FUNDING REQUEST APPLICATION FORM
Full Review

SUMMARY INFORMATION			
Applicant	NIGERIA CCM		
Component(s)	MALARIA		
Principal Recipient(s)	Under Additional Safeguard Policy		
Envisioned grant(s) start date	1-JAN-2018	**Envisioned grant(s) end date**	31-DEC-2020
Allocation funding request as per GF Allocation Letter	$313,409,111	**Prioritized above allocation request**	$272,378,981.75
Allocation funding request after CCM Program Split	$275,274,804.40		

IMPORTANT:

To complete this funding request, please:

- Refer to the accompanying ***Funding Request Instructions: Full Review****;*
- Refer to the Information Note for each component as relevant to the funding request, and other guidance available, found on the Global Fund website.
- Ensure that all mandatory attachments have been completed and attached. To assist with this, an application checklist is provided in the Annex of the *Instructions*;
- Ensure consistency across documentation.

Applicants are encouraged to submit a joint funding request for eligible disease components and resilient and sustainable systems for health (RSSH).

Joint TB/HIV submissions are compulsory for a selected number of countries with highest rates of co-infection. See the related guidance for more information.

This funding request includes the following sections:

Section 1: Context related to the funding request
Section 2: Program elements proposed for Global Fund support, including rationale
Section 3: Planned implementation arrangements and risk mitigation measures
Section 4: Funding landscape, co-financing and sustainability
Section 5: Prioritized above allocation request

SECTION 1: CONTEXT

This section should capture in a concise way relevant information on the country context. Attach and refer to key contextual documentation justifying the choice of interventions proposed. To respond, refer to additional guidance provided in the *Instructions*.

1.1 Key reference documents on country context

List contextual documentation for key areas in the table provided below. If key information for effective programming is not available, specify this in the table ("N/A") and explain in Section 1.2 how this was dealt with within the context of the request, including plans, if any, to address such gaps.

Applicant response in table below.

Key area	Applicable reference document(s)	Relevant section(s) & pages nb.	N/A
Resilient and Sustainable Systems for Health (RSSH)			
Health system overview	National Strategic Health Development Plan (NHSDP 2010 – 2015) (Ref 5)	Throughout document	☐
Health system strategy	National Health Act 2014 (Ref 33)	Throughout document	☐
Human rights and gender considerations (cross-cutting)	North East Health Sector Response Plan 2016 (Ref 14)	Page 10 Pages 19 - 21	☐
	Nigeria Humanitarian Needs Overview, 2016 (Ref 36)	Page 3	
Disease-specific			
Epidemiological profile (including interventions for key and vulnerable populations, as relevant)	National Malaria Strategic Plan 2014 – 2020 (Ref 11) Nigeria Malaria Indicator Survey 2010 (Ref 12) Nigeria Malaria Indicator Survey 2015 (Ref 2) World Malaria Report, 2016 (Ref 1) Rapid Impact Assessment (Ref 35)	Throughout document	☐
Disease strategy (including interventions for key and vulnerable populations, as relevant)	National Malaria Strategic Plan 2014 – 2020 (Ref 11)	Throughout document	☐

Operational plan, including budgetary framework	Saving one Million Lives (SOML) (Annex 5) PHC Revitalization (Annex 6)	Throughout document	☐
Program reviews and/or evaluations	Malaria Programme Review (MPR) 2012 (Ref 10) Technical Report of Drug Efficacy Studies 2009/2010 (Ref 34)	Throughout document	☐
Human rights and gender considerations (disease-specific)	Global Evidence on Inequities in Rural Health Protection: New data on Rural Deficits in health coverage for 174 Countries (Ref 6) Nigeria Demographic and Health Survey, 2013 (Ref 3)	Page 25; Page 96	☐
Health system overview	National Strategic Health Development Plan (NHSDP 2010 – 2015) (Ref 5)	Throughout document	☐
Health system strategy	National Health Act 2014 (Ref 33)	Throughout document	☐
Human rights and gender considerations (cross-cutting)	North East Health Sector Response Plan 2016 (Ref 14)	Pages 19 - 21	☐
Add rows as relevant, for any additional key area as relevant to the funding request			

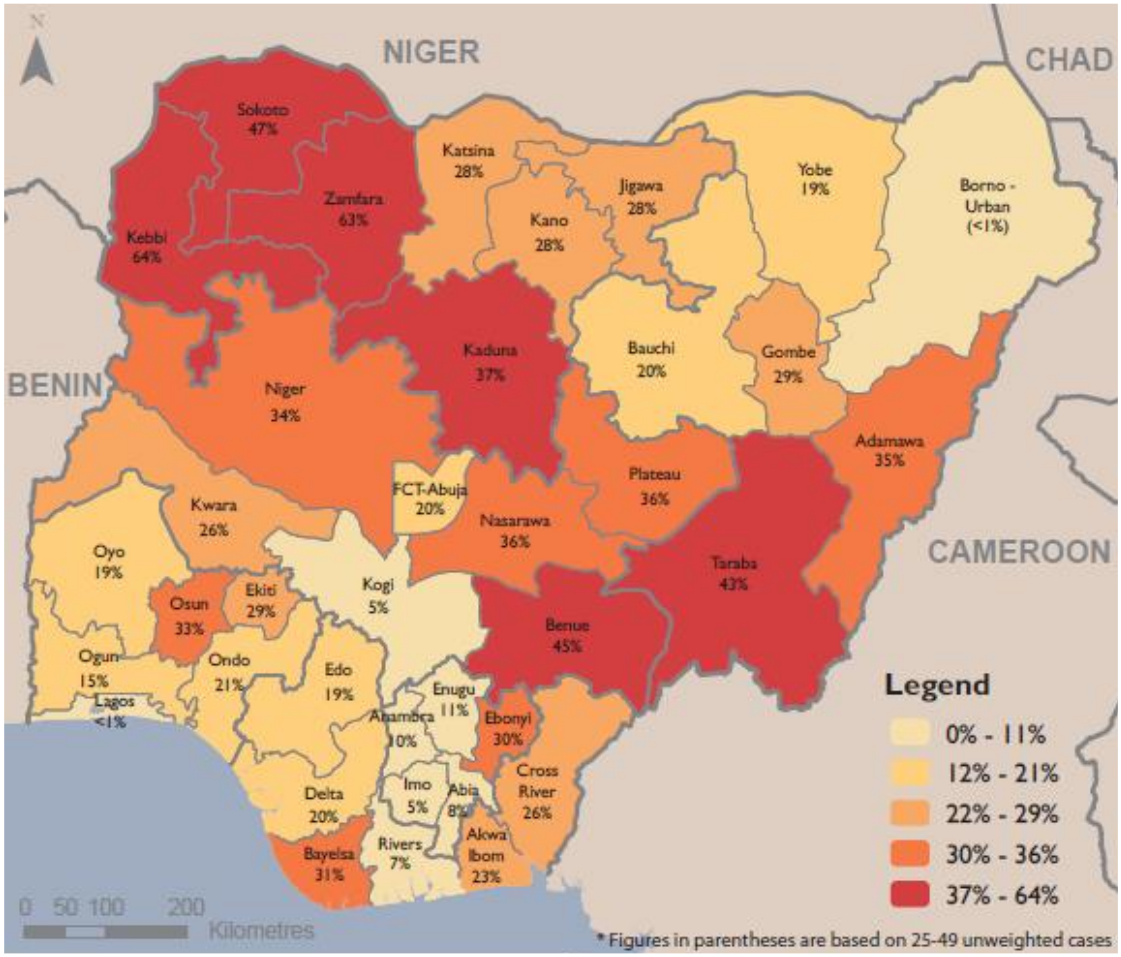
1.2 Summary of country context

To complement the reference documents listed in Section 1.1 above, provide a summary of the critical elements within the context that informed the development of the funding request. The brief description of the context should cover disease-specific and RSSH components, as appropriate, as well as human rights and gender-related considerations.

(maximum 2 pages per component)

1.2.1 Malaria burden, epidemiological trends and parasite species.

Nigeria is the most populous country in Africa with an estimated population of 199,220,487 in 2017 (projected from the 2006 Census). In 2016, the World Malaria Report estimated that Nigeria contributed 29% of the 212 million malaria cases and 26% of the 429,000 malaria deaths reported globally. Over the 2014-2015 period, Malaria accounted for 21% of general outpatient attendance and 32% of pediatric outpatient attendance in secondary health facilities across the country (RIA 2015; p7). The disease overburdens the already-weakened health system with nearly 60 million malaria cases each year (WMR 2016; pp 44 & 70). Nonetheless, there has been a reduction in the prevalence of malaria from 42% in 2010 (NMIS 2010; p63) to 27.4% in 2015 (NMIS 2015; p100). Variation in malaria prevalence between the states from the 2015 Malaria Indicator Survey is shown in Figure 1.1.



Source: NMIS 2015

Fig.1.1 Map of Nigeria showing malaria prevalence by state

The differences in malaria epidemiology across the country are also reflected by the variation in transmission; from stable and uniform throughout the year in the South, to highly intense and seasonal in the North. The most prevalent species (>95%) of malaria parasite in Nigeria is *Plasmodium falciparum* (NMSP; pp 28 – 32).

Based on the current malaria epidemiology and burden described above, malaria control is a priority in all the 37 States in the country. The US Presidential Malaria Initiative (PMI) is supporting 11 States. This request seeks funding for programme implementation in 13 priority states for the period 2018-2021.Funding by GoN from the Eurobond will cover 13 other states. The proposed 13 states to be covered under the global fund grant were selected based on epidemiological, operational, social, political and economic considerations [***Annex 1: Selection of States for GF Grant***]. Figure 1.2 also displays a mapping of the funding support across the states in Nigeria for 2018-2020.

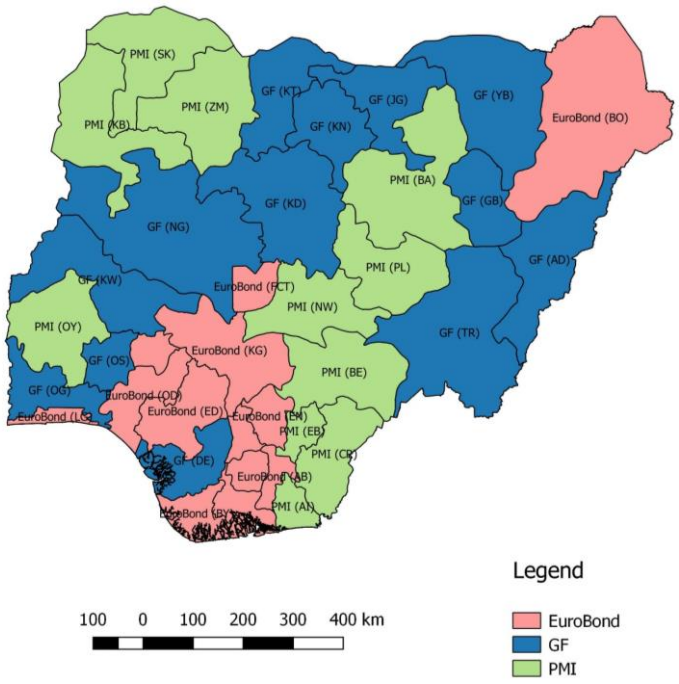


Fig. 1.2 Map of Nigeria showing 2018-2020 funding landscape

1.2.2 Vulnerable populations; human rights and gender-related barriers.

Although the entire population of Nigeria is at risk of malaria, children under five years, pregnant women and internally displaced persons (IDPs) in the northeastern part of the country are more susceptible with high morbidity and mortality.

Pregnant women and children under-five, who constitute a quarter of the population, are biologically susceptible to rapid progression of the disease and are disproportionately affected if malaria prevention and treatment services are inadequate. Up to 69%-75% of the population pay out of pocket for healthcare, which further worsens the high poverty rates among these vulnerable groups (NSHDP 2010–2015; p36; WHO Global Health Expenditure, 2014). For these reasons, there is increased focus in ensuring availability of malaria prevention (LLINs) and treatment (RDTs and ACTs) interventions targeting the vulnerable groups, by ensuring availability of free commodities at public health facilities and through community health structures, and providing subsidized services in the private sector where up to 66.2% of the population seek care (MIS 2015; p.57).

A recent assessment of the health system in Borno, Yobe, Adamawa and Gombe States (in North Eastern Nigeria) revealed that an estimated 7 million persons (46% of the total population of the four states) need health assistance (Nigeria Humanitarian Needs Overview, 2016; p3). Furthermore, the structures and equipment of nearly 800 health facilities, including 21 hospitals were damaged. Of these, 45% were completely destroyed (North East Health Sector Response Plan 2016; p21). In addition, other public infrastructure (roads, water system, electricity, etc.) have been largely damaged resulting in limited access

to social and health services. Malnutrition is also rife in these areas contributing to the cruel combination of poverty and disease (North East Heath Sector Response Plan 2016; p10). This request includes a specific allocation of, funds to procure LLINs, ACTs and RDTs for malaria control interventions for IDPs in response to the *North East Health Sector Response call* of the Federal Ministry of Health and partners; and to complement other planned interventions for these vulnerable populations.

In Nigeria, there is also a rural-urban divide in health indices; vulnerable groups in the rural population often fare worse than in the urban population. This is attributable to inequity in access to functional health facilities, skilled health personnel, and geographical barriers due to difficult terrains (Global Evidence on Inequities in Rural Health Protection: New data on Rural Deficits in health coverage for 174 Countries, 2015; p25). The 2015 Malaria Indicator Survey found that malaria and severe anaemia were twice more prevalent in rural children than their urban counterparts (NMIS, 2015; p96 & 99). Also, the NDHS 2013 showed that although national U5 mortality is 128 per 1000 live births in Nigeria, U5 mortality was higher among children living in rural areas (167 per 1,000 live births) compared to their counterparts in urban areas (100 per1,000 live births) (NDHS 2013; p117 & 120). Women living in rural areas reporting no access to Antenatal Care(ANC) were four fold higher (47%) than the women living in urban areas similarly reporting no access to ANC (11%) (NDHS, 2013; p128). Urban women were also more likely to have received 3 or more doses of IPTp during their last birth (24%) compared to rural women (16%) (NMIS, 2015; p89). This further justifies the importance of prioritizing vulnerable groups and addressing gender-related or socio-economic barriers to achieving universal coverage in malaria control interventions.

1.2.3 Brief Description of Health System including Community Level

The Nigerian Constitution provides the administrative context for the organization of health services. It places health on the Concurrent Legislative List (Section 17(a) of the Part II of the Second Schedule of the Nigerian Constitution, 1999) (National Health Act, 2014). The public health care system in Nigeria is in three tiers, each of which is affiliated with the administrative levels of government (NHP 2016; pp 7-9 and NSHDP 2010–2015; pp17-23).

In line with the National Health Act 2014, the Federal Government formulates health policies through the Federal Ministry of Health, and is responsible for tertiary health and specialized services through Teaching Hospitals, Federal Medical Centres, Specialist Hospitals and Medical Research Institutes (NHA 2014; p13). The State Governments provide secondary health care through the state General Hospitals, while the Local Governments Areas (LGAs) are generally responsible for primary health care services. Both States and LGAs receive resources from the federation account, a percentage of which is expected to be dedicated to health. The private health sector in Nigeria is vast and can be categorized as formal (hospitals, clinics and pharmacies) and informal (, proprietary patent medicine vendors(PPMV), etc.). The private sector operates under licenses and registrations issued by the Federal and State Ministries of Health as well as other agencies of government. NGOs and local communities provide complementary, and sometimes, holistic services at all levels of health care.

Federal and State Ministries of Health have agencies under their jurisdiction such as the National Primary Health Care Development Agency (NPHCDA), National Agency for Food, Drug Administration and Control (NAFDAC), and State Health Management Boards responsible for a range of health service related functions. In the same regard, the Local Government Areas (LGAs) have the Ward Health Committees, Village Health Committees, Private Health Care Providers, and Traditional and Alternative Health Care Providers that enhance service delivery and community mobilization. Table 1.1 provides a summary break down of the 34,173 functional health facilities in Nigeria through which malaria services are provided.

Table1.1: Health Facilities in Nigeria by Type and Ownership, 2012

Type	Ownership		Total
	Public	Private	
Primary	21,808	8,290	30,098
Secondary	969	3,023	3,992
Tertiary	73	10	83
Total	22,850	11,323	34,173

Source: Department of Planning, Research and Statistics, FMoH, 2011

1.2.4 Nigeria's response to Malaria

Major strides have been achieved in the recent past in the implementation of life-saving malaria control interventions in Nigeria. For example, between 2009 and 2016, an estimated 100 million Long Lasting Insecticidal Nets (LLINs) (Annex 10) have been distributed nationwide towards achieving universal coverage. Quality assured Artemisinin-based Combination Therapies (ACTs) are increasingly more available in public and private health facilities as well as at community level.

Access to malaria diagnosis has improved significantly since the introduction of malaria RDTs and as well as strengthened Quality Assurance for malaria microscopy. The proportion of fever cases tested by RDT among under-five children, increased from 3.3% in 2011 to 21.2% in 2012, reaching an impressive 75.5% in 2013 (Analysis of HMIS/DHISv2). Of the 7,584,700 RDTs distributed and utilized over this period, 3.2% was consumed in 2011, 24.8% in 2012 and 72.0% in 2013 (Logistics Data). Coverage of Intermittent Preventive Treatment of malaria in pregnancy (IPTp) with 2 or more doses of *sulphadoxine-pyrimethamine* (SPs) increased from 5% in 2008 to 37% ~~47~~% in 2015 (NMIS 2015, p91). Newer approaches have been used to channel focused interventions through the health system inclusive of the community level thus increasing access to malaria commodities and services for all. These efforts have resulted in a 36% reduction in malaria prevalence among under-five children from 42% in 2010 to 27% in 2015 (NMIS 2015, pp 98 – 103).

1.3 Past implementation and lessons-learned from Global Fund and other donor investments

a) List recent disease-specific Global Fund grants from the 2014-16 allocation period and summarize key lessons learned from their implementation.

b) Include lessons-learned from specific HSS grants or any HSS investments embedded in the disease-specific grant(s) from the 2014-16 allocation period as applicable.

c) Outline lessons learned from investments by other donors as applicable.

For each of the above, explain how these lessons learned are taken into account in this funding request.

(maximum 1 page per component)

Between 1st February 2015 and 31st December 2016, Nigeria implemented a US$400,253,346 Malaria grant under the New Funding Model of the Global Fund (code-named – NGA-M-NMEP-636, NGA-M-SFH-637: Contributing to Rapid and Sustained Scale-up of Malaria Control Interventions for Impact in Nigeria). The NMEP grant was recently submitted for non-costed extension until December 31, 2017, as well as the new malaria grant NGA-M-CRS (both grants pending for Board Approval), to cover the essential services under the third year of implementation period.

The following components were funded in these grants: LLINs distributed through mass campaigns and routine systems, parasitological diagnosis and treatment of malaria at facility and community in both public and private sectors, IPTp, strengthening Procurement and Supply Chain Management (PSM), Private Sector Co-payment Mechanism (PSCM) for ACTs, Surveillance, Monitoring and Evaluation, and Social and Behavioral Change Communication (SBCC). Some of the keys lessons-learned across the intervention areas are summarized in Table 1.2 below, and have been taken into consideration in planned implementation of activities in this new grant:

Table 1.2: Key Lessons learnt in implementation of the 2014-2016 Allocation period

***INTERVENTION* AREA**	**LESONS-LEARNED IN GLOBAL FUND GRANTS IMPLEMENTATION**
Vector Control (LLINS)	▪ *Some of the planned mass campaigns were delayed due to late arrival of LLINs*. In this new grant, early commencement of procurement processes, improved communication and timely delivery of LLINs will ensure that mass campaigns are implemented on schedule (NMEP Campaign report 2015; p54).
Case Management (Facility-Public)	▪ *The fragmented & partial coverage of facilities for case management interventions prevented consolidated approach to service delivery at sub-national level*. Therefore, state wide coverage for a full suite of case management interventions in the public sector is proposed in this application.
Case Management	▪ *Weak implementation arrangements prevented the commencement and smooth implementation of iCCM*. We have learnt that inclusive

(ICCM)	planning, coordination, and firm implementation arrangements are critical for a successful iCCM program.
Case Management (Facility-Private)	▪ *Proper diagnosis and treatment of malaria in private sector was limited in range and scope*. Therefore, scaling up supportive interventions through Outreach Training and Supportive Supervision (OTSS and commodities) in the private sector improves access to quality malaria case management (SFH 2016 Annual Report; p10 & 11). Increased availability of RDTs and ACTs along with OTSS will reduce the gap in testing and adherence to test results where most people seek treatment for fever (SFH 2016 Annual Report; p8).
Case Management (CO-PAYMENT)	▪ T*he Co-payment mechanism forced down the price of* ACTs in the private sector and therefore increased access to quality assured ACTs nationwide. Thus, continued subsidy of quality assured ACTs will increase access to effective treatment for malaria.
Procurement & Supply Chain Management	▪ *Bureaucracy in engagement of third party logistic companies (3PLs) delayed availability of commodities at health facilities*. Early engagement of 3PLs will reduce effect of the bureaucratic process and ensure timely availability of commodities at service delivery points. ▪ Quantification assumptions used in NFM were based on morbidity data in the absence of representative consumption data and led to inaccurate estimation in the stock of health products for use in the facilities. The decision to implement across the entire state is expected coupled with plans to incorporate consumption data (where available) are expected to improve the accuracy of quantification estimates at all levels. Activities will include strengthening Logistics Management Information system through the National Supply Chain Integration Project (NSCIP) and Logistics Management Coordination Units (LMCUs).
Advocacy, Communication & Social Mobilization	▪ *There was a lack of coordination across partners on malaria messages, leading to fragmented and inconsistent messages.* Therefore, focusing on strengthening coordination at all levels will ensure the development of harmonized centerpiece messages which will result in a uniform, consistent strategy ▪ *Social mobilization messaging was poorly targeted, not yielding the desired behavior change.* Thus, attention will be put on ensuring a targeted Social and Behavioral Change Communication (SBCC) so as to achieve improved utilization of malaria interventions *(*HSCL & SFH 2016*; p28 - 35).*
Surveillance, Monitoring and Evaluation /Operations Research	▪ There was increased reporting from PHC facilities (timeliness and rate of reporting improved from 26% in 2013 to 52% in 2015 (NMEP 2015 Annual Report; p38), *however, the quality of reported data from these facilities did not significantly improve.* The LGA data validation meetings which contributed to the improved reporting will be maintained with more attention to quality and complemented with strengthened Data Quality Audits (DQAs) as measures to improve further reporting and data quality. ▪ *There was limited analysis and use of data at all levels for decision-making*. Regular data analysis and improved feedback at national level increased data use. At subnational level, more frequent data

	analysis and feedback would enhance data use (NMEP DQA report 2016; p22). ▪ *Previously, there were parallel reporting channels from facilities, which overburdened an already stretched health system.* Reporting through the national instance (DHIS) using the harmonized system (HMIS) was observed to improve data availability for decision-making in a sustainable manner. The new grant will continue to entrench this approach.
Program Management and Finance	▪ *The design of the NFM limited the distribution of commodities to selected health facilities in LGAs, coupled with imprecise quantification estimates lead to low absorption*. Therefore, Implementation of activities will be scaled up to all facilities in the states. ▪ *Using several Sub-Recipients led to high program management and oversight cost*. Thus using fewer SRs in the new grant will allow for greater efficiency, value for money and free up additional resources for service provision.

Other partners, primarily USAID/PMI and DFID supported SUNMAP project; have implemented malaria interventions in Nigeria too. Lessons learnt from implementing these projects were similar to those learnt from NFM implementation. Specific lessons learnt are summarized in Table 1.3 below:

Table 1.3: Lessons learnt from implementation of other donor-supported projects

INTERVENTION AREA	LESSONS-LEARNED FROM OTHER DONOR INVESTMENT
Prevention (IPTp)	▪ *There were variations in ANC attendance across the country, which impacted on uptake of IPTp*. The areas with low ANC attendance benefitted from addition of community outreach with HCWs thus increasing the uptake of IPTp2.
Prevention (SMC)	▪ SMC being a new intervention, there were concerns regarding acceptability and feasibility of implementing it within the Nigeria context. *Use of community structures to implement SMC has been found to be effective*.
Case Management (Facility-Public)	▪ *Use of off-site training alone did not adequately address service flow and system challenges, which sometimes contributed to service quality challenges*. Targeted facility based training was better at addressing the service flow.
Case Management (Facility-Private)	▪ *Traditional training approaches appropriate to public sector were not necessarily applicable to private setting in terms of the content and duration*. Therefore, adapting the approach and curricula to suit to needs of private providers maximizes the training experience and optimizes results in the private sector. ▪ *Periodic ACT price availability studies provided assessment of ACTs coverage.* Similar studies in future will address information needs for decisions around price subsidy and understanding contribution of government and out-of-pocket spending for malaria (ACTWatch Outlet Survey Results, 2015; p46)
Social	▪ *There was low involvement and reporting of malaria programs in the*

Mobilization, Behavioral Change Communication	*media.* Training of journalists/health editors and targeted advocacy to media houses improved involvement of the media and increased reporting for malaria. This enhanced engagement led to discounted rates for airing of malaria messages.

SECTION 2: FUNDING REQUEST (Within Allocation)

This section should describe and provide a rationale for the program elements proposed for this funding request. Attach and refer to completed **Programmatic Gap Table(s), Funding Landscape Table(s), Performance Framework and Budget**, and refer to national strategy documents as applicable.

To respond, refer to additional guidance provided in the *Instructions.*

Ensure that the funding request as described in questions 2.1 and/or 2.2 meets the focus of application requirement as outlined in section 2.3.

2.1 Disease-specific funding request

Not applicable if the application is a standalone RSSH request.

Given the context and lessons learned outlined in Section 1,

a) Describe the disease-specific funding request(s), the rationale for prioritizing modules and interventions, and how these choices ensure the highest possible impact with a view to ending the three diseases and removing human rights and gender-related barriers to accessing services.

   For any priority modules for which gaps are difficult to quantify in the programmatic gap tables, explain here the barriers being addressed, the proposed interventions and the population or groups involved.

b) Explain how the funding request addresses the key funding gaps reflected in the Funding Landscape Table(s) for the disease program(s) in the current allocation cycle, and specify other actions planned to cover remaining gaps.

For funding requests including both HIV and TB components:

c) Describe the coordination of joint TB and HIV strategies, policies and interventions at different levels of the health system, including community systems, and expected impact and efficiencies from the joint programming.

Ensure the answer appropriately reflects the separate disease programs in addition to cross cutting modules where appropriate.

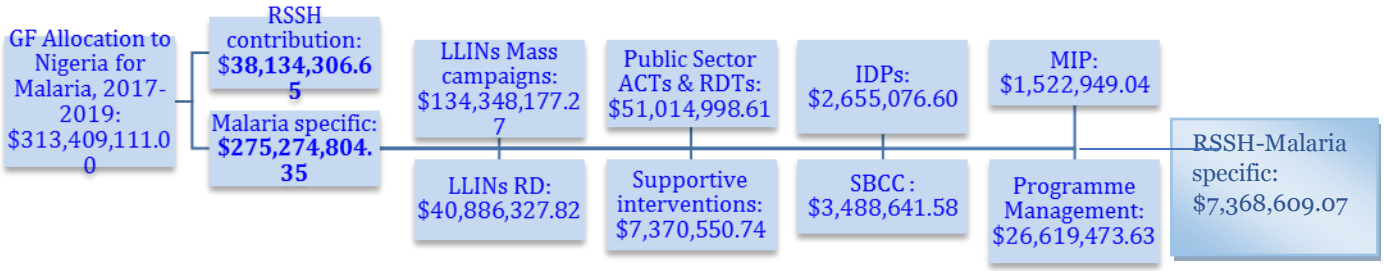
(maximum 4 pages per component)

The funding request has taken cognizance of the accompanying **Programmatic Gap Table, Funding Landscape Table, Performance Framework and Budget**, and the **National Malaria Strategic Plan 2014-2020,** as applicable. Also, the country has prioritized selected interventions to be implemented in 13 focus states, after excluding states to be supported by USAID/PMI and the Government of Nigeria (GoN). The implication is that the whole country stands to be covered for most interventions. For geographical scope, given the peculiar context described in Section 1, graded criteria based on epidemiological, operational, social, political and economic considerations were utilized to select the states [***Annex 1: Selection of States for GF Grant***]. The thirteen states are: Kano, Kaduna, Katsina, Adamawa, Jigawa, Niger, Taraba, Kwara, Osun, Delta, Gombe, Yobe and Ogun, which account for 38% of the total population of Nigeria and 42% of the malaria burden (NMIS 2015, p100). Eight of these states (Kano, Kaduna, Katsina, Jigawa, Niger, Kwara, Osun and Ogun) were supported in

the NFM grant. In this grant, statewide coverage of services will be provided to all functional facilities, as a key lesson learnt from the patchy implementation of the NFM grant. The selected interventions and activities funded have been prioritized based on their proven high impact, global and local historical antecedents that have accounted for a 35% decrease in malaria prevalence from 42% in 2010 to 27% in 2015 (NMIS 2015, p101), and the limited resources available in this grant.

To further reduce mortality, the priority is on full coverage of **malaria case management** in the public sector in all 13 states which will include: procurement of ACTs, RDTs and Injectable Artesunate for proper management of malaria; supportive interventions such as outreach training and supportive supervision (OTSS) of health workers in both the public and private sectors. The second priority will be **universal coverage with LLINs** through mass campaigns in all the 7 states due for replacement in 2018 and LLINs for routine distribution in all 13 states through ANC and EPI over the 3-year implementation period. The country is expected to meet the full need of SP for IPTp from domestic resources, however, funding for OTSS for MIP will be implemented in all 13 states under this grant. Other areas included for funding include enhanced **SBCC activities** to promote adoption of appropriate practices for malaria control, in addition to overarching **Programme Management and SM&E**. The full range of health systems strengthening activities such as PSM and HMIS improvements are prioritized under the **RSSH component** and its related modules. Funding for malaria has been allocated as summarized in Figures 2.1 and 2.2 below:

Fig 2.1: Allocation of malaria funding to interventions



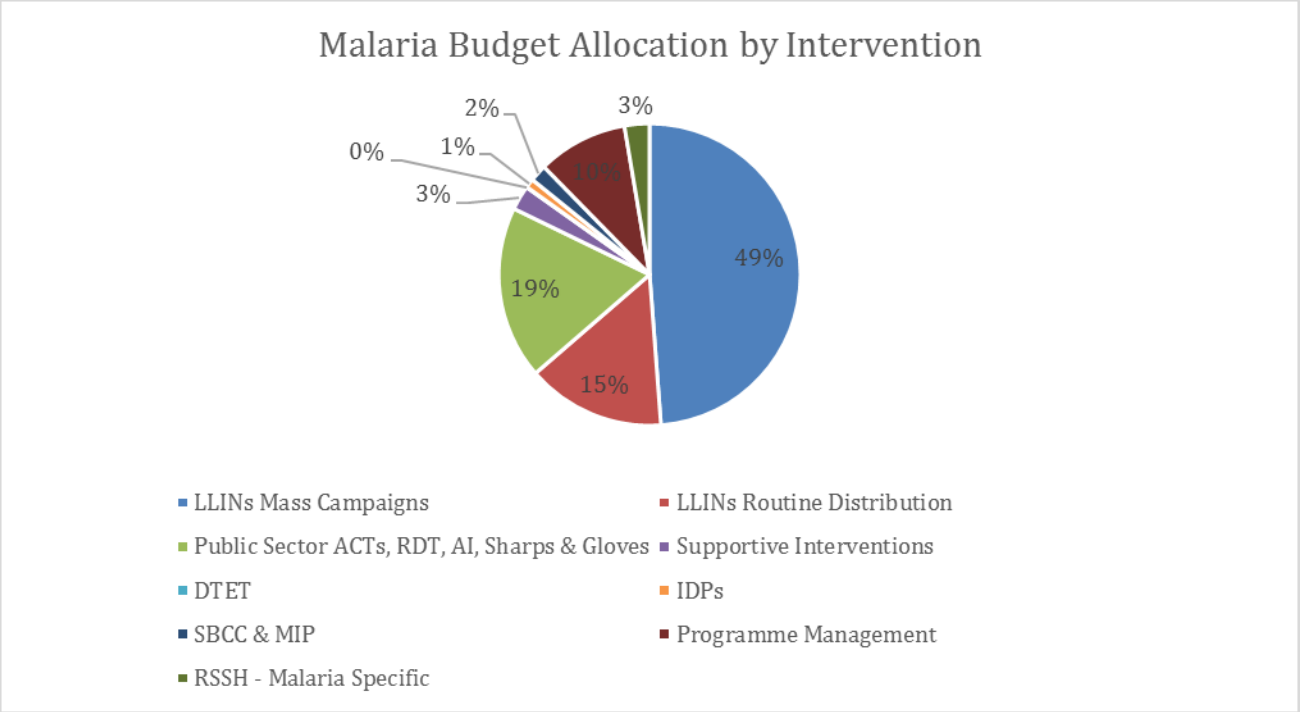


Fig 2.2: Proportional allocation of funds within malaria interventions

A. VECTOR CONTROL

LLINs - Mass Campaigns: Nigeria uses the rolling mass campaigns approach. During the period of this grant (2018-2020), thirty-six states plus FCT with a total population of 196,591,427 will be due for replacement campaigns, requiring 120,139,205 LLINs (refer to Nigeria Malaria Programmatic Gap Analysis: LLIN Mapping 2017-2022). PMI has committed to provide 34,726,130 LLINs for 11 of the states leaving a gap of 85,413,075 LLINs for 26 States. The GON will mobilize domestic resources along with other donors and Eurobond to provide 37,180,644 LLINs for 13 states, leaving a gap of 48,232,432 LLINs for mass campaigns in the 13 states targeted with GF resources. Based on availability of funds, this application has prioritized LLIN campaigns in the 7 states due in 2018 (31,612,883 LLINS to cover a population of 51,730,172 persons). This leaves a gap of 6 states due for replacement campaigns in 2020 (16,619,549 LLINs), which are prioritized, in the above allocation request (PAAR). Under this grant US **$134,348,177.27** is requested to cover the cost of procuring the LLINs and operational costs of distributing the requested 31,612,883 LLINs for the prioritized 7 states in 2018. The costs for warehousing and in-country distribution of the LLINs and other commodities are budgeted under the mandatory deductions from the grant.

Previous investments in mass distribution of LLINs resulted in accelerated progress towards universal coverage. In particular, the previous GF grant support to LLIN campaigns contributed to improved national average of LLIN ownership from 42% to 69% (NMIS 2010 & 2015, p58). The investment from this grant request will increase the LLIN ownership, access and use in the targeted states, uplift National LLINs coverage levels and contribute to the overall reduction in the disease burden.

LLINs – Continuous Distribution: The country requires 34,324,680 LLINs for routine distribution in 37 states. PMI will provide 9,411,156 LLINs for 11 states where it will be operating. The GON will provide 11,926,849 LLINs to cover 13 other states. This leaves a gap in the 13 states allocated to GF requiring 12,986,675 LLINs. DFID will provide 1,246,009 LLINs to fill part of the gap in 6 states among the 13 GF states. The country requests US **$40, 886, 327.82** to procure a total of **11,740,666** LLINs in addition to LLINs provided by DFID to meet the full need for nets through routine channels (ANC and EPI) for 2018 and

2019, and 2020. ANC and EPI distribution channels have been prioritized to ensure the most vulnerable groups are targeted and reached, thereby reducing the malaria related morbidity and mortality among pregnant women and children U5.

B. Case management:

Facility-Based Treatment: The 13 states require 47,380,203 ACTs, 36,089,597 RDTs and 1,038,822 Injectable Artesunate to meet 100% of public sector needs for uncomplicated and severe malaria respectively in public facilities over the 3 year implementation period (see Programmatic Gap Tables for details). DFID will procure 2,695,415 ACTs, 5,764,255 RDTs and 138,355 Injectable Artesunate to cover part of this need. This application has prioritized the procurement of **44,684,789 ACTs**, **30,325,342 RDTs** and **900,467** Injectable Artesunate (treatments). US **$51,014,998.61** is requested to meet these needs. Additionally, US **$6,125,554.42** is requested for supportive interventions such as OTSS in the public sector to ensure that health workers adhere to national guidelines on proper diagnosis and treatment of malaria.

OTSS aims to improve the quality of malaria case management at facilities and will include addressing the challenges of health workers who have been trained and training health workers who have not received any previous training. The supportive supervisory team will comprise of relevant health personnel from the government and other technical experts cutting across the areas of diagnosis, treatment etc. The team will identify facilities, categories of personnel, higher level issues to be addressed, monitor quality of services eg RDT and microscopy, commodities and tools. Defined and approved curriculum and job aids will be utilized for this purpose eg for external quality assurance (EQA). Clinical meetings with health workers in targeted health facilities and sensitization of health professionals through professional associations eg Medical and Dental Council of Nigeria (MDCN) and regulatory bodies e.g Pharmaceutical Council of Nigeria (PCN) will be conducted. In the private sector training of health workers will be conducted through the professional associations and regulatory bodies.

Diagnosis: To reduce presumptive treatment of malaria, which is currently widespread, the country plans to strengthen parasite-based diagnosis in both public and private sectors. We plan to strengthen laboratory and clinical capacity through expansion of outreach training and supportive supervision (OTSS) to health facilities. In the health facilities, we will work to improve the accuracy of diagnosis through expanded quality assurance/quality control activities and training of microscopists.

In states and LGAs where RDT use is already high in health facilities, we plan to renew focus on maintaining an appropriate level of microscopy capacity (at secondary and tertiary health facilities). High quality malaria microscopy is essential for severe malaria case management, management of other disease conditions and as a technique for evaluating drug resistance.

***Treatment*:** To improve compliance of health workers to the national treatment guidelines (treatment of only malaria positive cases with ACT), health workers and clients need to demand testing before treatment and believe the results. This will be achieved through provision of both RDTs and ACTs and strengthening the component of health worker supervision through OTSS.

Funding in the 2014-2016 allocation similarly prioritised provision of ACTs and RDTs, contributing to the reduction in the malaria prevalence; an increase in facility-based testing rate for fever from 50% in 2015 to 82% in 2016 in public facilities (Analysis from HMIS/DHISv2), although with limited increase in testing of fevers in the private sector. Though the testing rates have improved, the health facility test positivity rate still remains high at 72% in 2016 (Analysis from HMIS/DHISv2). However, among health facilities

participating in an EQA exercise in 11 states, an increase in the detection agreement rate from 5% in 2012 to 80% in 2015 was observed. There was also a reduction in the false positivity rate from 70% in 2012 to 0.9% in 2015 (MAPS EQA Lessons; p4). Continued prioritization of the activities outlined above will contribute to a further reduction in morbidity and mortality due to malaria.

Therapeutic Efficacy Study (TES): There are 14 sites used to conduct TES across the country to ascertain the efficacy of the first line medicines – AL and ASAQ. With technical assistance from WHO and funding from PMI and the Global Fund, NMEP conducts TES in at least 7 sites every two years across the country; representing the different eco-epidemiological zones. In the 2010 study, Adequate Clinical and Parasitological Response (ACPR) of 99.1% and 96.9% for ASAQ and AL respectively was observed (Technical Report of Drug Efficacy Study 2009/2010, p29) and subsequent ones will provide evidence for continued use or otherwise of ACT. The planning for the implementation of TES in 2017 has commenced and will be conducted in 7 sites with already committed funds from PMI and GF. For the 2019 TES, we request US **$150,000** for DTET to be conducted in 3 sites in 2019 to complement the four sites to be supported by PMI. The results from the TES will guide the malaria treatment policy in the country.

Vulnerable populations, Human Rights And Gender-Related Interventions: US **$2,655,076.60** is requested to contribute to the health sector response to internally displaced persons (IDPs) in 5 states in the North East zone. Due to on-going insecurity from conflict with Boko Haram, where about 7 million people in 5 states in the North East (Adamawa, Borno, Bauchi, Gombe, Yobe) are in need, of which 2.2 million are IDPs, 1.8 million are within host communities and 3 million are inaccessible (North Eastern Health Sector Response, p13 - 20). However, while recognizing the barriers to accurately estimating the needs in these fluid populations, this grant will procure and contribute 1,000,000 ACTs, 1,000,000 RDTs and 500,000 LLINs to the emergency response efforts under the North-Eastern Health Sector Response in this region, to meet the peculiar need/s of IDPs in the North-East zone (North East Health Sector report 2016, p20). The Boko Haram armed conflict has created a human rights situation, resulting from a break down in the delivery of health services through routine systems. It has worsened the vulnerability of the already vulnerable population (pregnant women and children U5) in this region, therefore warranting special attention.

Implementation based on state wide coverage will ensure that all functional health facilities in the rural, urban and hard to reach areas will be targeted for support. Specific interventions like MIP and routine LLIN distribution through ANC and EPI will focus on the vulnerable population. SBCC activities at the community level targeting heads of households and caregivers will improve male involvement and address gender issues at household and community levels.

Private Sector Case Management: We request the sum of **$ 1,094,996.32** for supportive intervention such as OTSS to strengthen malaria diagnosis, treatment reporting and overall adherence to the national policies in 100% of the private health sector (hospitals, clinics, pharmacies, and retail medicine/drug vendors) in the 13 selected states, where a significant proportion (66%) of the country population seek care (NMIS 2015 p52). In addition, the need to sustain the gains of the Private Sector Co-Payment Scheme (PSCM), which will cover at least 50% of the entire private sector demand for ACTs, has been prioritized in the above allocation request (PAAR).

Diagnosis: To reduce presumptive treatment of malaria, which is currently widespread, the country plans to strengthen parasite-based diagnosis in private sectors. We plan to work to strengthen capacity to diagnose with RDT through expansion of outreach training and supportive supervision (OTSS) to health facilities.

***Treatment*:** To improve compliance of health workers to the national treatment guidelines (treatment of only malaria positive cases with ACT), health workers and clients need to demand testing before treatment and believe the results. This will be achieved through strengthening the component of health worker supervision through OTSS.

Funding in the 2014-2016 allocation had also prioritised interventions to improve accurate malaria diagnosis and appropriate treatment in private health facilities and this had contributed to the reduction in malaria prevalence. Support to targeted facilities in the private sector on the NFM showed an increase in testing rate for fever from 81% in health facilities and 68% in the community in 2015, to 84% and 77% respectively in 2016. A positivity rate of 68% was also observed in both in 2016 (SFH 2016 Annual Report of GFM Grant, p8). This is however masked by the fact that overall, testing rates in the private sector are still very low (testing rate of 11% in 2013 and 12% in 2015) (ACTwatch 2015 p28). Training/supportive supervision, disposal of sharps and consumer demand for testing are key barriers to the availability and use through the private sector channels. Continued prioritization of the activities outlined above will contribute to a further reduction in morbidity and mortality due to malaria.

C. Specific Prevention Interventions

Intermittent Preventive Therapy–in Pregnancy: No request is made for procurement of SP for IPTp under this application, as the GON will fully meet the country's need for SP for the 3 year period**.** However, we request US **$1,522,949.04** for strengthening of MIP services in 100% of health facilities in the 13 states. These activities include improving the capacity of ANC health workers to deliver improved MIP services through training and supervision; intensifying the delivery of IPTp services through Focused Antenatal Care (FANC) by facilitating stronger collaboration with Reproductive Health, pharmaceutical and related ancillary services, to improve its implementation as directly observed therapy (DOT).

While there has been a 185% increase in IPT2 uptake from 13% in 2010 to 37% in 2015 (NMIS 2010, 2015; page 88) however, this is still significantly below the 2016 national target of 75%. IPTp3 uptake in 2015 remained low at 19% (NMIS 2015, page 88). Investment in MIP shall result in a progressive increase in uptake of 3 or more doses of IPTp in line with the national guideline, to meet the national target of 100% by 2020 and reduce further the malaria related morbidity and mortality among pregnant women.

D. Social and Behavioural Change Communication (SBCC)

SBCC supports all the intervention areas, and thus is cross cutting. We thus request **$3,488,641.58** to fund SBCC activities to support and effect positive behavior change among community members, health providers and policy makers towards successful adoption and use of malaria prevention, diagnosis and treatment services, provision of high quality malaria services at point of care and increased commitment to the implementation of malaria control interventions. Activities to be implemented include: community mobilization on malaria and sensitization meetings for opinion leaders at the community and village levels. The main strategy for achieving this will be Interpersonal Communication. These SBCC activities will be deployed to support the following areas; Vector Control (specifically use of LLINs provided through Mass Campaigns and routine distribution); appropriate Malaria Case Management among health workers (in both Public and Private Sectors) and specific Preventive Interventions (IPTp). The implementation of these activities will be contextualized to meet specific objectives and specific target groups. This will be state specific and stratified based on specific intervention need, target group and the expected impact.

SBCC has contributed to an increase in knowledge, better attitude and increased uptake of malaria interventions. Comparison between results of MIS 2010 & 2015 shows increase in knowledge of causes of malaria from 81.7% in 2010 to 87.8% in 2015; and increase in ITN use from 22.9% in 2010 to 37.3% in 2015. SBCC activities have also contributed to

improving health-seeking behaviour in public facilities among mothers with children under 5 who had fever in the 2 weeks preceding the survey from 26% to 30.4% (NMIS 2010 p40, NMIS 2015 p51). '*Multichannel BCC campaigns as well as other media were effective in contributing to an increase in net culture, hanging and use, particularly by vulnerable groups'* (The impact of behaviour change communication on the use of insecticide treated nets: a secondary analysis of ten post-campaign surveys from Nigeria 2016, Page 15). The effective coordination and implementation of ACSM activities using targeted/result-oriented strategies will enhance the adoption of appropriate behaviors for increased community participation and ownership. SBCC as a crosscutting intervention is key to the successful uptake of malaria interventions. It will help to sustain the gains made so far and further improve the outcomes of Vector Control and Case Management interventions.

E. Health Management Information System and Monitoring & Evaluation

Improving Program and data quality: The sum of US **$1,056,305.63** is requested for strengthening program and data quality. This comprises periodic assessment of programme implementation data and reports generated from facilities to improve data quality and service delivery. Specific activities to be implemented include: (a) strengthening M&E coordination through regular coordination meetings at state and National levels; (b) regular Data Quality Audits (DQA) at all levels of reporting and training of M&E officers to conduct DQA (c) Quarterly DQA by national malaria program to states and LGAs to provide opportunity for advocacy, on-the-job training and mentoring of M&E officers and strengthen logistics support for commodities. Periodic assessment of service data through field supervision or coordination mechanisms will help to ensure good data quality and improve programme implementation. DQA visits by NMEP to states and LGAs improved data quality from 30% in May 2015 to 34% in December 2015 (NMEP Annual report 2015, p43). Availability of quality data and efficient service delivery would ensure improved quality of care provided at health facilities and help track progress in programme implementation.

Enhancing Capacity for Data Analysis, Evaluation, Review and Transparency: The sum of US **$1,833,748.59** is requested for this intervention to improve dissemination, demand and use of data by government and partners for programming through the following activities: (a) Strengthen program evaluation and conduct MPR in 2019; (b) Develop and implement an Operational Research (OR) agenda for the malaria program, targeting questions that impact program implementation; (c) Strengthen malaria surveillance coordination at all levels; and (d) Develop quarterly malaria bulletin and annual report. These are needed to strengthen information management and provide evidence for decision-making. The AQUAMAT study (where Nigeria was one of the sites) provided evidence that informed the change from Quinine to Injectable Artesunate for treatment of severe malaria. A recent study showed the need for community-based delivery of IPTp-SP to improve access particularly in rural populations characterized by poor access to IPTp and low ANC attendance (Determinants and interventions to strengthen Delivery of IPTp through public and private sector providers in Nigeria 2016**,** page 55). Implementation of OR and its broad dissemination would provide documented evidence to guide decision-making and appropriate policy change.

Surveys: US $2,457,619.96 is requested to fund periodic population-based surveys such as the Malaria Indicator Survey (MIS-2019) and Rapid Impact Assessment (RIA-2018) to bridge the data quality gaps from existing weak routine data systems. Also NMEP and partners will conduct the omnibus survey to evaluate the effectiveness of SBCC activities in changing behaviours. Malaria parasite prevalence has dropped from 42% in 2010 to 27% in 2015 (NMIS 2015, page 99). Periodic Surveys as above will provide data to monitor progress towards attaining the country's target of <5% parasite prevalence and universal LLIN coverage (1 LLIN per two persons) by year 2020.

F. Programme Management

Policy, planning, coordination and management of national disease control programs: The sum of US **$4,950,873.07** is requested to fund policy, planning and coordination activities spearheaded by the NMEP in its stewardship role of the national malaria response. Planned activities include: providing oversight and organizing coordination meetings within and across programs as well as with other malaria stakeholders, providing technical assistance (TA) to states for supportive supervision, development of Annual Operational Plan (AOP) together with states and partners that captures all activities; facilitating Programme Reviews (MPR) and development of new NMSP (linked to the new NHSP); staff capacity assessment and development through trainings and mentorship programmes; stakeholder engagements and public/media events; and advocacy for resource mobilization (at national, states, private sector levels). The sum of **US$3,000,000** will be provided to WHO for technical assistance to the National Malaria Programme.

It is critical for the NMEP to continue to exercise its function as the focal coordination organ among partners for a unified malaria response (within the framework and principles of Roll Back Malaria Partnership), as well as ensure quality support to sub-National levels.

Grant Management: The sum of US **$21,407,398.56** is being requested to finance grant management activities, which include: support for engagement of human resources; provision of operational expenses including logistics; purchase and maintenance of office and IT equipment for PRs and SRs; conduct of oversight and supervision of SRs; and internal and external audits. The GF performance rating for one of the PRs over the period of the 2014-2016 grant was sustained at B1. Moving forward, it is imperative to prioritize activities that will ensure a sustained level of high performance in grant administration by prospective PRs.

Resource Mobilization: **$261,202** is requested to support a series of proposed resource mobilization activities by NMEP to increase domestic resources from both public and private sector in Nigeria. NMEP will develop a resource mobilization strategy that will guide these activities and through concerted efforts and engagements with both Federal and state governments, make the case for increased funding for malaria. Similarly, NMEP will conduct a series of private sector engagement activities to increase the support for malaria activities from private sector companies, for instance through Corporate Social Responsibility. In order to expand the reach of malaria services and to sustain the gains made so far, it is imperative that the country increases financing of malaria activities from domestic sources, if we are to achieve the target of malaria elimination in Nigeria.

2.2 RSSH funding request	
The Global Fund strongly encourages funding requests for RSSH investments to be submitted within a ***single*** application, and preferably to be requested in the first submission.	
Does this funding request include an RSSH component?	☐ Yes ☒ No
If yes, describe the request below and how it is strategically targeted. Referring to the national health strategy, gaps and lessons learned outlined in the previous section, describe the funding request for RSSH and how the investment is strategically targeted to strengthen systems for health and achieve greater impact on the diseases. In your explanation, refer to the Funding Landscape Table on 'government health spending', Performance Framework and Budget as appropriate. Note that it is optional to complete a Programmatic Gap Table for RSSH. **(maximum 3 pages)**	

[*Applicant response*]:

If no:

a) Indicate when the RSSH funding request was/will be submitted; and,

b) **If the RSSH funding request has not yet been submitted**, highlight below the elements of the planned RSSH investment that will directly support the disease program in this funding request.

(maximum ½ page)

The Nigeria Country Coordinating Mechanism (CCM) has agreed on a country split of $275,274,804.35, $215,881,287.01 and $92,241,428.34 for Malaria, HIV and TB respectively for this allocation period, with $38,134,306.65 being the allocated contribution from malaria for RSSH. [Annex 2: CCM Program split]. Malaria will contribute $38,134,306.65 (12%) of its allocation to meet 40% of the RSSH needs (program specific and cross-cutting). The funding application budget of $286,358,010.38 is inclusive of the $ 11,083,206.02 for the malaria specific RSSH activities leaving $27,051,100.63 for the cross-cutting component of the RSSH. In addition, $18,400,000 has been costed in this budget as malaria portion to the mandatory contribution dictated by the GF, to cater for services such as warehousing and distribution of health products. The broad areas to be funded through RSSH include: strengthening of the procurement and supply chain management, routine HMIS and community health systems which will be integrated with other disease programs (HIV and TB) geared at strengthening the overall health system. **The RSSH request will be submitted together with the HIV/TB joint proposal in May 2017.**

Funding to RSSH will strengthen the health systems for effective and efficient health care delivery, through a range of integrated HSS-related activities of NSCIP, DHIS national instance, Community systems strengthening for active case detection across ATM, capacity building for task shifting/sharing, School health programs, Maternal and child health services, joint advocacy, OTSS and strengthening laboratory systems for increased access to diagnostic services across disease areas.

To address the peculiarities across disease areas, each disease component will use a portion of its RSSH contribution for specific system strengthening needs.

Malaria specific RSSH activities for which a portion of RSSH resources have been set aside include:

- Improving program and data quality by strengthening M&E coordination through regular coordination meetings at state/National levels; regular DQA at all levels of reporting and training of M&E officers to conduct DQA and quarterly DQA by national malaria program to states and LGAs, and LGA level data validation meetings.
- Enhancing capacity for data analysis, evaluation, review and transparency by strengthening program evaluation and conducting MPR in 2019; developing and implementing an OR agenda for the malaria program; strengthening malaria surveillance coordination at all levels and developing quarterly malaria bulletin and annual report.
- Conduct periodic population-based surveys such as the Malaria Indicator Survey (MIS-2019) and Rapid Impact Assessment (RIA-2018) and another OR
- Improve harmonization of LMIS at National and subnational levels.
- Print and distribute malaria commodity reporting tools; including supporting bi-monthly collection of facility commodity reports; and support quarterly supervision of health facilities by State logisticians.
- Support periodic QA for malaria commodities (Bi-annual) in addition to conducting post-market surveillance.
- Develop and implement financial tracking system(s) for PRs and SRs. This will improve accountability and provide financial information for the update of the annual National Health Accounts.

2.3 Focus of application requirement [1] This question is required for Lower-Middle Income (LMI) and Upper-Middle Income (UMI) countries. It is not applicable for Low-Income (LI) countries. To respond, refer to guidance provided in the *Instructions.*	
For LMI countries: - Does the funding request focus at least 50% of the budget on: disease-specific interventions for key and vulnerable populations; programs that address human rights and gender-related barriers and vulnerabilities; and/or highest impact interventions?	☒ Yes ☐ No
- For RSSH, does the funding request primarily focus on improving overall program outcomes for key and vulnerable populations in two or more of the diseases, and is it targeted to support scale-up, efficiency and alignment of interventions?	☐ Yes ☐ No
For UMI countries: - Does the funding request focus 100% of the budget on interventions that maintain or scale-up evidence-based approaches for key and vulnerable populations, including programs that address human rights and gender-related barriers and vulnerabilities?	☐ Yes ☐ No
Ensure that the funding request as described in questions 2.1 and/or 2.2 meets this focus of application requirement.	

[1] Refer to the Global Fund 2017 Eligibility List for income level. LMI and UMI countries have specific requirements in terms of the focus of applications as set forth in the Global Fund Sustainability, Transition and Co-Financing Policy.

SECTION 3: OPERATIONALIZATION AND RISK MITIGATION

This section describes the planned implementation arrangements and foreseen risks for the proposed program(s). Applicants are encouraged to **attach an updated Implementation Arrangements Map.** To respond, refer to additional guidance provided in the *Instructions.*

3.1 Implementation arrangements summary

Do you propose major changes from past implementation arrangements, e.g. in key implementers, flow of funds or commodities?	Yes ☐ ☒ No

If **yes**, provide an overview of the new implementation arrangements and elaborate how these changes affect the operationalization of the grant.

If **no**, provide a summary of high-level implementation arrangements focusing only on lessons learned for the next period.

In **both cases**, detail how representatives of women's organizations, key populations and people living with the disease(s), as applicable, will actively participate in the implementation.

Include a description of procurement mechanisms.

(maximum 1 page)

Nigeria will continue with the dual track grant implementation arrangement aligning with the public and private sector service component, as it was in the 2014-2016 NFM grant. For the public sector implementation, one Government (NMEP) and two Non-Governmental Organizations (NGO), namely: Catholic Relief Services (CRS) and Society for Family Health (SFH) as Principal Recipients (PRs) are being proposed. Based on the lessons learnt and the need for effective coordination, the Government PR will provide oversight and coordination of the national response and will overlap in the implementation with the NGO PRs in the implementation of the grant pertaining to all activities.

The grant will provide support to the 13-targeted States for malaria prevention and control activities, as well as contribute towards efforts to strengthen M&E and PSM systems. Support will be provided through direct engagement with some States as SRs or indirectly through NGO SRs who will work alongside States to implement grant activities. Two of the states in this request were SRs in the previous grant; the proposal is to continue to engage them as SRs. The PRs will continue to build the capacity of all the States by leveraging the funds for RSSH.

The number of NGO SRs to be used under the grant will be limited to three (3), based on key lessons learnt from NFM implementation where thirteen (13) NGOs were engaged. This will allow for greater efficiency, value for money and free up additional resources for service provision. Two NGO SRs will implement activities in the public sector, each covering a specific geographic area (5 or 6 States each). An additional NGO SR (1) will implement social mobilization activities in the public and private sectors across the 13 States.

All health products will be procured through the Pooled Procurement Mechanism (PPM). The PRs in coordination with NMEP will, through the Global Fund, be responsible for placing orders with the PPM agents. The PRs will coordinate with the PPM agents and track all

procurement orders to Nigeria up to the final agreed warehouses at the National or sub-National levels. The PR will also be responsible for ensuring that all ordered health products are reconciled against what is received at the warehouses from the PPM agent in a timely manner to address issues raised in the previous audit (OIG Audit Report, 3 May 2016, page 8).

In line with the country's present arrangement towards strengthening the National Supply Chain Integration Project (NSCIP), warehousing for the key disease programmes, including malaria, all health products procured through the PPM will be delivered to zonal warehouse hubs in Nigeria, namely Cross River, Sokoto, Gombe, and Imo state, as well the "warehouses in a box" in Lagos and Abuja. The only exception to this will be the LLINs that will be delivered directly to the state central medical stores because of the large space requirement for storage. A third party service provider will manage distribution of health products, including reverse logistics. The PRs will work with NMEP, NSCIP, SON and NAFDAC to provide quality assurance of health products in compliance with national and Global Fund requirements.

The involvement of women's organizations in the implementation of malaria grants in the past has contributed immensely in reaching, educating and mobilizing women for increased uptake of malaria interventions, particularly for children under 5 and pregnant women. Women's organizations have conducted education and mobilization activities through house-to-house IPC sessions, women-focused dialogues and meetings. In the new grant, the Social Mobilization SR will continue to involve women's organizations at the community level to sustain the gains, address gender-related barriers and further increase uptake and strengthen the referral system to ensure linkages to health facilities/providers.

The program will deliver health products to the SMoH's central medical stores, where they will be warehoused prior to distribution to IDPs and other vulnerable populations in the Northeast. The program will key into the existing United Nation (UN) system and contribute to the malaria component of the North Eastern response through the national program. The UN system will work with the State Logistics Management Team, the SMEP and the Incident Management Team for Northeast emergencies.

Attached is the implementation arrangement map [**Annex 3: Implementation Arrangement Map**].

3.2 Key implementation risks
Using the table below, outline key risks foreseen, including those that were provided in the *Key Program Risks* table shared by the Global Fund during the Country Dialogue process. You can also add key operational and implementation risks, which you identified as outstanding over the previous implementation period, and the specific mitigation measures planned to address each of these challenges/risks to ensure effective program performance in the given context. Applicant response in table below.

The below table summarizes the key risks as identified in the GF portfolio analysis, which could impact effective implementation of the program over the 2018-2020 timeframe, and proposed mitigation measures. Additional risks and mitigation measures are described in ***Annex 4: Additional risks and mitigation actions***

Table 3.1 Implementation risks and mitigation actions

Risk Category (Functional area)	Key Risk	Mitigating actions	Timeline
Financing for national malaria programs	Failure to obtain the expected Eurobond to finance malaria programs in 13 states	1. Sustained advocacy to Ministry of Finance to ensure that adequate resources are availed for malaria programs nationally	March – December 2017
M&E	Poor quality and availability of M&E data at sub-national level	2. Public Sector PR deploys PR/SR M&E staff to SMoHs to provide ongoing TA and capacity strengthening.	Q1/2018 – ongoing
		3. ATM partners invest in coordinated approach to strengthening M&E through RSSH component as part of the country's Funding Request.	Funding Request – end of grant cycle
		4. PR works with DPRS to activate community component and secondary health facility component on DHIS.	Q2/2018
		5. Ensure regular DQAs conducted: NMEP and malaria partners conduct biannual DQAs to States; SMEPs conduct regular DQAs to LGAs and health facilities.	Q1/2018 – ongoing
		6. NMEP, with support of PRs, ensure availability of SOPs and data collection tools at health facilities.	Q1/2018
Programmatic	Low absorptive capacity and delays in implementation	1. PRs ensure staff recruitment and SR selections are concluded during grant making and prior to signing next grant agreement.	Grant-making (End of 2017)
		2. PRs and the Global Fund to agree on adequate staffing of key units necessary for efficient operations, such as procurement and finance, to drive absorption.	Grant-making (End of 2017)

		3. NMEP to institutionalize regular meetings to analyze budget versus expenditures and take appropriate actions; NMEP will set-up detailed budget in accounting system to facilitate tracking of line items.	Q1/2018
Programmatic & Finance	Assurance that program implemented and resources are properly accounted for at local level (across wide geographic area)	1. PRs conduct regular monitoring visits to States and local levels.	Q1/2018-ongoing
		2. PRs proactively identify and respond to warning signs (e.g. delayed reports, inaccuracies) by sending teams to investigate identified issues on ground.	Q1/2018-ongoing
		3. PRs use ICT (including biometric data) to track attendance at trainings/meetings, distribution of health products, and provide managers at national level with access to information from field in real-time.	Q1/2018-ongoing
		4. PR conducts regular audits and impromptu spot checks.	Q1/2018-ongoing
Finance	Weaknesses in finance functional leadership resulting in errors and delays in reporting and poor financial oversight	1. PRs will conduct effective performance reviews of Finance staff and hold leadership accountable for results.	Q1/2018-ongoing
		2. PRs will leverage RSSH funds to support GF PMU in states serving as SRs to set-up accounting systems for management of grant resources and reporting.	Q2/2018-Q3/2018
Finance	Weak filing and archiving systems resulting in ineligible expenditures	1. NMEP to procure equipment (e.g. scanners) and put in place procedures to facilitate electronic filing and archiving.	End of 2017
Finance	Fraud	1. NMEP will develop a fraud and whistleblowing policy.	End of 2017
		2. PRs sensitize staff and beneficiaries on whistleblower policy and mechanisms for reporting suspected fraud.	Q1/2018-ongoing
		3. PRs continue use of “cashless” payment options (e.g. mobile money, bank transfer).	Already ongoing
Procurement and supply management	Treatment disruptions in public sector due to stock-outs or loss of health products	1. NMEP and PRs will involve States and other relevant stakeholders to ensure timely and accurate quantification of health product needs.	Q1/2018-ongoing
		2. PRs will use reputable logistics providers with valid goods-in-transit insurance to ensure secure, on-time delivery of products.	Q1/2018-ongoing
Procurement and supply management	Fragmentation of supply chain system resulting in unreliable recording and reporting practices	1. ATM partners will invest RSSH funds in the National Supply Chain Integration Project (NSCIP) to support operationalization of an integrated system for distribution of health products.	Q1/2018-ongoing
		2. PRs will provide orientation to State personnel to promote the effective roll-out of the National Supply Chain Policy.	Q2/2018

		3. PR will deploy PR/SR PSM staff to States to provide ongoing TA and capacity strengthening to improve commodity recording and reporting.	Q1/2018-ongoing

SECTION 4: FUNDING LANDSCAPE, CO-FINANCING AND SUSTAINABILITY

This section details trends in overall health financing, government commitments to co-financing, and key plans for sustainability. Refer to the **Funding Landscape Table(s)** and supporting documents as applicable. To respond, refer to additional guidance provided in the *Instructions.*

4.1 Funding Landscape and Co-financing	
a) Are there any current and/or planned actions or reforms to increase domestic resources for health as well as to enable greater efficiency and effectiveness of health spending? **If yes,** provide details below.	☒ Yes ☐ No
b) Is this current application requesting Global Fund support for developing a health financing strategy and/or implementing health-financing reforms? **If yes,** provide a brief description below.	☒ Yes ☐ No
c) Have previous government commitments for the 2014-16 allocation been realized? **If not**, provide reasons below.	☐ Yes ☒ No
d) Do current co-financing commitments for the 2017-19 allocation meet minimum requirements to fully access the co-financing incentive, as set forth in the Sustainability, Transition and Co-financing Policy?[2] **If not**, provide reasons below.	☒ Yes ☐ No
e) Does this application request Global Fund support for the institutionalization of expenditure tracking mechanisms such as National Health Accounts? If yes or no, **specify** below how realization of co-financing commitments will be tracked and reported.	☒ Yes ☐ No
(maximum 2 pages)	

4.1a) Current reforms show increasing government commitment to provision of resources for health:

i. *Health Insurance*: The National Health Insurance Scheme (NHIS) covers both the formal and informal sectors, including private sector. In the 2016 budget, NHIS was allocated NGN49,031,950,206.00 (http://www.budgetoffice.gov.ng); equivalent to US $160m. Also, Community Based Health Insurance Scheme (CBHIS) was instituted to support the artisans and other informal sectors access quality and standard health services at a minimal cost (Ogun Community–based Health Insurance- Araya, 2016).

ii. *Program for Results initiatives:*

[2] Refer to the Sustainability, Transition and Co-Financing Policy.

a. The Saving One Million Lives Initiative (SOML-PforR) provides an opportunity for States to address governance and management issues towards ensuring greater focus on results; increased accountability; improved measurement; and encouragement of innovation. [See Annex 5: SOML Implementation Framework; SOML 2016]. The SOML is financed by a US $500 million International Development Association credit from the World Bank to the Federal Government and then disbursed to the states as grants, based on performance improvement in maternal and new born indices, which is expected to attract additional financing for some malaria activities.
b. Eurobond: The Federal Government of Nigeria has sold a US $1 billion Eurobond to foreign investors from which NMEP is to receive US $300m to finance malaria activities over three years (US $100m annually). This innovative financing mechanism will be performance-based allowing Nigeria to obtain resources to finance its programs including malaria. The Eurobond funds will be used to implement malaria activities in 13 states [Abia, Anambra, Bayelsa, Borno, Edo, Ekiti, Enugu, FCT, Imo, Kogi, Lagos, Ondo and Rivers states].

iii. *PHC Revitalization:* The Government of Nigeria has initiated the revitalization of 10,000 PHCs in the 9,423 wards from the 774 LGAs in Nigeria. The revitalization program involves upgrading the existing PHCs to acceptable minimum standard as recommended by WHO which includes provision of qualified medical personnel, facility and medical equipment etc. [Annex 6: PHC revitalization framework and budget].

iv. *Pharma-grade Commodity Stores*: In the light of non-availability of Government-owned Pharma-grade facilities for the storage of health products in the public sector, the Government of Nigeria has offered some existing Central Medical Stores in 5 States for upgrade to the status of Pharma-grade with support of partners (NSCIP, 2016). The GON has also provided some of the human resources for management of these facilities. The warehouse structures made available are in Cross River, Gombe, Imo, Lagos and Sokoto states and will serve as regional warehouses. In addition, the Federal Government provided land for the construction of another pharma-grade facility in Abuja, with the support of partners.

v. *Private Sector Engagement Strategy:* The strategy, a PPP Platform, launched in 2016 by the Malaria Ambassador, Alhaji Aliko Dangote, provides a framework for private sector investment/engagement in Malaria Control. Additionally, the partnership between TANA netting and local partners for production of WHOPES approved LLINs in Nigeria has reached advanced stage [Annex 7: concept note for NMEP Local Manufacture Capacity 2015].

vi. *Presidential Committee on North-East Intervention (PCNI):* This is another special intervention of the Federal Government aimed at increasingly meeting UHC. The PCNI with a budget of US $44.95m [NPHCDA/DPRS-FMOH] was inaugurated on October 2016 to facilitate the immediate provision of basic social and natural resource management infrastructure and services in the communities affected by the Boko Haram insurgency, thus assisting the promotion of resettlement, recovery, and welfare of the internally displaced persons (IDPs), and the returnees.

4.1b) Request for GF support for developing a health financing strategy and/or implementing health financing reforms:

Most recently, NMEP, with the assistance of RBM, engaged a Technical Assistant to begin development of the Malaria Local Financing Strategy towards increasing State and Federal level funding for malaria [Annex 8: NMEP Domestic Financing ToRs].

Though initial work had begun, the Country intends to complete the process. However, there may be additional need to leverage the initial work to expand scope beyond malaria. Hence, this current application will be requesting Global Fund's support of US $45,000 to contribute to NMEP sustainability Plan.

4.1c) Demonstration of WTP:

Though the country is currently in economic recession, [NBS, GDP 2016], coupled with the consequential inability of the Federal and State governments to meet their recurrent financial obligations, following sustained high-level advocacy, the Federal Government has appropriated US $15,798,831 for OIG refunds and GoN counterpart funding in the 2017 Federal Budget for all the three disease streams [Annex 9: 2017 Nigeria Budget, P.1147]. In addition, Nigeria's Counterpart Fund of US $45.7m for the NFM will be met through the Eurobond.

4.1d) Government expenditure on health aims to achieve implementation of the National Health Act through the universal health coverage (UHC) goals:

There has been increase in the absolute financial allocation to health and malaria from the Federal budget. Through Human Resources costs, investments in equipment and commodities, and other health-related costs, the Federal Government of Nigeria has met the NFM co-financing requirements of US $100,206,308. These costs include those of the National Health Insurance Scheme (NHIS), which at a budget of NGN49,031,950,206 (US $160,760,492) in 2016 [http://www.budgetoffice.gov.ng] represents a core strategy for addressing UHC by addressing barriers to access to health care for the major causes of ill health (notably malaria). For the 2017-2019 allocation period, the projected commitment from NHIS alone is over US $700m, hence this exceeds Nigeria's co-financing requirement.

Table 4.1: Federal and Health Allocation

FEDERAL BUDGET (US $, 000)					
ITEM	**2014**	**2015**	**2016**	**2017**	**TOTAL**
FEDERAL BUDGET	16,268,852	14,288,524	19,934,426	23,934,426	74,426,229
HEALTH BUDGET	861,450	844,405	843,875	997,347	3,547,079
Malaria Budget	4,892	3,320	3,818	16,625	28,658

4.1e) National Health Accounts:

The Government of Nigeria in its current pursuit for accountability is progressively becoming more aware of the value of tracking resources for health. Through the Global Fund's support, FMOH institutionalized National Health Accounts, the framework, tools and technical support to set up a harmonized, integrated platform for annual and timely collection of health expenditure data will be realized. This will strengthen the capacity of FMOH to monitor and report health expenditures annually using existing global standard frameworks. In addition, these expenditures will be analysed to produce relevant data for national planning purposes. If accessed, the Government of Nigeria will designate about US $150,000 of the fund from

GF Funding Request 2018-2020 for institutionalization of mechanisms for routine health and disease expenditure tracking. Reports from the strengthening exercise will be shared with the Global Fund.

4.2 Sustainability

Describe below how the government will increasingly take up health program costs, and actions to improve sustainability of Global Fund financed programs. Specifically,

a) Explain the costs, availability of funds and the funding gap for major program areas. Specify in particular how the government will increasingly take up key costs of national disease plans and/or support health systems; including scaling up investments in programs for key and vulnerable population, removal of human rights and gender-related barriers and enabling environment interventions.

b) Describe actions to improve sustainability of Global Fund financed programs. Specifically, highlight key sustainability challenges of the program(s) covered by the funding request, and any current and/or planned actions to address them.

(maximum 1 page)

4.2a) The existing gaps for key interventions are highlighted in Table 4.2 for the period 2018 – 2020 as per the gap analysis, before inclusion of GF 2018 – 2020 allocation.

For interventions with funding gaps as reflected in Table 4.2, Nigeria will be requesting the GF to co-finance these interventions in order to sustain gains already made, while programming for sustainability and transitioning through engagement in high level advocacy for increased resource mobilization.

Table 4.2 Programme/Intervention Areas, Available Fund and Percentage Needs Financed

INTERVENTION AREAS	TOTAL NEEDS	AVAILABLE FUND BY SOURCE		TOTAL AVAILABLE FUND	GAPS	% NEEDS FINANCED
	2018-2020 ($)	EXTERNAL (including PMI and DFID)	DOMESTIC including Eurobond	2018-2020 ($)	2018-2020 ($)	
LLIN	662,478,523.82	193,246,273.94	210,474,611.41	403,720,885.35	258,757,638.47	61%
ACT	341,077,941.74	96,108,060	118,514,878.21	214,622,938.21	126,455,003.53	63%
RDT	150,363,564.73	43,319,172.66	52,247,059.63	95,566,232.29	54,797,332.44	64%
IPTp	33,558,446.46	9,743,946.77	12,348,598.81	22,092,545.58	11,465,900.88	65.9%

SMC	43,702,366.85	4,562,347.41	23,747,758.30	28,310,105.71	15,392,261.14	64.8%
Total	**1,231,180,843.60**	**346,979,800.78**	**417,332,906.36**	**764,312,707.14**	**466,868,136.46**	

Specifically, the Government will increasingly take up program costs of the National disease plan by:

i. Ensuring that evidence-based annual malaria plans and budgets (at national and subnational levels) feed into the overall health sector development plans;

ii. Advocate for States to maintain and increase funding for malaria in the state annual budgets;

iii. Increasingly utilizing government personnel to provide the required technical input to implement malaria programs.

4.2b). Challenges:

- Low prioritization of malaria program at national and sub-national levels
- Inadequate coordination of the private sector for malaria control
- Health worker attrition and unplanned transfers

These challenges will be addressed through targeted advocacy to policy makers and parliamentarians for the approval and release of full budgetary allocation for specific programs in a timely manner; specifically by:

i. Ensuring inclusion of malaria line item and funding within the states and National Medium Term Expenditure Framework (MTEF).
ii. Ensuring that the established PHC Development Boards/Agencies in states prioritize malaria interventions.
iii. Ensuring implementation of the Private Sector Engagement Strategy.
iv. Advocating for adequate allocation of funds for health programmes through special federal-led initiatives such as SDG, SOML, and PCNI.
v. Strengthening efforts to harmonize partner implementation to enhance synergy and increase effectiveness.
vi. Strategic engagement of National and sub-national relevant authorities for human resource retention.

SECTION 5.1: PRIORITIZED ABOVE ALLOCATION REQUEST

All applicants are requested to detail a prioritized above allocation request. To respond, refer to guidance in the *Instructions* and fill in the table below.

Provide in the table below a prioritized above allocation request which, following the TRP review, could be funded using savings or efficiencies identified during grant-making or put on the register of UQD to be financed should additional resources become available. The above allocation request should include clear rationale and should be aligned with programming of the allocation for maximum impact. In line with the Global Fund's Strategy to maximize impact and end the epidemics, the prioritized above allocation request should be ambitious (for example, representing at least 30-50 percent of the within allocation amount).

Applicant response in the table below.

SUMMARY INFORMATION	
Applicant	Nigeria CCM
Component(s)	Malaria
Total above allocation request (US$ or EUR)	**$272,378,981.75**

Prioritized Above Allocation Request

Provide in the table below a prioritized above allocation request which, if deemed technically sound and strategically focused by the TRP, could be funded using savings or efficiencies identified during grant-making, or put on the Register of Unfunded Quality Demand to be financed should additional resources become available from the Global Fund or other actors (e.g. private donors and approved public mechanisms such as UNITAID and Debt2Health). This above allocation request should include clear rationale and should be aligned with the programming of the allocation for maximum impact. The request should reflect the order in which interventions will be funded if additional resources become available. In line with the Global Fund's Strategy to maximize impact and end the epidemics, the prioritized above allocation request should be ambitious (for example, representing at least 30-50 percent of the allocation amount).

Malaria – *Copy the table as needed, if your funding request includes more than one component*

Module	Interventions	Amount requested	Brief Rationale, including expected outcomes and impact (how the request builds on the allocation)
Vector Control	LLINs Mass Campaigns in 6 States in 2020	$67,309,174.16	6 States in 2020 will be due for LLINs mass replacement campaigns requiring 16,619,549 LLINs. This is highly prioritized to ensure continued coverage of the population in these States in line with the WHO universal coverage for LLIN, and to ensure that gains made are not lost due to decline in net ownership.
Vector Control	Entomological Monitoring	$1,300,000	Entomological monitoring is required to generate information sufficient to enable country-level planning of insecticide resistance management (IRM) and re-engineering of vector control strategies. Insecticide resistance has currently been reported across the five ecological zones of the country, and this poses a threat to vector control interventions. There are 14 sentinel sites for entomological surveillance across the country. Funding from PMI is supporting 6 sites (Ebonyi, Nasarawa, Bauchi, Sokoto, Akwa Ibom, and Oyo). As part of the process to strengthen the malaria vector surveillance and insecticide resistance monitoring and management in the country, Nigeria plans to cover the remaining sentinel sites. The country also plans to pilot innovative vector control interventions including PBO LLINs in selected sites in line with WHO recommendations and the NMSP 2014-2020.

			This is important to provide the needed evidence towards effective management of Insecticide resistance in the country.
Case Management	iCCM	$6,000,000	There is a need to expand access to healthcare for hard- to- reach communities across the country. The National iCCM Guidelines will guide selection of eligible communities. The RAcE Project in Niger and Abia states will end in December 2017. UNICEF, DfID, and BMGF are supporting iCCM activities selected states. iCCM has been prioritized in the above allocation to enable the country sustain the current programme initiated in 2 states under NFM grant. This will improve access to prompt diagnosis and treatment within the community targeting the most vulnerable, children under 5 years. The country will leverage other funding for non-malaria commodities
Case Management	Seasonal Malaria Chemoprevention	$115,747,269.43	Across the country, 227 LGAs in Nine States are eligible for SMC. With funding from UNITAID, 37 LGAs will be covered up to 2018 and PMI plans to fund SMC in 58 LGAs across 3 states in 2018.according to the state selection document, 122 LGAs (4 states) are eligible for SMC within the 13 GF supported states. To cover the eligible children over the next 3 years, in selected LGAs for SMC implementation under the GF grant, 13,977,294 children need to be reached with SMC. Being able to implement SMC will lead to rapid decline in malaria prevalence, contributing to overall goals of Nigeria's malaria control programme
Case Management	PSCM for ACT	$82,022,538.16	The ACTs through the PSCM has helped to balance the price of antimalarials ACTs in the country and ensuring equitable access to quality-assured first line treatment. In Nigeria, 62% of the population seek care in the private sector therefore the. availability and affordability of quality assured ACTs will improve malaria case management and To complements the case management in the public sector, funds are required to procure 107,924,392 doses of ACTs through PSCM, (at national scale), over a 3-year period.This meets 50% of full private sector needs.. The country also proposes to increase co-payment contribution for from 20% to 40% over the lifetime of the grant.
TOTAL AMOUNT		**$272,378,981.75**	