



CENTER FOR
INTERFAITH ACTION
on global poverty

Kerry Medek
GHR Foundation
10350 Bren Rd West
Minnetonka, MN 55343

March 30, 2011

Dear Kerry:

Please find enclosed the independent evaluation report on the GHR-funded Faiths United for Health program in Nigeria, conducted by Wise Solutions LLC in collaboration with the Center for Communications Programs-Nigeria (CCPN). The report presents findings related to CIFA's work with the Nigerian Inter-Faith Action Association (NIFAA) in the three pilot states in Nigeria.

The report provides an independent view of this interfaith approach to fighting malaria, and indicates that NIFAA offers a sustainable and replicable model to address this pressing health issue. Moreover, NIFAA's interfaith trainings provide an avenue to gather with colleagues from other religions, and contribute to greater understanding and social interaction between trained faith leaders.

The report highlights NIFAA's exceptional growth: NIFAA has made great strides, especially given its youth. The report notes that nearly 20,000 Christian and Muslim leaders have been involved in NIFAA programming throughout Nigeria. The leaders have not only been trained to combat the threat of malaria, but have also developed greater understanding and increased social interactions across religious lines, highlighting the promise, potential and efficacy that NIFAA holds as a transformational philanthropic model.

These achievements and the impact of NIFAA would not have been possible without the GHR Foundation's support of this important, life-saving work.

Please feel free to be in touch should you have any questions or concerns about this report. We look forward to speaking with you again soon.

Many thanks.

Sincerely,

J. Andreas Hipple
Director of Programs
Center for Interfaith Action on Global Poverty

The Faith Effect: Nigeria

NIFAA Monitoring and Evaluation Results for Interfaith Action against Malaria

The independent evaluation conducted by Wise Solutions LLC on the Faiths United for Health Campaign in Nigeria highlights the efficacy and promise of the partnership between the Center for Interfaith Action on Global Poverty (CIFA) and the Nigerian Inter-Faith Action Association (NIFAA). It indicates that the pilot program model has achieved swift success, yet also has room for growth. The following are excerpts and distillations from the report.

Program Impact

- Evaluation data indicate a clear impact on knowledge and attitudes, and reported net utilization. Comparison of reported net usage in a “NIFAA state” with a state in which NIFAA was not active shows a significant difference in reported net utilization (51.6 percent in a NIFAA state versus less than half that in demographically comparable state).
- The NIFAA program is cost-effective. Even in the absence of significant follow up and supervision, it is proving effective. Using a simple formula and some assumptions, cost-effectiveness can be evaluated in three ways:
 - Cost-effectiveness by contact:
 - 6,500 trained faith leaders X 100 contacts per faith leader. When this number is divided by 2/3 of the total NIFAA budget (for the 2 out of 3 states where implementation has taken place), we find it takes \$0.65 to reach and train each faith leader.
 - Cost-effectiveness by the common media measure of exposures:
 - Given the malaria prevention messages were repeated in worship centers during prayer and at other spiritual events such as weddings, we can assume each individual had three exposures, leaving the cost at \$0.21 per exposure.
 - Cost-effectiveness per number of beneficiaries reached:
 - Assuming the 100 contacts are couples representing a household with seven members (children, servants, extended family) the cost per beneficiary would be \$0.043.
- Faith leaders who train other faith leaders (“FL1s”) are found to be “getting the message” of the training, acting on it for themselves, and imparting it correctly to other faith leaders and their congregants.
- Training tools have been effective, yet there is scope for revision and developing additional training materials and modalities to enhance impact. Data collection is at an early stage. Monitoring and evaluation systems, along with other management systems, should be more fully developed and implemented.

The CIFA/NIFAA Partnership

- CIFA has provided NIFAA with both organizational and project support. NIFAA’s partnership with CIFA is seen as a positive and contributing factor to the growth and success of NIFAA. CIFA’s value is in its ongoing advocacy, flexibility, and credibility. CIFA has also been used as a neutral third party in making sensitive management changes and as an intermediary with other organizations, such as the World Bank and the National Malaria Control Programme (NMCP).
- The CIFA/NIFAA partnership has played a critical role in the start-up phase. As NIFAA aims to continue in social development and interfaith cooperation, the CIFA/NIFAA partnership will remain important. The partnership can play a key role as NIFAA undergoes its next phase of stabilization, growth, credibility building, and sustainability.

Faiths United for Health Campaign

Evaluation Report

March 2011

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Acronyms

ACSM	Advocacy, Communication and Social Mobilization
ACT	Artemisinin Combined Therapy
BCC	Behavior Change and Communication
CCPN	Center for Communication Programs Nigeria
CIFA	Center for Interfaith Action
DFID	UK Government Department of International Development
GoN	Government of Nigeria
IPT	Intermittent Preventive Treatment
IRS	Indoor Residual Spraying
LGA	Local Government Area
LLIN	Long-Lasting Insecticide-Treated Net
LQAS	Lot Quality Assurance Sampling
NDHS	Nigeria Demographic and Health Survey
NIFAA	Nigeria Inter-Faith Action Association
NIREC	Nigerian Inter-Religious Council
NMCP	National Malaria Control Program
RBM	Roll Back Malaria Partnership
RDT	Rapid Diagnostic Test
SP	Sulfadoxine Pyrimethamine
SuNMaP	Support to the National Malaria Control Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

The Faiths United for Health (FUH) Campaign is a pilot program of the Nigeria Inter-Faith Action Association (NIFAA) that uses an interfaith action approach of Muslim and Christian religious leaders to educate and motivate Nigerians in the battle to eradicate malaria. Some 20,000 faith leaders have been involved in the program thus far, with concentrated effort in the states of Akwa Ibom, Benue and Kaduna.

A mid-term evaluation of the FUH campaign and NIFAA was conducted to assess the effectiveness of this new institution and its centerpiece program. The evaluation consisted of formative and early-impact analysis including data collection from 1132 respondents, fieldwork in three states and the capital city, and interviews with over 100 key informants.

The FUH campaign is clearly having an impact in moving Nigerians to a greater knowledge of the causes of malaria and prevention measures, particularly in leveraging greater use of long-lasting insecticide-treated bednets. There is good evidence of enhanced interfaith connections, greater trust, and good will through interfaith action in the fight against malaria. The National Malaria Control Program (NMCP) has recognized the importance of NIFAA in complementing their efforts to roll back malaria, especially in the difficult area of advocacy, communication and social mobilization. NIFAA has been established as a new and promising model for interfaith action and, in a short period of time, has developed a competent staff, an effective model, useful tools, and good systems.

NIFAA's training products and messages, as well as its training tools, techniques, and communications can be further differentiated to target the different stakeholder groups and to increase their efficiency. A focus on further extending the network of faith leaders that are mobilized against malaria and providing incentives to sustain their involvement in the campaign will be important going forward. NIFAA should purposely enhance its coordination with the NMCP's state-level activities and with state-level RBM coordinators through NIFAA's ad hoc committees and its impressive network of faith leaders. The reach of the FUH campaign thus far is not as deep as anticipated. However, with the recommended monitoring and evaluation systems strengthening, NIFAA will be in a better position to target recruitment of faith leaders, understand cascading impacts, and measure the effectiveness of its program.

The evaluation assessed performance and impact against the following:

Malaria Program Impact and Activities

- *Are NIFAA's faith leaders having a significant impact on net-utilization and net-hanging rates?*¹

Evaluation data indicate a clear impact on knowledge and attitudes, and reported net utilization. In addition, comparison of reported net usage in a "NIFAA state"

¹ Bullets from the CIFA scope of work for Wise Solutions implemented evaluation.

with a state in which NIFAA was not active shows a significant difference in reported net utilization. Key evaluation findings on knowledge and reported behavior change are as follows.

Table 1. Comparative Analysis – Pre-Post Measurement of Knowledge and Behavior

<p>Faith Leaders</p> <p>Ownership of LLINs Kaduna: Pre: 11.3% Post: 84.9% Akwa Ibom: Pre: 35.2% Post: 77.8%</p> <p>Reported ever use of LLIN Kaduna: Pre: 11.3% Post: 73.5% Akwa Ibom: Pre: 42.6% Post: 79.6%</p> <p>Perception of LLIN effectiveness Kaduna: Pre: 16.9% Post: 39.6% Akwa Ibom: Pre: 21.4% Post: 57.6%</p> <p>Knowledge on malaria causes/symptoms Kaduna: Pre: 98% / 94% Akwa Ibom: Post: 100%/98%</p>	<p>Followers</p> <p>Ownership of LLINs Kaduna: Pre: 15.5% Post: 57.7% Akwa Ibom: Pre: 19.2% Post: 31.7%</p> <p>Reported ever use of LLIN Kaduna: Pre: 18.3% Post: 84.5% Akwa Ibom: Pre: 35% Post: 60.8%</p> <p>Perception of LLIN effectiveness Kaduna: Pre: 26.7% Post: 80.3% Akwa Ibom: Pre: 56.6% Post: 82.5%</p> <p>Knowledge on malaria causes Kaduna: Pre: 60.5% Post: 71.8% Akwa Ibom: Pre: 41.6% Post: 77.5%</p> <p style="text-align: right;">Source: CCPN Survey 2010</p>
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- *How effective is the training-of-trainers model? How can it be improved?*

It is very cost effective. In the absence of follow up and supervision it is still effective but less so at each level down in the cascade.

- *How can coordination between CIFA, NIFAA, the NMCP, and other partners be improved to ensure that interfaith action is maximally effective?*
NIFAA will continue to benefit from CIFA support particularly in strategic planning, systems development and outreach. Pro-active communication from NIFAA to the NMCP and state-level Roll Back Malaria teams will be critical as program activities expand.
- *How is FUH working at the congregational level? Does the training provide religious leaders with a deep enough understanding of the key issues/messages? Are they delivering the messages?*
Faith leaders (FL1s) are found to be “getting the message” of the training, acting on it themselves, and imparting it correctly to other faith leaders and their congregants.
- *Are the training and data-collection tools appropriate and effective?*
Training tools have been effective, yet there is

**Illustrative
Cost-Effectiveness Analysis**

A very rough illustrative calculation (6,550 trained faith leaders in two of the three states x 100 contacts per faith leader divided by 2/3 of the total budget of NIFAA = \$0.65 per contact) gives a very good and very conservative cost-effectiveness ratio. If one uses the common media measure of exposures as the measure of effectiveness, we know that the message was repeated in the worship center and in other spiritual events like weddings. If you assume three exposures then the cost per message exposure would be \$0.21. Another way to calculate effectiveness is the number of beneficiaries reached, so if the 100 contacts are couples and each couple represents a household with seven members (children, servants, extended family) the cost per beneficiary would \$0.043.

scope for revision and developing additional training materials and modalities to enhance impact. Data collection is at an early stage, and so were of limited value at the time of the evaluation. Monitoring and evaluation systems, along with other management systems, should be fully developed and implemented.

Christian-Muslim Relations

- *Did engaging in interfaith training help Muslim and Christian faith leaders establish greater trust and understanding of each other?*
The interfaith training did contribute to greater understanding between trained faith leaders. The training content was less important than the opportunity for interaction and the awareness that very significant religious leaders were saying “this is ok.”
- *Is there evidence that this contributed to any positive transformation of Muslim-Christian relations at the local level?*
The interfaith component was strongest at the highest level of faith leader training (FL1). As the training cascaded down, both the message and the opportunity for interfaith cooperation diminished. There were not specific messages or actions the faith leaders could take. Also, opportunities decline because the faiths are often separated geographically. The fact that NIFAA and the project were interfaith added to its prestige even where no interfaith activities were carried out.
- *What are the strengths/weaknesses of the interfaith element of the program?*
The strength of the interfaith approach is it taps into concerns about sectarian violence. It adds a message that is cost free, and the faith leaders become more open to interfaith activities because of their own advocacy.
- *How can the opportunities for Muslim-Christian collaboration be strengthened throughout the course of the state-level work?*
Funding of additional joint activities, support for travel for FLs, interfaith cross training and followup at the state and LGA level will be useful.

The NIFAA model provides a useful example of interfaith action in Nigeria and can be deployed against other economic and social development issues. In addition, the NIFAA model can and should be shared outside of Nigeria as a useful platform for education, engagement, and change toward a variety of national-level development challenges.

BACKGROUND

Half of the world's population lives in areas where malaria is a risk. It affects 247 million people each year and of those who become ill, over a million die annually. Africa carries the highest malaria burden, reporting the vast majority of cases and over 90% of malaria deaths. It is the leading cause of death in young children; 85% of malaria deaths occur in children who have not reached their 5th birthday. Pregnant women are also particularly vulnerable to the disease as pregnancy reduces immunity and results in negative impacts on maternal health and fetal outcomes. Malaria also causes a drain on economic growth. Malaria accounts for over 40% of public health expenditures in Africa. Absences from school, combined with productivity losses due to morbidity and premature mortality, also hinder economic progress.

Within Africa, Nigeria is among the top five countries hardest hit by malaria and has emerged as a major public health issue in Nigeria. Annually, malaria affects over 100 million people in Nigeria and costs the country an estimated 880 million USD in treatment costs and lost productivity. Moreover, it causes 60% of outpatient visits and 30% of inpatient admissions.

Malaria kills 11% of pregnant women in Nigeria. The Nigerian Ministry of Health recommends intermittent preventative treatment (IPT) for malaria during antenatal care visits.² As of 2008, only 8% of all pregnant women received any IPT for malaria prevention during antenatal care visits and only 2% received the recommended full-scale regimen. Nigeria's children are also especially vulnerable to malaria. The disease kills 25% of Nigerian children before their first birthday and, on average, a Nigerian child suffers from malaria twice a year. Only 2% of children presenting a fever received the recommended malaria treatment of Artemisinin Combined Therapy.³ The survey discovered that only 8% of households in Nigeria own at least one insecticide-treated bed net. While bed net availability has been low, usage of bed nets, even when available, is lower.⁴

As a result of Nigeria's dire malaria situation, a response gradually began to form to address the crisis. Nigeria joined the Roll Back Malaria (RBM) Partnership in 1998, and participated in a summit of African heads of state focusing on malaria in 2000. Nigeria, as part of the partnership, created a National Malaria Control Program in the Ministry of Health and established a five-year strategic plan to move toward a "malaria-free Nigeria." The Government of Nigeria's (GoN) long-term vision is to achieve universal access to malaria prevention and treatment. The GoN's National Malaria Control Strategic Plan 2009-2013 seeks to:

² However, less than half of pregnant women in Nigeria have the minimum recommended four antenatal care visits. In fact, over a third of Nigerian women receive no pre-natal care at all.

³ Including children presenting with a fever over a two-week period prior to the 2008 NDHS, a full 16% of the sample population.

⁴ The 2008 NDHS found that only 6% of children under five and 5% of pregnant women slept under treated bed nets the night before the survey, though this is up from 1% for each category in 2003.

- ❖ Cut in half malaria-related mortality by 2010 against a 2000 base
- ❖ Reduce prevalence in children under five to 17% by 2013
- ❖ Achieve 80% coverage of households with LLINs by 2010
- ❖ Have 80% of pregnant women and children under five actually sleeping under a Long-Lasting Insecticide-Treated Net (LLIN) by 2010.
- ❖ Conduct indoor residual spraying to reach 8% of households by 2010 and 20% by 2013
- ❖ By 2013, have 80% of fever patients over five years of age in clinics receive a malaria diagnostic test, and 80% of those presented with fever/malaria receive appropriate and timely treatment
- ❖ And, by 2013, 100% of pregnant women in ante-natal clinics are to receive at least two doses of IPT (using Sulfadoxine Pyrimethamine)

International donors supporting this effort in Nigeria include the World Bank, the Global Fund for AIDS, Tuberculosis and Malaria, United Nations Children's Fund (UNICEF), Department for International Development (DFID), United States Agency for International Development (USAID), and others. Funding is being provided for commodities: some 63 million bednets and their distribution, prevention drugs for pregnant women; treatment drugs, indoor spraying materials; advocacy/communication/social mobilization; capacity building at the national, state and local level; monitoring and evaluation; and operations research.

Given the enormity of the malaria problem and the ambitious disease control targets set, some of which have already been missed, the Government of Nigeria welcomes a multi-pronged approach, particularly in the realms of advocacy, communication and social mobilization. The faith community shares the GON's concern of leveraging behavior change to deliver their followers from sickness and death. Faith leaders have unique access and credibility and can join in efforts to communicate, educate, and motivate all Nigerians to safeguard their health.

PROGRAM DESCRIPTION

With its large, diverse, and dispersed population, the logistical challenges of a nationwide malaria campaign in Nigeria are daunting. Even more overwhelming is the need for detailed information and motivation to ensure effective and continued use of the preventive and treatment resources being made available. The success of the malaria eradication program rests not just on providing commodities and services to the population, but on getting people to use them. Only one channel has the reach and credibility to change the behavior of all Nigerians – faith leaders. Over 98% of Nigerians describe themselves as being very religious. Most associate with either Muslim or Christian denominations. Through the Christian Association of Nigeria and the National Supreme Council for Islamic Affairs, and utilizing their networks of faith leaders from the national to the community level, it is estimated one could reach 78 million Nigerians. These Nigerians would receive accurate information, suited to their life situation, reminders and motivation to continue with healthy behaviors, motivation to address community approaches like environmental cleanup, and all from an existing, low cost, and credible source.

The Faiths United for Health (FUH) campaign is a program designed to utilize Muslim and Christian faith leaders to spread the word about malaria and leverage behavior change. FUH is supported by the Nigerian Inter-Faith Action Association (NIFAA), the Center for Interfaith Action (CIFA), and the National Malaria Control Programme (NMCP), which are in turn supported by a variety of other donors and institutions.

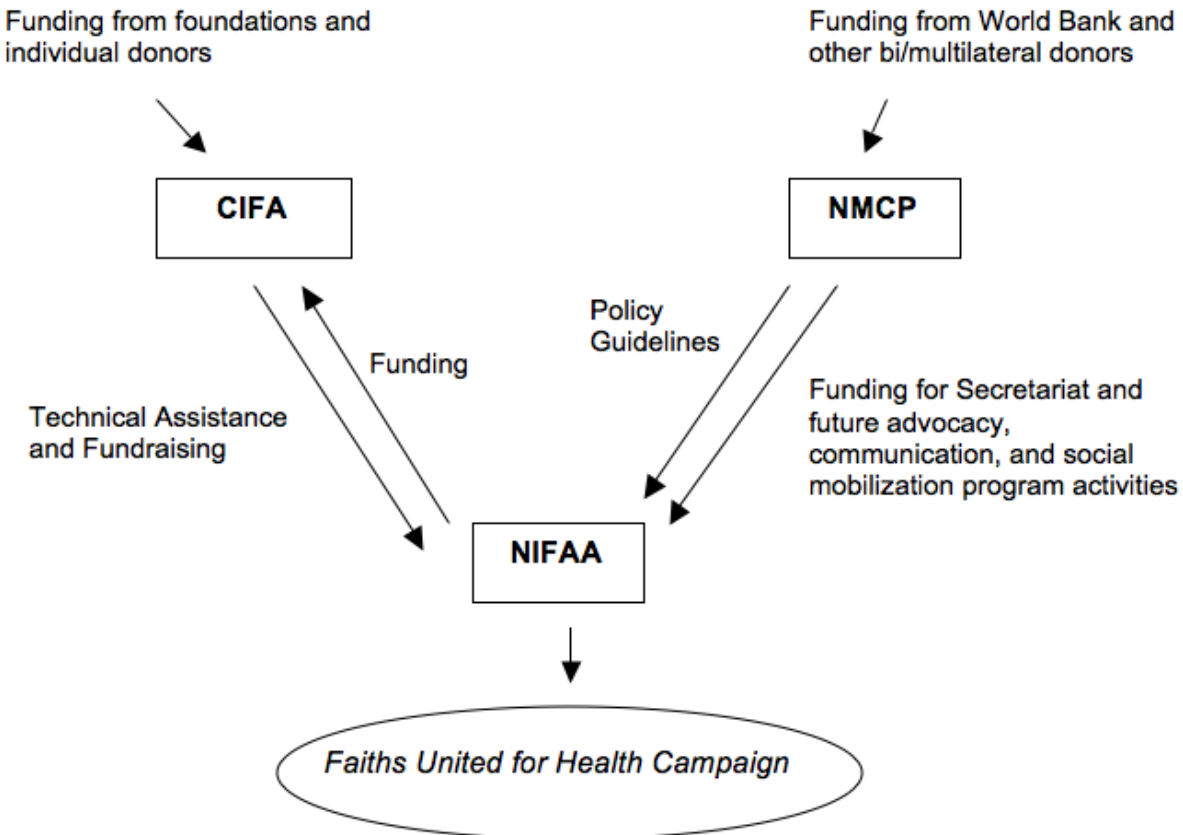
CIFA is a US-based non-governmental organization (NGO) that was created through its predecessor organization at the National Cathedral, the Center for Global Justice and Reconciliation. CIFA seeks to improve the capacity and effectiveness of the global faith community in its effort to combat poverty and disease. CIFA aims to increase interfaith coordination and action on the ground, mobilize resources, share best practices, and conduct advocacy. Together with Christian and Muslim faith leaders, CIFA developed the Interfaith Action Association (IFAA). IFAA is a NGO platform that links a nation's multi-faith community, national government agencies, and international resource providers through a partnership framework.

The in-country IFAA that was launched in Nigeria is the Nigerian Inter-Faith Action Association. It was formally established at World Malaria Day on April 29, 2009 by co-chairs Sultan Mahamadu Sa'ad Abubaker of Sokoto, President-general of the Nigerian Supreme Council of Islamic Affairs, and Archbishop John Onaiyekan, the then-president of the Christian Association of Nigeria. NIFAA was established to “coordinate and resource Nigerian religious institutions to respond to common public problems, with the goal of increasing interfaith participation, cooperation, and action in national poverty reduction and disease campaigns.” NIFAA is led by its Executive Director, Bishop Sunday Nduiwo Onuoha. NIFAA is an independently-registered Nigerian NGO staffed by Nigerians with a majority-Nigerian (and Nigerian-led) board of directors. NIFAA is supported by CIFA through regular correspondence and working site visits.

NIFAA is leading a full-scale mobilization of Muslim and Christian faith leaders across the nation to combat malaria through its Faiths United for Health (FUH) campaign. NIFAA's goal is to equip every mosque and church, every imam, pastor and lay faith leader in Nigeria to deliver key malaria prevention and treatment messages.

The funding structure is outlined in the following diagram.

Figure 1. FUH Funding Structure



The stated objectives of the FUH campaign are to:

1. Train Muslim and Christian faith leaders across Nigeria to deliver key anti-malaria messages to their congregants and the broader community by giving the faith leaders the knowledge and tools to integrate these messages into their sermons and other religious discussions.
2. Equip Nigeria's faith leaders with the tools and knowledge that will allow them to teach their congregants and other community members how to reduce the scourge of malaria by concrete actions, such as using mosquito bed nets correctly and consistently, seeking treatment as recommended, and

encouraging the most vulnerable community members to take action to reduce their mortality and morbidity risks.

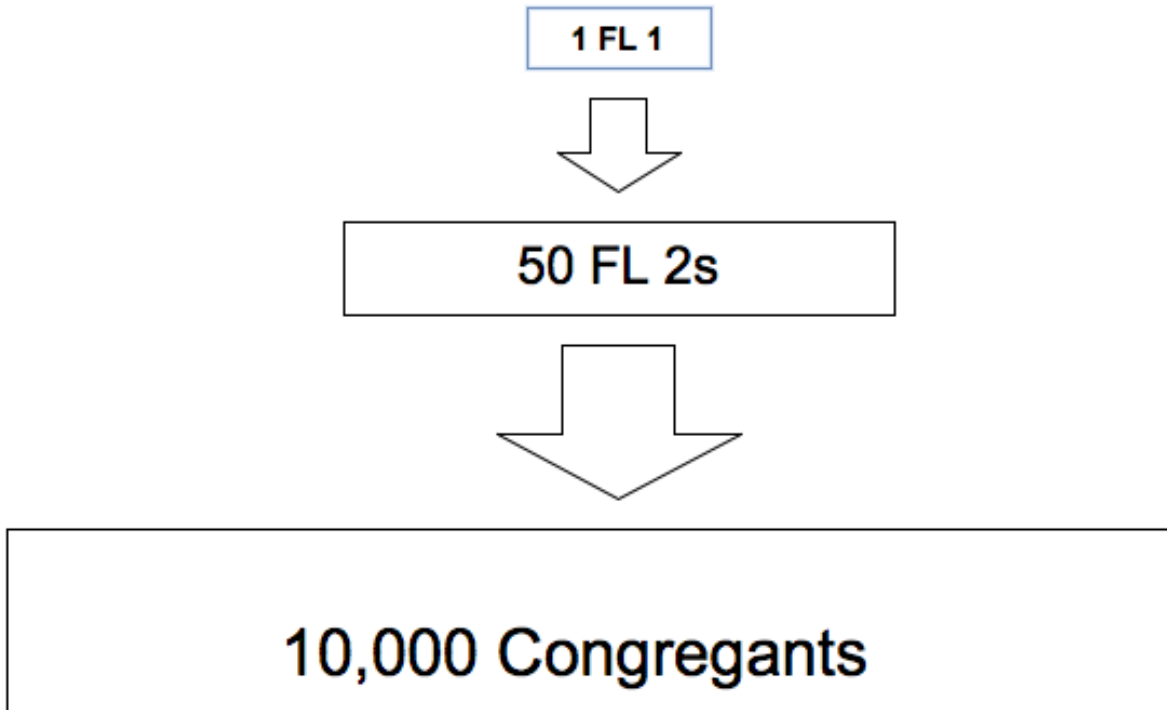
3. Develop an intentional process built into the multi-faith training system that will allow participants to reflect on their interfaith engagement using “action-together” vehicles to systematically promote mutual understanding – or “pluralism in action.”
4. Draw upon the growing trust and linkages developed through common action in order to spread the word that such action is effective and transformational in addressing the poverty and health-related challenges of diverse multi-faith communities.

There are six key messages conveyed through the FUH training. These are:

1. All, in particular women and children under five, should sleep under a long-lasting insecticide-treated bed net.
2. Pregnant women should get two doses of malaria prophylaxis.
3. Indoor spraying should be welcomed.
4. Recognize malaria symptoms and seek treatment.
5. Follow and complete the full course of treatment.
6. Keep the environment surrounding households clean and clear of standing water.

The FUH Campaign model, as implemented currently by NIFAA, proposes to train 10 faith leaders (FL 1s) from each local government area (LGA). Each of these lead trainers would then train 50 faith leaders (FL 2s) in each of their respective geographic areas and faith communities. Nationally, that would yield approximately 390,000 trained faith leaders. Based on the assumption that each faith leader would reach out to 200 congregants with messages on malaria prevention and treatment that would raise awareness and leverage behavior change, each of the initial FL 1s could reach 10,000 congregants. The diagram below illustrates the potential impact that could stem from just one trained faith leader.

Figure 2. Cascade Impact Model



Combining the impact of the planned ten FL1s from all LGAs, the impacted population would be 78 million people, just over half the total population of Nigeria. Assuming this impacted population consists primarily of adults, as it would using the churches and mosques, given the high dependency ratios in Nigeria, the number of indirect beneficiaries would be much higher. And, assuming lateral influence from faith leaders and impacted community members and continued action, it is feasible that the entire population of Nigeria could be reached.

The FUH campaign model is intended to mobilize community- level health volunteers. Evaluators were not aware that any significant or systematic mobilization of health volunteers had occurred. Better monitoring and support for health volunteers can provide an even deeper channel for messages and continued motivation to improve health behaviors, particularly as the NMCP rolls out its activities related to advocacy and community social mobilization at the local level.

To implement the FUH campaign, NIFAA established a small secretariat, developed training materials, and began conducting national-level convenings of faith leaders focused on malaria and interfaith action. These were followed by targeted interventions in three Nigerians states: Akwa Ibom, Benue, and Kaduna.

Key achievements to date include:

- A high-level sensitization for 110 faith leaders in Kano State (September 2009);
- A national launch of CIFA's and NIFAA's Faiths United for Health campaign, with training for 148 faith leaders representing all 36 states participating, witnessed by then-Minister of Health, the UN Special Envoy for Malaria, the Sultan of Sokoto, Archbishop Onaiyekan, and other influential leaders (December 2010);
- A high-level sensitization for 111 faith leaders in Bauchi State (January 2010);
- Former U.K. Prime Minister Tony Blair and former Nigerian President Olusegun Obasanjo attended a day-long training for 192 Nigerian religious leaders from the Federal Capital Territory to lend their moral support to the NIFAA effort (February 2010);
- In Akwa Ibom, 276 faith leaders (FL 1s) were trained (March and May 2010); They have trained 6,298 of their local faith-leader colleagues (FL 2s) (March-present 2010);
- A high-level sensitization for 172 faith leaders was held in Rivers State (March 2010);
- Organized special sermons focused on malaria at Abuja's Methodist Cathedral of Unity and Apo Legislative Quarters Mosque, with national press coverage, in recognition of World Malaria Day (April 2010);
- In Kaduna State, 191 Muslim and Christian faith leaders were trained as FL 1s; they went on to train 6,837 FL 2s (June 2010);
- In Akwa Ibom, a special NIFAA Ad Hoc Advisory Council of 12 faith leaders was constituted to provide leadership to NIFAA's efforts to support the anti-malaria campaign in that state (June 2010);
- In Benue State, 271 faith leaders have been trained as part of a general sensitization prior to bednet distribution;
- In Kaduna State, an Ad Hoc Advisory Council was created (August 2010);
- The Days of Reflection was held in Abuja on September 29, 2010. 36 faith leaders from three states participated in an interfaith dialogue on action and transformation. Including press, NMCP representatives, NIFAA and CIFA staff and several board members, close to 70 people attended the day-long event;
- A guide entitled "Stopping a Killer: Preventing Malaria in our Communities" was produced by CIFA and disseminated. An initial Toolkit brochure was produced by CIFA. A revised version was developed by NIFAA, incorporating feedback from National Malaria Control Programme Advocacy, Communication, Social Mobilization Technical Working Group.
- A results-based contract is being negotiated with the NMCP to expand to six other states.

EVALUATION METHODOLOGY

In order to assess how the program is working and what it is achieving, the evaluation envisioned by CIFA called for two separate data-collection exercises. The first was a process evaluation of the CIFA – NIFAA FUH Initiative. The second component was an impact evaluation to determine if FUH interventions are achieving the desired outcomes. The questions to be addressed are:

- Did engaging in interfaith training help Muslim and Christian faith leaders establish greater trust and understanding of each other? Is there evidence that this contributed to any positive transformation of Muslim-Christian relations at the local level?
- What are the strengths/weaknesses of the interfaith element of the program?
- How can the opportunities for Muslim-Christian collaboration be strengthened throughout the course of the state-level work? How effective is the training-of-trainers model? How can it be improved?
- Are NIFAA's faith leaders having a significant impact on net-utilization and net-hanging rates?
- How can coordination between CIFA, NIFAA, the NMCP, and other partners be improved to ensure that interfaith action is maximally effective?
- How is FUH working at the congregational level? Does the training provide religious leaders with a deep enough understanding of the key issues/messages? Are they delivering the messages?
- Are the training and data-collection tools appropriate and effective?

The methodologies of both components are as follows.

The Process Evaluation

The process evaluation used qualitative research methods to assess the processes, capabilities, and implementation of the CIFA – NIFAA partnership and NIFAA's implementation of its support role to the national malaria eradication program. The sources of information for the evaluation included:

- Focus groups and in-depth interviews with faith leaders
- Interviews with NIFAA state coordinators
- Interviews with NIFAA national staff
- Interviews with NMCP staff at the federal level
- Interviews with NMCP/ Roll Back Malaria (RBM) staff at the state level
- Interviews with donor partners involved in the RBM interventions
- Review of data on training results

Data collection was conducted in Abuja, and the three states where NIFAA has been active with CIFA support: Benue, Kaduna, and Akwa Ibom. Field work was conducted during the September – November 2010 time period.

The process evaluation issues used to prepare the process evaluation followed the FUH implementation stages.

- How did NIFAA build support with state governments, religious institutions, and malaria stakeholders?
- How did NIFAA coordinate with state-level teams?
- How does the personnel structure and level fit against the level of effort and job requirements?
- How were faith leaders identified?
- How were faith leaders trained?
- What is the structure for sustainability and scaling up?

As information was collected, some of the questions and issues were modified or dropped and some new questions were raised. These modifications are addressed in the Findings and Recommendations section.

The Impact Evaluation

The Center for Communications Programs Nigeria (CCPN) was contracted on a parallel track by CIFA to evaluate the reach and impact of NIFAA's activities under the FUH campaign. CCPN's scope of work is summarized as the following:

- Develop a field implementation plan with NIFAA cooperation.
- Harmonize data collection protocols with NIFAA and Wise Solutions.
- Work with NIFAA to ensure state readiness for field work.
- Identify areas and communities for study with NIFAA.
- Develop a representative sampling strategy with categories of key audiences described.
- Identify, recruit, and orient field staff for data collection.
- Conduct fieldwork.
- Analyze the data collected.
- Write a draft and final report on the results of the assessment.

The ideal design for the evaluation would have been to conduct baseline data collection before training and net distribution, and then follow-up with data collection after the program had sufficient time to increase knowledge and change use-behavior. However, because of the timing of the evaluation, only one state government – Benue – had not yet conducted net distribution, and so NIFAA training was delayed long enough to do a baseline measurement. Hence, there is post-intervention data from Kaduna and Akwa Ibom with no baseline, and pre-intervention data from Benue, with no follow-up data on which to assess impact.⁵

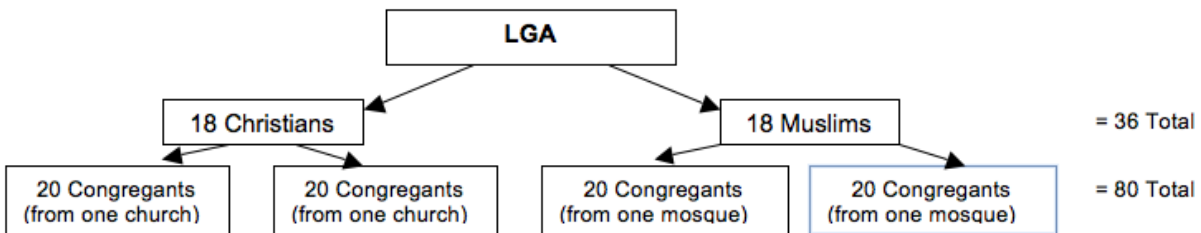
Impact evaluation respondents were selected from the following groups:

⁵ The original evaluation design called for post-intervention data collection, but to date the Benue state government has not distributed nets, so training has not yet started. With no impact to be measured it was decided to cancel the post-data collection.

- Male and female community members
- Christian and Muslim members of religious associations
- Youth in school and out of school
- Representatives from civil society
- Community and traditional leaders
- Traditional informants such as town announcers
- Muslim and Christian leaders

Totalling 1,132, survey respondents were both urban and rural residents, of both genders, and spanned socio-economic classes. The target number of respondents for the quantitative portion of the survey was 250 from each of the three states. Respondents were selected from two LGAs within each state, one rural LGA and one urban LGA, from two of the state’s three senatorial zones. In each LGA, 36 respondents were selected, of which 18 were Christian and 18 were Muslim. From each group of 18, two respondents were randomly selected. Surveyors then distributed questionnaires to 20 congregants from the church or mosque of the two randomly selected responders. The process for selecting survey respondents in each LGA is depicted below.

Figure 3. Respondent Selection Model at LGA Level



The questions that were asked of these respondents were aimed to assess their knowledge of malaria signs and symptoms and their own bed net use, both at the time of the interview and with recall to the time before the respondents would have received malaria messages. The recall data was collected in order to compensate for the lack of concrete baseline data in both Kaduna and Akwa Ibom states. In Benue state, baseline data was collected about knowledge, attitude, and practices, as well as sources of information on health and malaria in particular.

FINDINGS AND RECOMMENDATIONS

NIFAA's Organizational Structure

Organizational Findings

NIFAA is governed by an 11-person Board of Trustees that is co-chaired by the heads of Christian Association of Nigeria and the Nigeria Supreme Council for Islamic Affairs. These are also the co-chairs of the Nigerian Inter-Religious Council (NIREC). The Board of Trustees has a majority of Nigerian trustees, one female member, and three international members. Current membership is as follows:

- His Grace Dr. John Onaiyekan, Archbishop of Abuja, Co-Chairman of NIFAA, President of the Christian Association of Nigeria
- His Eminence Muhammadu Sa'adu Abubakar, Sultan of Sokoto, Co-Chairman of NIFAA, President of the Nigeria Supreme Council for Islamic Affairs
- Dr. Abdul Lateef Adegbite, Secretary General of the Nigeria Supreme Council for Islamic Affairs
- Hajia Bilkisu Yusuf, Journalist
- Mark Dybul, O'Neill Institute for National and Global Health Law, Georgetown University
- Ian Linden, Tony Blair Faith Foundation
- Prof. Is-Hag Oloyede, Vice Chancellor, University of Ilorin, Nigeria
- Prof. J.A.M. Otubu, Provost of University of Abuja, Nigeria
- Tom Woods, Center for Interfaith Action on Global Poverty

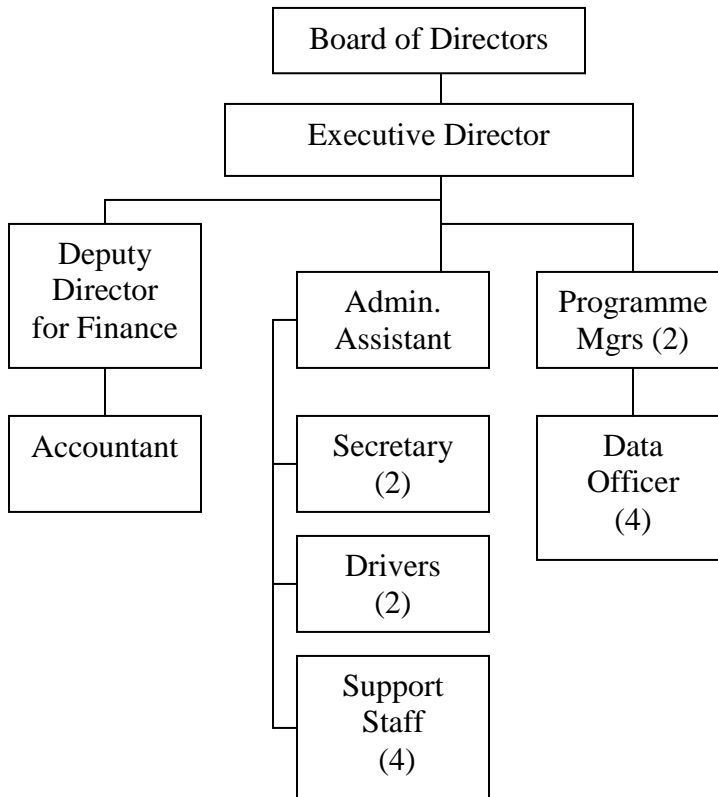
Other than the co-chairs, trustees sit as individuals. There are three-year renewable term limits.

The board meets regularly, the meetings are minuted, and it appears that the board provides good oversight and support to NIFAA's activities and program resources. The board also provides NIFAA with appropriate governance and guidance. Attention could be given to enhancing the gender balance on the board and looking at the skills mix needed for a balanced and robust board.

Staffing. The NIFAA staff is quite small, consisting of an Executive Director, two program managers, an administrative assistant, a Director of Finance, an accountant, four data analysts (who are on a temporary assignment that is funded by CIFA), and eight support staff. Much attention has been paid during recruitment to building a team that is balanced in terms of gender and religion. Of the 18 staff, there are seven females and 11 males, and 10 Christians and eight Muslims. There is one medical doctor and one certified accountant on the staff. KPMG is engaged as the external auditor.

The organogram is as follows:

Figure 4. Current Organogram for NIFAA



One hole in the current structure is the staff at the state-level. One state has a full-time manager, one has a part-time manager, and another has no manager. The gaps in state management have been effectively dealt with by frequent visits from headquarters personnel. Unfortunately, this overloads the staff that would be better used in training, supervision, and donor liaison. The issue of state managers came up in discussions with RBM managers, who wanted greater coordination, better communication, and a larger role for NIFAA in local advocacy. Another state-level staffing issue to consider is the need to formalize NIFAA’s network. NIFAA offers access to millions of Nigerians through a network of religious leaders. Formalizing the network with staff and a physical presence in the states and, in some cases, the LGA levels will help implement and create demand for NIFAA from other development sectors.

NIFAA should prepare for expansion by starting a technical consultant database. These technical experts can be area specialists (agriculture, community development, microfinance) or methodologists (research, training, media relations). Their role can be to support NIFAA technically, and to help market NIFAA across donors and different fields.

The staff size and the flat reporting structure (everyone reports to the Bishop) require the recruitment of an intermediary. It is recommended that NIFAA recruit a program

manager to oversee all field activities. Since the current and immediately foreseeable activities are malaria related, it is recommended that the position be filled by a person with medical training – a doctor or experienced public health specialist. This position is also likely to increase in importance because additional activities and funding are likely to be health related until NIFAA can expand its credentials to non-health projects.

Because of its pending growth, NIFAA will need a personnel management system. The current headquarters staff is smart and dedicated. The policy of balancing faiths is very strictly observed, without any apparent cost to effectiveness. During interviews with staff, no one had a scope of work for their position, no one could describe the qualifications for various positions, and the recruitment process varies depending on the position. A similar situation exists at the field-level for state managers, the advisory group, and FL1s. Despite its informality, the system seems to have found skilled and dedicated workers. With a larger staff and six new states to manage, personnel issues are likely to create more problems without formal guidelines and written procedures.

Ad hoc Committees. Ad hoc committees were established in Kaduna and Akwa Ibom states in lieu of standing staff or a more formalized state level structure. Each committee has a compensated lead member, one lead is part-time and one is full-time. Each ad hoc committee is comprised of 12 members with four members representing each of the three senatorial zones. Committee members meet periodically to review activities and issues related to program implementation. Ad hoc committee members expressed an interest in having some identification or credentialing that would distinguish them from other FL1s and allow them to interact more formally with local officials and communities, as well as with their peer faith leaders. The roles and responsibilities function and minutes of the activities of the ad hoc committee are still somewhat informal and could use some clarification and formalization.

The name “Ad hoc Committee” also reflects the informal status the group holds in the NIFAA structure. Based on their actual functions they could also be called local management advisory or leadership committees. The name “Ad hoc” reflects NIFAA’s current unwillingness to formalize the function of these committees in the larger organizational structure and longer-term strategy.

Management Structure. The management structure of NIFAA is small and without hierarchy. There are only three levels of staff and all staff have access to the Executive Director. This environment has fostered a strong sense of camaraderie, team identity, commitment, and flexibility in staff responsibilities. The inexperience and age of NIFAA has led to a very informal management structure. The quality and the commitment of the small staff compensate for the lack of formal structures, but with the pending growth of the organization, management systems will be needed. Accounting systems are critical and are currently being developed and applied. The accountant and the administrative assistant have been trained in the World Bank accounting system. Examples of management systems that do not currently exist, but that will be needed in the future, include:

- Staff development and training
- Time and attendance tracking
- Vehicle use policies
- Travel policies
- Clear scopes of work and responsibilities
- Performance monitoring
- Donor and partner liaison
- Supportive supervision of implementation
- External communication/public relations

As part of funding agreements, donors could mandate some of these systems.

Organizational Recommendations

- Develop a Management Strategy. NIFAA should undertake a strategic planning exercise on organizational management. CIFA and/or a management consultant could greatly facilitate this process. The strategy would look at where the organization wants and needs to be at the end of each year for the next five years. The strategy can be reviewed every year to see if targets are being met and if any modifications are needed to meet changing circumstances.
- Management Information Systems. NIFAA should develop systems to get information that supports management and innovation. These systems are needed in order to ensure the future effectiveness of a growing NIFAA and to professionalize the organization.
- Financial Systems. Donors require financial transparency, and good financial management is even more important for a faith-based organization. NIFAA has already developed financial systems, which are currently being upgraded. However, the finance systems should also be able to inform decision-making on new activities, alternate implementation strategies, and cost-benefit analysis.
- Trainee Database. NIFAA has already started a database of FL1s and 2s (with funding from CIFA). Unfortunately, the way the database was designed, it is simply a contact list stored on a computer. It is not searchable and it has no capacity to keep additional information on each member of the trainee network (e.g. religious affiliation, back up contacts, training received, LGA to help assess coverage in the state). Since the network of faith leaders is NIFAA's primary tool, formalizing the network and facilitating communication increases the effectiveness of NIFAA. A fully functional and well-maintained database of trainees is a critical component of NIFAA, and part of a long-term strategy for marketing and increasing the impact of the organization.

- Activity Monitoring and Reporting System. NIFAA needs a system for field activity reporting. The system would be used to regularize reporting, facilitate supportive supervision, meet donor and Government of Nigeria reporting requirements, aid in financial planning, identify problems, and identify positive local models for replication.
- NGO Partnerships. NIFAA should be building relationships with a broad range of national NGOs. These relationships would provide the basis for future partnerships. These NGOs might become clients by using NIFAA to implement communication and/or behavior change activities in their areas of interest. They might also share technical skills to help NIFAA prepare proposals or to design projects.

CIFA/NIFAA Partnership

Partnership Findings

CIFA has provided NIFAA with both organizational and project support. NIFAA's partnership with CIFA is seen as a positive and contributing factor to the growth and success of NIFAA. CIFA's value is in its ongoing advocacy, flexibility, and credibility. CIFA has also been used as a neutral third party in making sensitive management changes and as an intermediary with other organizations, such as the World Bank and the National Malaria Control Programme (NMCP).

Partnership Recommendations

The CIFA/NIFAA partnership has played a critical role in the start-up phase. As NIFAA aims to continue in social development and interfaith cooperation, the CIFA/NIFAA partnership will remain important. The partnership can play a key role as NIFAA undergoes its next phase of stabilization, growth, credibility building, and sustainability.

Areas where additional CIFA support will be needed include:

- Developing a strategic plan
- Creating an advocacy strategy
- Establishing a management information system
- Developing an organizational prospectus to expand NIFAA's marketing
- Planning for the upcoming World Bank program
- Creating a communication strategy
- Harmonizing operations with NMCP
- Building an operations research capacity in NIFAA to test and justify approaches
- Developing leadership
- Increasing NGO partnerships with NIFAA
- Engaging with the USAID MAPS project.

Training Content and Messages

Training Findings

The NIFAA model uses a cascade-training approach. The course and content are consistent because there are only two trainers who generally work in tandem and use the same training materials. The curriculum, content, and messages are contained in a single document called the “Toolkit.” The NIFAA Toolkit is a comprehensive brochure. It serves as training curriculum, a reference for Faith Leaders, and a job aid for managing contacts. The Toolkit was pre-tested, reviewed by stakeholders, and generally found to be helpful, accurate, and consistent with the scope of NIFAA’s malaria agenda.

The design of the training also supports interfaith action. First, the recruitment of more open-minded faith leaders helped to ensure dialogue and opportunities for changes in attitude. Second, putting the faith leaders together in one training room with one agenda ensured interaction and collaboration. The training required that all faith leaders be together and interact in an environment that respected religious differences. The evaluators observed one major convening (the Day of Reflection) and two state-based Ad Hoc Committee meetings. These meetings gave a strong sense of collegiality through open-seating, personal discussions, interfaith tables at lunch, shared transport, and social interaction (attendance at birthday parties and family funerals). Since the training was the only opportunity to build this collegiality, it must be credited with supporting the interfaith agenda. Third, the provision of models for Muslim and Christian sermons ensured equal resources for both, and the practice sessions created

The Toolkit and training content

- An introduction and Call to Action
- Malaria facts
- The summarized NIFAA messages are:
 - Cause: Mosquito bites cause malaria. They bite at night. They live in areas with standing water.
 - Prevention: Sleep under a treated bed net, which acts as a barrier. The nets are safe for adults and children.
 - Prevention: Clean the environment of breeding sites.
 - Prevention: Pregnant women should get an intermittent preventive treatment (IPT) drug from her health center and use it at least twice during the pregnancy.
 - Treatment: Recognize the symptoms, get medical care, and if there is no improvement return to the medical facility.
- Bed Net Use
- Instructions: Air, Hang, Sleep, Roll up, Wash, Dry, Mend
- Tools for Action (channels for delivering the malaria messages)
 - Sermon Starters/Guides (Muslim and Christian)
 - Group Discussion Guide
 - House-to-House Visitation Guide
 - An illustrative schedule for implementing the above activities
- Volunteer “Advocacy” Checklist – “Get a Net” activities before net distribution during (household) visits
 - Why use nets?
 - How to get a net
 - Enough nets for each household to get two
 - Net use and care
 - NIFAA messages
- Volunteer “Monitoring “ Checklist – “Use the Net” activities after net distribution during household visits
 - Net received
 - Net hung
 - Used every night
 - Knowledge of net care
- NIFAA Contact Information

the sense that faith leaders share a common role and set of problems reaching their congregants.

The group discussion guide in the Tool Kit is intended to address a larger community. However, environmental cleanup, the most important role the community can play, receives only one line in the guide. On the interfaith side, the guide encourages participation with other houses of worship. This participation is good, but this evaluation's findings suggest that an invitation to all members of the community, regardless of religion, would generate a lot of interfaith participation. This strategy should be added to the training materials.

Saving souls is the traditional religious activity of ministering to the human spirit. NIFAA, however, was asking the faith leaders to put a major effort into saving not only the spirit, but lives as well. Saving lives addresses the health and well-being of the individual and his/her community. The training made the synergistic link between a healthy body and a healthy spirit. Since both Biblical and Quaranic scriptures share this view, it created a common vision theologically and provided greater motivation to incorporate malaria eradication into the spiritual agenda of the faith leaders.⁶ A sermon guide entitled "Stopping a Killer: Preventing Malaria in our Communities" was disseminated to faith leader trainers and trainees.

"There are three big mountains in climb in order to achieve behavior change: knowledge, attitudes, and practices. I have seen faith leaders to be a trusted, credible voice. In Africa, this makes a difference."

~ USAID Project Manager

Training Recommendations

The Toolkit brochure carries a heavy information load. It is a training curriculum, a project strategy, an IEC tool, a project description, a fieldwork scheduler, and an address book. It is also expected to be useful to management, trainers, FL1s, FL2s, and volunteers. As the FUH Campaign moves forward, it should consider revamping the toolkit so that is more flexible, more focused, more easily changed, less expensive to produce, and more appropriate for all communication and skill levels.

The Toolkit content is no longer relevant. The Toolkit focuses on getting and hanging bed nets. However, at the time of the evaluation two of the three NIFAA states and all six of the pending World Bank states have already completed distribution and some public education. The program objectives should change to focus on: using nets, buying extra nets, spraying, and environmental cleanup, addressing the most vulnerable populations, early treatment, and the availability of free medicines. The following are specific suggestions for developing a more useful Toolkit.

⁶Adopted from a review of the theological content and implications of the Faiths United for Health Project. Edward P. Antonio, "CIFA/NIFAA Nigeria Trip Highlights," preliminary, October 2010.

- The illustrative schedule of activities included in the Toolkit represents a rarely seen timeline of net distribution and FUH activities. The schedule takes up too much space given its limited usefulness. It should be dropped.
- The Group Discussion Guide questions are not really a guide as much as they are a test. Their effectiveness is limited by asking questions intended for an individual respondent and not a group.
- The Toolkit is heavily weighted toward bed net usage as the major behavior-change focus area. It pays less attention to treatment, environmental cleanup, and prevention for high-risk groups.
- The interfaith component was communicated in the way the training was structured, by creating a common and universally hated enemy – the mosquito, and by showing the shared values between physical and spiritual health. The “common enemy” theme is reflected in the oft-heard aphorism: “*The mosquito goes to the mosque on Friday and the church on Sunday.*” The focus on ending malaria and the avoidance of any discussion of religious doctrine was effective in creating a common enemy and a common goal of protecting people from malaria deaths.
- Break the Toolkit into discrete pieces so that it can be mixed and matched with the needs of the users.
- The Toolkit is a one-size-fits-all tool. It would be useful if there were toolkits relevant for the skills and functions of the FL1, FL2, and volunteers.
- The FL1s, 2s and volunteers are all expected to do training and motivation. Yet, there are no tools to help them be better trainers. A new tool could help these groups better communicate with the trainees, address specific problems that have arisen, develop training plans for different groups, answer more complicated questions about malaria or the RBM program, monitor their own performance, combat misinformation and rumors, identify leaders that can model good practices, and use training aids. Generic training materials are widely available and a working group including a few ad hoc committee members could develop the draft tool(s).
- The Toolkit should include training aids such as a poster with bed net hanging graphics, pictures of poor environmental practices, and examples of the packaging of the anti-malarial medicines that are available for free from the health center. These may be available from the Ministry of Health, but, if not, they should be developed rapidly by NIFAA.
- The Sermon Starter materials should be expanded and made into a separate tool. The sermon tool should cover such issues as: continued use and maintenance of the nets, buying nets if you do not have enough, environmental cleanup, getting the community to act responsible in preventing malaria, mobilizing the community to

address the increased seasonal risks of malaria, and addressing rumors. The tool should also be structured to support presentations made outside the mosque or church. It could also provide guidance in giving sermons to special groups, including school children, youth, men, women, police, and school teachers. The Sermon Starter should also be big enough to read when giving a sermon.

- Tools to help FL1s, FL2s, and volunteers do community mobilization should be added to the Toolkit.
- The House to House Visitation Guide seems to have been written when there was still little experience with the home visitation. A small working group of FL2s and volunteers might be able to make the materials more relevant to the changing situation and the realities of the field.
- The Monitoring Checklist should include questions on: environmental cleanup; a pregnant woman in the house; children under five in the house; sought treatment if had malaria; knowledge of where to get free malaria medication; and if there are enough nets in the house.

Advocacy

Advocacy Findings

NIFAA has done ad hoc advocacy as part of its implementation of the malaria program. The advocacy efforts have brought both appreciation and criticism from the state RBM managers. They appreciated the visits and meetings with state-level officials and the associated media coverage of the malaria campaign. However, the criticisms were that the advocacy was insufficient relative to its potential impacts. Advocacy suggestions included regular, ongoing advocacy on the malaria program that could be performed by on-the-ground teams at the state-level in combination with NIFAA headquarters staff and leadership. Advocacy efforts should include some time for malaria, the local media, and recognition of leaders and champions within the community. It was also recommended that advocacy should be a strategic component of future activities.

Advocacy Recommendations

Like any country, Nigeria has a host of gatekeepers – national government, local government, international agencies, the business community, labor unions, traditional leaders, and the media. It is difficult to achieve social change if the gatekeepers do not open the gates. NIFAA has “star power” to be an effective advocate and change agent due to its interfaith leadership, credibility, and network of local faith leaders. For this reason, it is recommended that NIFAA develop an advocacy strategy for the FUH Campaign and any other initiatives it undertakes. A brief framework for a malaria advocacy strategy would include:

- Statement of objectives (e.g. bed net use, build interfaith cooperation at the community level)
- Gatekeeper targets for advocacy (e.g. State governors, large employers, RBM Managers, state legislatures, national or local media)
- Specific behavior desired of gatekeepers (e.g. budgeting for and dispersing resources to distribute nets, more educational programming on local radio stations regarding effective net use, employers distributing nets as prizes for performance).
- Identify partners who might share your objectives, including other NGOs, faith-based groups, corporations, and donor agencies.
- If the media is to be used as a way to influence gatekeepers, a media strategy should be developed. Potential topics include media, messaging, talk shows, editorials, paid advertisements, contests, events, and celebrity endorsements.
- Identify champions or leaders to carry the message to the gatekeepers (e.g. faith leaders, celebrities, athletes)
- An implementation approach that addresses national versus local priorities, synergies between activities or events, timelines, indicators for monitoring progress or achievement, and budgets.

Implementation of an advocacy strategy can be just as important as the community-level work in having the desired impacts. By undertaking strategic advocacy, NIFAA will develop a skill that will serve them in all areas of social development. The importance of advocacy strongly suggests that the activity be formalized with a written strategy, a staff allocation, and a budget.

Building NIFAA's Network

Network Findings

The FUH Campaign used a small, paid staff to build a network and mobilize an army of volunteer faith leaders and unpaid volunteer labor. NIFAA's relationship with the network is informal, with limited contact with any volunteers below the ad hoc advisory group, and no rewards for the work beyond "jewels in their crown in heaven." Interviews and observations by the evaluation team found the FL1 and FL2 cadres to be smart and dedicated. Communication with the head office through the two program managers is open and supportive, but it is almost completely between the advisory group and the program managers. Where there is no state manager, there is little supervision or monitoring of field level activities.

Network Recommendations

One of the most critical aspects of NIFAA's sustainability is the formalization of its network of faith leaders. NIFAA has two major products that it can market to funding agencies. First, it has credibility and associated influence as a national faith-based

organization. Second, it has a network with the ability to mobilize at the grass-roots level with minimal effort and cost.

NIFAA itself offers no rewards for the volunteers' work. This approach has worked well thus far for a single intervention focus on malaria, but repeated calls to faith leaders making an average of \$66 per month will surely lead to unmotivated volunteers and lots of drop outs from the network. If NIFAA is to be sustainable, it needs the continued support of its network of volunteers. It is recommended that NIFAA institutionalize its volunteer network with organizational changes and recognition. It would most likely be counterproductive to regularize a stipend or regular honorarium for volunteers. This would reduce their credibility in the community and it would create an employer-employee relationship that would be difficult to administer. It is recommended that NIFAA consider non-monetary incentives.

Possible examples of incentives include:

- Ad hoc Committees – lapel pins, business cards, certificates, honorarium for providing technical support to NIFAA (as trainers or consultants to new project areas, for helping develop new materials like model sermons, for doing evaluations or spot checks).
- FL1s (including ad hoc advisory group members) – Certificates, study trips, regular give-away materials for FL2 and volunteer health workers, recognition in the media.
- FL2s – Certificates, “thank you” ads in local media, bags, give-aways to distribute, update training.
- Volunteers – house signs, certificates, prizes for service, seasonal signs that remind the community that malaria will soon be a greater risk, hand out materials that are a “gift” to the households visited.
- Houses of worship – signs that acknowledge the congregation’s support for NIFAA activities, prizes for interfaith activities, small grants for related church/mosque projects.
- Community - signs, banners (ex. “This Community is Fighting Malaria” or “This is a Malaria Free Community”), and linkages with other development activities that would give malaria-free communities priority for service (road repair, water wells, school repairs).
- Families – stickers for protected households and give-aways like calendars.

To build and protect the network, NIFAA needs to make organizational changes that reflect the network’s importance. Changes should include:

- Staff and budget to support the network.
- Recognizing the cooperative partnership by formalizing the relationship.
- Recommendations from field interviews include: identification cards to increase legitimacy, a full-time state manager to coordinate and communicate, more materials for distribution to facilitate access, and provide the traditional gift of visitors.
- Building and maintaining a database of volunteers.
- Recognition with a letter that welcomes them to the NIFAA family, and a handbook of

- expectations, contacts, benefits and costs of participation, scopes of work, etc.
- Reporting mechanisms (for problems and successes).
- Recruiting mechanisms to replace drop-out volunteers and get new ones in new project areas.
- Training structure for new volunteers or to implement a new program.

Coverage

Findings

The FUH Campaign was the first test of NIFAA and of the faith leader as a health educator model. One technical issue that was not addressed, but that must be in subsequent work, is the completeness of coverage. The selection of faith leaders was not purposive, but opportunistic. The primary group of faith leaders was selected by NIFAA and local faith organizations based on perceived leadership and the likelihood that they would “do a good job.” These faith leaders in turn picked additional faith leaders that they knew to train, who then also picked faith leaders, who picked volunteers. Since each faith leader was picked by a leader they knew, selection tended to be geographically and faith/denomination concentrated. This problem was widely-recognized in the field. There were two consequences of the opportunistic selection of faith leaders: 1) some communities got a strong anti-malaria message, while others got a weak or no message; and 2) it undermined the interfaith component. Future activities that are implemented should ensure broader coverage. Coverage should also be mapped (possibly using the volunteer data- base) to identify underserved areas. Coverage policy should also consider priorities such as high-risk communities, poor communities, and communities with limited access to health services or information.

The model used by NIFAA to estimate coverage was that each trained FL-1 would train 50 FL-2s. Each FL-2 would directly or indirectly reach 200 congregants. Each Local Government Administration (LGA) would have 10 FL-1s. If this model were extrapolated out to national level, virtually every household in Nigeria would get malaria messages through faith leaders.

There is no way to measure actual coverage, because we cannot estimate the population reached directly or indirectly with message. Future household surveys by the RBM Program and their partner donors can and should ask specifically about faith leaders and sources of information and motivation for malaria knowledge and actions.

Examination of NIFAA data on reported faith leader involvement and cascaded recruitment and training of other faith leaders gives us a more realistic picture of what the model should be, or where the actual coverage needs to improve.

- The model says each FL-1 would train 50 FL-2s. In fact the average number of FL-2s trained is 38. The range is between 10 and 50 FL-2s per FL-1. A large number of FL-1s had exactly 50, but never more, FL-2s. This raises a number of questions:
 - Are faith leaders inflating numbers to meet the 50 target?
 - Why are faith leaders stopping at 50?

- How many FL-2s can a volunteer FL-1 be expected to effectively recruit and manage?
- How widely are FL-1s recruiting and training – within their church or across faiths?
- The model says 10 FL-1s for each LGA. The average number of FL-1s for the 54 LGAs in Kaduna and Akwa Ibom is 3.2.
 - Was this a budgetary or management decision to under-recruit FL-1s or not cover all LGAs in the two states?
 - In a roll out of the malaria training in other states is the first priority to get a few faith leaders in every LGA or to get more coverage in a selected number of LGAs?
 - What are the criteria for setting the number of FL-1s for a LGA: population, malaria burden, support from the state government?
 - How is the interfaith component of the project supported by the selection and number of FL-1s?
- The model says 200 congregants per faith leader will be reached. The evaluators asked faith leaders the size of their congregations and the range was 50 to 200. In all likelihood, 200 congregants is too high as an estimate of direct communication. On the other hand, if indirect communication is included it is probably too low. Each of the congregants has a household that will get the message indirectly. The health volunteers provide additional coverage by working at the community level and not just within the congregation. Also the CCPN data shows that many faith leaders put malaria messages into other events that they were involved in, like wedding and baptisms. For planning purposes it would be useful if NIFAA did a small study of selected faith leaders to get an estimate of the reach of messages in sermons, in other events, by health volunteers, and how many people in the community got the message indirectly (i.e. from neighbors, family members, community leaders).

Interfaith Activities

Findings

There was a general consensus among faith leaders that the interfaith component was valuable and interesting. There was a strong sense that communal violence was a serious problem and that the kinds of interactions and sharing supported in the FUH Campaign could combat the problem. The best opportunity the evaluation team had to witness interfaith action was in the ad hoc committee meetings. The committee participants have had the greatest exposure to NIFAA's interfaith message. For many of the participants it was hard to identify their faith. There was no segregation in seating, in eating lunch, or in traveling together. Shared experiences at funerals, weddings, and other events were part of the background discussions.

In other discussions with individual faith leaders the interfaith approach was also highly regarded, but several interesting issues were raised. In some areas, interfaith events are difficult to organize because the Christian and Muslim communities are

geographically separated. It was recommended that there would have been greater interfaith cooperation if there had been funding for travel. In addition, there is some competition/friction between Christian denominations. This suggests that training materials be reviewed and modified to support intra-faith collaboration on malaria eradication.

Working with National and State RBM Managers

Findings

RBM Managers felt that NIFAA has great credibility, access to all religious networks, and a deep reach. NIFAA was viewed as a “welcome partner” and a real asset to the malaria eradication program. While other faith-based groups were being used, RBM managers reported that NIFAA brought a new energy to the efforts and that the interfaith component was a new and useful strategy. The linking of religion and malaria prevention was seen as a powerful tool for changing behavior.

“NIFAA, a welcome organization.”

~ RBM Manager

Recommendations

NIFAA could utilize RBM managers and other state-level team members in training, not only in speeches at launches.

RBM Managers expressed an interest in NIFAA participating in the larger planning process by attending coordination meetings. To facilitate greater participation it was recommended that NIFAA formalize its local structure (office and permanent staff).

It was also suggested that the large network of faith leaders could play an important role in providing feedback on the situation in the field (misinformation, availability of malaria medicines, price being charged for free medicines, or communities needing spraying). NIFAA could mobilize communities to identify and get malaria patients to a treatment facility.

Impact of the FUH Campaign

Summary of findings:

Table 1. Comparative Analysis – Pre-Post Measurement of Knowledge and Behavior

<p>Faith Leaders</p> <p>Ownership of LLINs Kaduna: Pre: 11.3% Post 84.9% Akwa Ibom: Pre: 35.2% Post: 77.8%</p> <p>Reported ever use of LLIN Kaduna: Pre: 11.3% Post: 73.5% Akwa Ibom: Pre: 42.6% Post: 79.6%</p> <p>Perception of LLIN effectiveness Kaduna: Pre: 16.9% Post: 39.6% Akwa Ibom: Pre: 21.4% Post: 57.6%</p> <p>Knowledge on malaria causes/symptoms Kaduna: Post: 98% / 94% Akwa Ibom: Post: 100%/98%</p>	<p>Followers</p> <p>Ownership of LLINs Kaduna: Pre: 15.5% Post: 57.7% Akwa Ibom: Pre: 19.2% Post: 31.7%</p> <p>Reported ever use of LLIN Kaduna: Pre: 18.3% Post: 84.5% Akwa Ibom: Pre: 35% Post: 60.8%</p> <p>Perception of LLIN effectiveness Kaduna: Pre: 26.7% Post 80.3% Akwa Ibom: Pre: 56.6% Post: 82.5%</p> <p>Knowledge on malaria causes Kaduna: Pre: 60.5% Post: 71.8% Akwa Ibom: Pre: 41.6% Post: 77.5%</p>
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The appropriateness of using worship centers as channels of communication for health issues:

A basic assumption of the FUH campaign was that using faith leaders and worship centers as channels for transmitting behavior change messages to the public would be acceptable. The impact survey strongly validated this assumption.

In Benue state, where there had been no interventions, surveyed faith leaders gave hospitals and worship centers as the two most acceptable sources of health information. In Akwa Ibom and Kaduna, where the FUH activities had taken place already and malaria messages were in the worship centers, the approval rating was also high. In Kaduna, worship centers, followed by radio/media, were the most acceptable sources of health information. In Akwa Ibom, worship centers were highly ranked by Christian faith leaders as the most appropriate, while Muslim faith leaders preferred community leaders and health-extension workers. However, all faith leaders agreed that worship centers were “very appropriate.” In Kaduna 74% and in Akwa Ibom over 94% of faith leaders reported worship centers as their source of health information.

Benue followers reported that worship centers were a “very appropriate” place for sharing health information. In Kaduna, 75% of followers found worship centers to be the preferred source for health information, second only to radio. An impressive 97% of Christians and 87% of Muslims found worship centers to be very appropriate sources of health information. In Akwa Ibom it was 95% of Christians and 100% for Muslims.

Clearly worship centers are a powerful and appropriate channel of communicating health messages. In the two states where the intervention has gone forward, virtually

all followers (98% in Akwa Ibom and 87% in Kaduna) got malaria messages where they worshiped. It was also found that the malaria message had started to move beyond the worship center. For example, in Kaduna state, 60% of faith leaders put health messages in religious seminars, 57% in community events, 28% in burials, and 21% in weddings.

The impact of training on faith leader behavior

Post-training knowledge of malaria was high for faith leaders in Kaduna and Akwa Ibom. Specifically, understanding was high on causes, prevention, economic and social impact, and effectiveness of LLINs, suggesting the training was successful in imparting its messages.

Ownership of LLINs rose from 11% to 85%, and ever use rose from 11% to 74% among faith leaders in Kaduna. Ownership of LLINs rose from 35% to 78% and ever use from 43% to 80% among faith leaders in Akwa Ibom.

There was a significant change (both in absolute and in statistical terms) in the knowledge and behavior of faith leaders because of their participation in the Faiths United for Health campaign. A question for NIFAA is why is net use among faith leaders not at 100%?

Despite this, the conclusion is that the training and participation in the project is leveraging behavior change from the faith leaders who are informing their followers and providing a model for members of their community.

The impact of malaria messages on follower behavior

In Kaduna, followers had high levels of knowledge (90+%) of the causes, symptoms, and treatment for malaria. Ever use of LLINs rose from 18% to 85%. Followers with a positive perception of LLIN effectiveness rose from 27% to 80% after the intervention.

In Akwa Ibom followers' knowledge of malaria was also high, with the number of followers knowing the cause of malaria almost doubling after hearing sermons on malaria. Use of the LLINs went from 35% to 61%.⁷ The proportion of followers who believed LLINs were effective against malaria rose from 57% to 83% after hearing sermons on malaria.

The messages from faith leaders to followers clearly had an impact. The change in use levels should be considered in the context of the net distribution program. Household use of nets can increase because nets are available to them. So we should be careful

⁷ We have not reported on the level of ownership of LLINs even though this dramatically increased. The level of use is higher than the ownership of LLINs. The explanation given by the field teams was that women who were often answering the questions did not think of themselves as owning the bed nets. The belonged to the Government or they belonged to their husband who was head of household.

in claiming causality, although given changes in knowledge and attitudes it is likely that among the followers more people were willing to use the nets they received, installed them correctly, and used them properly.

Further verification of the impact of the NIFAA malaria interventions

Preliminary results from the Lot Quality Assurance Survey (LQAS) conducted in seven Nigerian states in June-July 2010 show that in Akwa Ibom state, where NIFAA has trained over 6,000 religious leaders to deliver faith-based malaria prevention messages including advocating net usage, more than twice as many children under five slept under a net (51.6%) as in nearby Anambra State (25.1%) the night before the survey.

Program Expansion and Sustainability

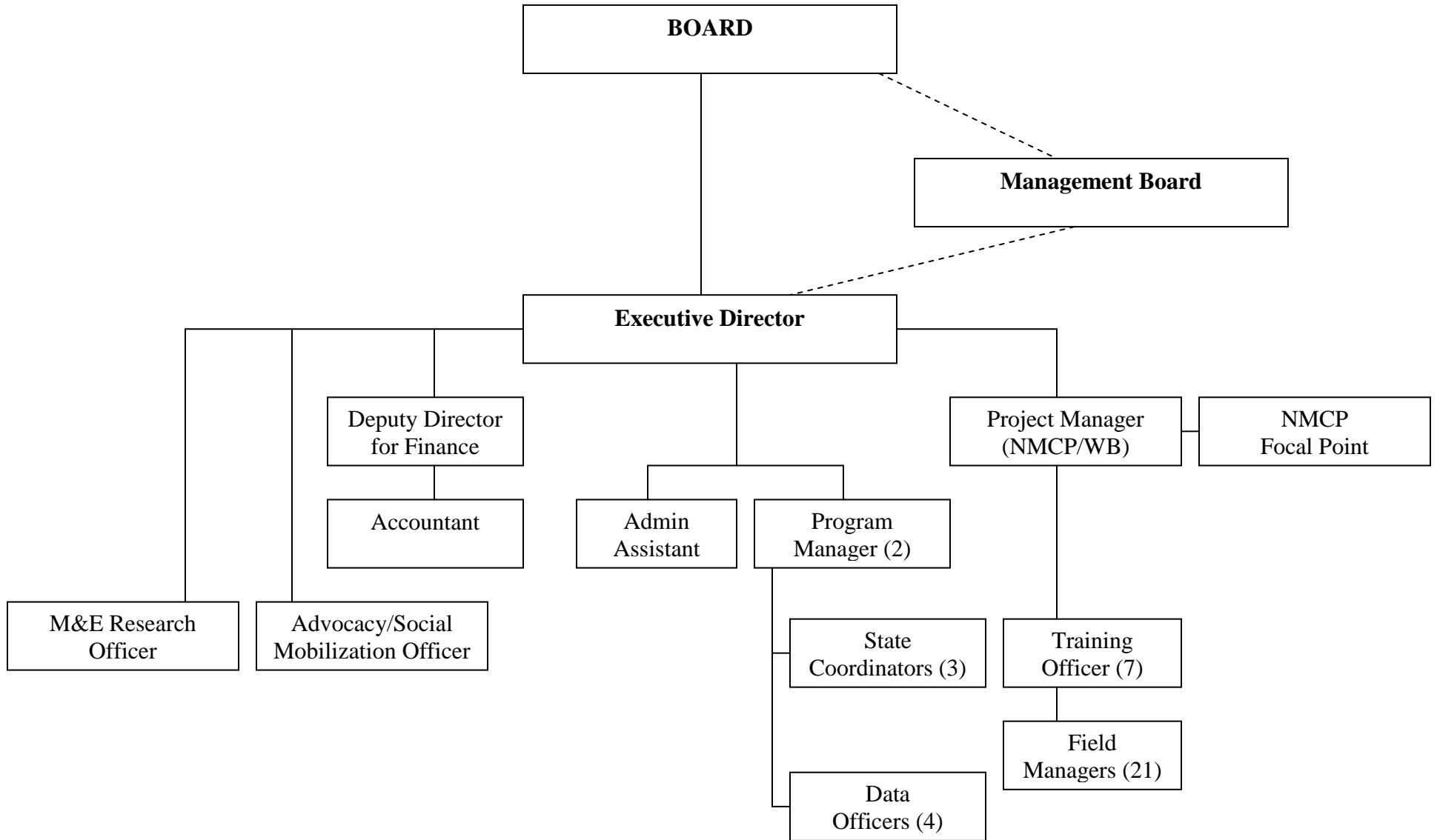
Findings

The National Malaria Control Programme (NMCP), utilizing a portion of their World Bank-funded Booster Program 2 loan, will allocate approximately \$1.5 million to NIFAA for social mobilization activities in seven states (Akwa Ibom, Anambra, Bauchi, Gombe, Jigawa, Kano and Rivers) over an 18-month period. Using the interfaith approach, NIFAA is to leverage increases in (1) LLIN utilization, (2) preventative treatment of pregnant women, (3) knowledge of malaria symptoms in target population, and (4) malaria treatment in children. This innovative financing mechanism provides 60% of base funding with acceptable performance and reporting, with an option of 80% if at least three out of seven states show achievement of $\frac{3}{4}$ of outcome targets, or 100% disbursement of funding if six out of seven States meet $\frac{3}{4}$ of targets, as determined by third-party evaluators. The contract will require 33 staff positions, at least 29 of whom are net additions to the current NIFAA payroll.

Recommendations

In light of NIFAA's upcoming World Bank-funded expansion, NIFAA must expand to meet the World Bank's staffing requirements. A sample expanded organogram is included below that would satisfy the World Bank's staffing requirements for NIFAA.

Figure 5. Proposed Organogram for NIFAA



Additional Recommendations

Measure cost effectiveness

The use of faith leaders to carry health messages has several benefits – credibility, the width and depth of reach, and the ability to motivate the community and do follow-up. But one of the most powerful is the low cost of generating an exposure to the message. The NIFAA approach is especially cost effective because it uses an unpaid volunteer labor force to carry its malaria messages to the households. A financial review and impact analysis necessary for a cost effectiveness analysis of NIFAA's program was not part of the scope of work of this evaluation. However, there is absolutely no doubt that if the analysis were done the results would have been a remarkable cost effectiveness ratio.

The calculations used in the box on cost-benefit in the Executive Summary are illustrative and do not include such factors as: the credibility of faith leaders, the additional contacts of the health volunteers, the access to hard-to-reach populations, the leveraging behavioral impacts of making malaria a community issue, the effects of faith leaders modeling positive bed net behaviors, and the opportunities for follow up and continuing motivation. It also does not reflect the impact of NIFAA advocacy on national and state level officials implementing the RBM Program.

While we know the FUH Project is cost effective, it is still recommended that a more detailed costing and impact monitoring be done. The benefits of the studies would be to:

- Help NIFAA and donors budget for expansion of activities (e.g. the cost to train one FL1)
- Help market NIFAA to other donors, and for other social-welfare issues (ex. civil society, immunization, sanitation)
- Help promote the interfaith approach beyond Nigeria
- Help NIFAA be more strategic in making program decisions that effect impacts.

Another recommendation for NIFAA is based on the last point – strategic decision making. The FUH Campaign was NIFFA's first activity and with it came the funding for the start up of the organization. Characteristically for a new organization, NIFAA was conservative in its approach and budgeting. As a consequence, decisions were made to: have a minimal staff at the headquarters and at the state level; limit the amount of advocacy; provide a small range of materials for trainers and beneficiaries; do minimal supervision and follow up; focus primarily on the distribution and use of bed nets; not modify support or approach to address local circumstances; and to provide little or no motivation beyond training to faith leaders that are the heart of the FUH Project and NIFAA. All of these decisions have a potentially limiting effect on the impact of the FUH Campaign. NIFAA's frugality and caution should be applauded. However, It is now a more mature organization with effective management, a good reputation, a successful

project and expanding funding. The evaluation team recommends NIFAA become more strategic in its decision-making by considering costs in the context of potential impact, actual impact, sustainability of impacts, and opportunities for innovation.

Integrate Malaria Interventions

The malaria campaign in Kaduna State was run by UNICEF. UNICEF is the only RBM partner to have integrated malaria interventions into its primary health care program. NIFAA should have used the opportunity in Kaduna to develop an approach that addresses the strength and weaknesses of integrated health programs. The ability to work in an integrated health project is a useful set of skills for future malaria activities and for future involvement in other health issues.

Improve the Evaluation of Faith Leader Training

The current pre/post training evaluation is almost useless as a management tool for NIFAA. It fails to cover some important issues, and since the faith leaders do not sign the test sheets, it is impossible to do a real pre/post comparison.

- Since interfaith understanding is major objective of NIFAA, some opinion/attitude questions should be added to measure change.
- It may be helpful to provide some open-ended questions (i.e. what worked, what was useful, what did you like best) to help improve future trainings.
- The results of the pre/post tests are difficult to interpret, explain, or use to improve training. Because the tests are anonymous it is not possible to make the standard pre-post comparison of each participant or to summarize the change (ex. mean score). Tests should not be confidential, but if it is a coding system should be utilized to allow for tracking of results.

Develop a Model of Faith Leader Involvement in Social Change

The use of faith leaders and the interfaith approach offer significant potential for expansion: across Nigeria; to other countries; to other health problems; and to other social issues requiring grass-roots behavior change. Testing and documenting various facets of the program will give NIFAA greater credibility with donors, improve the program, and help transfer lessons learned. The use of operations research is the common approach to doing this, and it is already being done in the SunMap program.

Illustrative questions that could be answered with operations research techniques are:

- Characteristic of an effective faith leader
- Benefits and timing of refresher training

- Approaches to building congregational involvement in community change
- Impact of additional skills training for religious leaders – counseling, community mobilization, working with youth.
- Assessing the utility of job aids.
- The association between behavior and health impact (use of nets and incidence of malaria).

CONCLUSION

NIFAA has accomplished a great deal in a short period of time. A small team -- representing balance in religion and gender -- has created training materials, conducted high-level sensitizations, and trained faith leaders. This training has cascaded to other faith leaders, who have then reached out to congregants. They have established advisory committees and state-level coordinators in two states to sustain program activities. Apart from a small cadre of staff, the program is implemented by religious-leader volunteers. The cost-effectiveness of the program and its impact on interfaith cooperation are leading attributes of its success.

NIFAA will be strengthened through selective staff expansion, investment in monitoring and evaluation systems, and enhanced financial management. There is an ongoing and important role for the Center for Interfaith Action to play in supporting strategy development, management systems strengthening, fundraising and innovation. Expansion to additional states as envisioned in the World Bank-funded contract with the National Malaria Control Programme will call for greater formalization of the management structure and deepening of state-level governance and delivery mechanisms. Training materials need to be differentiated based on audiences and additional training support materials developed. The thrust of the training and communication should now move beyond bednet usage to the full range of prevention and treatment messages. As NIFAA deepens its work in malaria and builds capacity of the organization, there are opportunities for expansion of their interfaith platform for action and impact on other health and development issues in Nigeria. NIFAA can and should be used as a model in establishing interfaith action programs in other countries with attention to sharing their experience elsewhere in Africa.

REFERENCES

ADRA Mozambique. (2010). *Together Against Malaria: 2007-2010 Final Report*. Mozambique.

Antonio, Edward P. (2010). *CIFA/NIFAA Trip Highlights*.

Antonio, Edward P. (2010). *Questions: African Pluralism - Nigeria Project*.

Baume, C. A., Reithinger, R., & Woldehanna, S. (2009). Factors associated with use and non-use of mosquito nets owned in Oromia and Amhara Regional States, Ethiopia. *Malaria Journal*, 8, 264.

Boulay, Dr. Marc. (2010). *Evaluation of the Integrated LLIN Mass Distribution and Child Health Campaign in Sokoto State, Nigeria*.

Center for Interfaith Action and IMA World Health. (2010). *Stopping a Killer: Preventing Malaria in our Communities*. Washington, DC.

Center for Interfaith Action on Global Poverty. (2009). *Letter of Inquiry to GHR Foundation From the Center for Interfaith Action on Global Poverty. Faiths United for Health: Mobilizing Interfaith Action Against Malaria in Nigeria*.

Center for Interfaith Action on Global Poverty and Nigerian Inter-Faith Action Association. (2010). *Three State Roll-out Financial Report*.

Center for Interfaith Action on Global Poverty and Nigerian Inter-Faith Action Association. (2009). *Memorandum of Understanding*.

Center for Communication Programs Nigeria. (2010, September). *Proposal submitted to the Center for Interfaith Action on Global Poverty & The Nigerian Inter-Faith Action Associations*.

Federal Ministry of Health, & National Malaria Control Program. (2009). *Nigeria strategic plan 2009–2013*. Abuja, Nigeria. Available at <http://nmcpnigeria.org/f/STRATEGIC%20PLAN%202009-2013.pdf>

GHR Foundation. (2009). *Grant Agreement to the Center for Interfaith Action Association*.

GHR Foundation – Muslim Christian Common Action Initiative. (2010 May). *Interim Monitoring Report*.

GHR Foundation – Muslim Christian Common Action Initiative. (2010 July). *Interim Monitoring Report*.

Global Fund to Fight AIDS, Tuberculosis and Malaria. (2008). *Proposal form—Round 8 (single country applicants): Country coordinating mechanism (CCM), Nigeria*. Available at: http://www.theglobalfund.org/grantdocuments/8NGAM_1730_0_full.pdf

Global Fund to Fight AIDS, Tuberculosis and Malaria. (2009, May). *Global Fund Five-Year Evaluation: Study Area 3. The impact of collective efforts on the reduction of the disease burden of AIDS, tuberculosis and malaria*. Geneva, Switzerland: Author. Available at: http://www.theglobalfund.org/documents/terg/TERG_SA3.pdf

Gwatkin, D. R., Rutstein, S., Johnson, K., Pande, R. P., & Wagstaff, A. (2000). *Socio-economic differences in health, nutrition, and population*. Washington, DC: World Bank.

Hassan, S.-D, Malik, E. M., Okoued, S. I., & Eltayeb, E. M. (2008). Retention and efficacy of long-lasting insecticide-treated nets distributed in eastern Sudan: A two-step community-based study. *Malaria Journal*, 7(85).doi:10.1186/1475-2875-7-85

Kano State Economic Empowerment and Development Strategy. (2004, September). *Kano State Economic Empowerment and Development Strategy: Policy framework*. Available at: http://www.ng.undp.org/documents/SEEDS/Kano_State.pdf

Kano State Government. (2007). *Peoples of Kano*. Kano, Nigeria: Author. Available at <http://www.kanostate.net/people.html>

Malaria Consortium. (2009). *News release: An historic health campaign in Nigeria—millions of bed nets distributed to prevent malaria deaths*. Available at: <http://www.malariaconsortium.org/~malaqkmt/news.php?id=69>

Mapping Malaria Risk in Africa. (2005). *Nigeria: Distribution of endemic malaria*. Available at: <http://www.mara.org.za/pdfmaps/NgaDistribution.PDF>

Mechael, Dr. Patricia N. (2009). *A Review of Malaria Resources in Nigeria and other African countries*. *Malaria Control Communication*.

National Malaria Control Programme. (2010). *Fortnightly Report On Status Of Nigerian Universal LLIN Campaigns*.

National Population Commission [Nigeria] and ICF Macro (2009). *Nigeria Demographic and Health Survey 2008*. Abuja, Nigeria: National Population Commission and ICF Macro

NetsforLife. (2010). *2009 Evaluation Report (Presentation)*.

Nigerian Inter-Faith Action Association and the Center for Interfaith Action on Global Poverty. (2010). *Report of the Akwa Ibom Refresher Training With Faith Leaders On The Fight Against Malaria*.

- Nigerian Inter-Faith Action Association. (2010). *June 2010 Update*.
- Nigerian Inter-Faith Action Association. (2010). *NIFAA's Mode of Operations*.
- Nigerian Inter-Faith Action Association. (2010). *NIFAA Annual Report August 2009 – July 2010*.
- Nigerian Inter-Faith Action Association (2010). *NIFAA Refresher Zonal Level Refresher Training of Faith Leaders Ibom Hall, Uyo*.
- Nigerian Inter-Faith Action Association (2010). *NIFAA Operational Plan - State-Level Faith Leader Training Kaduna State*.
- Nigerian Inter-Faith Action Association. *The Constitution of the Nigerian Inter-Faith Action Committee*.
- Nigerian Inter-Faith Action Association. (2010). *Faiths United for Health. A Toolkit for Faith Leaders In Nigeria In The Fight Against Malaria*.
- National Malaria Control Programme. (2009). *Monitoring and Evaluation Plan for Malaria Control in Nigeria*.
- National Malaria Control Programme. (2010). *Report On Advocacy, Communication and Social Mobilization Activities During The Year 2010*.
- NMCP/MOH with Support from Sunmap. (2010). *Research Around Communication Issue for Malaria Control In Nigeria Research Tools*.
- Onuoha, Bishop Dr. Sunday N. (2010). *NIFAA's Support to the National Malaria Control Programme & its 2010 Net-Distribution Campaign (Presentation)*. Nigerian Inter-Faith Action Association.
- Oyekan, Dr. Maryam. (2010). *NIFAA's Support to the National Malaria Control Programme*. Nigerian Inter-Faith Action Association.
- Roll Back Malaria Partnership. (2007). *Nigeria: Progress and challenges towards SUFI*. Geneva, Switzerland. Available at: <http://www.rollbackmalaria.org/countryaction/nigeria.html#>
- Sa'ad Abubakar, Muhammad, Ayo Oritsejafor and Sunday Onuoha. (2010 November 3). *The war against malaria*. The Guardian.
- SuNMaP. *Update on post campaign survey findings in Kano, Anambra, and Cross Rivers states*.

SuNMaP, Malaria Consortium, MEASURE Evaluation, USAID Nigeria. (2009). *Retention, Use, and Achievement of “Universal Access” Following the Distribution of Long-Lasting Insecticidal Treated Nets in Kano State, Nigeria.*

UK Department for International Development. (2009). *Partnership for Transforming Health Systems Phase II (Paths2): Kano State.* Available at <http://www.paths2.org/state2.html>

United National Children’s Fund. (2007). *Malaria and children: Progress in intervention Coverage.* Geneva, Switzerland: Author.

World Health Organization. (2009). *World malaria report 2009.* Geneva, Switzerland: Author. Available at http://whqlibdoc.who.int/publications/2009/9789241563901_eng.pdf

Yé, Y., Sauerborn, R., Simboro, S., & Hoshen, M. (2007). Using modeling to assess the risk of malarial infection during the dry season, on a local scale in an endemic area of rural Burkina Faso. *Annals of Tropical Medicine and Parasitology*, 101, 375–389.

Yohannes, K., Dulhunty, J. M., Kourleoutov, C., Manuopangai, V. T., Polyn, M. K., Parks, W. J., Williams, G. M., & Bryan, J. H. (2000). Malaria control in central Malaita, Solomon Islands: The use of insecticide-impregnated bed nets. *Acta Tropical*, 75, 173–183.

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