,099,000	18,099,000	78,076,000	1.5% of Obj-4

MSP Objectives and Strategies	'2021 Cost	'2022 Cost	'2023 Cost	'2024 Cost	'2025 Cost	2021-2025 Total Cost	% of Cost per Obj & MSP Total cost
and implementation processes for malaria procurement and supply chain management							
Strategy 4.9: Lead the development and domestication of national and global malaria strategies, policies, frameworks and plans.	200,596,280	96,909,280	258,216,480	86,919,280	376,009,080	642,641,320	12.5% of Obj-4
Strategy 4.10: Institutionalize mechanisms for periodic malaria program progress and performance review using standardized methods/tools	69,004,000	62,557,200	64,962,000	62,548,000	62,548,000	259,071,200	5.0% of Obj-4
Strategy 4.11: Improve internal coordination and mechanisms for external coordination with development partners, private sector actors and Government MDAs	7,746,000	2,308,000	2,308,000	2,308,000	2,308,000	14,670,000	0.3% of Obj-4
Strategy 4.12: Strengthen processes for Malaria Program Human Resource Management including capacity development for malaria program delivery at national and sub-national levels	8,613,000	4,084,000	4,084,000	4,084,000	4,084,000	20,865,000	0.4% of Obj-4
Strategy 4.13: Strengthen processes for Malaria Program Human Resource Management including capacity development for malaria program delivery at national and sub-national levels	193,476,980	140,156,380	68,264,900	76,348,900	42,588,900	478,247,160	9.3% of Obj-4
Objective 5: Improve funding for malaria control by at least 25% annually through predictable and innovative sources to ensure sustainability at federal and sub-national levels	8,613,000	4,084,000	4,084,000	4,084,000	4,084,000	20,865,000	0.4% of Obj-4
Strategy 5.1: Reinforce policy-makers engagement for increased funding allocation and release for malaria management at all levels.	193,476,980	140,156,380	68,264,900	76,348,900	42,588,900	478,247,160	9.3% of Obj-4
Strategy 5.2: Strengthen proven-to-work stakeholders advocacy for	**276,469,600**	**301,489,865**	**305,375,040**	**297,721,840**	**216,969,040**	**1,398,025,385**	**0.1% of MSP**

MSP Objectives and Strategies	'2021 Cost	'2022 Cost	'2023 Cost	'2024 Cost	'2025 Cost	2021-2025 Total Cost	% of Cost per Obj & MSP Total cost
improved resources for malaria interventions							
Strategy 5.3: Advocate to and engage malaria PSM private sector partners and service providers in the funding of implementation of the malaria strategic plan and its objectives	62,574,800	-	-	62,574,800	-	125,149,600	9.0% of Obj-5
Strategy 5.4: Contribute to the resource mobilization for malaria control by demonstrating detailed needs for procurement, storage and distribution of malaria commodities, juxtaposed with existing funding gaps	89,812,800	54,566,000	53,454,000	80,048,800	53,440,000	277,881,600	19.9% of Obj-5
Strategy 5.5: Resource mobilization through highlighting of fund and commodity gaps, across all levels of government and partnerships: Explore available options in partnerships and existing funding arrangements to absorb "orphan" states that currently have no support for malaria programming	-	-	-	-	-	-	0.0% of Obj-5
Strategy 5.6: Deploy multiple mechanisms to mobilize funds and other resources to support management of commodities	65,328,800	65,328,800	65,328,800	65,328,800	65,328,800	261,315,200	18.7% of Obj-5
Strategy 5.7: Scale up Domestic Resource Mobilization through effective coordination and active engagement of relevant stakeholders and explore integration with existing health care funding platforms.	49,772,200	38,156,400	49,772,200	38,156,400	49,772,200	175,857,200	12.6% of Obj-5
Strategy 5.8: Build institutional capacity for financial management including, financial planning, budget tracking and evidence generation at national and sub-national levels	-	-	-	-	-	-	0.0% of Obj-5
Grand Total in Local Currency	**352,328,881,126**	**373,845,142,542**	**341,628,010,549**	**399,134,825,240**	**425,851,728,058**	**1,892,788,587,517**	**MSP mean**

MSP Objectives and Strategies	'2021 Cost	'2022 Cost	'2023 Cost	'2024 Cost	'2025 Cost	2021-2025 Total Cost	% of Cost per Obj & MSP Total cost
							Cost per Capita: 1,825
Grand Total in $US (exchange: N380)	$927,181,266.12	$ 983,803,006.69	$ 899,021,080.39	$ 1,050,354,803.27	$ 1,120,662,442.26	$4,981,022,598.73	MSP mean Cost per Capita: $5.0