

Funding Request Form

Allocation Period 2020-2022

Refer to the "Program Continuation" Instructions to complete this form.

Summary Information

Country(s)	NIGERIA
Component(s)	1. Malaria 2. RSSH
Planned grant(s) start date(s)	01 January 2021
Planned grant(s) end date(s)	31 December 2023
Principal Recipient(s)	FMOH-NMEP: Malaria CRS-Nigeria: Malaria MSH-Nigeria: RSSH PR2: RSSH
Currency	US Dollars
Allocation Funding Request Amount	Malaria: \$388,641,166 RSSH: \$50,644,580
Prioritised Above Allocation Request (PAAR) Amount ¹	Malaria: \$161,385,812.43 (41.5%) RSSH: \$35,799,112.93 (70.7%)
Matching Funds Request Amount ² (if applicable)	NOT APPLICABLE

¹ PAARs can only be submitted with the Funding Request. To complete a PAAR, fill-in the Excel template that you will receive from the Global Fund Secretariat.

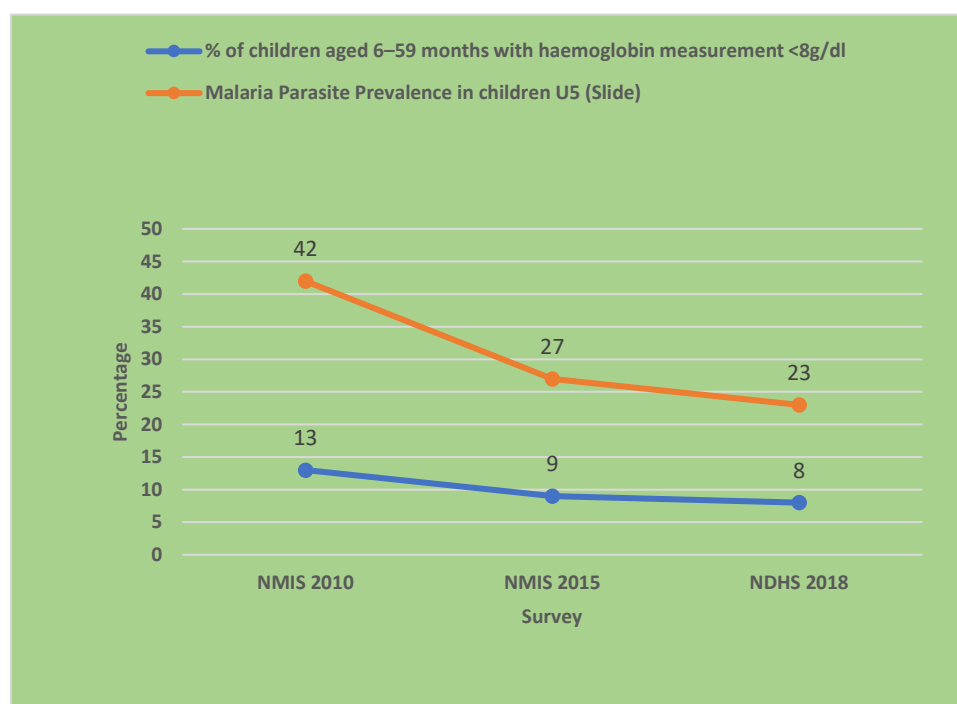
²This is only relevant for applicants with designated matching funds as indicated in the allocation letter.

1. Investing to Maximise Impact to End the Epidemics.

Malaria

Overview: The goal of the National Malaria Strategic Plan (NMSP) 2014-2020 was to reduce the malaria burden to under 5% and malaria-related mortality to zero (Annex 3: NMSP 2014-2020). While these goals may not have been achieved, substantial declines in malaria prevalence were attained, from 42% in 2010 to 23% in 2018 (Annex 4: Nigeria Demographic and Health Survey (NDHS 2018; see Figure 1.1).

Figure 1.1 Malaria Parasite and Anaemia Prevalence

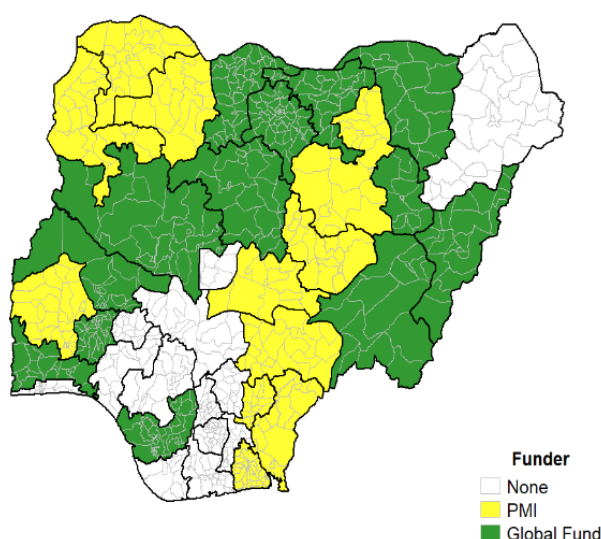


Reduction of the burden of disease over the NMSP's period was heterogeneous across States, in all likelihood due to a combination of such factors as variability in external funding, limited domestic funding, and variations in access to care and health-seeking behaviour, among others. Additionally, there were significant funding gaps for 13 of the States unsupported by the Global Fund (GF) or the President's Malaria Initiative (PMI), where there were only limited funds available to replace long-lasting insecticidal nets (LLINs). This contributed to the limitations in progress.

The results of the Malaria Programme Review (MPR) indicate that the country has achieved some success in increasing coverage for key preventive interventions (LLINs, intermittent preventive treatment in pregnancy (IPTp) and seasonal malaria chemoprevention or SMC), and in improved diagnosis and treatment, but is not on track to meet the ambitious targets of the NMSP. The recommendations of the MPR, however, do not indicate a need for a change in overall policy or technical approach for disease prevention or case management; instead suggesting that 'a more result-focused and State-specific intervention mix for the National Malaria Elimination Programme (NMEP) — based on the epidemiological indices, sociodemographic peculiarities and acceptable strategies — should be employed in the next NMSP development in order to accelerate progress towards elimination' (c.f. Annex 5: Malaria Programme Review 2019 Report p. 34). Under the support received as part of the High Burden to High Impact (HBHI) approach, Nigeria implemented a comprehensive stratification and intervention mix analysis to ensure improved efficiencies in targeting interventions so as to achieve greater impact (c.f. Annex 6 NMEP/WHO Malaria Stratification Map 2020).

Figure 1.2 shows current donor support by States. Although not shown in the map, the Department for International Development (DFID)/UKaid support overlaps with that of the GF in five States. Of the 36 States and Federal Capital Territory (FCT), the GF supports 13 states and PMI 11 States, leaving 13 States without partner support for which the Government has recently received approval for securing an International Development Association (IDA) credit of approximately US\$200 million to support the unfunded 12 States + FCT (illustrated by the white areas on the map). The current GF malaria grant, being implemented by two Principal Recipients (PRs), is worth US\$313 million (NMEP US\$14 million and Catholic Relief Services (CRS) US\$269 million); while the RSSH grant is US\$ 43 million. Drawing from available evidence, lessons learnt and inputs from technical partners and key stakeholders, the following paragraphs provide some explanation of how the interventions currently being implemented through the existing GF-supported malaria programme continue to be relevant and on track to achieve the desired results and impact.

Figure 1.2 Map of Donor Support by State



Vector Control

LLIN Mass Campaigns: Nationwide, LLIN mass campaign targets for 2018 and 2019 were achieved in those States supported by the GF and PMI but not in the remaining 12 States plus FCT, due to lack of funding, and for which Federal funding was still being expected. Table 1.1 below summarises the performance of the GF-supported States, challenges and lessons learnt.

Table 1.1 Vector Control

Intervention	Scope & achievement	Lesson/Challenges	Plans Going Forward
LLIN: Mass campaign in National and GF 13 States	LLIN mass campaign: National: 87% (achieved 28.2M of 32.3M planned) GF-13 States: 105% (achieved 23.1M, 24.2M planned): (LLINs Mass Campaign Reports) Jan-Dec 2019)	Use of information technology for development (ICT4D) improved accountability, effectiveness and efficiency of LLIN campaigns. Vector surveillance data on vector resistance informs choice of LLINs.	To sustain effective universal preventive coverage: GF allocation to fund LLIN replacement campaign in all 13 States in 2021-2023; number of piperonyl butoxide (PBO) vs pyrethroid-only nets to be ascertained based on vector resistance data.
Routine LLIN distribution via antenatal care (ANC) and Expanded Programme on	National: 65% (DHIS/HMIS, Jan – Dec 2019) GF-13 States: 63% (DHIS/HMIS, Jan - Dec 2019)	Uptake of LLINs via ANC and EPI low nationwide; remaining stock of procured routine nets to be used in 2021.	Use social and behaviour change (SBC), Malaria-Reproductive, Maternal, New-born, Child and Adolescent Health (Mal-RMNCAH) integration to increase uptake; invest savings from low

Immunisation (EPI) clinics			utilisation to support SMC for high impact.
Surveillance	Functional Entomological Surveillance sites in five of 13 GF supported states, 11 other States by PMI	Results from the 16 sites found pyrethroid resistance by all vector species and across all ecological zones.	<ul style="list-style-type: none"> • MPR vector resistance surveillance to be scaled up nationwide to inform choice of LLIN States/locations. • GF to support scale up to all 13 States in 2021-2023.

The engagement of subnational stakeholders and the use of information communication technology for development (ICT4D) led to efficiency gains and better data management, resulting in improved LLIN campaign coverage and cost savings. Warehousing of LLINs for campaigns conducted in 2019 was supported by the States after improved advocacy, thus enhancing State contribution, participation and ownership of these campaigns. In 2020, the plan is to distribute PBO nets and new nets in three States; Adamawa State: 2,888,912 PBO nets, Kwara State: 2,300,000 (500,000 Royal Guard nets and 1,800,000 Interceptor G2 nets) and Osun State: 3,051,703 PBO nets and 200,000 pyrethroid only LLINs. The deployment of next generation nets (IG2 and Royal Guard) in Kwara and Oyo States will provide an opportunity to evaluate their effectiveness in addressing the problem of insecticide resistance using resources from the ongoing GF grant.

Insecticide resistance monitoring (IRM) will be scaled up in all 13 States during the current grant. The IRM for the States for which an LLIN campaign is planned for 2021 (Gombe, Jigawa, Katsina and Ogun) will be conducted in 2020 but the results will not be available early enough to meet the procurement lead time. Since these States are among those with the highest combined risks of prevalence, incidence and mortality, the country has adopted the interim strategy to deploy PBO nets in the four States until adequate data on mixed function oxidases (MFO) become available in keeping with the World Health Organization's (WHO) recommendation. Also, as an interim measure, the costing of LLINs for the 2021-2023 period has applied the assumption that PBO nets will be needed in all 13 States, pending the availability of IRM data. The potential cost-saving that might accrue to the Programme from the procurement of conventional nets when IRM data become available for each of the States will be invested in another high impact intervention, such as SMC in States that are currently in the Prioritised Above Allocation Request (PAAR).

Malaria stratification maps have recently been developed and these provide information for a more tailored approach to intervention deployment. Although the LLIN quantification currently includes urban populations, the Programme is working on a detailed micro-stratification in large urban areas and this will inform further targeting of nets in urban areas. Any savings made through this process will be reprogrammed to fill key gaps identified in the PAAR.

Routine LLIN Distribution: The uptake of LLINs distribution to pregnant women and infants through ANC and EPI clinics has been low nationwide, including in the GF-supported States (see Table 1.1 above), despite the availability of LLINs at State stores in the GF States. A study to determine the root cause and develop solutions for this is planned within the current grant. The NDHS 2018 showed that use of insecticide-treated nets (ITN) by pregnant women was 58% in all households and 81.7% in those living in households with at least one LLIN. This suggests that access to ITNs is a key determinant in ITN utilisation (NDHS 2018, pp. 312-313). The GF grant will continue to promote the uptake of LLINs through a combination of mass campaign and the routine distribution of LLINs, supported with effective SBC strategies. During the next grant period, LLINs for routine distribution at ANCs and EPI clinics in 2021 will be taken from those LLINs remaining under the current GF grant's procurement, while the routine LLINs for 2022 and 2023 will be requested under PAAR. Savings from the 2021 LLINs will be reallocated to contribute to the procurement of medicine (SPAQ) required to conduct SMC in six of the ten eligible high burden States to reduce malaria morbidity and mortality among children aged three to 59 months during the malaria transmission seasons in 2021, 2022 and 2023.

Case Management

Public Health Facility Diagnosis and Treatment: Diagnosis and treatment for malaria in public health facilities (HFs) continues to improve in both GF-supported states and nationwide. The Programme collaborates with the National Agency for Food and Drug Administration and Control (NAFDAC) to ensure that antimalarial medicines and rapid diagnostic tests (RDTs) are quality-assured. Table 1.2 shows the achievements, challenges and lessons learnt in case management with an emphasis on future plans.

The Table indicates that investments by the Government of Nigeria (GON) and key partners (such as the GF and PMI) are achieving the desired results; they have had a noticeable impact at the HF level and should therefore be sustained. Poor adherence of health providers to negative RDT results, however, remains a challenge. The NMEP has also developed guidelines for the quality of care (QOC) in malaria case management to guide the implementation of quality improvement interventions with a focus on facility and local government area (LGA) levels (Annex 7: Malaria Quality of Care Guidelines). These Guidelines are aligned with the Federal Ministry of Health (FMOH) guidelines for maternal, new-born and child health (MNCH). Implementation of both the malaria and MNCH QOC guidelines will be integrated at subnational and facility levels.

Breakthrough ACTION Nigeria (with support from the United States Agency for International Development, USAID) conducted a formative assessment to investigate the root causes of poor provider adherence to treatment guidelines. The NMEP will collaborate with USAID to explore the feasibility of translating the findings and proposed solutions into remedial action. (Annex 8: Breakthrough ACTION Report 2019; pp. 1-14).³

Community Level Treatment and Integrated Case Management of Childhood illnesses (iCCM): The GF supports iCCM implementation in Kebbi and Niger States. From inception in 2018 to end July 2019, a total of 1,964 volunteers were trained as Community-oriented Resource Persons (CORPs): 1,155 in Kebbi State and 809 in Niger State (Annex 9: iCCM Report, Malaria Consortium 2019, p.6). There have been improvements in community level malaria testing and treatment in iCCM implementing areas (see Table 1.2 above). The Government has fully integrated iCCM as a component of the National Primary Healthcare Development Agency (NPHCDA) Community Health Influencers, Promoters, Services Programme (CHIPS) supported by the Basic Health Care Provision Fund (BHCPF) (Annex 11). CHIPS is a strategy designed to transition all current community-based workers (CBWs) from vertical programmes and to harmonise all community-based programmes into a single national programme (see Annex 10: CHIPS Guidelines). During the period of 2021-2023, the GF will continue to support iCCM in Niger State while Kebbi State (which has an under-five mortality rate (U5MR) of 252 per 1,000 live births) will be supported by USAID-integrated primary health care (PHC) funding. Jigawa State, which has the next highest U5MR of 213 per 1,000 live births (NDHS 2018, *op. cit.* p. 169). During the 2021-2023 period, GF funds will support provision ACTs and RDTs for malaria case management through the CHIPS in Jigawa and Niger States. Jigawa and Niger States are among the first group of States to commit to commence implementation of the CHIPS programme using the BHCP fund.

Table1. 2 Case Management

Intervention	Scope and Achievement	Lesson/Challenges	Plans Going Forward
Case Management Public facility (GF supports 10,127 HFs in 13 States)	National (DHIS/HMIS 2019): %Fever Tested in public HFs: 92% % treated with artemisinin-based combination therapy (ACT): 94% GF-13 States (DHIS/HMIS 2018 & 2019): %Fever Tested: 2018=71%; 2019= 93% % treated with ACT: 2018=73%; 2019=98%	Poor adherence to negative RDT results. Provider behaviour study (Breakthrough Action, USAID).	GF will continue to support interventions in 13 States as in the current grant with quality improvement actions. Based on therapeutic efficacy studies (TES) results and WHO guidance. dihydroartemisinin-piperaquine (DHP) will be procured as a third ACT.
Severe malaria (13 States)	GF supports injection Artesunate in 561 secondary and 15 tertiary Health Facilities in 13 States	Data from nationwide study of severe malaria used for planning and quantification. NMEP has introduced rectal artesunate for pre-referral	GF will continue to support injection Artesunate. NMEP will request GF support for rectal Artesunate as pre-referral

³ Breakthrough ACTION Nigeria: Provider Behaviour Change Activity Formative Assessment Update Report

		therapy in the community, informed by WHO guidance	treatment at the community level in 2021-2023.
Community/iCCM (integrated case management of childhood illnesses) Kebbi State: all 21 LGAs Niger State: 16 of 25 LGAs	National survey: % under-fives with fever that had finger or heel prick for test: 13.8% % of children who took any ACT: 52% (NDHS 2018, <i>op. cit.</i> , p.322, Table 12.11;) GF supported States (Page 325, Table 12.13 iCCM Reports): % of fever tested with RDTs in community: 2018: 17%; 2019: 99.42% (HMIS, iCCM report); % malaria cases treated with ACT in community: 2018: 18%; 2019: 98.9% (iCCM Report)	<ul style="list-style-type: none"> • Low iCCM coverage nationwide. Lack of non-malaria medicines • Optimum Diagnosis and treatment of malaria increased by > 60 percentage points between 2018 and 2019 following iCCM implementation • Capacity of CORPs select from IDP groups were built under the current grant to support malaria case management in the IDP camps. 	iCCM integrated into CHIPS under NPHCDA with the BHCPF (Annex 10: CHIPS Guidelines; Annex 11: BHCPF). GF will continue support to iCCM as part of CHIPS in Niger State while USAID integrated PHC grant will support Kebbi. The malaria case management (CM) intervention for IDPs will continue to be implemented using CORPs, considering that this intervention is an emergency response to the humanitarian crisis in these locations. CORPs selected from among the IDPs to ensure acceptability and ease of engagement.

Treatment of Severe Malaria: The current GF grant supports the procurement of injectable Artesunate for treating severe malaria in primary, secondary and tertiary HFs in the 13 States. The GF grant supported a nationwide facility-based study of severe malaria; and the findings are being used to improve planning, quality of care and quantification of health products (Annex 12: Severe Malaria Study Report, NMEP 2020). In order to strengthen measures for accountability of the injections procured with GF resources, variables for capturing and reporting indicators for severe malaria at service delivery points have been incorporated into the revised national HMIS tools that are being currently rolled out. Also, HMIS officers in secondary/tertiary health facilities have been trained to report directly to the DHIS. In order to improve the treatment of severe malaria at the community level, a pilot study is being conducted on the use of rectal Artesunate as a pre-referral treatment with support from the Clinton Health Access Initiative (CHAI). The NMEP has decided to implement the use of rectal Artesunate for community level pre-referral treatment of severe malaria, based on WHO guidance and evidence from early findings from the Nigerian study of a multi-country implementation research on introduction rectal Artesunate for pre-referral treatment of severe malaria (Annex 13: CARAMAL Interim Report 2019). During the 2021-2023 period the GF will support procurement of rectal Artesunate for phased implementation of pre-referral treatment in the 13 States; and will continue to support the supply of injectable Artesunate.

Vector Control and Malaria Case Management Support to Internally Displaced Persons and Hard to Reach Communities: Between 2018 and 2019, 500,000 LLINs were procured for the internally displaced persons (IDP) malaria intervention through the current GF grant. The IDPs who lived among their host communities received LLINs during mass campaigns and through routine distribution in ANC and EPI clinics. Insecurity due to insurgencies and difficult topography made several communities and populations hard to reach; but these populations in Delta, Kaduna, Katsina and Niger States were reached with LLIN distribution. The current GF grant also supports the provision of malaria case management services to IDPs in Adamawa, Gombe, Taraba and Yobe States. The strategy for the IDP malaria interventions involved identification of CORPs from the IDPs, with language considerations being a key factor. These CORPs were trained in malaria testing and treatment and provided RDTs and ACTs on a bi-monthly basis (depending on services delivered as well as verified consumption pattern). The CORPs are supervised by Community Health Extension Workers (CHEWs) working in focal HFs as well as IDP officers engaged by the Programme. In 2019, a total of 447,806 IDPs with suspected malaria were seen, of which 447,551 (99.9%) received a parasitological test with RDT. Of all the cases tested, 338,210 (75.6%) were positive, of which 336,072 (99.4%) received ACT. The malaria positivity rate of 75.6% shows the importance of targeting this vulnerable population with malaria interventions. Adequate funds will be allocated under the GF grant to sustain these services for the IDPs and refugees within the GF-supported States throughout 2021-2023. Under the proposed grant, it is intended to sustain the current coverage of IDPs and, through effective partnership with security agencies and humanitarian

stakeholders, leverage proven innovations, specifically, polio infrastructure and the use of existing Government structures to reach the underserved populations in hard-to-reach communities affected by insurgency.

Private Sector Engagement: Evidence exists that patent and proprietary medicine vendors (PPMVs), community pharmacists and private clinics are the first resort for malaria treatment for >60% of those seeking care (NDHS 2018, p.324), although the contribution of the private sector to the HMIS is less than 30% of HMIS current data. In private facilities, there is no system of enforcing or ensuring compliance. If this key part of the health sector remains neglected, the lack of standard diagnostic and treatment services in those facilities could undermine the goal of eliminating malaria in Nigeria. The NMEP's Private Sector Sub-committee provides the oversight functions of coordination, system strengthening and monitoring of the public-private partnerships (PPP) response. The Sub-committee has also developed a guiding document or Terms of Reference (TORs) and appointed a desk officer to support the process and guide the Programme's PPP response. The Affordable Medicines Facility - malaria (AMFm) which started in 2010 was an innovative funding mechanism that made it possible to deliver subsidised prequalified (PQ) ACTs into the private sector supply chain. The AMFm was transformed into the Private Sector Co-Payment Mechanism (PSCM) in 2012; and continued to provide PQ ACT until the end of the programme in 2017. The AMFm and PSCM were very successful and well received by all stakeholders. Surveys by NMEP and NAFDAC have shown an encouraging trend of a self-sustaining system for providing affordable and quality ACTs with prices of ACTs stabilising at US\$1.5 to US\$2. NMEP acted on Technical Review Panel (TRP) guidance to develop a plan to transition from PSCM to another, more sustainable private sector engagement strategy. In 2018, at the request of the GF, DFID supported the development of that plan (Annex 14a & b; ACT-RDT Market Transition Plan, NMEP, 2019, pp. 6-8).

The NMEP and its partners have developed a position paper that articulates the key actions on the private sector response. These actions are being proposed for support under this Funding Request (Annex 15: NMEP Position Paper on the Private Sector Response). Under the new grant, Nigeria intends to improve the quality of malaria control interventions by involving the private sector service providers as well as improving the enabling environment in order to achieve programme sustainability and expanded access. The following key actions for the private sector response are proposed under the Funding Request:

1. Strengthen the PPP Unit within the NMEP;
2. Improve the policy and regulatory environment;
3. Improve the malaria QOC in the private health sector;
4. Ensure product quality;
5. Provide commodity security;
6. Increase promotion;
7. Strengthen HMIS;
8. Advocacy to mitigate taxes and tariffs; and
9. PPP coordination.

These activities are described in detail in the Position Paper on the Private Sector Response under Annex 15. An initial sum of US\$840,00 from the GF grant will be invested to support the proposed private sector response for the period 2021-2023. The NMEP Private Sector Unit will undertake advocacy to raise more funding for the proposed intervention from domestic private sector entities.

Intermittent Preventive Treatment for Malaria in Pregnancy (IPTp): IPTp implementation targets were achieved in the GF-supported States (113%; CRS Report Jan-Dec 2019) but achievement of national NMSP targets for IPTp was not achieved (35%, DHIS/HMIS 2019), due to frequent Sulfadoxine-Pyrimethamine (SP) stock-outs. The Government has fully integrated IPTp with RMNCAH services at national and subnational levels. Mal-MNCAH integration and regular domestic funding through the BHCPF will boost IPTp uptake and coverage nationwide. Also, the country currently awaits the results of the Unitaid TIPTOP project pilot study of community IPTp in Ebonyi, Niger and Ondo States to decide whether to adopt community-based delivery of IPTp (Annex 16: TIPTOP Interim Report).

Seasonal Malaria Chemoprevention (SMC): SMC is currently being implemented in nine Sahel States with support from DFID, the GF and PMI (organised by the Malaria Consortium). GF support for SMC was implemented on an incremental scale: in 2019, only eight of the 122 LGAs within the GF-supported States were covered. However, following cost savings, and in line with the TRP/Grant Approval Committee (GAC) approval of additional States, coverage was increased to all 122 LGAs in 2020. The distribution of the LGAs are as follows: Kano 44, Katsina 34

and Yobe 17, making a total of 95 LGAs to be supported by the GF in 2020. In addition to those States, further support was provided to cover all LGAs in Borno State to mitigate against the impact of malaria among children under-five in North-east Nigeria. Jigawa, which has 27 LGAs, is being supported by the Malaria Consortium in 2020 and not by the GF (Annex 17: NMEP SMC Implementation Report 2019).

Implementation of SMC has achieved high performance with full coverage levels achieved in targeted areas for all four cycles each year. The percentage of children aged three to 59 months who received the full number of courses of SMC (three or four) per transmission season in the targeted areas was 105.75% with 3,996,326 under-five children covered while 3,778,927 was planned (Annex 17: *Ibid*). Recent malaria stratification mapping shows that six more States among the 13 States are eligible, bringing the number of GF-supported States eligible for SMC to ten (c.f. Figure 2.2 in Section 2). During the 2021-2023 period, the GF allocation will support the full coverage of SMC in five States (Jigawa, Kano, Katsina, Taraba and Yobe) of these ten SMC-eligible States while funding for SMC in the remaining five States (Adamawa, Gombe, Kaduna, Kwara and Niger) will be sought under PAAR.

Social and Behaviour Change Communication (SBCC): In the ongoing grant cycle (2018–2020), key SBCC interventions are delivered through: (a) social mobilisation approaches including interpersonal communication (IPC); (b) community dialogues targeting key local structures (viz. ward development committees (WDCs) and religious/social groups); (c) mass media (television, radio and bulk SMS); and targeted sensitisation of women's groups and advocacy by the Society for Family. Under the current grant, the SBC interventions have been applied to support: vector control (specifically, use of LLINs); appropriate care-seeking for malaria case management and specific preventive interventions (such as IPTp). Within each State, 25% of the population were targeted with IPC interventions. After 67% of the planned project timeline, 900,060 IPC sessions had been delivered, reaching 6,702,183 (153% of the proposed target) persons in 519 wards; and 10,773 community dialogues reaching 403,417 persons (109% of the envisaged target). The Programme disseminated 1,463,305 (25% of the envisaged target) SMS messages to heads of households and aired 18,315 media spots in the 13 states (DHIS-2, 2020)⁴.

The Advocacy, Communication and Social Mobilisation (ACSM) Strategy also included a civil society organisation (CSO) Accountability and Advocacy component coordinated by the Association of Civil Society Organisations for Malaria, Immunisation and Nutrition (ACOMIN Nigeria). This component engaged 195 CSOs/community-based organisations (CBOs) working at the community level to ensure community accountability, increase domestic resource mobilisation through sustained and targeted advocacy and coordinate community-based CSOs to promote the community ownership of interventions to control malaria, HIV and TB. Validated evidence showed that the work of the Accountability and Advocacy component resulted in improvements in infrastructure: the renovation of 13 PHC HFs), provision of water supply (nine boreholes and employment of 652 more health workers, leading to an improvement in the access to and uptake of services, as a result of targeted advocacy to Government and community leaders (Annex 18: ACOMIN Report, 2019).

The implementation of IPC in Gombe State was scaled up in 2019 to cover the whole State (instead of 25% of the LGAs in each State) as is currently the situation in other States). A follow up knowledge, attitudes and practice (KAP) study was conducted to identify measurable achievements, best practices, shortcomings and challenges, as well as provide recommendations for the scale up in other States. The findings confirmed: (1) the appropriateness of chosen intervention channels and indicated that 83.2%, 57.6%, 39.7%, of heads of households own mobile phones, radio and television sets respectively; (2) a high level of willingness by beneficiaries to adopt and maintain positive malaria related behaviours (88.5% for ACTs, 98.9% for RDTs and 98% for sleeping under LLINs); and (3) effective engagement of community stakeholders among other findings (see Annex 19: Report of Independent Evaluation of Social and Behaviour Change Communication Scale up Activities Gombe 2019, Blake & Harper 2019)⁵.

Despite the success achieved so far, the coverage of certain interventions remains low in some States, necessitating more formative research to identify barriers and effective solutions. For example, the 2018 NDHS survey found that ITN use by under-five children in all households varied in the GF-supported States, being highest in Jigawa (82.6%), Kano (74.3%) and Katsina (72.5%), and lowest in Taraba (24.2%), Osun (32.4%) and Kwara (34.1%). There was a similar pattern of use by pregnant women (NDHS 2018, pp. 316, 318) and the percentage of women that received at least three doses of SP (IPTp3) was 16.1% (NDHS 2018, pp. 303). The uptake of IPTp has been adversely affected

⁴ SFH DHIS is accessible on <https://sfhnigeria.dhis2.net/>

⁵ Independent Evaluation of Social and Behaviour Change Communication Scale up Activities Gombe 2019 – Blake & Harper pp.7-10, 36-78

not only by the frequent stock-outs of SP (due to poor domestic funding) but also because of behavioural factors and barriers which need to be addressed through SBC. As indicated, the implementation up of SBC interventions will consider the current levels of uptake of key preventive interventions (LLINs and IPTp) and poor care-seeking for fever. The need for evidence to determine the areas of focus and type of SBC messaging is illustrated by the ITN use behavioural gap analysis of the 13 Global Fund supported States (Table 1.3).

Table 1.3 Household ITN Access, Use Behavioural Gap in the 13 GF-supported States

GF Supported States	% Household Population with Access to an ITN	% Household Population that Slept under an ITN	Behavioural gap	Comments
Adamawa	45.2	42.6	2.6	<ul style="list-style-type: none"> This analysis shows the difference between percentage of the household population with access to an ITN and percentage that slept under an ITN the night before the survey. When ITN access is higher than ITN use, it is indicative of gap in the net use behaviour. The programme needs to focus behaviour change communication (BCC) more in these areas to identify the barriers to net use and applying the right BCC to remove such barriers. This analysis shows that Gombe, Kwara, Ogun, Osun and Taraba States have significant behavioural gaps that require targeted SBC.
Delta	29.2	28.5	0.7	
Gombe	48.3	40.9	7.4	
Jigawa	86.1	87.1	-1.0	
Kaduna	51.0	54.3	-3.3	
Kano	63.3	65.1	-1.8	
Katsina	71.3	64.7	6.6	
Kwara	49.6	30.4	19.2	
Niger	29.0	29.0	0	
Ogun	44.2	35.9	8.3	
Osun	32.7	26.8	5.9	
Taraba	24.7	20.2	4.5	
Yobe	53.2	53.7	-0.5	

Source: NDHS 2018; pp. 312-313.

The behavioural gap analysis presented in Table 1.3 indicates that States with zero or negative difference between access and use (viz. Jigawa, Kaduna, Kano and Katsina, Yobe) are likely to increase ITN use if access is increased and the positive net use behavioural pattern is reinforced. On the other hand, ITN use is likely to remain relatively low in States like Gombe, Kwara and Ogun, even with improved access, unless the behavioural barriers to ITN use are removed through SBC.

Building on the recommendations of the study and lessons learnt, the Programme proposes to: (1) continue IPC in 260 wards within the eight states out of the 13 states of implementation as well as increase the coverage of IPC from 25% to 50% (from 162 to 324 wards) in a stratified manner, targeting more rural areas in five states where the behavioural gap on malaria control interventions is evident from NDHS. These states include Gombe, Kwara, Ogun, Osun and Taraba; (2) continue, but stratify radio and television messaging focusing on the urban areas and forging the social movement 'zero malaria starts with me', in the remaining eight states of Adamawa, Delta, Katsina, Kano, Jigawa, Kaduna, Niger and Yobe) to complement IPC messaging which will continue at 25% coverage; (3) continue SMS messaging to heads of households plus other household members; giving preference to the five states where previous studies (NDHS) showed behavioural gap, viz. Gombe, Kwara, Osun, Ogun and Taraba; and (5) continue advocacy and sensitisation in all 13 states of implementation. The social accountability mechanism being implemented by the CSO network will be scaled up from five to ten LGAs in each of the 13 GF-supported States and strengthened to promote citizens' engagement and improve confidence in malaria interventions in the public sector. As part of current efforts to increase contribution of States, the commitments of State Governments in all the 13 States to support radio and television messaging through State-owned electronic media outlets is expected to boost the reach of radio and TV messaging by at least 50% with potential cost savings that would contribute towards provision of high impact interventions such as SMC in two States which are still in PAAR.

The current SBC interventions (IPC /IPC]C and social mobilisation) targeted at improving ITN use, health-seeking behaviour of caregivers of under-five children and the uptake of IPTp by pregnant women remain a priority. So too does the need to address gaps in provider behaviour, such as non-adherence to treatment guidelines. The NMEP plans to leverage the formative SBC assessment (USAID-funded) which used behavioural economics to identify root

causes and interventions to improve provider behaviour and adherence to malaria treatment guidelines (Annex 7, *op. cit.*). Also, while continuing to apply existing evidence and proven practices and tools, an independent, national assessment of the effectiveness of current SBCC strategies will be conducted to further improve the effectiveness and targeting of ACSM strategies.

Surveillance Monitoring and Evaluation: Table 1.4 shows that the percentage of health facilities reporting promptly to DHIS-2 increased between 2018 and 2019 countrywide but the improvement was greater in the GF-13 States. A system of direct reporting to the DHIS-2 from secondary and tertiary HFs was implemented through the provision of tablet devices and trainings in the GF-supported states. The Nigeria Malaria Data Repository was also developed and operationalised. This provides data visualisation and access to both routine and non-routine data to enable evidence-based decision making. Periodic evaluations were conducted to measure impact indicators, such as the 2018 NDHS and rapid impact assessment. A survey was conducted across all public secondary and tertiary HFs in the country in 2019 and a national HF assessment in 2019. There was a 32% increase in formal private HFs reporting to the DHIS in 2019 (13,254) compared with 2016 (8,974). The Programme also scaled up Insecticide Resistance Monitoring (IRM) sites from seven to 16 States with a plan to scale up to the remaining States in order to generate evidence to appropriately target the deployment of PBO, Next-gen and conventional LLINs.

Table 1.4 Status of Key NHMIS, PSM and SBCC Indicators

Intervention	Scope & Achievement	Lesson/Challenges	Plans Going Forward
NHMIS: (national)	2019: 84% (30408 of 36,380 HFs) (NDHS/HMIS2019)	Integration of NHMIS in DHIS-2 is effective. Data quality issues still being addressed	Continue quality improvement through DQA and OTSS; pilot direct electronic data entry at facility. Support for integrated HMIS to continue 2021-2023
13 States	2018: 76% Timely Reporting 2019: 90% (9,006 of 10,383 HFs)	Secondary and tertiary facilities not reporting to DHIS-2 nationally	412 secondary and tertiary in GF-13 States trained and equipped with Tablets to report directly to DHIS-2 from Q1 2020
Supply chain management (national)	6,932 of 10,383 (67%) % with no stock-out for key commodities (HMIS 2019)	Disparity in LMIS and HMIS data; resolution via LMIS-DHIS triangulation	Supportive supervision, Triangulation of LMIS and HMIS - bimonthly at facility level; biannual at national level

Summary of Lessons Learnt: Lessons learnt from the current malaria grant as well as the actions taken or planned are summarised in Table 1.5.

Table 1.5 Summary of Lessons Learnt During the Current Malaria Grant

Module/ Intervention	Lessons Learnt and Actions (taken or planned)
Vector Control	<u>Lesson:</u> Significant improvement in mass campaign programming, targeting and data management due to deployment of ICT4D at scale with improved efficiency and accountability. <u>Action:</u> ICT4D to be deployed in all future LLIN campaigns.
SPI: SMC	<u>Lesson:</u> Successful implementation of SMC at pilot scale in few LGAs with high impact in 2019. <u>Action:</u> GF support to include deployment of SMC at scale across all LGAs of eligible four states in 2020. <u>Lesson:</u> Evidence from epidemiological and seasonality stratification exercise identified six additional SMC eligible States among 13 GF States. <u>Action:</u> Conduct of SMC in all 10 SMC eligible States in the GF supported areas will be prioritised for support within allocation.
SPI: IPTp	<u>Lesson:</u> Persistence of low IPTp coverage attributed to poor limited engagement of RMNCAH service and SP supply. <u>Action:</u> IPTp to be fully integrated within the RMNCAH-N (Annex 20: Mal-RMNCAH-N Framework, FMOH).
Case Management	<u>Lesson:</u> Sub-optimal QOC at the health facility level due to non-adherence to guidelines. <u>Action:</u> Development and operationalisation of QOC guidelines to support State and LGA engagement for ensuring quality health services provision and accountability

Community approach – iCCM	<u>Lesson:</u> iCCM implementation faced significant challenges due to low domestic funding for non-malaria commodities. <u>Action:</u> Integration of iCCM with NPHCDA CHIPS Programme with support from the BHCPCF.
Case Management: Private sector	<u>Lesson:</u> Limited engagement of private sector providers accounts for suboptimal quality of care and low reporting of routine data. <u>Action:</u> Interventions to strengthen laboratory services through External Quality Assurance (EQA) and onsite training and supportive supervision (OTSS) to be extended to private sector provision.
HMIS/LMIS discordance	<u>Lesson:</u> Disparity commodity delivery and utilisation information obtained via between DHIS2 and logistics management information system (LMIS). <u>Action:</u> Regular triangulation of LMIS and DHIS-2 data at facility, state and national levels
Data utilisation for planning	<u>Lesson:</u> Limited access and use of programme data for planning. <u>Action:</u> Development of the Malaria Data Repository to support the warehousing of data and make both routine and non-routine data available for use at all levels.

RSSH

Overview of the Health System

Nigeria has a pluralistic health care system with public and private health providers, with both modern and traditional health care systems. According to the Nigerian Constitution, 1999 (as amended), health care provision is the concurrent responsibility of the three tiers of the Government. The Federal Government is responsible for tertiary health care and also formulates health policies through the FMOH. This level also provides specialised services through the teaching hospitals, Federal medical centres, specialist hospitals and medical research Institutes. In addition to tertiary health care provision, the FMOH leads the implementation of specific public health programmes, e.g. the National AIDS and STDs Control Programme (NASCP), the NMEP, the National Tuberculosis and Leprosy Control Programme (NTLCP) and the National Immunisation Programme.

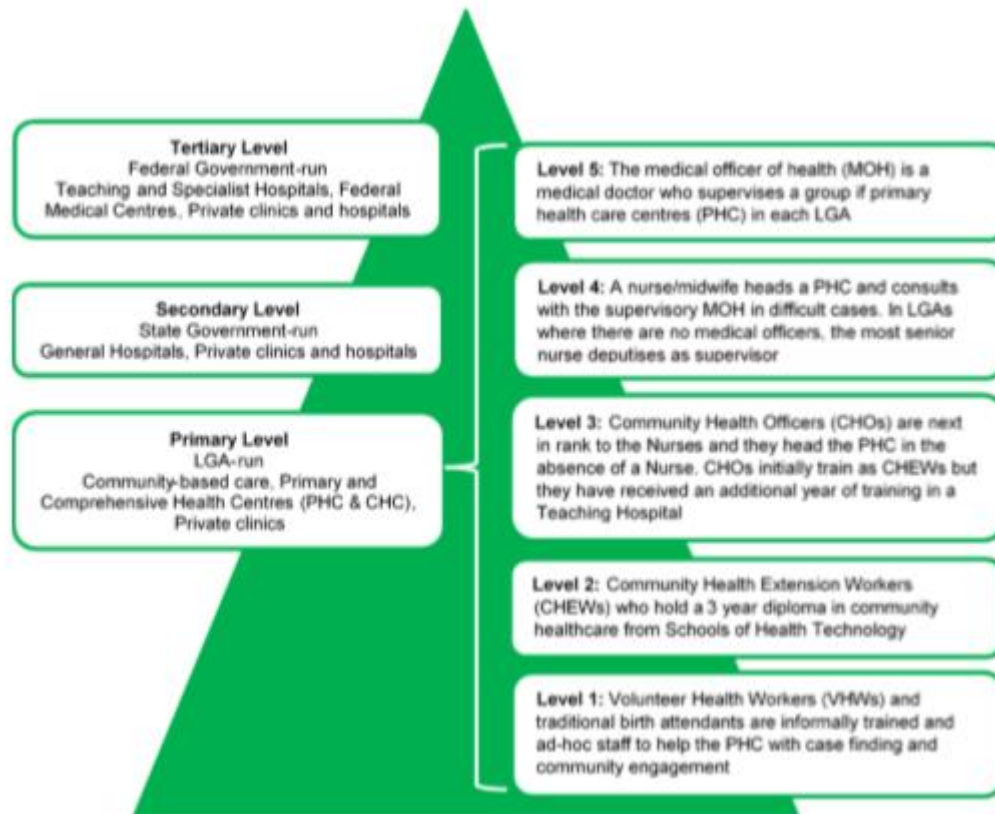
The State Governments provide largely secondary health care through the state General Hospitals and occasionally tertiary care through the State-owned Teaching Hospitals, they also coordinate PHC implementation at the LGA level through the State Primary Health Care Development Agency (SPHCDA). The State governments adapt national policies and strategies; and lead implementation of the AIDS, TB and malaria (ATM) programme interventions; and health strategies and priority activities, at the operational level.

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

The GON, at both Federal and State levels, provides financing for health services; however, most health expenses are borne by families and individuals as 'out-of-pocket expenses' (OOPE), while limited health insurance services are available.

Hence, as shown in Figure 1.3 below, LGAs have the responsibility for the first level of care, the PHC services; State Governments provide secondary level care while the Federal Government provides tertiary level care. The Federal and State Health Ministries, Departments and Agencies (MDAs) manage the implementation of these programmes at all levels (Annex 21: National Strategic Health Development Plan (NSHDP-II) 2018-2022).

Figure 1.3 Nigeria's Health System



Source: *NHSDP-II, op. cit. p.6*

The FMOH has prioritised the strengthening of its PHC system in order to achieve universal health coverage (UHC). As articulated in the National Health Act (NHA) and the National Health Policy (NHP), PHC is the foundation of Nigeria's health care delivery system. The BHCPE, as set out by the National Health Act, will fund delivery of the Basic Minimum Package of Health Services (BMPHS) including basic emergency obstetric and new-born care (BEmONC). Through the Reach Every Ward strategy (a population of 10,000-20,000 per ward), the FMOH aims to have at least one functional primary health centre in each political ward with the involvement of the Ward Development Committees (WDCs), comprising selected community members to ensure community participation and accountability.

In addition, community-based health care services are provided by various cadres of Volunteer Health Workers (VHWs) who are engaged by different public health programmes through various inconsistent standards and incentives. However, the recently launched CHIPS initiative aims to harmonise CHWs and to better define their roles and coordination. In addition, CHEWs are expected to spend at least 60% of their time on community-based health care service delivery.

Nigeria has a growing private health sector which provides 60% of the health care services through 30% of the country's conventional HFs – this includes the not-for-profit services provided by faith-based and non-governmental organisations (FBOs and NGOs); and private-for-profit providers. The broader private health sector also includes traditional medicine providers, PPMVs, drug shops and complementary and alternative health practitioners.

Based on an end-term evaluation of NHSDP-I, the following concerns were noted (c.f. Table 1.6 below).

Table 1.6 Lessons Learnt from the Implementation of NHSDP-I

Issue	Lessons Learnt
Failure to meet targets	While some progress had been made, achievements were lower than expected and the 2015 targets were largely unmet for most indicators.
Lack of focus on service delivery programmes	The Plan focused on health systems strengthening to the exclusion of services, perhaps because the evidence used to inform the strategy development was inadequate; this resulted in key priority areas not receiving the needed attention, for example, disease specific programmes.
Weak operational planning and budgeting	The NSHDP I matrix was prescriptive and not sufficiently robust; subsequently, it did not provide sufficient leeway for health practitioners to use it to develop operational plans. This led to a disconnection between the strategy and annual operational plan development and budgeting.
Lack of institutional framework	The FMOH did not put in place any structure or institutional arrangement to drive the implementation of the Plan and to provide guidance to the States.
High staff turnover	The frequent changes in leadership of the Department of Health Planning, Research & Statistics (DHPRS) leadership at both Federal and State levels also affected the effective implementation and monitoring of NSHDP I (loss of champions, changes in priorities and loss of institutional memory).
Late development of M&E structure	The NSHDP I Monitoring and Evaluation (M&E) framework was not developed until almost midway into the implementation of the Plan.

Priorities under NHSDP-II

NSHDP II builds on the successes of and lessons learnt from implementation of Nigeria's first NSHDP-I 2010-2016 which focused on strengthening the health system and prioritising PHC. NHSDP-I's end term evaluation showed that while some progress has been made, a lot more needs to be done to improve the nation's poor health indices which still rank among the poorest in the world. Recommendations included the following priorities for subsequent strategic health development plans:

- Greater focus on service delivery through the Essential Package of Health Care Services (EPHS).
- Define norms and standards of care at various levels of the health care system.
- Accelerate actions towards UHC by strengthening PHC through consolidating the ward health care system and strengthening referrals and emergency medical services.
- Strengthen the supply chain management system to ensure the sustainable supply of drugs, vaccines and commodities, especially life-saving commodities.
- Review and strengthen community-based healthcare services provision through the harmonisation of community-based healthcare providers and promotion of community participation.
- Step up actions to expand coverage and reducing financial barriers through social health insurance and improving government funding to the health sector.
- Improve the performance of HMIS, generation and use of health data and evidence for decision-making and institute a system for continuous improvement of quality of healthcare.
- Strengthen the coordination of the health sector investments and response.

Health System Strengths, Weaknesses, Opportunities and Threats (SWOT)

The strengths, gaps and challenges of Nigeria's multi-faceted health system are described below; Table 1.7 summarises the strengths, weaknesses, opportunities and threats of the health system which in turn informs the strategy direction of NSHDP II.

Table 1.7 SWOT Summary of the Health Sector by NSHDP II Priority Areas

Leadership and Governance	Community Participation in Health
<p>Strengths</p> <p>Legal, policy and coordination frameworks exist</p> <p>Weaknesses</p> <ul style="list-style-type: none"> • Delayed or poor implementation of policies and plans and programmes and key provisions of the NHA: <ul style="list-style-type: none"> ○ Implementation of NHA core provision such as the BHCPI yet to commence ○ Poor resourcing of health programmes ○ Weak implementation of sectoral and programmatic plans ○ Poor reflection of inequities in planning, programming and programmatic approaches ○ Suboptimal regulation and standardisation of services and practice provided by the public, private sector, including traditional medical practice • Weak coordination mechanisms <ul style="list-style-type: none"> ○ Weak coordination of government at all tiers/interface of the health systems at these tiers ○ Weak inter/intra sectoral collaboration ○ Programmes' compartmentalisation, fragmentation and weak collaboration and role conflict / overlap of functions • Weak mechanisms for accountability, transparency and responsiveness <ul style="list-style-type: none"> ○ Weak responsiveness, rigidity in structure and bureaucracy, reviews not being undertaken ○ Limited voice and accountability and Community Participation in Health 	<p>Strengths</p> <ul style="list-style-type: none"> • Existence of WDCs at ward level and of Facility Health Committees in some facilities • Structures for the engagement and participation of traditional rulers and religious leader exist and are functional • Strong community-based health programmes exist e.g. Integrated management of Childhood Illnesses (IMCI) and iCCM • Existence of multiple cadre CHWs and volunteers <p>Weaknesses</p> <ul style="list-style-type: none"> • Poor understanding of the concept and weak implementation of Community Participation in Health • Fatalistic outlook to disease causation and outcome • Increasing and differential financial incentives for community-based workers (CBW) threatening sustainability • Lack of harmonization and integration of community-based services leading to vertical programmes, duplication and waste of resources at the community level
Partnerships	EPHS
<p>Strengths</p> <ul style="list-style-type: none"> • PPP Policy, partnership platforms and guidelines for partnerships in place • Operationalisation of PPP arrangements at federal, state and LGA levels of care • Strong presence of development partners (DPs) • Existence of partner coordinating forum at all levels • Availability of basket funding for some public health programmes (RI, PHC) in some States 	<p>Strengths</p> <ul style="list-style-type: none"> • Policies, guidelines, standard operating procedures (SOPs) and/or treatment guidelines, etc. for delivery of health services are in place • Expansion and scale up of services such as immunisation, malaria and TB control, HIV services - leading to better coverages • Improved malaria control activities and outcomes • Improved integration of services such as the RMNCAH+N, TB and HIV integration

<ul style="list-style-type: none"> Improved inter-governmental partnerships (State and Federal institutions to leverage human resources for health (HRH) for service delivery) <p>Weaknesses</p> <ul style="list-style-type: none"> Weak alignment of DP support with national/State plans Ineffective coordination of health partners at all levels leading to inefficiency, duplication and/or overlap Poor transparency and accountability by some DPs Promotion of vertical programming and reporting that frustrates integration 	<ul style="list-style-type: none"> Intentional focus on PHC strengthening showing promising signs of improved access <p>Weaknesses</p> <ul style="list-style-type: none"> Poor and inequitable coverage with high impact cost-effective interventions Poor implementation of the Minimum Health Services Package (MSP) resulting in poor services quality Inequity in access to information and services (geographic, socio-economic and gender) Weak referral system and weak integrated supportive supervision (ISS) Rudimentary emergency medical services Poor linkage of community-based health care providers to the formal health care system Non/limited availability of services for some conditions/target groups (e.g. care of the elderly, mental health, youth friendly reproductive health services, services for persons with disabilities) Inadequate demand creation leading to low utilisation of available services Inadequate attention to social determinants of health
Human Resources for Health	Health Infrastructure
<p>Strengths</p> <ul style="list-style-type: none"> National HRH policy and strategic plan are in place have been domesticated by some States Infrastructure for National Human Resources for Health Information System (NHRHIS) is in place National task shifting and sharing policy and its SOPs have been developed and rolled out Variable capacity for HRH production exists in all States 14 regulatory bodies for HRH production, practice control and accreditation <p>Weaknesses</p> <ul style="list-style-type: none"> Poor implementation of HRH policy and strategy at all levels Maldistribution of HRH precipitating significant inequity in the health system Acute shortage of skilled health workers, especially at PHC level Gender inequity in the health workforce adversely affects service utilisation, especially by women Lack of reliable information for HRH planning and management Embargo on employment across many states worsens HRH availability Poor motivation leading to recurrent strikes ☐ Tremendous tension among health professions hindering collaboration and synergy in the health system Lack of scheme/standards of practice for some health cadres, e.g. M&E Officers Weak systems for ISS 	<p>Strengths</p> <ul style="list-style-type: none"> National Infrastructure Policy and defined minimum standards for HFs exist Large number of HFs across the country <p>Weaknesses</p> <ul style="list-style-type: none"> No health infrastructure development master plan to guide systematic implementation of the infrastructure policy Poorly equipped HFs, most in a severe state of disrepair Inadequate funding and capacity for effective infrastructure maintenance Limited investment in information communication technology (ICT) and communication infrastructure in the health sector Poor public power supply, water and basic sanitary facilities. Critical shortage of reliable transport for referral and general health facility management and operations No fleet management plan

Medicines, Vaccines, Commodities and Health Technologies	Laboratory Services
<p>Strengths</p> <ul style="list-style-type: none"> • Policies, guidelines and institutions exist • Available and willing to engage local manufacturers with WHO certification • NSCIP project made progress in integrating supply chains at all levels <p>Weaknesses</p> <ul style="list-style-type: none"> • Gross underfunding for medicines and other health products and equipment • Poor availability of essential and life-saving medicines • Poor storage conditions coupled by weak last mile distribution • Poor infrastructure and incentivisation of local pharmaceutical production • National vaccine production moribund • Increasing prevalence of anti-microbial resistance • Low investment in alternative medicine 	<p>Strengths</p> <ul style="list-style-type: none"> • Some public and private laboratory services capacity exists • National and Blood Transfusion Services Policies exist • Increasing pool of qualified laboratory personnel <p>Weaknesses</p> <ul style="list-style-type: none"> • Poor quality assurance and control of laboratory services and ineffective regulation of laboratory services • Poor networking of laboratory services • Inadequate availability and poor maintenance of lab equipment • Limited availability and inequitable distribution of skilled lab personnel • Poor supply chain management for laboratory consumables and supplies • Poor laboratory information management system • Poor linkage between clinical and research laboratory services Health
Health Information System	Health Research
<p>Strengths</p> <ul style="list-style-type: none"> • Establishment of the Health Data Governance Council (HDGC) and Health Data Consultative Committee (HDCC) chaired by the Honourable Minister of Health • Cascading of health data governance structures at subnational levels • Draft roadmap for strengthening the M&E system in place • DHIS-2 expanded and rolled out to all the States • Community-based HMIS tools developed and field tested <p>Weaknesses</p> <ul style="list-style-type: none"> • Fragmentation of reporting lines due to vertically funded programmes and huge burden for multiple reporting by limited health workers • Non-availability of reliable data for health planning and decision-making • Weak capacity for data analysis and use at all levels • DHIS 2 does not capture community-level health information • Poor feedback mechanisms and suboptimal ISS • Ineffective coordination of the M&E system at all levels • Lack of HMIS tools especially at health facility level • Poor reporting (service and financial) by the private sector and some development partners 	<p>Strengths</p> <ul style="list-style-type: none"> • National health research policy and guidelines and research institutions exist • Research governance and regulatory structures in place at all levels (National Health Research and Ethics Committee/NHREC) • Specific funds for research exist e.g. Tertiary Education Trust Fund (TETFUND) and the National Universities Commission (NUC) • Legal arrangements and institutions for IPR and technology transfer exist <p>Weaknesses</p> <ul style="list-style-type: none"> • National health research agenda exists but lacks funding and capacity for implementation • Lots of health research being conducted out of alignment with the national research priorities • Poor alignment between academic research and policy and/or implementation priorities • Weak promotion, coordination and regulation for health research and development • Limited investment by public and private sector in research and development • Weak enforcement of patent and intellectual propriety rights legislation • Poor networking/linkages between researchers • Weak repository of research products and information • Brain drain of researchers from health research institutes to universities

Public Health Risks and Emergencies	Health Care Financing
<p>Strengths</p> <ul style="list-style-type: none"> Existence of relevant and functional institutions e.g. Nigeria Centre for Disease Control (NCDC) and Emergency Operations Centre (EOCs), National Emergency Management Agency (NEMA) and State Emergency Management Agency (SEMA) Increasing pool of trained field epidemiologists Availability of policy, strategic plan, guidelines and tools for IDSR <p>Weaknesses</p> <ul style="list-style-type: none"> Delays in IHR compliance Weak surveillance system/ early warning signs Poor sub-national capacity for preparedness and response planning and implementation Surge capacity of HFs to respond to public health emergencies is poorly developed Weak network and capacity of public health laboratories 	<p>Strengths</p> <ul style="list-style-type: none"> Existence of health care financing (HCF) governance structures including the HCF unit of the FMOH and the NHIS A detailed NHCF & E Policy and implementation plan in place Provision of BHCPF in the NHA is a catalyst for UHC Development partner commitment and support for key public health programmes RMNCAH+N, Malaria, TB, HIV Most States have established State Health Insurance Scheme (SHIS) to reduce financial hardship at point of health care <p>Weaknesses</p> <ul style="list-style-type: none"> Very low budget allocation to health and poor release of budgeted funding to the health sector at all levels Very high OOE risk catastrophic health expenditure Poor national health insurance coverage and nascent SSHIS Weak health care financing implementation and tracking systems e.g. no subnational health accounts Weak overall regulatory mechanisms for health care financing actors and schemes including health maintenance organisations (HMOs), Community Based Health Insurance Scheme (CBHIS) and State Health Insurance Agencies Donor dependence at all levels for key public health programme funding
Cross-cutting Opportunities	Cross-cutting Threats
<ul style="list-style-type: none"> Positive economic outlook for the country Increasing donor presence and support Strong health leadership and enabling policy environment NHA and BHCPF are excellent opportunities to advance UHC 	<ul style="list-style-type: none"> Unpredictable and unsustainable HCF As Nigeria moves to middle income country status, donor funding is decreasing Fragility, civil unrest and emergence of public health disasters Changes in political leadership at all levels may affect policy consistency Weak multisectoral coordination limits effectiveness of response to health-related Sustainable Development Goals (SDGs)

Source: *NHSDP-II*, pp.42-44.

NSHDP-II articulates the position of Nigeria's health sector stakeholders in terms of the national health systems gaps, priorities and investment plan. The current RSSH grant (2018-2020) aligns with the priority areas of NSHDP II, particularly the Strategic Pillars 1,2,3 and 5 (see Annex 21 – NSHDP-II).

This RSSH Continuation FR is structured to deepen this alignment and ensure sub-national level investments that builds a national system that benefits field operations.

Current RSSH Implementation Status

The current GF RSSH grant (2018 - 2020) is supporting Nigeria's health system in four key areas:

- (1) Procurement and supply chain management (PSCM2);
- (2) Laboratory infrastructure and services;

- (3) HMIS; and
- (4) the State Approach.

Key activities supported by the current grant have included capacity strengthening for coordination, strategic and operational planning, developing and deploying data management tools, quality improvement strategies, programme management systems, deployment of technological solutions, and technical assistance for implementation. These activities have yielded good results in States across the country as reported in the RSSH-PR Progress Report (Annex 22). The cross-benefits of this grant's support in health systems investments have contributed to increased efficiency and improved coverage of health services to the population across the country, particularly for HIV, TB and malaria as reflected in the implementation status below.

RSSH Linkages with National Strategic Health Development Plan (NSHDP II) Strategic Priorities

The current RSSH grant investments align with the priority areas of the NSHDP II.

Halfway through the lifetime of the current grant, the absorption rate should be higher. Factors that have contributed to the lower than expected absorption rate include:

- (a) Late signing of the grants (implementation started mid 2019)
- (b) Sequential implementation of planned activities;
- (c) Role conflict among the stakeholders (including PR & SRs), which sometimes delayed arriving at a consensus and thus hindered progress;
- (d) Delays in PR providing some SRs with administrative costs to cover their expenses;
- (e) Delay in procurement processes, fulfilment of grant requirements and contracting of TSOs
- (f) Insufficient capacity and human resources at PR and Sub-Recipient (SR) levels and high staff attrition at government facilities.

That said, the current progress of implementation (see below) shows that the majority of interventions are now on track and significant progress – and, therefore, an improvement in the grant absorption rate – is expected from March 2020 onwards. Additional measures to improve absorption are listed below and include:

- The PR worked with the SRs to help to address most of the challenges;
- The release of the administrative costs to all SRs in February 2020, as well as provision of some infrastructure;
- Decentralising supervision and ensuring simultaneous implementation of planned activities.
- Ensuring mandate alignment and coordinated actions among the implementing entities.
- Country Coordinating Mechanism (CCM) support for PR-SR orientation and reorientation workshops on organisational behaviour and ethics.
- Increase in the scope and scale of investment in the State Approach. Please note that the State Approach deals with activities related to the **Health Sector Governance and Planning (Module 6)** of the Revised GF Modular Framework, 2019 pp. 18-19)).

Procurement and Supply Chain Management

The PSCM component supports interventions to improve the supply chain management that will lead to the uninterrupted supply of quality health commodities to HFs. Some key improvements have already been achieved: the proportion of public health facilities reporting on the National Health Logistics Management Information System (NHLMIS) – also known as the NAVISION platform – according to national guidelines (timeliness and completeness) improved from 36% in 2018 to 53% as at December, 2019 (Annex 22: RSSH-PR Progress Report).

In addition, the upload of TB data to the NHLMIS platform has commenced and is on track to be completed within schedule by the end of March 2020. Systems for logistics management and coordination in all 36 states and the FCT have been institutionalised through the Logistics Management and Coordination Units (LMCUs) in line with the policy to devolve functions to sub-national levels through the State Approach. This remains the country's investment strategy for this new application, to consolidate the gains of the ongoing grant. The integrated quarterly mentoring and supportive supervisory visits (MSSV) by the LMCUs to the LGAs and HFs have contributed to improving reporting rates and data quality, and the resulting timely decisions and actions that have ensured minimal stock-outs of commodities at facilities. Integration of laboratory commodities logistics into the general pharmaceutical logistics management has commenced and a pool of 26 master trainers have been trained positioned to take this process to scale.

To improve health outcomes, the grant supported the revision of the National Pharmacovigilance Policy (2013), through NAFDAC. Also, the National Supply Chain Strategic and Operational Plan (2020-2024) was developed under the leadership of the National Products Supply Chain Management Programme (NPSCMP), Department of Food and Drugs of the FMOH. The current grant and the new investment will be aligned with the new Plan. The Strategy is already annexed as Annex 29.

Laboratory Systems Strengthening

Key achievements under the current grant investment include: development of the draft National Laboratory Policy 2021-2025; strengthening laboratory coordination structures at national and state levels; end term evaluation of the National Medical Laboratory Strategic Plan (2015 – 2019); development of National Bio-risk Management Guideline and National Bio-risk Training Curriculum. The on-going grant also supported the national system to create a pool of Master Trainers for National Bio-risk Management as well as trained Health Facility Personnel on quality management systems. Seventy-four (74) Secondary Laboratories were enrolled into the National External Quality Assurance-Proficiency Testing Program; and there is ongoing support to quality management systems

Equally, the grant is supporting the development process of the new National Medical Laboratory Strategic Plan (2021 - 2025); the improvement and deployment of the laboratory information management systems and linking same to the national DHIS-2; infrastructural upgrade of 74 secondary laboratories (two per state) across the country; and strengthening the specimen transport system across the three diseases. (Annex 21, *op. cit.*).

Health Management Information Systems

The national HMIS interventions supported under the current grant include routine reporting, data quality, data analysis and use, review and transparency, interoperability of data platforms and M&E. These interventions are tailored towards meeting the RSSH performance framework indicators #1-#3 aimed at improving the HFs reporting rate on the DHIS-2 platform, completeness and timeliness of reporting, and e-reporting by supported HFs. These will result in improvements in some of the health information system indicators (e.g. numbers 12 and 18).

Data collection and reporting tools have been revised, and capacity built in their use among health care workers in 20 states and NHMIS Officers in all 36 States and the FCT. All HFs should report using only the revised tools with effect from 1 April 2020.

The DHIS-2 platform has been configured with the revised NHMIS tools. Efforts towards improvement in data use across the country included support for LGA Data Review Meetings in 40 LGAs; Data Use and Analysis Training for State HMIS Officers; and development of Data Demand and Use Strategy for the Nation. To improve data quality, the grant supported Data Quality Assurance Exercise at the national and state levels. Health Data Consultative Committee Meetings were equally supported to improve coordination of HMIS activities in 14 states. The grant also procured 150 tablets to support TB data reporting.

The recently established National Health Facility Registry (NHFR) has been expanded to 13 States + FCT while the deployment process is ongoing in additional 19 states (Annex 22, *op. cit.*). This work will be completed by April 2020 and linked with the DHIS-2. Given the significant increase in data linked to the national DHIS-2 it became necessary to increase the bandwidth of the national instance for efficient data processing; this expansion is ongoing and will be completed within the current grant. The grant equally supported an assessment of the Health Information Exchange and E-reporting assessment; report of these assessments is currently providing a guide for development of EMR systems in Nigeria. There is ongoing procurement of the revised NHMIS tools; and 1,000 tablets for supporting e-reporting and support towards establishment of Health Workforce Registry in 2 states.

State Approach (Health Sector Governance and Planning at State Level)

The State Approach strengthens the capacity of the States to coordinate and manage their health systems better, through public finance management systems strengthening and health financing interventions.

A landscaping assessment was conducted in the three beneficiary States of Imo, Kaduna and Oyo for the following domains of the health system: The State Health Insurance Scheme, public finance management, health labour market and State health accounts. Based on the findings of these assessments, technical assistance plans, work plans and budgets to address identified gaps were developed and currently being implemented in the states.

Benefits from the Current Grant

The States have also been strengthened to better coordinate their health sector. Each State has developed its customised health sector coordination work plans based on its specific needs, developed concept notes per activity on the work plan and is following through with implementation. Some activities implemented in Kaduna State were integrated into quarterly TB/HIV and malaria supportive supervision to 40 HFs, procurement supply management (PSM) quarterly review meetings, quarterly zonal level HIV review meetings, and the quarterly malaria control technical forums. The grant equally supported development of the Annual Health Sector Operation Plan 2020 for Kaduna State. Activities implemented in Oyo State included quarterly HIV technical forums, quarterly meetings of partners and stakeholders, quarterly TB technical forums, ATM quarterly coordination meetings, the mapping of potential private sector partners - Traditional Birth Attendants (TBAs), quarterly RSSH review meetings and joint evaluations of public health programmes in the State. In Imo State, activities implemented were the quarterly meetings of health sector partners and stakeholders, supportive and supervision visits to 54 HFs by State officials, quarterly HIV/AIDS control technical forums, quarterly TB control technical forums, quarterly malaria control technical forums, and biannual HIV/AIDS data validation meetings.

The expected outcomes of the investments in state level activities listed above is yet to be measured as at the time of this FR because of delayed implementation and the expected timeline to measure effects, health stakeholders are however optimistic of positive change in health systems domains of the benefiting states. The reports of subsequent periodic assessments will compare to the findings at baseline to objectively inform benefit(s).

Lessons Learnt

- Experience from the States' health sector coordination activities suggests that, with a little more support, some States may be able to play a more prominent role in managing and improving their programmes supported through the grant.
- Decentralisation of grant implementation could potentially improve efficiency and the PR-SR relationships.
- The use of technical service organisations (TSOs) helps keep activities on course. However, the selection and engagement of TSOs has tended to take longer than anticipated and this has been a major cause for some activities falling behind schedule. In future, adequate allowance must be made for the TSO recruitment process and ways must be found to streamline processes to minimise delays; and this will be addressed during grant-making.
- Involvement of the CCM and other stakeholders in grant implementation positively impacted on implementation and is critical for alignment and the avoidance of duplication.
- Current grant interventions would have benefited from simple but effective M&E and learning activities, set up from the onset. The RSSH PR is launching this now and will seek relevant resources from the GF for its support. This is critical to track, improve and learn from implementation; and should be done in collaboration with the grant's SRs and other key stakeholders.

Table 1.8 describes the achievements, issues and lessons learnt under the current grant; and plans going forward

Table 1.8 Health Management Information System

Intervention	Scope & Achievement	Lesson/Challenges	Plans Going Forwards
Training on the 2019 HMIS Tools Version 2019	All the 36+1 States were trained on the use of the NHMIS tools. LGAs M & E Officers were trained in over 700 local governments.	It is impossible to implement NHMIS activities in only some few states. Many states are orphaned and may lag behind if not supported. Building a pool of trainers at the subnational level makes the roll out of the data collection tools faster. Training of other	The new grant will focus in building the capacity of the private sector providers on the use of NHMIS tools and reporting. The GF grant will also support the retraining and printing of tools. It is planned that the grant will support the provision of Android phones to some private sectors and PHCs to facilitate reporting to

		programme officers on the use of data collection tools is important in improving data quality. The major challenge is the non-engagement of the private sector0-p=[] .+	DHIS 2. We will continue to use the State approach in the implementation of NHMIS activities. A national SOP has been developed to guide data collection, reporting and use of data.
Health Facility Registry and Master Facility List (HFR & MFR)	This was initially meant for 14 States but has now been scaled up to all the 36+1 States. The interoperability of the DHIS 2 with the HFR was undertaken.	Engagement of the States and the LGAs was the key to successful implementation and roll out.	The GF will support the States to update the HFR when need arises. The national level will continue to provide technical oversight to the States.
Integrated supportive supervision and DQA.	This is being conducted nationally.	The DQA was conducted without the full engagement of the programmes, hence the need to separate the ISS/DQA	DQA will be implemented as a programme specific activity while the ISS will be implemented as across-cutting activity. The State's capacities will be built to also do this while the national level will provide the States with capacities and tools for ISS and DQA. To improve the quality of data, HFs' capacities will be built in the areas of internal data quality assessment. Multi-disease teams will be constituted for data quality at the facility level.

Moving Forwards

Although Nigeria remains a GF-designated challenging operating environment (COE) – with worsening insecurity, steady inflation, slow gross domestic product (GDP) growth (less than the population growth rate), an increasing level of poverty and social displacement – some key health outcome and impact indicators have improved or stabilised in the course of the current programme. However, although there are variations between States, at the national level expenditure on health has declined significantly and information on health service delivery infrastructure, management and coverage remains scant. See the *Nigeria Health Programmes and Situation Analysis – February 2020* at Annex 24 for further information.

While the Government at both Federal and State levels provide some financing for health services, most health expenses are borne by families and individuals as OOPE.⁶ Only limited health insurance services are available; and, according to the 2018 NDHS, only 3% of women and men aged 15-49 have health insurance.

Support for the continuation of the RSSH Programme is being sought through this Funding Request in order to intensify ongoing efforts and support operationalisation of the revised policies, adopted strategies, developed plans, established platforms and improving systems to systematically achieve their objectives or mandates at the sub-national and facilities levels. A list of policies and plans relevant to this RSSH Funding Request is attached at Annex 25. An overview of the country's multi-level health system is provided in Annex 26.

To build on the achievements of the current RSSH grant and support the operationalisation of the revised policies and strategies will require further analyses of national health indicators because the national averages disguise the wide variations in health service coverage, BOD and health outcomes across Nigeria's different regions and States.

⁶ See Section 3.3 of the *Nigeria Health Programmes and Situation Analysis – February 2020*.

The current grant continues to support ongoing policy and strategy review activities, planning, monitoring, reporting and creation of standards across the prioritised modules. At the National Stakeholder Dialogue meeting, the health sector stakeholders agreed that, while these ongoing activities continue, this Funding Request (2021-2023) should focus on investments in States and other sub-national level modular systems to allow them to benefit from the national standards already established and to provide bespoke system solutions to their specific capacity gaps.

The current RSSH grant implementation provides an opportunity to expand the scope and scale of the ongoing State Approach and improve learning. Criteria for accommodating additional States may include present or previous SR-ship of GF grant(s), burden of ATM disease or health systems issues, performing States based on key indicators, reasonable geographic location and findings from rapid readiness assessments.

With the achievements of the current RSSH grant and continued investments through this Funding Request in strengthening and building on the systems improvements already initiated and at various stages of deployment for HIV/AIDS, TB, malaria and the broad health system at sub-national level, GF RSSH support aligns with the 'Theory of Change' of the NSHDP II – see Annex 21.

RSSH Fund Request (2021 – 2023) – Programme Continuation

Following on the key achievements and lessons from implementation of the current grant, the four prioritised modules are maintained and a split is proposed for the prioritised activities at both the Federal and State levels based on the mandates of the relevant stakeholders and where the greatest investment impact would be made.

This split will also help resolve some of the major implementation bottlenecks stated above, including over-centralisation of decisions or actions and mandate alignment. Operational level responsibilities – such as trainings, supportive supervision, integrated services, sub-national planning, and data analysis and use – will be managed by key entities at the State level that have received necessary support and guidance from the Federal counterparts.

This Funding Request therefore seeks to expand the scope of the **State Approach** under the **Health Sector Governance and Planning** module of the revised Modular Framework and invest directly to build RSSH across selected Nigerian States.

An additional two modules (**Community System Strengthening** and **Integrated Service and Quality Improvement**) are proposed to deepen the benefits of the ongoing RSSH investment. The benefits of ongoing systems improvement investments will not create the necessary impact if quality services are not delivered to the health sector clients in a more efficient way. To take some of the outputs of the current RSSH grant forward, community service and service integration are important areas of focus to guarantee the requisite impact on health service coverage and indices.

The current grant will continue to support activities around Federal-led policy and strategy reviews, planning, monitoring, reporting and setting of standards across modules.

The new State Approach: Health Sector Governance and Planning at State Level (Module 6)

The health sector actors agreed at the National Stakeholder Dialogue that a good proportion of the allocated funds should focus on system-wide investment at State level across the prioritised modules of this Funding Request. This will allow the selected States to benefit from the national standards already established and provide bespoke system solutions for the capacity, epidemiological and service coverage gaps responsible for the variations across the states and regions of Nigeria (c.f. Annex 24: Nigeria Health Programme and Situation Analysis 2020 Table 4, p. 35). This module will also help resolve at least three (3) of the implementation challenges of the on-going RSSH grant mentioned earlier. These challenges and expected effects of state engagement are listed below:

- ***Sequential implementation of planned activities*** – States as SRs or SSRs will simultaneously implement approved activities once the national standards and quality control mechanisms are established. Relevant Federal agencies and PRs will only provide required TA and supervision.
- ***Role conflict among the stakeholders (including PR & SRs), which sometimes delayed arriving at a consensus and thus hindered progress*** – The PR and Federal programmes will act less as implementers of GF supported activities as state level. Operational level roles will be devolved to relevant state entities with such mandates.
- ***Insufficient capacity and human resources at PR and Sub-Recipient (SR) levels and high staff attrition at government facilities*** – RSSH project implementation will leverage on existing human, institutional and

infrastructural capacities of the implementing states. This engagement will also help strengthen capacity of the states on HRH management.

The role of the different actors at the various levels of the Nigeria health system is summarised in Annex 27.

The Health Governance and Planning Module (State Engagement) will adopt **a phased approach** to direct engagement and support to 12 States over the three years (four States each year) of this Funding Request, based on the following selection criteria:

- Three States who are already implementing State Approach under the current grant.
- Nine additional states selected based on (i) the burden of ATM diseases, (ii) health coverage indicators (please see Table 4, p. 35 of Annex 24), (iii) relatively strong health system (to serve as learning centres and peer influencers) and (iv) strong political will.

The twelve states will lead the coordination and reporting of GF funded HIV/AIDS, T.B and Malaria activities using the platforms funded by this grant under the leadership of the Hon. Commissioner for Health in each state as described in the implementation arrangement below.

Implementation Arrangements for State Level Health Sector Governance and Planning (Replaces State Approach)

Under the political leadership of the Executive Governor of each of the supported States and the Honourable Commissioner for Health, a Project Coordination Unit (PCU) to oversee and coordinate the activities of all state level 'Managing Entities' and headed by an officer not less than a Director will be established to facilitate harmonisation of ALL the GF supported activities (including ATM and RSSH) and ensure that prioritised activities of the various modules of this FR are implemented as planned and are coordinated as follows:

- Procurement and Supply Chain Management – The managing entity is the State LMCU (capacity built by the current grant);
- HMIS – The managing entity is the State DPRS (they have received significant support from the current grant and other partners);
- Laboratories – The managing entities are the State Laboratory services, Laboratory Technical Working Group (TWG) and the Hospital Management Board;
- Community System Strengthening – The managing entities are the CSO Networks, Community Gatekeepers and traditional institutions;
- Integrated Service and Quality Improvement – The managing entities are the State PHC Board and the LGA Coordinators and
- Health Sector Governance and Planning for State – State Approach/engagement of the highest political and administrative level. This will be managed by the PCU under the office of the Hon. Commissioner for Health.

This level of engagement also allows a more coordinated approach towards private sector engagement through the departments or agencies of the State governments responsible for the registration and annual licencing of the formal and the informal private sector HFs.

Selection of state as SR or SSRs

1. The SR States: The states with relatively strong health system based on key health indices, service coverage information and demonstrable political will be selected as SRs under the RSSH grant. A total of six states are proposed under this arrangement.

2. The SSR States: The six states selected based on the burden of ATM diseases and relatively poor health service coverage or outcome information will serve as sub-SRs under the direct mentorship of a national SR and a strong TA plan. A strong political will is also required to provide effective leadership for state level coordination. Other implementation level support for the SRs and SSRs are summarised in Table 1.8.

Table 1.8 Implementation Support

Classification	Implementation Support				
	PR	Federal MDAs	WHO and State Partners	Independent Consultants	TSO
Sub-Recipient	Yes	Yes	Yes	Yes	
Implementing Unit	Yes	Yes	Yes	Yes	Yes (CCM)

The proposed prioritised modules and activities are listed below. Please note that the Federal level activities in many instances will benefit all levels (Federal, State and LGAs) without funding overlaps with activities to be supported directly through the State Engagement.

Module 1: Procurement and Supply Chain Management

The GF, in collaboration with other partners, has made significant investments in strengthening the national PSM system through the National Supply Chain Integration Programme (NSCIP). This has achieved some improvement as indicated in the implementation status earlier described, particularly in the areas of warehousing and coordination through the LMCUs at the State and national levels. However, the centrally managed last mile distribution has been poorly coordinated and inefficient despite its huge recurrent cost on both the GF and US Government-supported programmes. This inefficiency has been communicated by ALL of the 13 GF-supported State covered by the

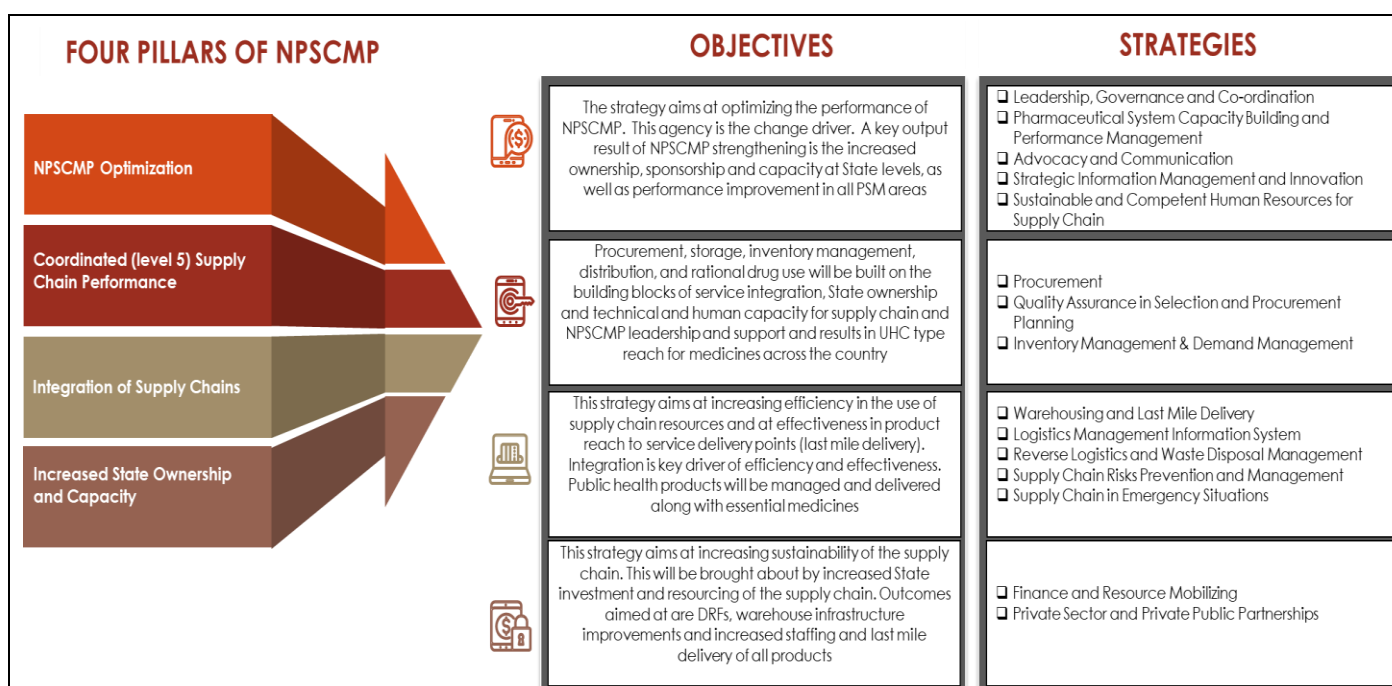
Box 1: Expectation of Revised Health Supply Chain Strategy

The overall strategy Statement for the National Health Supply Chain Strategic Plan, NHSCSP, (2020 – 2024) is to empower governments at the three levels to function effectively as stewards of the supply chain. It aims at forging a collaboration to implement a single channel of service delivery to the Nigerian client using lessons from the private sector to implement a sustainable, cost effective, UHC-aligned and dynamically responsive management system.

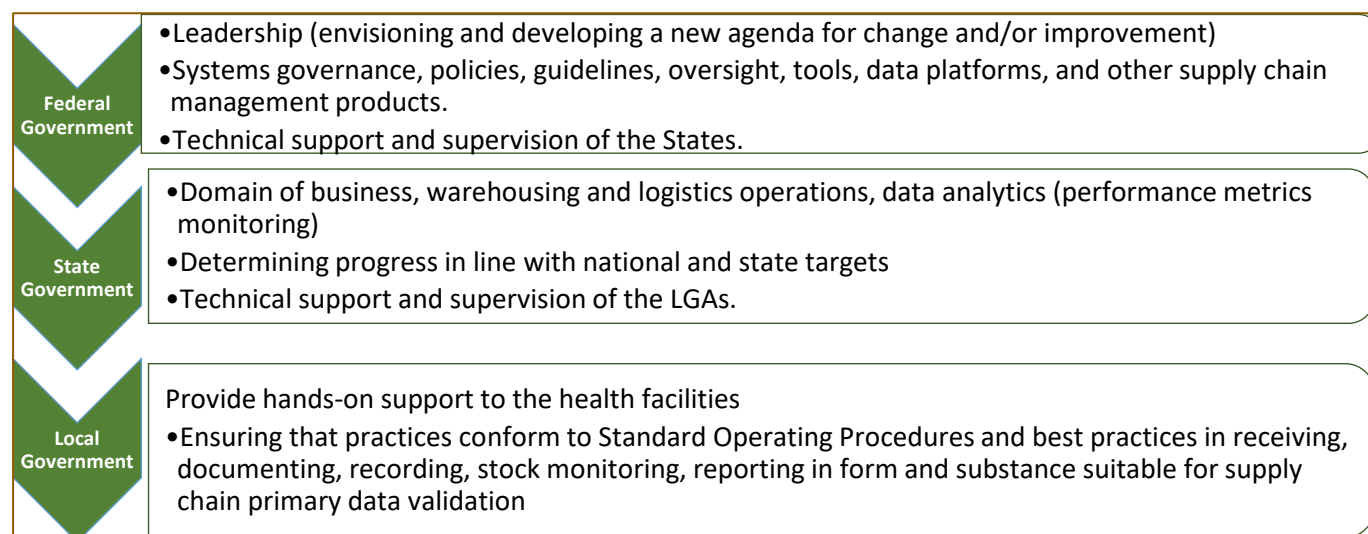
Malaria grant (c.f. Annex 23: Report on Stakeholders Meeting on HMIS/LMIS Data Triangulation, 7-8 August 2019, p.3) at every coordination meeting with NMEP and has been linked to the current Last Mile Delivery (LMD) model which relies on only six warehouses to service over 30,000 HFs spread across 36 states and FCT and 774 LGAs. One major resultant effect of this model was persistent 'proxy delivery' which predisposed commodities to poor management and pilfering. This consistent operational level feedback to the national programme although requires a detailed analysis of the complaints through a cost efficiency study, an independent investigation of the complaints should also be considered to allay the fears of the state level actors. However, a comparative analysis of budgets for distribution applied by GF and USG supported programs on one hand and state DRFs on the other hand was conducted by the NPSCMP. This analysis showed that on the average, GF and USG supported programs budget 23-25% of the cost of products for distribution while the state DRFs budget 3-4% of the cost of products for distribution.

The National Supply Chain Strategy and Plan, 2020-2024 outlines how the products in the zonal hubs will integrate with essential medicines at the state level. The efficiency expected in this approach to management will come from building capacity in each state to manage the integrated delivery rather than using one organization to run the entire country. By encouraging ownership by states (who understand their terrain), proxy deliveries will be eliminated, accountability will improve, and responsibility will be well managed. The main goal for integration is to make the program products be managed with the same cost effectiveness as essential medicines and to further strengthen the state warehouses to play the roles as cross docking centre - this model will enhance the NSCIP design. This new role implies that those state warehouses in the first place must be pharma-grade in terms of infrastructure and operations.

This Funding Request will prioritise further investments towards a more decentralised and well-functioning supply chain management system for efficient health service delivery. The investments will focus more on strengthening state ownership of operational level mandates as prescribed in the National Supply Chain Strategy (c.f. Annex 29 p.20) while supporting the national institutions to effectively perform their normative roles, oversight and capacity building across all levels and sectors. This prioritised interventions and activities of this FR is therefore based on the Four Pillars of the NPSCMP and their corresponding objectives.



Role Map: Procurement and Supply Chain Management



Please see also the cross-level roles of PSCM stakeholders in Annex 27.

Intervention 1.1: Strengthening Governance and Coordination

The following key activities are proposed to help strengthen PSM governance and coordination at national and sub-national levels, areas of weaknesses that are amply described in the Nigeria Health Systems Programmatic and Financial Situation Analysis February 2020 (Annex 24). The activities will also address some of the key gaps and challenges highlighted in the NPSCMP Strategy, 2020-2024 including (i) inadequate management capacity, (ii) duplication of roles between programs and (iii) performance issues on key supply chain indicators. The implementation of state level activities will significantly contribute to achieving a better national performance.

Federal Level

- PSM coordination meetings at national, states and LGA levels. This will be crucial for the integration of supply chains of all health programmes (including HIV/AIDS, TB and malaria) and reporting on key performance indicators in order to maximise benefits from synergies in the procurement, storage and supply of vaccines, medicines, laboratory supplies, family planning commodities and other medical supplies

State Level

- Coordination meetings for planning and reporting of ATM, Laboratory Supplies and other health commodities at the state and LGA levels.
- Supportive supervision and monitoring of ATM commodities, Laboratory Supplies and other health products.

Intervention 1.2: Strengthening Storage and Distribution Capacity**Federal Level**

- Support upgrade of the infrastructure of additional 12 State warehouses (through a co-financing mechanism) to pharma-grade level to enable functional DRF similar to the ones supported by DFID funded projects in Kano, Jigawa and Ekiti states. The GF support will also serve as an incentive for state level contributions and complements a state like Kaduna to complete the remaining phases of the on-going upgrade of the central warehouse to pharma-grade level. This state level upgrade will complement the existing six regional warehouses and help to further decentralise storage, improve time efficiency in last-mile distribution and ensure state ownership of ATM commodities and other health products.

State Level

- Support development and implementation of the maintenance plan of the upgraded warehouses and provision of relevant equipment and technology.

Intervention 1.3: Strengthening Regulatory and Quality Assurance Systems**Federal Level**

- Support NAFDAC to equip state Offices and Ports of Entry with 46 TruScan devices for rapid product quality screening: one per State office and one per Port of Entry. Investment in Truscan is to strengthen the capacity of NAFDAC to rapidly screen medical products at ports of entry and during periodic post marketing surveillance without subjecting every batch of medicines to expensive, time-consuming comprehensive laboratory evaluation. NAFDAC prefers the use of Truscan because it is hand-held; robust; non-destructive, can "see" through some packaging; no consumables required; qualitative and quantitative; low-middle level training required to operate, selective and sensitive with high degree of accuracy and precision. Nigeria has gained international recognition in the use of the Truscan for ports inspections and post-marketing surveillance. The detailed operational and maintenance plan for the devices is attached to this FR (c.f. Annex 34: NAFDAC Strategic Plan for Rapid, On-the-Spot Field Detection of Substandard and Falsified (SF) Medical Products using the Truscan Device in Nigeria).
- Strengthen existing NAFDAC ISO-17025 labs to conduct comprehensive analysis and Bioavailability /Bioequivalence (BA/BE) profiles of Pharmaceuticals and ATM diagnostics (e.g., Malaria and HIV RDTs).
- Strengthen NAFDAC role and capacity in pharmacovigilance and ADR monitoring and reporting.

State Level

- Train relevant state officers and facility staff on pharmacovigilance and ADR reporting for ATM and other health medicines.

Intervention 1.4: Logistics Data Quality Improvement**Federal Level**

- Continue strengthening the national health logistics management and information system, particularly with respect to timely and accurate reporting across all logistics areas.
- Scale up interoperability between: (i) State central medical stores (CMSs) and Zonal warehouses; (ii) DHIS-2 and NHLMIS; and (iii) NHLMIS and e-Po for the 12 new state stores

State Level.

- Strengthening capacity for quantifying, planning, forecasting health products and deployment of NAVISION platforms across disease programmes at the State and LGA levels to improve ATM and other health product visibility.

Intervention 1.5: Strengthen Health Commodities Integration and Sustainability

Federal Level

- Not applicable

State Level

- Strengthen DRF (including ATM products) implementation and resourcing at the State, LGA and, most importantly, at the facility level.

Intervention 1.6: Avoidance, reduction and management of health care waste

Federal Level

- Strengthening capacity of the national and sub-national stakeholders on waste management systems

State Level

- Support the state (through co-financing) in the provision of infrastructure and equipment for the collection, transport, treatment and disposal of health care waste that are compliant with environmental and occupational health standards

Expected Results

- A well-coordinated, efficient and sustainable Health Product Logistic Management System with improved product visibility and decision-making capability (including management of stock-outs), particularly at the sub-national level, ensuring that 95% of supported HFs are able to provide diagnostic services with tracer items available on the day of the visit or day of reporting.
- 50% of States will have pharma-grade warehouses and functional DRF similar to the ones supported by DFID-funded projects in Ekiti, Jigawa and Kano States and GF funded warehouses in .
- Existence of an integrated supply chain, which is State owned, agile and responsive to patient needs and delivers quality health products at affordable prices; and ensures that 95% of supported HFs providing services possess the tracer item (Malaria AL 1) on the day of visit.
- Restore the core mandate of NAFDAC on post-market medicines surveillance (ATM plus others), including rapid test kits, and ensuring GS1 implementation.

Module 2: Health Management Information Systems and M&E

Despite all the efforts and investment in the NHMIS, challenges and gaps still exist in the reporting and availability of data for action across all levels of care. Although 33+1 States are now reporting through the DHIS platform, there are thought to be 1,029 facilities not reporting.⁷ Reporting using electronic platforms received significant attention in the on-going RSSH grant implementation. A review commissioned to look at the Health Information Exchange (HIE) architecture and E-Reporting platforms discovered that there was no functional national governance structure for HIE in Nigeria despite the availability of an ICT strategy. The HIE structure in Nigeria was highly heterogeneous and fragmented. There were multiple software projects in different thematic areas; each operating under the purview of separate implementing partners/donors. There was no all-encompassing standard that would enhance exchange of information between the software. One key recommendation from the review is that open source EMR can be adopted with due consideration for the Nigeria's Federal nature and the agency of states and private facilities to make their own decisions. However, looking at the requirements for implementing EMR and considering the fact that not all facilities (especially PHCs) will need EMR, this should only be piloted with particular emphasis on the optimisation of existing EMR.

Routine reporting through electronic medical records (EMR) to the National Data Repository has been activated in 56 antiretroviral therapy (ART) sites, a further 193 ART sites are supposed to be completed by the end of March

⁷ RSSH Country Dialogue, Funding Request Progress Presentation, 20 April 2020.

2020. This is clearly not achievable, especially as some of those sites may prove to be more difficult; realistically, this work will have to continue throughout 2020 and follow-up work may have to extend into 2021.

Another major gap is data from the private sector. Routine reporting from the private sector has been insignificant, yet the sector provides health services for the larger proportion of Nigerians. Significant effort and investment is therefore needed to improve the reporting and monitoring of private health sector facilities.

Programmatic Scope: Interventions that cut across ATM and health-related issues across the country

Geographic Coverage: The NHMIS activities will be implemented across the country.

Expected Outcomes: Some of the expected outcomes of the investments under this Funding Request are: (i) availability of routine data for decision making; (ii) availability of complete and quality data on service delivery and commodities; (iii) data on CRVs; (iv) availability of information on patient-level data for longitudinal tracking; and (v) improved quality care.

Role Map: Similar in context with the role map of Module 1 above.

Intervention 2.1: Strengthening Routine Reporting of ATM and other health indicators

Federal Level

- Support coordination meetings for ATM and other health data analysis and quality checking through the establishment of Multi diseases Data Management Teams at all levels on a semester basis.
- Optimise existing open-source EMR platforms at secondary and tertiary facilities to capture ATM and other health conditions data and ensure interoperability with the DHIS2.0.

State Level

- Support quarterly State ATM and other health data Analysis and Quality Check and monthly analysis/check at LGA level.
- Train and deploy the revised NHMIS tools at all facilities (public and private).
- Phased deployment of electronic based HMIS reporting tools.

Intervention 2.2: Improving Programme Data Quality

Federal Level

- Train trainers (TOT) for data quality assessment across all levels of care including the communities
- Coordinate and support (on a semester basis) integrated supportive supervision to ensure periodic DQA at national, state and LGA levels.

State Level

- Support quarterly DQA at programmatic and facility level at State level and monthly meetings at the facility level.

Intervention 2.3: Support Period Reviews/Evaluations of National Policies, Strategies and Plans

Federal Level

- Support periodic development or review of the Strategic Health Development Plans and other National Health Strategies.

Intervention 2.4: Implementation of Cross-Cutting Surveys

Federal Level

- Support the FMOH to conduct national cross-cutting surveys such as the National Health Facility Survey and National Hospital Discharge Survey.

Intervention 2.5: Support Data Analytics, Demand and Use

Federal Level

- Strengthen the States' capacity for data analytics and report writing/dissemination.

State Level

- Conduct quarterly health data (including ATM) analysis and use meetings with the leadership of each State Ministry of Health and at the LGA/facility level.

Expected Results:

- A strengthened national HMIS with at least 95% of HFs reporting complete data and 90% of HFs reporting in a timely manner into the national platform.
- Improved electronic reporting of ATM and other health data using the eDHIS-2 in at least 50% of HFs.
- All public sector EMR are optimised to support ATM reporting using open source EMR.
- Improved data management and use at the local level – 50% of LGAs will be able to produce periodic analytical report(s) as per the nationally agreed Plan and share them with the decision makers.

Module 3: Strengthening National and Sub-national Laboratory Systems

The Nigeria's laboratory system is organized along 3 levels - primary, secondary and tertiary. Each is respectively associated with the local, state and federal governments. The private sector (not for-profit and for-profit) also contributes to the healthcare of the population through health facilities including laboratory services run by faith-based organizations, non-governmental organizations and individuals. The oversight function of medical laboratory services at the federal level is domiciled in the Department of Hospital Services/Medical Laboratory Services Division, this level supports laboratory at teaching and specialist hospitals for diagnostic services and conducting research.

The Nigeria Centre for Disease Control is the country's national public health institute, with the mandate to lead the preparedness, detection and response to infectious disease outbreaks and public health emergencies. The Directorate of Public Health Laboratory Services within the NCDC manages the National Reference Laboratory, Gaduwa, the Central Public Health Laboratory, Lagos and the few regional NCDC collaborating laboratories.

The state government is generally responsible for healthcare at the secondary level of healthcare delivery which includes laboratory services at the states teaching and specialist hospitals. The LGA Council is mainly responsible for primary level laboratory service with support from the national and state programmes.

The private health sector in Nigeria provides laboratory services which are also categorized along primary, secondary and tertiary service delivery based on the sophistication and specialization of test menu they provide and the available human resource.

The current RSSH grant supports improvement of laboratory systems needed to implement effective malaria, HIV/AIDS, TB and other health programmes as described earlier in the Implementation Status.

It also supports infrastructural upgrade of selected laboratories and skills upgrading on maintenance of biosafety cabinets for three Biomedical Engineers.

However, the current support is limited to clinical laboratories, leaving a big gap in the public health laboratory component of the National Laboratory System. The emergence of several diseases of public health importance with possible effect on ATM diagnostics requires that the public health laboratory facility in Nigeria is strengthened to allow a coordinated response to these epidemics.

The Medical Laboratory Science Council of Nigeria (MLSCN) Continuous Quality Improvement checklist has been adapted for use and support to selected laboratories towards achieving accreditation. Several other ongoing support activities will be intensified under the proposed grant as set out in the prioritised activities below.

Role Map: Similar in context with the role map of Module 1 above.

Intervention 3.1: Laboratory Leadership, Governance and Management

Federal Level

- Support quarterly National Laboratory Technical Working Group and other coordination meetings.

- Support implementation of national policies and guidelines on biosafety and biosecurity and laboratory waste management at sub-national levels.

State Level

- Support quarterly State Laboratory Technical Working Group and other coordination meetings.
- Support the laboratory-clinic interphase programme in 37 facilities (one per State) in order to increase the uptake of laboratory services.

Intervention 3.2: Laboratory Infrastructure and Equipment

Federal Level

- Infrastructural upgrade of 37 Public Health laboratories in 36+1 States in addition to 74 clinical laboratories already supported by the current grant.
- Provide support for previously upgraded laboratories to meet MLSCN minimum requirement of equipment for services at their level.

State Level

- Support each State to develop its Medical Laboratory Equipment Maintenance Plan including training and retraining of biomedical engineers.
- Training of biomedical engineers to manage and oversight the Maintenance Plan.

Intervention 3.3: Specimen Referral Systems and Results Communication

Federal Level

- Review and update the sample referral linkages to include all health facilities listed in the Health Facility Registry providing ATM and RMNCH services.
- Support the Nigerian Postal Service (NIPOST) involvement in the sample referral system (including training).

State Level

- Strengthen and expand sample referral network for epidemic prone diseases for outbreak response at State level.

Intervention 3.4: Laboratory Information Management System

State Level

- Support the operationalisation of LIMS system for surveillance reporting of ATM and other disease in the States.

Intervention 3.5: Laboratory Quality Management System

Federal Level

- Conduct periodic Quality Management System (QMS) assessments at supported laboratories using the MLSCN Continuous Quality Improvement Checklist structured in line with ISO 15189 quality standards for medical laboratories.
- Support implementation of WHO AFRO's framework for strengthening integrated disease surveillance and response capacities in Nigeria as it relates to laboratory services

State Level

- Provide State level training in QMS to quality officers in all newly selected laboratories using the pool of trainers.

Expected Results

- Strengthened coordination and productivity of the supported laboratory to improve access to ATM and other services by at least 50% of their baseline values.
- 50% of States in Nigeria with at least one functional public health laboratory to respond to disease outbreaks and other public health concerns (including ATM).

- All upgraded laboratories meet the MLSCN minimum requirements of equipment for ATM and other health services.
- At least 50% of States in Nigeria develop and operationalise their equipment maintenance plans.

Module 4: Community Systems Strengthening

Key interventions and prioritised activities of Community Systems Strengthening will be coordinated through the CSO Networks working with the sub-national level entities including CBOs, community gate-keepers and community level interests in the selected States.

Role of Stakeholders:

The CSO Networks working as SRs or Implementing Units will work with ATM Disease Programmes (plus other MDAS) at federal and state levels, their state level counterparts, relevant community stakeholders including the WDCs to design implementation plan for PRs approval and subsequent implementation. The WDC coordinates all the community level interventions and verifies the activities implemented.

This Funding Request focuses on Community Based Monitoring as the major intervention to promote social accountability and quality improvement. The expected results for community level ATM services will be captured by the disease specific FRs.

The following activities have been prioritised for this Funding Request

Intervention 4.1: Community-based monitoring

Federal Level

- Support development of relevant guidelines, tools and acquisition of relevant equipment for mapping of CBOs and for data collection, analysis and use in collaboration with CSO networks.
- Support the CSO networks in their coordination and supervision of the community level activities.

State Level

- Support States to map, assess (using agreed standardised tools and patient feedback) and strengthen the existing community led platforms to improve coordination, planning and effective linkages between communities and formal health systems.
- Support the CSOs, key populations and networks to conduct community-based monitoring of ATM activities (including medication stock-outs) and other services availability, accessibility, acceptability and quality through client satisfactions methods, exit interview or mystery clients.

Expected Results

- Strengthened community led coordination and planning through the WDCs in all the States supported by the grant.
- Support Client/Beneficiary Satisfaction Survey

Module 5: Integrated Service Delivery and Quality Improvement

To improve critical health outcomes in Nigeria, high-impact interventions are required to bring PHC services closer to households in communities. Specifically, while supply-side improvements are essential to ensure that PHC facilities are made functional, complementary community-level interventions are necessary to further expand access to basic services (including Malaria, T.B, HIV&AIDS Maternal and Child, etc), restore citizens 'confidence in the PHC system, improve demand for health services as well as improve the effectiveness of outreach services through community mobilisation to reach the vulnerable target population. The multiplicity of VHW-style programmes, driven by various stakeholders has led to considerable verticalization of community health structures, poor coordination, inefficiencies and concerns about value for money. It is noteworthy that many of these programmes are similar in context and concept, yet they are not comprehensively linked in a way that enables programmes to leverage these existing structures to implement critical interventions for the attainment of one common goal.

As part of its mandate to coordinate the development of the PHC systems in Nigeria, with the oversight of the Minister of Health, the NPHCDA has continued to explore mechanisms to address challenges inherent in the VHW model for Nigeria, and to scale-up the programme from the various models that have been developed over the years. While carrying out interventions to improve the supply of PHC services, it is important that community-level health personnel focus on ensuring that households in need of such services are informed and motivated enough to demand as well as use these services at all levels. The intervention also needs to be implemented nationally, be locally contextualised and driven, and connected to community level accountability structures as well as the local and national health system. It is on this basis that the NPHCDA is guiding the implementation of the Community Health Influencers, Promoters and Services (CHIPS) Programme. (c.f annex 10 – CHIPS Operational guideline pg. 13-14)

The key intervention and prioritised activities for Integrated services and quality of care in this Funding Request (2021 – 2023) will require strategic support from the NPHCDA working with the national ATM programmes and the State Primary Health Care Development Agencies (SPHCDA) to deliver integrated service at the facility and the community level.

Role and Responsibilities for Integrated Service Delivery and Quality Improvement

The roles and responsibilities of key stakeholders in the CHIPS Initiative are set out in Table 1.8.

Table 1.8 Stakeholder Involvement in CHIPS Programme Implementation

Level	Team	Composition	Support/Oversight
National	National	NPHCDA	FMOH, FMOWSD, the Federal Ministry of Education (FMOE), other MDAs, development partners (DPs), NGOs, private sector, academia, professional associations, financial institutions, traditional institutions, religious leaders, National Council of Women Society of Nigeria, CSOs, International Finance Corporation (World Bank Group)
Zone	Zonal PHC	NPHCDA, SPHCDA	DPs, NGOs, private sector, traditional institutions, traditional institutions, religious leaders, National Council of Women Society of Nigeria, CSOs,
State	State PHC	SPHCDA, NPHCDA State Team Leads	SMOH, SMOWASD, SME, other MDAs, DPs, CSOs, professional associations and academic institutions, financial institutions, NGOs and the private sector, traditional institutions, religious leaders, National Council of Women Societies of Nigeria, Youth Council, faith-based organisations (FBOs)
LGA	LGA PHC	Local Government Health Authority Management Team (LGHAMT), NPHCDA ZTOs, SPHCDA ZTOs	CBOs, traditional institutions, National Union of Road Transport Workers (NURTW), NGOs, faith-based organisations, religious leaders, National Council of Women Society of Nigeria, Market Women Association, CSOs
Ward	Ward PHC	Officer in Charge of PHC facility CHEW Ward Focal Person CHIPS Agents	Ward Development Committees, traditional institutions, NURTW, CBOs, religious leaders, Market Women Association, CSOs, Youth Group, FBOs

The following are the prioritised activities for this Funding Request in line with the strategic priorities of the CHIPS Operational Guidelines (please see Annex 10)

Intervention 5.1: Service Organisation and Facility Management

Federal Level

- Provide technical assistance and oversight for the operationalisation of the CHIPS initiative and the delivery of the Essential Package of Health Services (including iCCM, RMNCAH + Malaria, Integrated TB/HIV services, etc. at the PHC level).

- Conduct Integrated Supportive Supervision (ISS) by the three disease programmes (ATM) coordinated by the DHPRS of the Federal Ministry of Health every semester.

State Engagement

- Support the State Primary Health Care Board to identify and train CHIPs, WDC and other community representatives on the relevant guidelines developed by NPHCDA/FMOH.
- Support the adoption and operationalisation of the National Task Sharing and Task Shifting Policy at the State and the LGA levels.
- Support the payment of stipend to the CHIPS for the delivery of community level integrated health services.
- Conduct quarterly state level Integrated Supportive Supervision by the three disease programmes to be coordinated by the DPRS and the Project Coordination Unit.

Expected Results



- The national CHIPs strategy becomes operational in at least 30% of the political wards in Nigeria and supporting the delivery of ATM services.
- Strengthened community level reporting – at least 30% of wards submitting service delivery reports from CHIPS integrated into HMIS

Module 6: Health Sector Governance and Planning (for State) – State Engagement

Federal-level support for NHA

Many of the key health indicators show wide disparities in epidemiology and service coverage across the geopolitical zones and States of the country (see Table 4, p. 35 of Annex 24, *Nigeria Health Programmes and Situation Analysis – February 2020*). The current grant will continue to support activities around Federal-led policy and strategy reviews, planning, monitoring, reporting and setting of standards across modules. Health sector stakeholders in Nigeria agreed that a good proportion of the allocated Fund should focus on system-wide investment across all Modules of the RSSH Funding Request. This will allow the selected States to benefit from the national standards already established and provide bespoke system solutions for the capacity gaps responsible for the variations across the states and regions of Nigeria.

Role Map for State as a Sub-Recipient or Implementation Unit of RSSH Grant

 <p>State Government</p>	<ul style="list-style-type: none"> • Receives Technical Guidance and Support from the Federal Government • Domain of business - Coordinates all state level GF investments across all modules • Determines progress across thematic areas in line with national and state targets • Technical support and supervision of the LGAs.
 <p>Local Government</p>	<ul style="list-style-type: none"> • Receives Technical Guidance from State and Responsible for health system reports • Coordination of all supports from federal, states and IPs on ATM and others • Provide hands-on support to the HFs and ensure that practices conform with SOPs • Responsible for resource management and accountability

Intervention 6.1: Improving Health Stewardship, Financial Management and Accountability at Federal and State Level

Federal Level

- Support implementation of the National Health Account

State Level

- Support health sector coordination, planning and supervision – including investments on Modules 1-5 above and the state level GF activities on ATM.

- Implement periodic systems capacity assessment using standardised tool(s) and support implementation of capacity improvement plan
- Support financial reporting, budgeting, efficient use of health resources and social accountability of the State budget, state health insurance scheme, BHCPF and other sources.
- Strengthen capacity for public financial management, fiscal responsibility and reporting based on lessons learnt from the on-going RSSH grant implementation.

Expected Results

- Strengthened coordination and Plan Implementation by the supported State – 90% of supported States showing improvement in State Annual Operational Plan (AOP) implementation using national standardised tools.
- Improved financial accountability and reporting with at least 90% of supported States publishing their annual health sector financial report.
- Systematic improvement in systems domains of modules 1-5 above based on periodic assessment reports.

2. Epidemiological Contextual Updates

Malaria

Country Epidemiological Context

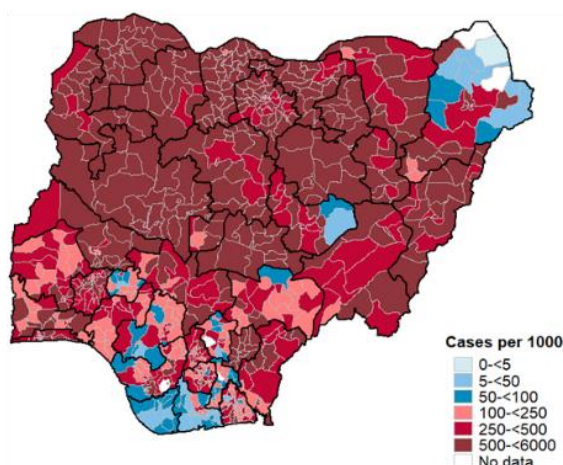
With a population estimate of 219,420,117 in 2020, Nigeria accounts for 25% (57 million) and 24% of global malaria cases and deaths respectively, ranking highest among the 10+1 HBHI accounting for 80% of the global burden of malaria. Nigeria recently undertook a comprehensive stratification of the malaria context to provide strategic information to guide a targeted approach to the deployment of malaria interventions (Annex 6, *op. cit.*)⁸.

Figure 2.1 shows the distribution of malaria burden of disease (BOD) based on the combination of prevalence, incidence, under-five mortality, ecological, entomological, levels of urbanisation and access to HFs. The map shows that the area with very high malaria transmission and under-five mortality spans the northwest through the north-central to the north-eastern regions of the country, while the burden of malaria and under-five mortality is moderate to low in the south west, south-south, south-eastern regions and north-east bordering Chad, with some foci of high transmission. Ten of the 13 States supported by the GF malaria grant fall with the very high BOD area while three (Delta, Ogun and Osun) are in the moderate to high BOD area.

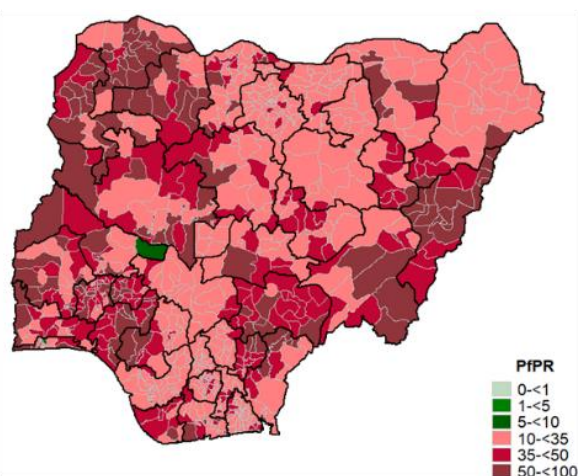
Figure 2.1 Malaria Burden of Disease Map

⁸ Use of strategic information to drive impact - Stratification and intervention mixes, WHO Malaria Technical Support to Nigeria NMEP (Presentation Slides, WHO 2020)

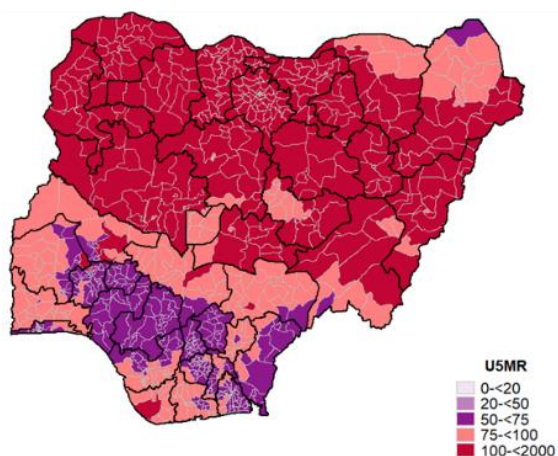
a) Malaria cases per 1000 population, 2018 (NMEP-WHO)



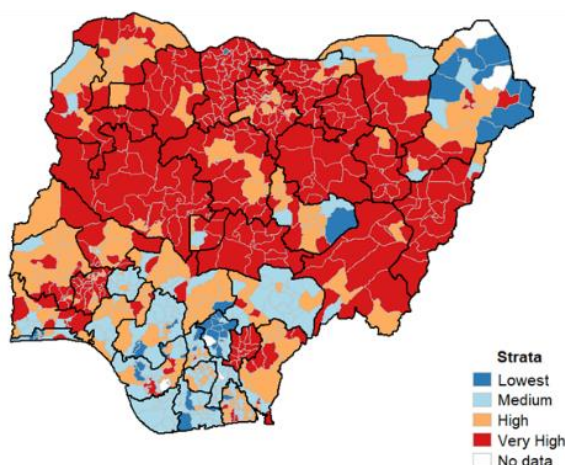
b) *P. falciparum* parasite prevalence in 2-10 years of age, 2018 (NMEP – Malaria Atlas Project)



c) Mortality rate in children under five, 2017 (IHME)



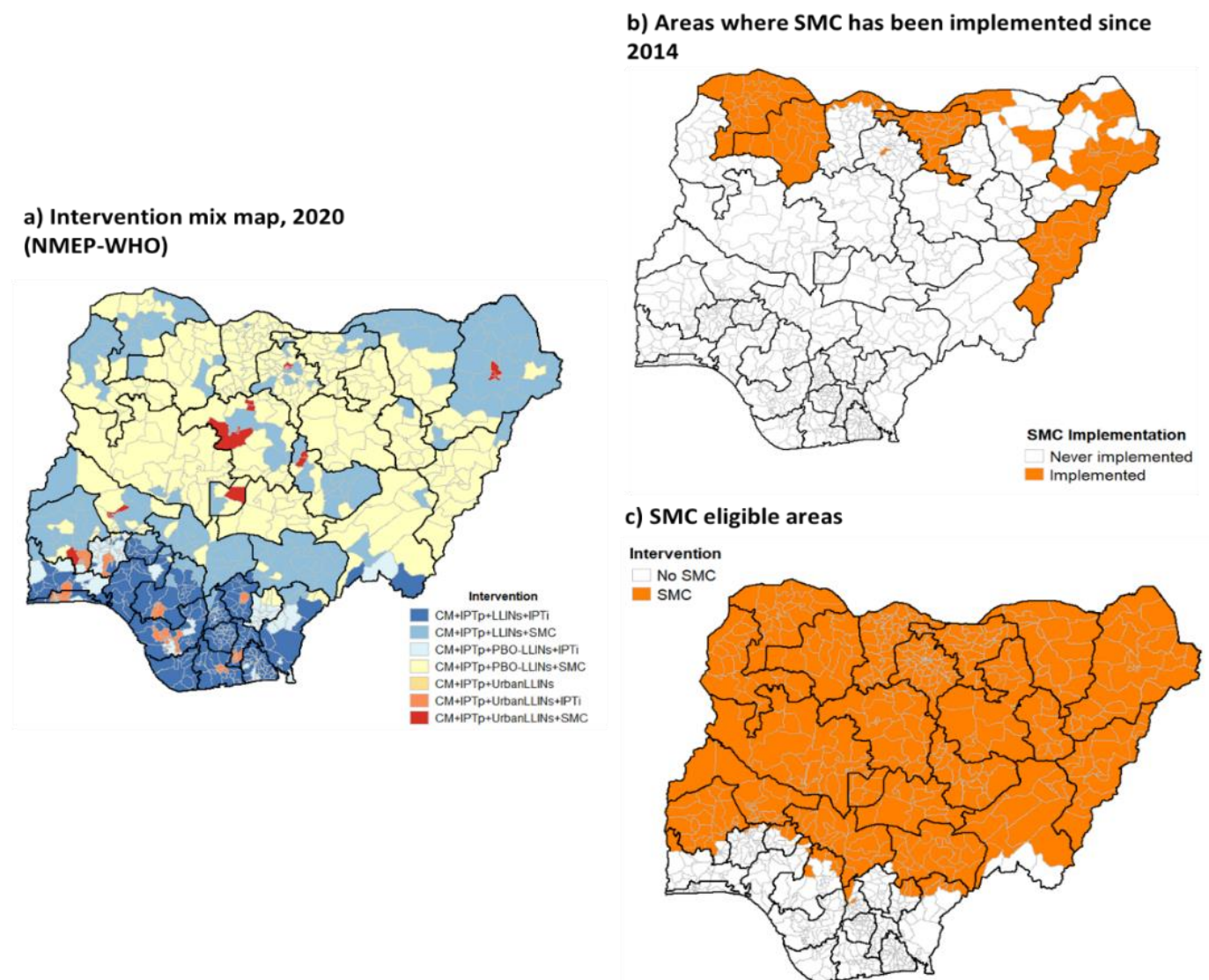
d) Combined burden map, 2018 (NMEP-WHO)



Source: WHO/NMEP 2019

The stratification exercise also provided empirical analysis for targeting interventions at various subnational populations based on their respective epidemiological, ecological and health system contexts (see Figure 2.2 for SMC eligibility).

Figure 2.2 SMC Eligibility



Based on this information, there are three key interventions needed throughout in the country: (1) Case Management; (2) IPTp; and (3) Vector Control.

SMC is applicable to 60% of the States constituting the northern and middle belts. Regarding vector control and due to cost challenges, LLINs are to be deployed as PBO-LLINs only in the highest BOD areas and where there is confirmed high prevalence of insecticide resistance (IR), while the Pyrethroid-only LLINs will be used in low prevalence urban centres. IPTi is being considered for introduction as implementation research in the southern states but the high rate of SP resistance in the South poses a challenge (Annex 31: Nigeria 2004 Roll Back Malaria (RBM) Annual Report, pp.14-15)

The stratification analysis showed that several states in the Sahel and Savannah areas have high seasonality (more than 60% of rainfall occurring in four consecutive months) and high transmission rates. Hence, under-five children in these States were considered eligible for SMC implementation as shown in figure 2.2. This implies that 10 other states may be targeted for SMC in addition to the nine states that are currently targeted. Expanding SMC to these 10 States is bound to significantly reduce malaria mortality since these States all fall within the areas with the highest BOD of malaria as shown in Figures 2.1 and 2.2. Nigeria is working on a detailed micro-stratification in large urban areas and this will inform further targeting of nets in urban areas. Any savings made through this process will be reprogrammed to fill key gaps identified in the PAAR.

Important Changes in Trends in Incidence/Notification Rates or Prevalence: The country has recorded some reduction in the incidence of malaria, and malaria mortality as a result of sustained investment in deployment of LLINs and effective treatment with ACTs to which the GF has made a major contribution (see Figure 2.3 and 2.4).

Figure 2.3: Malaria Incidence per 1000 Population

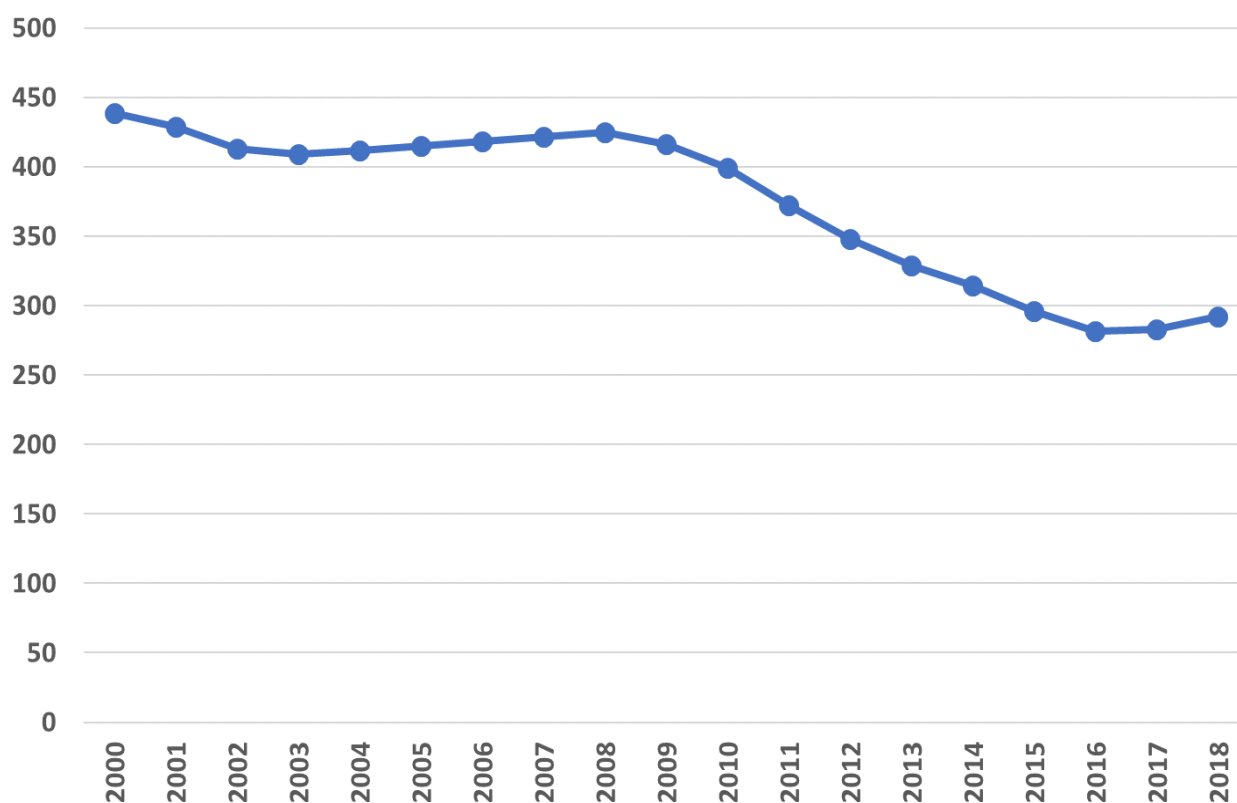
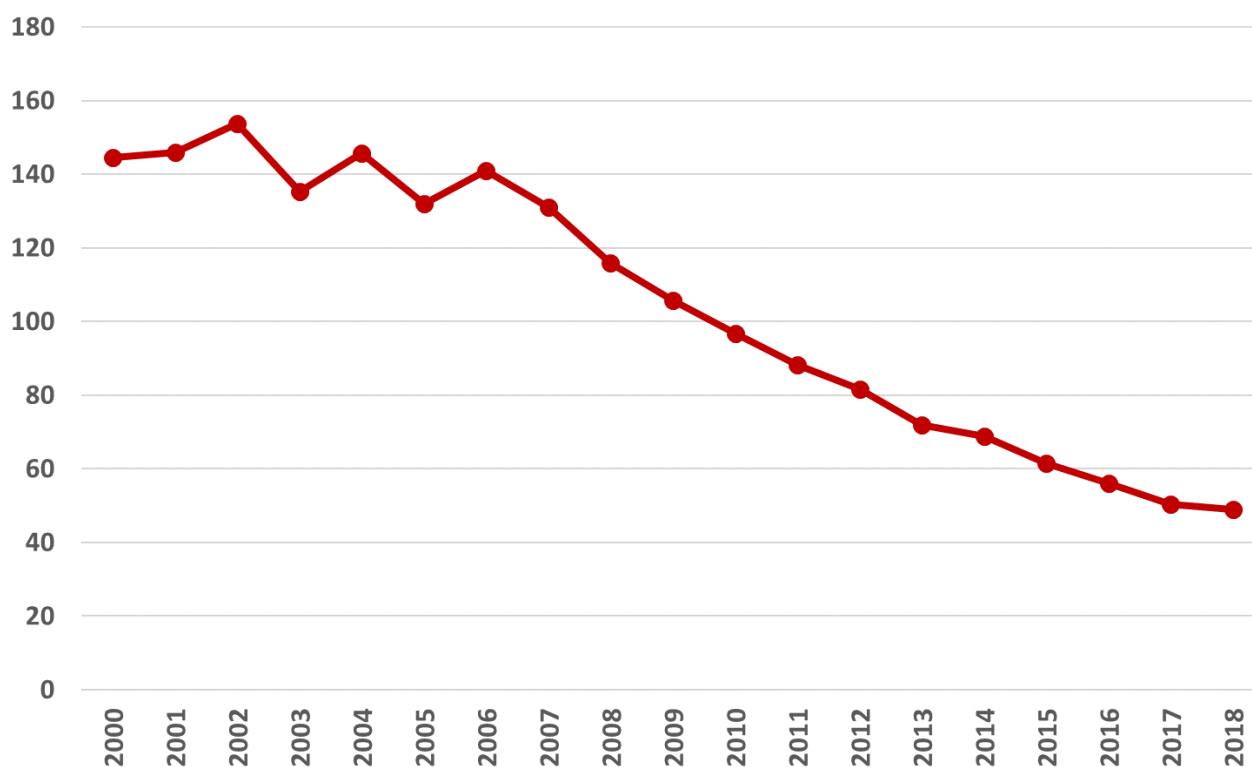


Figure 2.4: Malaria Mortality per 100,000 Population



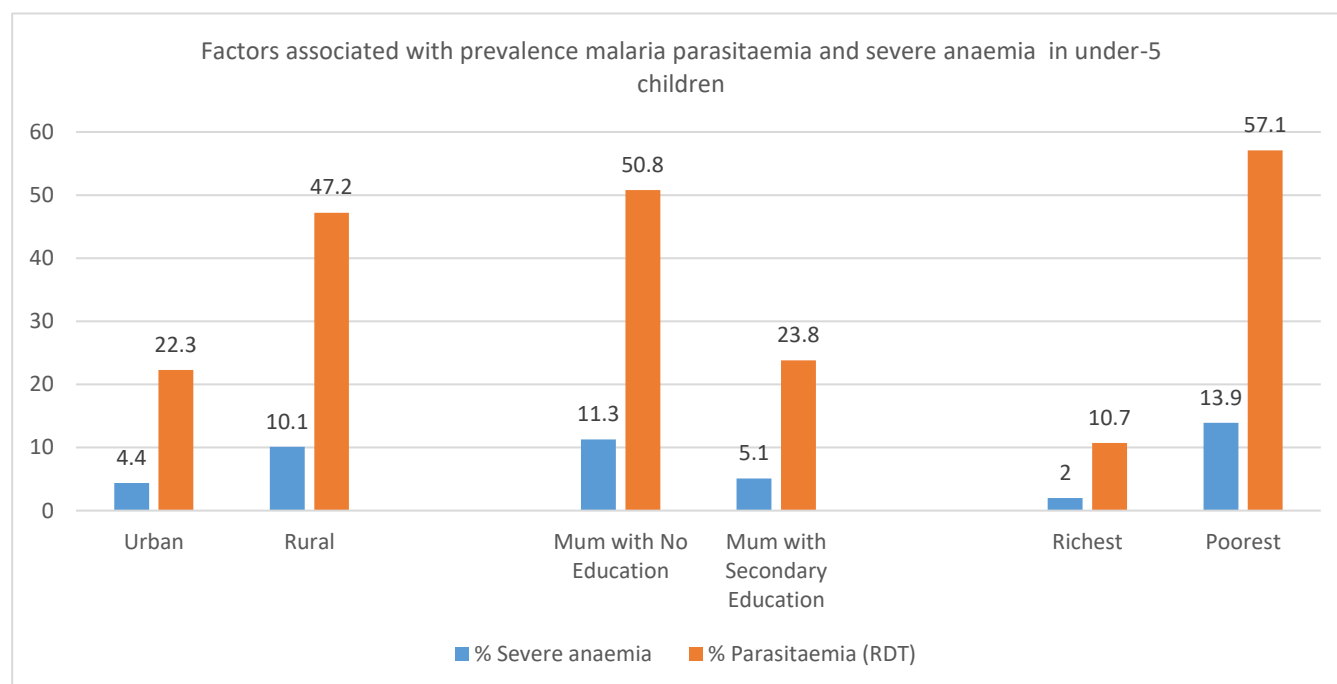
Source for both graphs: WMR 2019

Malaria case incidence decreased from 450 per 1,000 in 2000 to 300 per 1,000 in 2018 and, over the same period, malaria-specific mortality fell from over 140 per 100,000 to below 50 per 100,000. The NDHS 2018 showed that there had been a reduction in the prevalence of malaria in children under five years from 27.4% in 2015 (NMIS 2015; p.100) to 22.6% in 2018 (NDHS 2018; p.331, Table 12.16). The survey result showed that the levels of reduction in malaria prevalence in 2018 compared to the 2015 survey results varied widely between the States. The largest reductions (> 20%) were recorded in Benue (32%), Zamfara (27%), Nasarawa (23%) and Taraba (22%); while the least reductions (< 1%) were recorded in Ebonyi (0.5%), Akwa Ibom (0.4%) and FCT (0.1%).

The NMEP commissioned the reanalysis of specimens obtained in 2018 from the NAIIS to assess the prevalence of HRP2 antigens with molecular techniques and compared finding with those obtained by RDT and microscopy during the 2018 NHDHS in the 13 GF supported States. Preliminary result showed higher prevalence rates of HRP2 antigen positivity compared to RDT and microscopy. Despite the difference, the HRP2 technique was able to differentiate States by high and low burden of infection. The analysis also showed that malaria prevalence was higher among children aged five to nine years than those younger or older (Annex 35: NAIIS Malaria Reanalysis Report). Further analysis of these specimen may provide some information on HRP2 deletion in the area.

Key Social, Structural and Behavioural Drivers of the Epidemics: Some of the observed variabilities in the response of the disease across States may be connected to sociocultural and behavioural drivers such as belief in the effectiveness of malaria medicine (NDHS 2018; pp 297), increased net use by children under five years and pregnant women (NDHS 2018; pp 301) and improved malaria case management (DHIS 2019 data for testing and treatment). A recent national survey showed a mother's low level of education and belonging to the lowest wealth quintile were associated with higher malaria prevalence among children under five. The prevalence was more than twice in rural than urban areas, and the upper quintile was least likely to have malaria (NDHS 2018; pp 330-331). In a bid to address the higher malaria prevalence rate in rural compared to urban populations, households in rural and poor settings have been consistently prioritised during LLINs mass campaigns leading to relatively higher ITN access in rural (52.2%) than urban (41.3%) households; and similarly higher utilisation among the rural (49.1%) than urban (35.6%) populations (NDHS 2018, pp.312-313). Implementation of SBCC intervention will take into account the particular information needs of these disadvantaged subpopulations, leveraging the community-based, CSO-driven Accountability and Advocacy strategy being implemented under the current grant.

Figure 2.5: Variations in Prevalence of Malaria Parasitaemia and Severe Anaemia



Source: NDHS 2018 p. 313

Changes in Human Rights and Gender-Related Barriers and Inequities: Since the last Funding Request, there has been a progressive spread of insecurity across Nigeria⁹ including increased cases of the abduction of health workers. These insecurities have led to continued displacements of individuals and communities. The epicentre of North East insurgency in Nigeria are Adamawa, Borno and Yobe states, but IDPs are spread across all six North-East States to include Bauchi, Gombe and Taraba.

The beneficiaries of the IDP programmes are IDPs from different parts of the North-East and refugees from Cameroon, Chad and Niger who fled from their villages following severe security challenges. The IDP population increased from 1.9 million in 2018 to over two million in 2020¹⁰. The conflict in Cameroon has resulted in 44,247 refugees (47% of whom reside in host communities) in Akwa Ibom, Benue, Cross River and Taraba States. There are 8,099 of these refugees in Taraba State, one of the GF-supported States¹¹. The current GF malaria grant supports all the functional HFs in each of the 13 GF supported States but, in view of the limited access and social deprivation of IDP communities, the NMEP designed a special IDP malaria intervention to improve IDP access to services. This approach aims to ameliorate constraints associated with displacement, such as the increased risk of human rights violations, limited access to public services (including health and malaria-specific services), economic deprivation and poor access to social amenities.

Apart from established biological predilections, pregnant women and children under-five are also beset with traditional, cultural and economic barriers to healthcare services including malaria interventions. Women and children constitute the majority of IDPs and refugee populations; and their vulnerability is significantly aggravated by displacement. Their health and social needs are diverse and demand a wide range of services, such as reproductive health, immunisation, nutrition, prevention of such common diseases as pneumonia and diarrhoea, and ATM prevention, treatment and care. In such a setting, an integrated approach is the preferred way of delivering those healthcare services.

In a bid to improve hard-to-reach populations' access to healthcare, the current grant supports iCCM in Kebbi and Niger States. These will continue in the 2021-2023 period as an integral part of the NPHCDA CHIPS programme, with additional domestic support from the BHCPEF. The GF will continue to support Niger in this regard, while Kebbi will be supported by the USAID PHC project fund. Insecurity due to insurgencies and difficult terrain make several communities and populations hard to reach. Special efforts were made to distribute LLINs in these hard to reach populations in Delta, Kaduna, Katsina and Niger States during the current grant through partnership with security agencies and community-based actors. The lessons learnt from these activities will be applied in the next grant period. The NMEP will continue to work with other agencies (including NEMA, the Red Cross, the United Nations High Commission for Refugees (UNHCR), the United Nations Children's Fund (UNICEF) and WHO) to achieve this by providing ACTs, Artesunate (rectal and injectable), LLINs and RDTs towards the care of IDPs and hard-to-reach communities within the 13 States supported by the GF grant.

Entomological Surveillance/Insecticide Resistance Monitoring (IRM): The need to use IRM data to inform the deployment of effective LLIN has led to scale up of the IRM sites from seven to 16 States and a plan to scale up to the remaining States. Figure 2.6 shows the vector resistance monitoring sites.

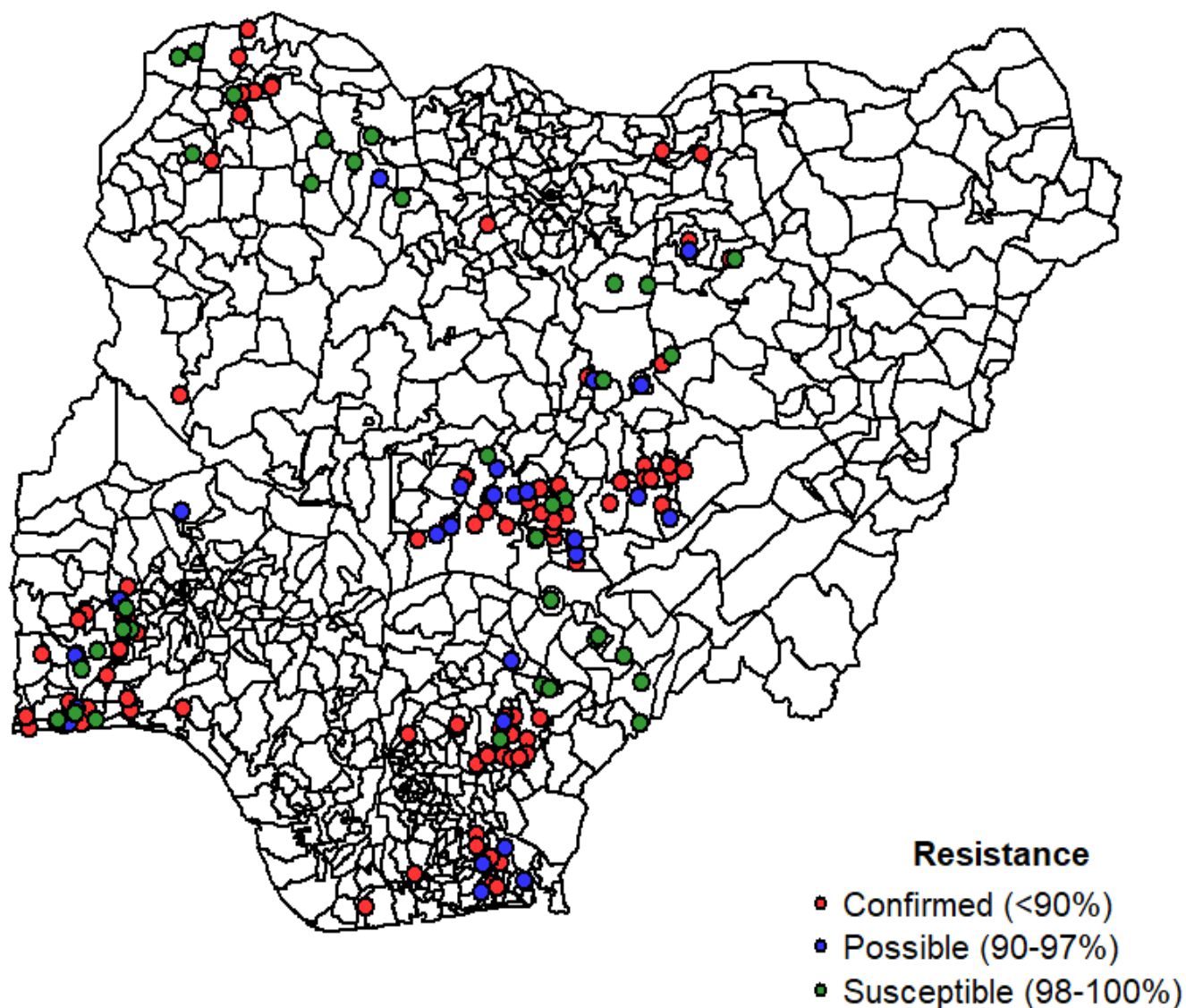
The findings from these IRM activities have provided evidence of resistance to all three pyrethroids used in ITNs but reversible by addition of PBO to the pyrethroid which informed the deployment of PBO nets in Ebonyi State in 2019. Results of IRM studies will form the basis for LLINs placement in the new grant period. In order to determine the vector susceptibility status of the States to determine the type of nets to be procured for LLIN campaigns in the 2021-2023 period, IRM studies have been scheduled to commence in the various locations as soon as the rains begin in 2020. NMEP plans to commence the IRM early enough to ensure that the insecticide resistance status of each State will be known at least one year ahead of the planned date of the LLIN campaign to allow an adequate lead time for the procurement of the appropriate type of LLINs.

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

¹⁰ <https://dtm.iom.int/nigeria>

¹¹ <https://data2.unhcr.org/en/documents/download/73512>

Figure 2.6: Insecticide Resistance Monitoring Sites

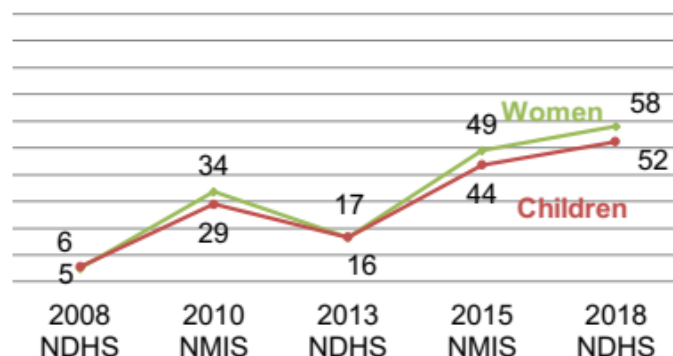


Source: NMEP-WHO)

Drug Resistance/Antimalarial Drug Therapeutic Efficacy Studies: Therapeutic Efficacy Testing (TES) was conducted in three regions (South-east, North-central and North-west) in 2018, representing three different epi-ecological zones to guide malaria treatment policy in the country. The results demonstrated that all three ACTs molecules namely, Artesunate Amodiaquine (AA), Artemether Lumefantrine (AL) and Dihydroartemisinin Piperaquine (DHP) were efficacious against uncomplicated *Plasmodium falciparum* malaria mono-infection with overall polymerase chain reaction (PCR)-corrected adequate clinical and parasitological cure rates (ACPCR) values of 98.9%, 98.2% and 100% for AA, AL and DHP respectively (Annex 32: NMEP Preliminary report of 2018 TES; p. viii). TES is planned for an additional four sites in 2020. Moreover, Nigeria plans to conduct TES on an alternate site basis across the 14 sentinel sites in the country. A study on the monitoring of SP-resistance markers in the context of community IPTp implementation is ongoing in Ebonyi State. The study, which was approved by the WHO Research Ethics Review Committee (ERC), commenced in 2018; the results are expected to be available in 2022 to inform programme decision-making on the use of SP as a preventive treatment. There has been a persistently low uptake of AA, especially among doctors in the rural communities. There is also concern that the concurrent use of SPAQ for SMC and use of AA for treatment of uncomplicated cases in the same areas may increase AA drug pressure with the increased likelihood of the emergence of resistant mutants of *P. falciparum* species. This justifies the need to introduce DHP, mostly to substitute AA in SMC implementation areas.

Coverage of Interventions in the General Population and Key/Vulnerable Populations: Nigeria has achieved and sustained an increase in the use of ITNs, especially by the pregnant women and under-five children (See Figure 2.5).

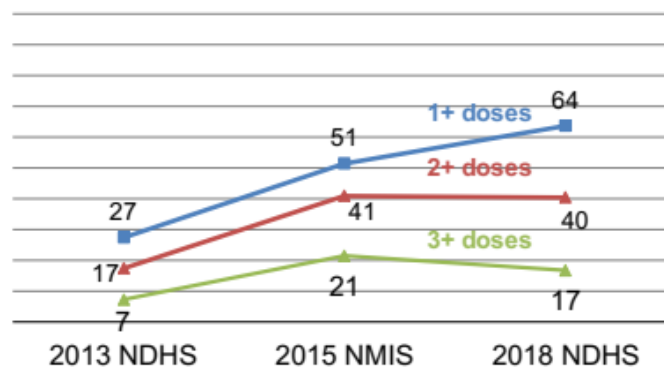
Figure 2.5 ITN by Pregnant Women and Children Under-5



Source: NDHS 2018, pp.301

In 2018, ITN use by pregnant women in all surveyed households was 57.5%; and 51.7% for under-five children (NDHS 2018 pp. 316, 318). Generally, ITN use was higher in rural (56.3%) than urban (44.6%) areas; and higher in the lowest wealth quintile (59.2%) than the highest (39.6%). GF-supported States in the North West were among the States that recorded the highest levels of ITN use with Jigawa topping the list at 87.1% use among household members, 95.7% by pregnant women and 89.1% by under-five children (NDHS 2018, pp. 313, 316, 318). The percentages of women that received at least two doses (IPTp2) and at least three doses (IPTp3) of SP for intermittent preventive treatment for malaria in pregnancy (TPTp) in 2018 were 40.4% and 16.1% respectively (NDHS 2018, pp. 321) – see Figure 2.6. IPTp coverage was higher among women in urban areas (IPTp3=20.7%) than in rural areas (IPTp3=14%); and higher in the highest wealth quintile (IPTp3=24.1%) than the lowest quintile (IPTp3=12.1%).

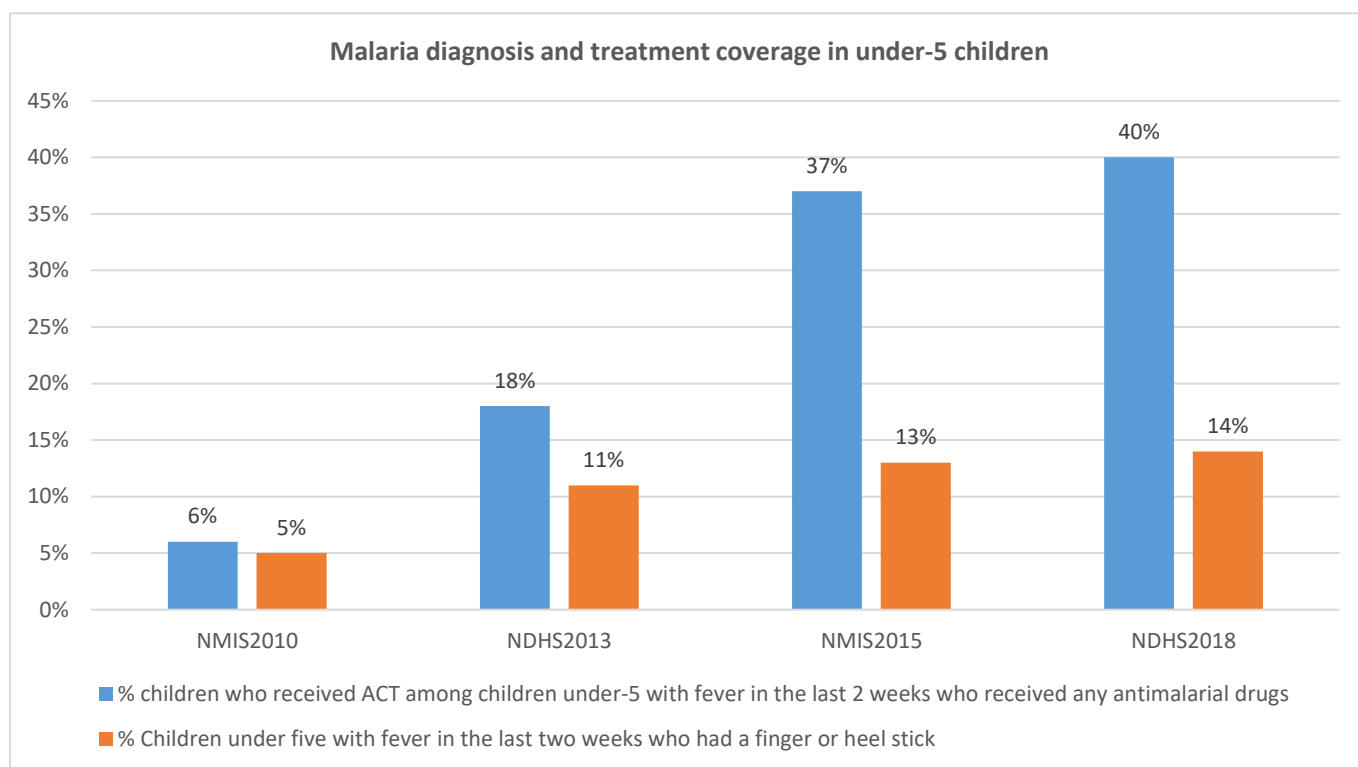
Figure 2.6: Trends in Use of IPTp-SP in Pregnancy



Source: NDHS 2018, pp.303

Figure 2.7 shows the coverage rates of malaria diagnostic test and ACT use from household surveys with steady but modest improvements over time. While HMIS (DHIS-2) shows nationally high rates of parasitological tests in public HFs (82%) and the GF States (93%), population surveys show that 13.8% of under-five children with fever have had a finger or heel prick test; with coverage higher in urban (16.2%) than rural (12.7%) areas; and higher in the highest wealth quintile (18.4%) than in the lowest quintile (10.6%). The proportion of children with fever who received ACT was 28%, with higher coverage among the urban and richest populations than the rural and poorest (NDHS 2018, p. 323).

Figure 2.7: Trends in Population Coverage of Malaria Testing and Treatment



RSSH

Although Nigeria is undergoing an epidemiological transition, infectious and parasitic diseases such as diarrheal diseases, HIV/AIDS, malaria, meningitis and tuberculosis are the leading causes of morbidity and mortality (33% in 2016¹²), particularly in women and children under five years old; with respiratory infections accounting for some 14% and cardiovascular diseases 11%.¹³

The 2018 Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) provided an estimate of 1.9 million persons living with HIV; this compares with the earlier estimate from the 2012 National HIV and AIDS and Reproductive Health Survey (NARHS 2012) of 3.4 million.¹⁴ However, the HIV prevalence rate, at 1.5% of the general population, has remained constant over the past three years although there are significant variations between States, from 5.6% in Akwa Ibom State to 0.3% in Jigawa and Katsina States.¹⁵

As stated in Section 1, there are wide variations in health service coverage, BOD and health outcomes across Nigeria's different regions and States.¹⁶ For example, the U5MR range from 30 deaths per 1,000 live births in Ogun State to 252 deaths per 1,000 live births in Kebbi State (NDHS, 2018, p.165); the proportion of pregnant women who received ANC from a skilled provider ranged from 15% in Kebbi State to 97% in Imo State (NDHS, 2018 p.174); the 33.8% malaria prevalence rate in children in the North-West region is more than double the prevalence of 15.6% in the South-South region (NDHS 2018, p.330); while the proportion of women with live births tested for HIV during ANC ranged from 67.2% in South-East Nigeria to 42.2% in North-West Nigeria (NDHS 2018 p.6).

Life expectancy is an important health indicator and a key component of the global Human Development Index (HDI) which ranks the social and economic development of nations. In Nigeria, life expectancy at birth in 2016 was 54.5 years, an increase of 7.5 years from 2007, but still remaining below the national target of 70 years by 2015 and the global average of 71 years. The healthy life expectancy of Nigerians was 47.4 years in 2016, which implies 6.8 years of compromised health. Regionally, Nigeria compares poorly - the life expectancy of Ghanaians is 10 years

¹² WHO, 2019, *Global Health Estimates 2016: Deaths by Cause, Age, Sex, by Country and by Region 2000-2016*

¹³ *Ibid.*

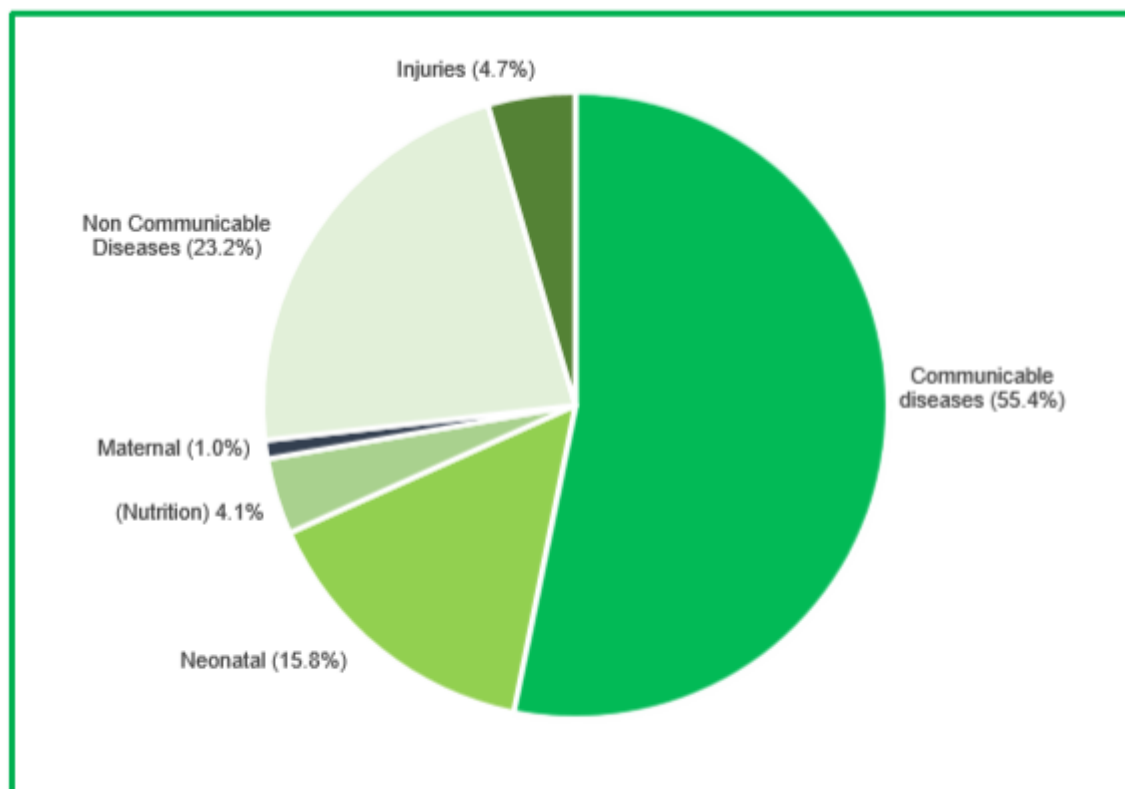
¹⁴ However, according to the World Population Review (<https://worldpopulationreview.com/countries/nigeria-population/>) there are currently 3.1 million people living with HIV.

¹⁵ *The 2019 Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS 2019).*

¹⁶ See Table 4, page 35 of Annex 5, *Nigeria Health Programmes and Situation Analysis – February 2020.*

more. According to the 2016 Global Burden of Disease Study, while Nigeria is undergoing an epidemiological transition, communicable diseases still constitute the bulk of BOD.

Figure 2.8: Leading Causes of Morbidity in Nigeria (2016 Global Burden of Disease Report)



Source: NHSPD-II, *op, cit.*, p. 10

About 50% of children are malnourished; childhood malnutrition rates not only remain poor but in fact have worsened in the last two decades. Other social determinants of risk and outcomes of HIV, TB and malaria are widespread.¹⁷ There are challenges in guaranteeing access to services for IDPs, and the pressure it puts on the health and social systems, especially in the North-East which has a large number of IDPs.

The moderate progress made in systems improvement and service coverage has not produced a significant shift in the epidemiological profile of Nigeria compared to other nations globally. In the past 15 years, there has been a progressively slow decline in maternal and under-five mortality (until a slight increase in the U5MR in 2018); the pace of reduction and geographical disparities, however, remains a huge concern.

Like the other previous national surveys, the most recent Nigeria Demographic and Health Survey 2018 report also shows regional and State level inequities in the U5MR with the North-East and North-West zones of the country at 134/1,000 and 187/1,000 live births respectively being two to three times higher than that of the South West and South-South zones of the country (62/1,000 and 73/1,000 live births respectively). Similar regional variations can be observed for maternal mortality, the level of malnutrition, malaria prevalence, immunisation coverage and so on.

There was a decline in the U5MR from 128.6 per 1,000 live births to 119.9 per 1,000 live births between 2013 and 2018 and a decline in the infant mortality rate from 80.5 per 1,000 live births to 75.7 per 1,000 live births over the same period. However, these – and other – health impact indicators are influenced by wealth quintiles and the mother's educational level, with a threefold difference between mothers with no education and those with post-secondary level education.

¹⁷ FMOH (2017), *Nigeria Multiple Indicator Cluster Survey 2016-17, Survey Finding Report*, October 2017

Malaria prevalence for children under five declined from 42% in 2010¹⁸ to 27% in 2015¹⁹ and further dropped to 23% by the end of 2018.¹⁰ Similarly, women's knowledge of the vertical transmission of HIV increased from 53% to 72% between 2013 and 2018 respectively among women of child bearing age.

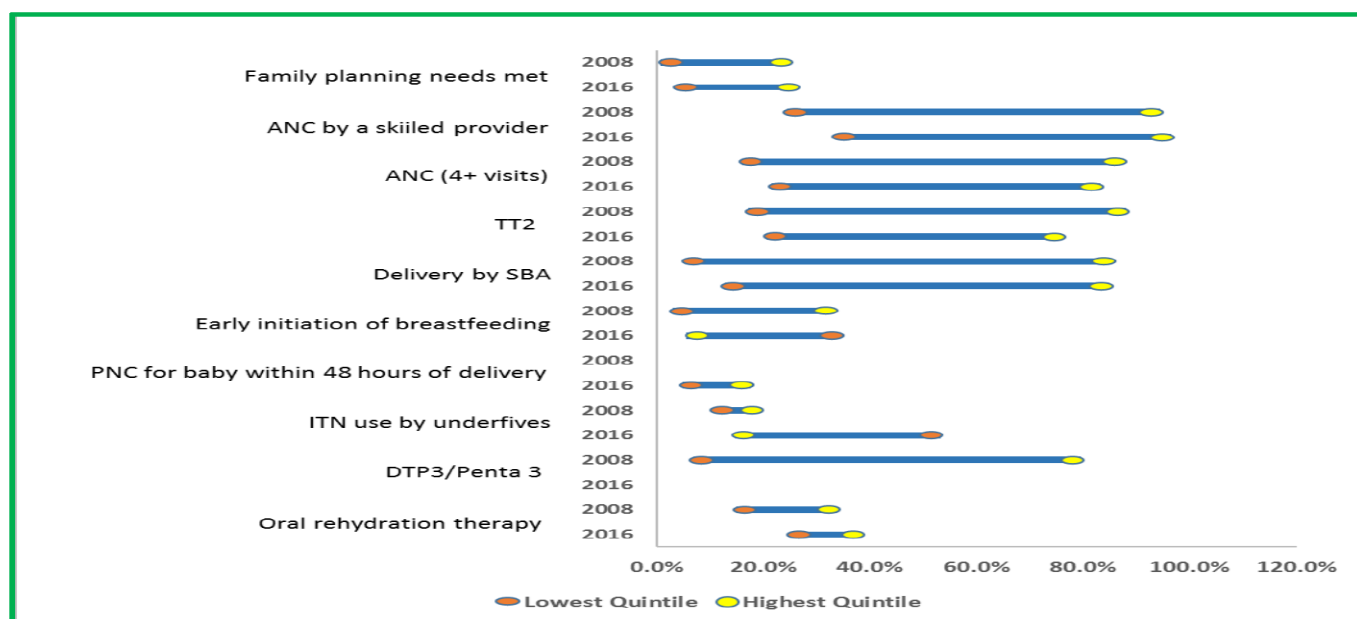
The proportion of women who received ANC from a skilled provider increased from 61% in 2013²⁰ to 66% by the end of 2018²¹ and the maternal mortality ratio declined from 576 per 100,000 live births in 2013 to 556 per 100,000 live births in 2018.²² However, in 2018 the percentage of women age 15-49 years with a live birth in the last two years who were attended by skilled health personnel during their most recent live birth was only 43%²³; and maternal mortality remains a major concern. Nearly 20% of all global maternal deaths occur in Nigeria. Between 2005 and 2015, it is estimated that over 600 000 maternal deaths and no less than 900 000 maternal near-miss cases occurred in the country.²⁴ Although maternal mortality has consistently declined year by year, at the modelled rate of 917 per 100,000 live births, Nigeria had the fourth highest maternal mortality rate in the world in 2017.²⁵

Women who are unable to deliver at a formal HF and deliver at home without a skilled attendant are at higher risk of maternal death. Other notable risk factors for maternal mortality in Nigeria include high fertility and early marriage, with adolescent girls at increased risk of obstructed labour and maternal death.

Every national survey (MICS, NDHS, the National Health Facility Assessment (NHFA), Standardised Monitoring and Assessment of Relief and Transition (SMART), etc.) conducted over the years shows wide disparities in access to health care services and coverage across the geopolitical zones and States of the country. Furthermore, disparities persist between rural and urban areas and across educational and socio-economic status. Higher disease burdens and much lower access to health care services are most common in the northern zones of the country, rural areas, among people of lower educational status and the lowest wealth quintiles.

Figure 2.9 highlights the extent of inequities of the RMNCAH services by wealth quintile.

Figure 2.9 Inequitable Access to the Continuum of RMNCAH Services by Wealth Quintiles



The findings of the National Nutrition and Health Survey (NNHS 2018) also showed mixed results, with a general improving trend in most indicators and a stagnation or deterioration in other indicators, but remain far below the

¹⁸ Nigeria Malaria Indicator Survey, 2010

¹⁹ Nigeria Malaria Indicator Survey, 2015

²⁰ National Demographic and Health Survey, 2013

²¹ National Demographic and Health Survey, 2018

²² National estimates.

²³ *Ibid.*

²⁴ Source; WHO at <https://www.who.int/reproductivehealth/maternal-health-nigeria/en/>

²⁵ Source: <https://www.indexmundi.com/g/r.aspx?c=ni&v=2223> (2017 data).

national and international targets. Improving trends were observed in immunisation coverage for measles and penta3, in deworming, and some public health indicators — especially improved malaria prevention and treatment. In the light of the results of the several surveys, policy and programme implementation should discourage a 'one size fits all' approach and ensure specific focus by zone, State and age groups for specific interventions.

3. National Policies and Strategies: Revisions and Updates

Malaria

The Country's current strategy for malaria elimination is based on the NMSP 2014 - 2020. The Strategic Plan states the Government's goal to achieve pre-elimination status and articulates its priority thrusts for vector control, prevention in those at high risk and malaria case management.

The NMSP will expire in December 2020. However, the MPR has indicated that there will be no significant changes in the strategic direction of the malaria elimination programme in the new strategic plan. The NMSP focuses on strengthening institutions, improving collaboration and integration and efficiency in programme delivery but there is no major shift in policy or strategic direction. The new NMSP will also highlight the evidence-driven State based differentiated approach to targeting effective interventions. This is based on the current Stratification Guidelines 2019 which reveals that different strategies and interventions may be adopted in different states for greater impact.

Table 3.1 lists the implementation guidelines and protocols which have been developed or updated to improve implementation efficiency.

Table 3.1 Malaria Programme Implementation Guidelines and Protocols

S/N	Programme Area	Document	Year of Adoption	New Approach
1	IVM	National LLIN campaign implementation guidelines	2019	The use of ICT4D to improve accountability and efficiency in mass net distribution.
2	Case Management	iCCM Guidelines	2019	Modifications in criteria for selection scope of work and clarification of roles and responsibilities based on the integration of CHIPS programme and iCCM.
3	Case Management	QOC guidelines	2019	Introduced standardised and institutionalised mechanisms for assessing the quality of service delivery; structure, process (provision of care and client experience of care) and outcomes.
4	PSM	Malaria Health Product Logistics Management System SOPs	2019	New tools to improve quality and availability of commodity distribution data. This also provides guidance for LMIS-HMIS data triangulation.
5	SME	Stratification guidelines	2019	Employing geographical variables in addition to sociodemographic considerations for the deployment/coverage of malaria control interventions (specifically LLINS and SMC).
6	SME	SOP for Data Management	2019	Direct data capture to improve reporting from secondary and tertiary facilities (commenced but SOP to be updated in first quarter 2020).

The new NMSP will also highlight the evidence-driven State based differentiated approach to targeting effective interventions. This is based on the current Stratification Guideline 2019 which reveals that different strategies and interventions may be adopted in different states for greater impact. It is important to mention that the current NSHDP II 2018 -2022, which will also serve a key guiding document for the development of the new NMSP, outlines

specific predetermined objectives and interventions for the control of endemic diseases including malaria and that this does not represent a significant shift from strategies outlined in the current NMSP.

RSSH

Although a draft document was referenced, NSHDP II had yet to be finalised before the submission of the previous RSSH Funding Request; and finalisation and adoption by all health sector stakeholders occurred shortly after.

NSHDP II provides the normative and technical approaches for building RSSH in Nigeria. The strategic pillars and priority areas of NSHDP II are anchored on the objectives of the revised National Health Policy 2016 which recognises Nigeria's aspiration to attain UHC through PHC and the alignment of national targets to the expectations of the SDGs.

The National Health Policy 2016, which is expected to remain the overall guiding policy for at least the duration of the period of this Funding Request, stipulates that PHC is the bedrock of Nigeria's health care delivery system and the National Health Act 2014 prescribes the BHCPF to provide sub-national level resources to fund delivery of the BMPHS including basic emergency obstetric and new-born care.²⁶

NSHDP II also articulates the strategies for health systems improvement at the community level with the support of WDCs, comprising selected community leaders and members to ensure community participation, monitoring and accountability. In addition, community-based health care services (CBHCS) will be guided by the recently launched CHIPS initiative which aims to harmonise CHWs and to better define their roles and coordination, with CHEWs expected to spend at least 60% of their time on CBHCS delivery. A year on, the results were reported to be encouraging; for example, in Nasarawa State, where CHIPS was launched, there has been a 45% increase in ANC attendance.²⁷

Table 3.2 highlights the policies and strategic documents that are valid and applicable to proposed interventions under this RSSH Funding Request and those that have been revised or updated to accelerate delivery of results.

Table 3.2 Policies and Other Documents Applicable to Proposed RSSH Interventions

Document	Year of Adoption	Application to Proposed Interventions
National Health Policy	2016	Provides overarching direction for Nigeria's health system and emphasised PHC as the bedrock to UHC since 1988 when the first policy was developed.
National Strategic Health Development Plan II (NSHDP II)	2018	Articulates the Health Sector Priorities for investment and valid until 2022. A midterm review is expected in 2020 and its results are most unlikely to affect the priority areas.
National Pharmacovigilance Policy	2013	Revised in 2019 and the new Policy will support this FR.
Nigeria PSM Strategic and Operational Plan, 2020 - 2024	2020	Draft document shared. When finalised and approved, the priorities identified in the plans will be supported through the grant under this Funding Request.
National Laboratory Policy and Strategic Plan,	2020	The aspirations are consistent with the priorities of this FR. GF support will support Plan implementation.
National Laboratory Strategic Plan		To be incorporated into NSHDP II
Nigeria National Action Plan for Health Security 2018-2022	2018	NAPHS seeks to strengthen the International Health Regulations (IHR) core capacities by adopting strategies, establishing priorities and implementing activities intended to close the identified gaps with the goal of preventing, detecting, and responding to public health threats. It is relevant to all interventions.
NHMIS Strategic Plan 2019-2024	2020	To be incorporated into NSHDP II

²⁶ Minimum standard for primary health care in Nigeria,

²⁷ Source: <https://allafrica.com/stories/201905010390.html>

Nigerian Health Information System (HIS) Policy	2014	To be updated.
HIS Strategic Plan 2014-2018	2014	To be updated and incorporated into NSHDP II.

4. Opportunities for Integration

Malaria

Overview of Malaria Request: The proposed investments in all the modules and interventions prioritised for this Funding Request are summarised in Table 4.1. The initiatives for the integration of the various interventions with the TB, HIV and other service delivery entities at national and subnational levels to enhance outcome, implementation efficiency and sustainability are included in this table.

Table 4.1: Proposed Malaria and RSSH Investments and Opportunities for Integration

Budget Summary (Malaria/RSSH) By Module	Total (US \$)	% of split	Opportunity for integration
Vector control	187,727,722	42.7%	Entomologic monitoring data used in sector-wide integrated vector management
Case management	61,520,635	14.0%	iCCM integrated with NPHCDA CHIPs with impact on pneumonia, diarrhoea nutrition, EPI, and ATM.
SPI: Seasonal malaria chemoprevention (SMC)	76,268,367	17.4%	SMC pharmacovigilance integrated with NAFDAC integrated programme.
RSSH: Health sector governance and planning	3,010,731	0.7%	Includes a State-led approach which fosters integration, efficiency and sustainability.
RSSH: Health management information systems and M&E	16,210,683	3.7%	Sustains the gains of integrated with LMIS and DHIS2; introduction of electronic medical record system will enhance integration, data quality and timeliness
RSSH: Health products management systems	27,617,569	6.3%	Investment in national PSM system will ensure efficient delivery of medicines for ATM and other healthcare programmes
RSSH: Laboratory systems	5,620,745	1.3%	Improved quality of diagnosis for ATM and across all levels of the health sector
RSSH: Integrated service delivery and quality improvement	3,524,193	0.8%	OTSS and quality of care integrated for ATM, RMNCAH and other diseases at State, LGA and HF levels. Investments in ATM commodities to support IDPs is part of integrated service provision in IDP camps.
RSSH: Community systems strengthening	5,372,957	1.2%	Includes CSO-driven community advocacy, accountability and SBC
Program management (Malaria & RSSH)	52,432,145	11.9%	Integration of implementation with State approach will increase efficiency, State ownership and sustainability
TOTAL Malaria + RSSH Budget (US\$)	439,285,745	100.0%	
Total PAAR (Malaria + RSSH)	197,184,925.36	44.9%	% of Malaria + RSSH Split [\$439,285,745]
Malaria PAAR (US\$)	161,385,812.93	41.5%	% of Malaria Split [\$388,641,166]
RSSH PAAR (US\$)	35,799,112.93	70.7%	% of RSSH Split [\$50,644,580]

More details have been provided to describe how the RSSH components of the malaria grant have been integrated with the broader health system to increase programme efficiency to achieve improved disease outcomes and sustainability.

Some of the constraints in the current malaria RSSH grant implementation have been: the quality of data reported through the HMIS/DHIS; low private sector reporting; variations between data on the NHLMIS and the HMIS; low IPTp coverage; and non-availability of non-malaria commodities for effective iCCM implementation.

Health Products Management Systems: The NPSCMP under the Department of Food and Drug Services (DFDS) of the FMOH covers HIV, TB and malaria, including vaccines and family planning (FP) and coordinates all in-country supply chain systems. This programme integrates the warehousing, distribution and reporting of health products across all programmes. However, the inadequate number and location of axial warehouses has affected the efficiency of the distribution system. The GF grant currently supports and distributes health products 10,127 health facilities (HFs) in the 13-States supported by the GF malaria grant. From the outcome of a recent ABC analysis, the “A” and “B” categories of HFs cumulatively contribute 92% of the malaria caseload in a total of 6,861 public HFs (68% of HFs). During the 2021-2023 implementation period, the NMEP plans to prioritize the “A” and “B” HF categories made up of 6,283 (91.5%) Primary, 561 (8.2%) Secondary and 15 (0.2%) Tertiary HFs for distribution of health products with the aim of improving the effectiveness and efficiency of the supply chain system. The next grant will strengthen the capacity of NPSCMP to effectively manage and coordinate all in-country supply chain systems. This grant will further improve data quality, the procurement of electronic devices for selected LGA LMCUs and secondary/tertiary HFs under a phased implementation approach as well as ensuring there is interoperability of HMIS - LMIS on DHIS; and NHLMIS data is operationalised and institutionalised for end-to-end data visibility. Investments will also be made in: (a) enhancing the collaboration between NAFDAC and NPSCMP to strengthen pharmacovigilance systems at national and subnational levels to report adverse drug reaction, post market surveillance and QA/Q; and (b) developing and integrating the health care waste management policy and implementation plan, and training HCWs to improve their competency in proper waste management practices.

Health Management Information System (HMIS): Routine malaria data reporting from all HFs is fully integrated into the DHISv2 under the national ‘one’ HIS that also captures other programme data such as that from HIV, non-communicable disease (NCDs), RMNCAH+N and TB. This Funding Request is intended to further strengthen the HMIS system to include robust private sector and community data reporting and use for decision making. Onsite electronic reporting from HFs, which has been rolled out for secondary and tertiary HFs under the current grant, will be further enhanced to include its phased implementation at PHC level to improve reporting rates, timeliness and data quality. The grant will additionally support integrated supportive supervision (ISS) integration across all diseases to further strengthen capacity and quality service delivery at subnational levels. The current malaria electronic based DQA will be further used to triangulate with other DQA outcomes to improve overall health delivery system at all levels. To improve reporting from the private sector, the grant plans to train private HFs on NHLMIS tools and direct electronic reporting into the DHIS. The grant will continue to support ongoing efforts at integrating the community level reporting system into the broader HMIS. Priority will also be given to operational and implementation research to provide evidence-based data to support effective programme implementation and improvement in access to and use of malaria data through the Malaria Data Repository and State level data control rooms. The ongoing HMIS-LMIS data triangulation will be extended to facility level to strengthen accountability and improve data validity.

Laboratory Systems: Under the current grant, considerable efforts have been made to strengthen laboratories through the training of laboratory scientists on malaria microscopy and EQA the supported States in collaboration with the Henry Jackson Foundation Medical Research International (HJFMR). The next grant will additionally support an integrated EQA for malaria and TB, as well as the upgrading and equipment of two national reference laboratories with PCR capabilities across the country.

Community Systems: The grant will continue to support community-based monitoring through Accountability and Advocacy efforts, ongoing in the current grant. Interventions will be scaled up from five LGAs in each of the states. Data generated will be collated at the integrated (ATM) community observatories and transmitted to the DHIS through the community health information system (cHMIS) to be operationalised and functional within CSS. With the launch of the Mal-RMNCAH+ N coordination framework at both national and sub-national levels, the next grant aims to support the operationalisation of the framework in collaboration with the Department of Family Health and NPHCDA to ensure improved coverage of IPTp and LLIN at ANC and EPI clinics as well as improved efficient service delivery to reduce client waiting time. The grant also plans to leverage the CHIPS initiative to provide a package of

basic health care services, including malaria, to improve iCCM coverage and other malaria services, particularly for hard-to-reach communities.

Financial Management Systems: The grant will ensure synergies with other DPs in grant financial management and build the capacity of the PRs and SRs in treasury management and managing financial risk, as well as supporting grant-related accounting software for greater efficiency.

Health Sector Governance and planning: The grant will support the strengthening of human resources for health, including at the community level. In addition, the funds will further strengthen health sector coordination at national and subnational level for efficient health care delivery and build stronger governance and resource mobilisation systems through the development of a resource mobilisation framework and a holistic PPP strategy, framework and operationalisation.

RSSH

Nigeria's National Health Policy and the NSHDP II seek to promote healthy lives and improve the wellbeing of the population by ensuring universal access to quality health care services (including HIV/AIDS, TB and malaria services) based on a foundation of revitalised PHC. The achievement of this goal will only be possible by adopting and optimising interventions that will ensure the provision of the requisite inputs and strengthen the systems necessary for the delivery of quality health care services in an integrated manner.

The 2018 Nigeria Health Programme and Gap Analysis²⁸ undertaken for the Funding Request submitted in that year noted that: 'Currently, selection and procurement processes for Nigeria's major disease programmes are not fully integrated: This has resulted in seven separate national supply chains for vaccines, HIV, malaria, TB/leprosy, family planning and nutrition commodities. Each supply chain is supported by the donors supporting the different disease programmes; UNICEF for nutrition, the United Nations Population Fund (UNFPA) for FP commodities, the Global Fund and the National Tuberculosis and Leprosy Control Programme (NTBLCP) managing TB/leprosy commodities, the Global Fund and the NMEP for malaria, the Global Fund and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) for HIV drugs and test kits, and GAVI for immunisation. There is also an essential medicine supply chain managed by NPHCDA and the LGAs.

An important view – put forward by the FMOH's DFDS in its recent presentation on PSM investment priorities²⁹ – should be borne in mind: 'The cost of running supply chains for public health programmes through regional warehouses and the 3PLs is currently too high and cannot be sustained by sub-national level governments after donor exit. Investment to improve on performance is no longer yielding commensurate results mainly because of the 'free mind-set' attributed to the donor dominant programmes.' This view highlights the importance of ownership: programmes must be owned and driven by those who will continue to be responsible for delivering services, and not by DPs.

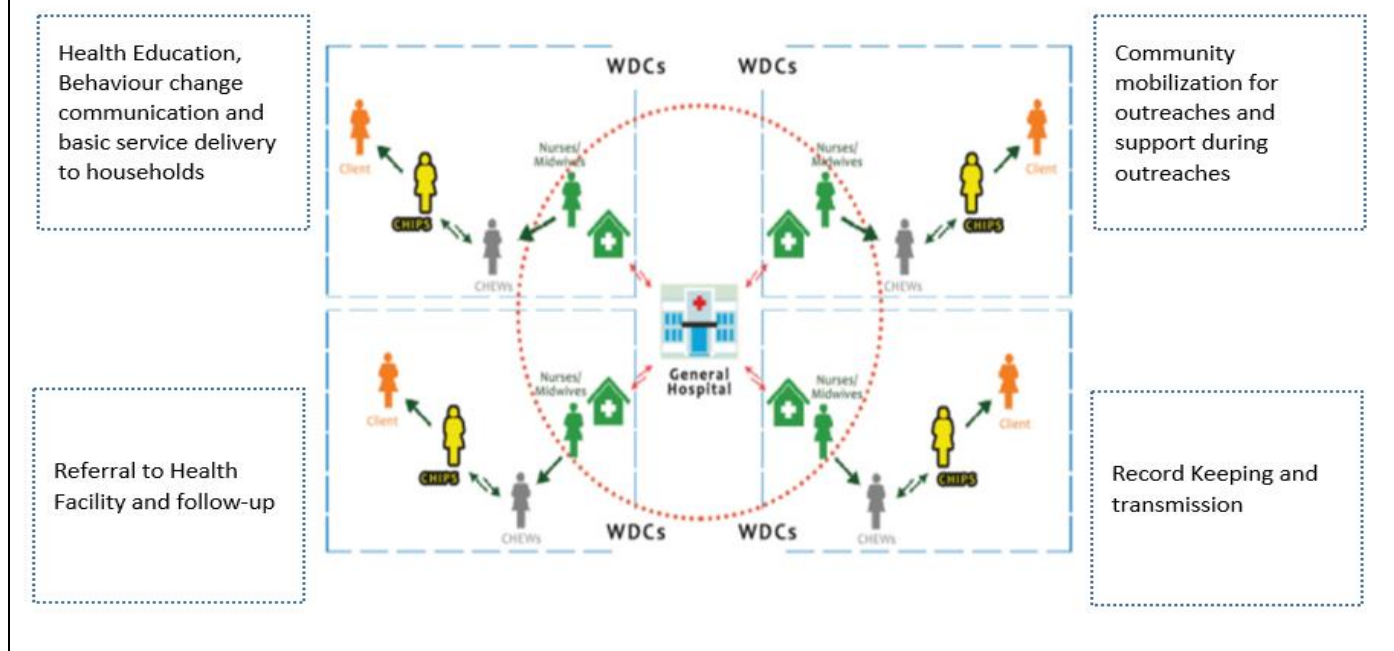
The gap mentioned above is being addressed by the current RSSH grant through the formation and capacity improvement of Federal and State LMCUs and the development of a National Supply Chain Strategy, 2020-2025 (Annex 26). The implementation of this plan will help integrate the health product supply chain.

Opportunities for integration and plan harmonisation within each system domain particularly at the sub-national levels, has been presented in Module 6 of Section 1 above. However, integration of ATM and other health services will be delivered through the CHIPS initiative coordinated by NPHCDA and operationalised through the State Primary Health Care Development Agency (SPHCDA) providing direct hand-on support to the PHC facilities and the communities. The responsibilities for different stakeholders on CHIPS are presented in Table 1.8 above and the conceptual framework is presented in Figure 4.1 below.

²⁸ M.A. Campbell White & C. Chikwendu, *NIGERIA: Health Systems Programmatic and Financial Situation Analysis*, April 2018, p.41.

²⁹ NPSCMP FDS MFOH, *TGF Grant Investment Priorities: PSM 2020-2025*, 12 February 2020.

Figure 4.1 Conceptual framework for the CHIPS Programme



5. Promote and Protect Human Rights and Gender Equality

Malaria

Currently 1.8 million people (440,000 women, 364,000 men, 614,000 girls and 516,000 boys) are internally displaced in Nigeria, with 94% of the displacement attributed to ongoing conflict and over 80% of IDPs in Borno State, and > 60% residing outside IDP camps among host communities, making it harder to access the population with assistance, and adding pressure on weak health system and available resources. Six LGAs in Yobe and two in Adamawa State are hard to reach due to insecurity. It took collaboration with security agents and other community-based actors in these areas to get LLINs to the communities in these LGAs. The programme adopted an intervention strategy that involved the identification of CORPs that speak the local language, training them in testing and treatment of malaria and providing them with ACTs and RDTs, engaging CHEWs to supervise them. Also, 3,407 out of 16,225 settlements in Niger State and 2,657 out of 12,009 settlements in Kebbi State are hard to reach. Through the iCCM intervention in Kebbi and Niger States, 390,700 malaria cases were confirmed and treated using ACT by CORPs in the hard-to-reach communities. The current GF grant is supporting these State governments to implement iCCM to increase access to malaria case management in these hard to reach populations. In Adamawa, Gombe, Taraba and Yobe States, the current grant funded the IDP malaria intervention that provided 314,000 IDPs with quality malaria diagnosis and treatment services. Through this initiative supported by the current grant, 414,735 IDPs with fever were tested (99%), and 315,139 confirmed (76% test positivity rate) and treated with ACTs by CORPs (Programme reports/PUDR results, 2019).

;

The distribution of LLIN during mass campaigns reaches all family members including women and children. Also, routine LLIN distribution through ANC and EPI clinics targets pregnant women and children under-five; an average of three million nets were distributed through the routine ANC and EPI clinics per year within the current grant period. The plan for the next grant is to strengthen the routine distribution channels in order to sustain the current gains. The bi-annual MNCH week will be used to promote LLINs and IPTp.

Pre-existing gender inequalities, due to unequal access to opportunities, have contributed to limited resources and skills among women and girls, which have increased their vulnerability and exposure to abuse, including sexual exploitation. Those in inaccessible areas lack access to food, supplies and services, are at high risk of abuse, and are not able to engage in their normal livelihoods such as farming and trade due to limited movement associated with insecurity. The current grant supports appropriate interventions targeting those vulnerable populations.

The NMEP will be implementing the Malaria Matchbox in 2020 to better refine program implementation to reach the underserved. The Matchbox assessment aims to help malaria stakeholders identify i) which specific populations are most at risk of malaria and/or underserved in the current healthcare programs taking into account the potential influence of their characteristics including age, sex, gender, occupation and ethnicity among other. The assessment also aims to identify barriers faced by underserved and vulnerable groups in accessing malaria and primary healthcare services in general; and seeks to elaborate on intervention that can improve the capacity of national malaria elimination programme to address the needs of specific groups in an inclusive, effective and equitable manner. For instance, there is need for better understanding of barriers to healthcare and malaria control services faced by women and infants in such States as Niger (33%) and Yobe (35.8%) with very low ANC coverage rates (NDHS 2018, p. 25). There is also a need to better understand the vulnerability different types of migrants such as refugees and illegal or undocumented migrants, and the barrier that they face in accessing healthcare and malaria interventions.

In a bid to improve collection data on gender and age, HMIS register for health facilities has been revised to enable disaggregation data on gender (F/M) and age (children <5 & population >5years). Also, recent national surveys like the 2018 NDHS collected data that are disaggregated into age, sex, residence, Socioeconomic status.

RSSH

The Constitution of the Federal Republic of Nigeria 1999 (as amended in 2010) provides for the protection of rights and equality of all Nigerian as stated in Chapter 2 of the document which deals with the 'Fundamental Objective and Directive Principle of State Policy'. Section 17, sub-section 3d of the Constitution states that – ***the state shall direct its policy towards ensuring there are adequate medical and health facilities for ALL persons.***³⁰

Although the current RSSH grant identified the need for providing system-wide equal opportunities for all persons, especially the vulnerable populations, specific emphasis was not given to priority actions that deal directly with the identified gaps; and it was assumed that this will be dealt with by the implementers at the operational level. The grant implementation is also limited on indicators and other instruments to measure and document systems improvement(s) related to human right and gender equality.

It is therefore pertinent to modify and intensify activities that will promote and protect human rights and gender equality in the new RSSH application across relevant prioritised modules of Nigeria's application based on the findings of the revised Programmatic Situation Analysis.

Situation Analysis

The NDHS 2018 showed that 82% of surveyed household in Nigeria are headed by men. The majority of currently married women said that decisions about their own health care (56%) and about major household purchases (59%) are made mainly by their husbands. The survey also showed that 45.8% of women of childbearing age (15-49 years) have a financial barrier to accessing care and 11% needed permission from their husband/partner to access care.

About 67.1 % of the population live below the poverty line.³¹ Inequality in terms of income and opportunities has been growing rapidly and has adversely affected poverty reduction. Poverty is more predominant in rural rather

³⁰ The 1999 Constitution of the Federal Republic of Nigeria

³¹ <http://www.nigerianstat.gov.ng/library#content5-6>

than urban areas and is characterised by major regional inequalities, with 90% of the poorest people living in the north of the country.³²

Gender discrepancies are pronounced with 34.9% of adult women with no formal education compared to 22.6% of men in the same population (NDHS, 2018). The employment status of the surveyed population also showed that 31.6% of women of childbearing age were unemployed in the past 12 months preceding the survey compared to an 11% unemployment rate for men.

The employment of women in the formal sector is low at only 36%. Nigeria ranks 152 out of 188 countries on the gender-related development index (UN Women, 2016). There are significant differences in these indices between the 36 States, with the northern States generally having much higher rates of female illiteracy, and fewer girls in school and women in employment compared to the south.

Discrimination against people living with HIV/AIDS, though declining, still persists in most communities in Nigeria. 57% of urban dwellers and 60% of rural dwellers showed discriminatory attitudes towards HIV positive persons. This behaviour is worst in the South-West region of Nigeria (76% among women and 71% among men).

Gender violence, particularly sexual violence, remains a major public health concern in Nigeria, with 31% of women having been physically abused since age 15 and 5.5% physically violated during pregnancy. The NDHS 2018 also showed that 9.1% of surveyed women have experienced sexual violence.

Focus/Scope of Interventions

Policy makers, implementing entities, health care administrators, care providers, women and children, men, community gatekeepers, key populations, NGOs, CBOs, etc.

Geographical Coverage

National level, States, LGAs, facilities and communities

Implementation Stage Considerations

The following areas of focus will influence implementation of prioritised activities listed in the module above across the thematic areas. These are the operational level micro-planning considerations and are not costed separately in this FR.

1. Health Information Management System

- Routine reporting of gender-based violence (GBV) and human rights violation (HRV).
- Revise tools to include indicators for GBV and HRV.

2. Health Product Supply Management

- Product supply for key populations and hard-to-reach communities.
- Logistic management in humanitarian emergencies.

3. Integrated Service Delivery & Quality Improvement

- Managing barrier to access for women, children and ATM patients.
- Involvement of key populations in service delivery.

4. Health Sector Governance and Planning

- Planning and budgeting for vulnerable populations and humanitarian emergencies.
- Strengthen the capacity of regulatory authorities to empower them for enforcement when necessary.

5. Community Systems Strengthening

- Support community-based monitoring and social accountability – through CBO and WDC engagement.
- Support community mobilisation and BCC using traditional methods – using ACOMIN model
- Programme for hard-to-reach communities using the UNICEF model (EU funded project success stories attached).

³² Federal Republic of Nigeria (2018). *National Strategic Health Development Plan (NSHDP) II*.

6. Effectiveness of Implementation Approaches

Malaria

The current PRs (NMEP and CRS) and their SRs (Management Sciences for Health (MSH), Malaria Consortium (MC), Society for Family Health/SFH) were instrumental in the current grant performance and the country plans to maintain/consolidate these gains by maintaining these PRs and SRs. This will mitigate against any transition delays or start-off risks, and also help to contain associated programme management costs.

NMEP currently focuses on its core mandate of coordination and oversight of the national program including the GF malaria grant while CRS is responsible for SR management, including overseeing financial reporting and monitoring; programmatic reporting and grant specific PSM oversight. The SRs are focused on supporting the implementation of interventions at state level. This arrangement led to the timely and quality implementation of interventions accounting for the absorption rate of 80% between 2018-2019 and a grant ratings B1 in 2018 within the current grant. The programme has identified potential risk to programme implementation and summarized the mitigating measures in Annex 43.

The performance of the current Malaria Grant is summarised in Table 6.1.

Table 6.1 Current Malaria Grant Performance

Fund absorption rate & performance rating	2018	End 2019
Absorption rate: NMEP	82%	82%
Absorption rate: CRS	96%	97%
Grant rating	B1	Pending

In the proposed new grant, the NMEP would take on additional roles such as supervising the State SRs to be engaged during the next grant. This will facilitate efficient and sustainable engagement with the State structures and mechanisms. All PSM and additional in-country monitoring and distribution costs will be maintained by CRS. The Implementation Arrangement Map for the Malaria component of this Funding Request is attached as Annex 36 while the spreadsheet that describes the roles and responsibilities of the Malaria PRs and SRs is attached as Annex 37. We have also attached the organogram for the two Principal Recipients, NMEP and CRS as Annex 44a and 44b.

NMEP will continue to engage WHO towards provision of Technical Assistance (TA) to the grant. WHO will support among other components, the strategic initiatives like the New Net evaluations, Improvement of Quality of Care, the implementation, monitoring and galvanizing support towards the HBHI approach, strengthening of malaria surveillance including micro-stratification for better intervention targeting, advocacy and galvanize top political support, programme performance monitoring and assessments including Rapid Impact Assessments, Burden estimation and surveys. Other TA areas include Programme planning and reviews, grant implementation monitoring using agreed capacity assessment tools and processes that are aligned with global standards; quality assurance and capacity development in implementation of LLIN distribution; mentorship in programme coordination and management at sub-National levels to complement and prop the National Strengthening private sector engagement and data reporting. Being a humanitarian agency, WHO will also support the design, monitoring and implementation of malaria in the Complex Operating Environments (COEs)

State Engagement: In addition to the current implementation arrangement, in keeping with national efforts to increase State participation in grant implementation, specific steps will be taken to devolve duties to States through a Memorandum of Understanding (MOU) with all participating States. The MOU will specify expected roles for States and co-financing commitments. A set of agreed criteria will be applied to identify State SRs among the GF-supported States to identify two States with strong political will and public health leadership as SRs (Annex 38: Criteria for Selecting States as Sub-recipients). This is a deliberate phased transition approach to move towards

grant implementation by the States, thereby fostering ownership and sustainability. This will require a mix of human resources capacity in each State with the additional oversight by the PRs to further strengthen the States' financial management systems and mitigate any potential risk. The risks likely to be associated with State-led implementation as well as the suggested mitigation actions are summarised in Table 6.2.

Table 6.2 Risks Linked to State-Led Implementation

Risk Category	Key Risk	Mitigation Actions
Grant implementation	<ul style="list-style-type: none"> Delay in start-up of grant in identified states and transitioning delays from NGO-SR to State SR Inadequate capacity for project management including coordination Low absorptive capacity and delays in implementation 	<ul style="list-style-type: none"> Early commencement of negotiations Types of implementation roles could vary depending on the capacity of each State and comparative advantages. Some States may not be SRs but serve as implementing agents only in areas where they have the requisite capacity. Training of state team on programme management. Embedded short term technical assistance (TA) to support project management.
Financial management	<ul style="list-style-type: none"> Inadequate skills for financial management Non availability of dedicated account for malaria 	<ul style="list-style-type: none"> Training of state team on financial management. As a condition precedent, States to open a dedicated bank account with double signatories for financial operation.
M&E	<ul style="list-style-type: none"> Inadequate capacity for data management and use at subnational level 	<ul style="list-style-type: none"> Embedded short term TA to support M&E and National Malaria Data Repository (NMDR) Training health care works on data demand and use through improving on the LGA integrated Monitoring and Supervisory Visit (iMSV) and hands-on onsite mentorship. Upgrade the infrastructure in the data control room in the states to be able analysis data monthly, provide feedback and use for decision making. Expand ongoing data review meeting to include health management leadership for real-time update to improve timely decision making.
Coordination	<ul style="list-style-type: none"> Inadequate coordination of responsive entities Vertical mandates 	<ul style="list-style-type: none"> Establish periodic coordination platforms.

ABC Analysis: The GF currently supports approximately 10,127 HF in the 13 States. Plans will be instituted to significantly improve the monitoring of commodities versus cases within a manageable number of HF NMEP has undertaken ABC analysis, an inventory categorisation, to improve the efficiency of delivery of commodities to HF supported by the GF (Annex 41: NMEP ABC Analysis Report Summary). Nigeria grouped the selected public facilities into A, B and C Models, and disaggregated HF as follows: A= 4,004 (40%), B= 2,857 (28%) and C= 3,266 (32%). The 'A' category, with about a 75% case load, has 40 % of the total HF while the 'B' category, with a 17% case load, has 28% public HF, and the 'C' category, with about an 8% case load, represents 32% of public HF. Priority will be given to categories A and B facilities, with a view to improving efficiency and significant savings in logistics costs. Based on this analysis, GF support in the 2021-2023 implementation period will be focused on the 6,861 HF in the A and B category which account for 92% of the malaria case load in the 13 supported States; these will include 6,283 primary HF, 561 secondary and 15 tertiary HF.

Improving efficiency and effectiveness of LLIN delivery modalities: The GF and NMEP commissioned a technical assessment of the efficiency and effectiveness of the LLIN mass distribution campaign and routine LLIN distribution implementation as per national standards and guidelines, to identify challenges and bottlenecks and make recommendations to address them. The assessment provided very useful findings and made several suggestions

that would improve the effectiveness of these LLIN distribution channels and will guide planning and implementation of both modalities by the Programme and all implementing agents. The report of this assessment is attached as Annex 39. Another report of an efficiency analysis of donor-funded malaria interventions in Nigeria, specifically LLIN distribution through routine and mass distribution and the related social and behaviour change communication conducted by ICF is also attached as Annex 40. The analysis identified drivers of inefficiencies and best practices to improve efficiency. The recommendations emphasised mechanisms to address primary cost drivers, relying on a reduction in procurement price of LLINs, the number of personnel cadres and allowances paid, strengthening supply chain management systems to reduce logistics costs, and capitalising on in-State presence to encourage State engagement and financial support (see Annex 40; pp. x-xi, 51-53)

Update on Nigeria's COE Status: In the COE of Northeast Nigeria, where there are security challenges and fiscal constraints, the Programme is implementing an IDP malaria service delivery approach which entails collaborating with humanitarian partners to mitigate against the risk and remove the bottlenecks inherent in effective implementation of malaria prevention and treatment interventions. For example, the GF is supporting SMC implementation through WHO, an organisation which is able to deliver in such a challenging and complex environment. WHO, though not a current SR under the grant, was identified to play this role because of its comparative advantage of having organisational capacity, mechanisms and track record of working in COEs. The country will use the findings from the planned malaria matchbox assessment to further tailor the activities targeting IDPs in the four core COE states, namely, Adamawa, Gombe, Taraba and Yobe.

RSSH

The current grant is implemented by a PR (MSH) and three SRs – the FMOH's Department of Health Planning, Research & Statistics (DHPRS), NCDC and NPSCMP. Implementation is also supported by the TSOs for the State Approach. Although there was a significant delay in the commencement of full implementation of grant coupled with some relationship management issues at inception, the recent achievements of the current RSSH grant are pointers to an improved pace and rapid implementation if the momentum is maintained.

The factors responsible for low absorption rate (23%) in the early part of RSSH implementation include the slow implementation pace, role conflict, inadequate capacity and an inability to manage complex relationships. Many of these concerns have been largely resolved.

RSSH Risk Management

Risk Category	Key Risk	Proposed Mitigation Actions
Grant implementation	<ul style="list-style-type: none"> Delayed implementation of project - including procurement processes and contracting of Implementers Low grant absorption Slow and sequential implementation of planned activities Role Conflicts Insufficient capacity and human resources at PR and Sub-Recipient (SR) Measuring Results 	<ul style="list-style-type: none"> Fast track all contracts signing and procurement processes as agreed in implementation road-map Timely disbursement to implementers and decentralise actions to states as SRs or SSRs Engage additional PR and simultaneous implementation of allocated mandates Role clarifications and mandate allocation at point of grant signing Recruitment of experienced staff and embedded Tas where necessary Adopting a national standard for measuring systems improvement results
Coordination	<ul style="list-style-type: none"> Weak Federal and State levels coordination 	<ul style="list-style-type: none"> Establish a PMU at the Federal Ministry of Health and PCU at the implementing states
Monitoring and Supervision	<ul style="list-style-type: none"> Vertical uncoordinated monitoring and supervision by disease programmes and IPs 	<ul style="list-style-type: none"> Develop Integrated Supportive Supervision Plan with the Disease Programmes, Thematic Area programmes and the IPs.

- Strengthen and support state level stakeholders to conduct periodic ISS and reporting
- Implement Joint Programme Reviews

To further improve the absorption rate and the deepen the benefits of the current grant, the following solutions are suggested:

- Allow simultaneous implementation of planned activities at Federal and State levels;
- Build relationships and ensure mandates are aligned or re-aligned;
- Invest in orientation and re-orientation trainings for the PR and SRs on leadership, systems and Organisational Behaviour; and
- Invest more in the States directly – number and scope.

The expanded approach to State level support proposed in this Funding Request can be frontloaded and funded by the current grant to set the pace and generate lessons for the 2021–2013 implementation period.

To ensure a smooth and continuous implementation of the back-to-back RSSH grants, this Funding Request proposes that:

1. The present PR and SRs are retained.
2. A second PR is engaged, preferably from one of the existing SRs, to allow for seamless role adjustment.
3. Responsibilities are shared between the two PRs based on their respective technical strengths and core mandates.
4. Additions SRs are recruited to support implementations.
5. States with relevant capacities and able to make needed commitments become SR of RSSH grant.
6. The GF Country Team (GFCT), CCM and strong TA support and oversight be provided periodically.

7. Co-financing and Sustainability³³

The Nigeria allocation envelope for ATM for 2017-2019 was US\$660,686,133. Given that Nigeria is in the lower middle-income country (LMIC) category, her co-financing requirement for 2017-2019 was US\$99,102,920 (15% of the allocation). Nigeria's Minister of Finance signed a commitment letter that the GON would invest in excess of the minimum amount (NGN66,131,303,412.65 which is equivalent to US\$216,823,945 using an exchange rate of NGN305). This commitment letter was based on the 2018 health budget and aligned to specific budget lines. Table 7.1 below summarises the GON's investment in health in 2018 alone: US\$109,162,514.22 which exceeds the co-financing requirement for 2017-2019 of US\$99,102,920.

Table 7.1: Report of Co-Financing Commitments for The Current Implementation Period

Detail	Approved Budget (NGN)	Expenditure (NGN)	Expenditure (USD)
Placing 60,000 HIV Treatment	408,004,596.00		
National Tuberculosis and Leprosy	15,000,000.00		
Global Fund Replenishment	3,000,000,000.00	2,940,594,002.40	9,641,291.81
Counterpart Funding	2,400,000,000.00	2,400,000,000.00	7,868,852.46
National AIDS Control Authority	4,533,501,678.65	4,061,117,222.28*	13,315,138.43
Procurement of ACTs	102,999,500.00		
TB Treatment Procurements	406,007,238.00	61,098,383.27	200,322.57
Procurement of Test Kits	40,790,400.00		
The National Health Act	55,150,000,000.00	13,775,000,000.00**	45,163,934.43
National Health Insurance Scheme (Formal Sector)		10,056,757,229.58***	32,972,974.52
Total	66,056,303,412.65	33,294,566,837.53	109,162,514.22

* Based on actual government spending to support HIV/AIDS programme implementation, including the treatment programme in Abia and Taraba states.

** This relates to disbursements from federal to state governments related to the Basic Health Care Provision Fund (BHC PF).

*** Actual total NHIS payments for 2018 was N43,725,031,432.96 adjusted for projected proportion spent on malaria treatment using 23% malaria prevalence (NDHS 2018).

The National Health Accounts 2017 reported that the GON (Federal, State and LGA) spent a total of US\$1,381,557,377 (NGN 421,375,000,000) in 2017 (see Annex 30: National Health Accounts 2017). This amount exceeds the overall minimum co-financing requirement target set for the allocation period 2017-2019.

For the current allocation period (2020-2022), the envelope is a total of USD\$ 890,597,667 with a co-financing requirement of USD\$ 133,589,650. The Government has secured credits from three international banks to fund health sector interventions in 13 states of the Federation for the next five years, 2020-2024. This includes a World Bank credit of US\$650 million signed on 24 February 2020, of which US\$200 million is specifically for the Malaria IMPACT project (Annex 41a and 41b). The Board of the Islamic Bank has also approved US\$100 million for the Nigeria Malaria IMPACT project (Annex 42); while US\$64 million has also been successfully negotiated for malaria but is yet to be signed by the Board of the African Development Bank. Cumulatively, these loans amount to US\$364 million which exceeds the required 15% co-financing commitment for health investment stipulated in the allocation letter for the next allocation period of 2020-2022. In addition, the BHC PF, which stipulates at least 1% of the consolidated revenue fund for the basic health service package, is now a statutory deduction and is a key source of domestic health financing.

³³ Note that information derived from the supporting documentation provided in response to the questions below, including information on funding landscape or domestic commitments, may be made publicly available by the Global Fund.

Sustainability: Nigeria's main source of revenue remains crude oil and global politics determine the price based on market forces beyond the control of the Nigerian Government. The funds accrued which determine the annual budgetary allocation for the implementation of the work plans of the Government Ministries Departments and Agencies (MDAs) thus vary from year to year. The COVID-19 pandemic is already impacting on the price of crude oil as it has dropped as low as US\$30, far below the benchmark used for the 2020 national budget which is US\$57. The implication of this is that the 2020 budget may have to be adjusted as it would be difficult to fund it under the current circumstances. The Government would harness other mechanisms and opportunities to increase domestic funding for its health programmes in a more sustainable manner. This becomes even more relevant given that the COVID-19 pandemic will likely impact the global economy such that a decline in donor funding may become inevitable. Some of the mechanisms for increasing domestic resourcing of Nigeria's health sector are summarised below.

Social Health Insurance Scheme: This is the cornerstone of Nigeria's health financing strategy to attain UHC. The National Health Insurance Scheme (NHIS), though established over a decade ago, currently supports only about 3% of the population, and especially those in the formal sector. For the period 2017-2019, the NHIS paid out a total of US\$457,042,001 for health services provided to enrollees in the formal and informal sectors. The agency is undergoing structural reforms to reposition it for more efficient services and place the country on track to achieve UHC. Similarly, social health insurance schemes have been introduced at the State level to provide financial protection to the majority of citizens at the point of accessing health care. The schemes are progressing, with all 36 states and FCT having established a State Health Insurance Scheme (SHIS). At the moment, the benefit packages include malaria, but not HIV/AIDS and TB treatment; however, efforts are ongoing to address this situation.

The GON BHCPF: States have commenced to draw down the 1% Consolidated Revenue Fund allocated to the BHCPF each year in accordance with the provisions of the National Health Act 2014. This will aid the implementation of the BMPHS. Fifty percent of the funds are allocated for health services, including malaria, to be administered through the NHIS. Criteria for assessing the funds include establishment of a SPHCDA, evidence of annual budgetary provision and release for operational expenses of PHC and setting up a State Social Health Insurance Agency to manage the health insurance pathway of disbursement (Policy Brief March 2015: implementing the BHCPF in Nigeria, BHCPF Operational Manual 2018)

Co-financing Requirements for States: The M|OU with States will specify the co-financing expectations and commitments of each of the 13 supported States. States will be required to invest a proportion of their BHCPF towards fulfilling their co-financing commitments. The MOU will specify the type of commodities and other mandatory support to be required from the States as part of increased state engagement and co-financing requirements. Some of the expected State co-financing contributions include (but are not limited to) the following: (a) Provision of SP for IPTp; (b) warehousing and security of commodities, (c) support for airtime in State electronic media for planned SBC messages, and (d) logistics support for last mile delivery of commodities to hard-to-reach communities. The NMEP is working towards getting commitment letters from the 13 States by the time of grant signature, engaging advocacy at the highest level from Federal to States.

Drug Revolving Fund Schemes (DRF): The State DRF initiative, which is currently in practice at all Secondary and Tertiary institutions, is a self-sustaining approach. The new grant will explore the option of expanding this approach by starting selected States and LGA to transition to DRF schemes to sustain coverage and availability of malaria commodities. The new GF grant will support technical assistance for documentation and dissemination lessons learned from GF States like Jigawa, Kaduna and Kano, and which are currently implementing successful State-led DRF schemes. Secondary facilities in the 13 GF States with DRFs that are not functional will be given technical support and a seed stock of malaria commodities to strengthen their schemes. This is a key investment focus of the RSSH proposal in line with the National Health Supply Chain Strategy and Implementation Plan 2020 – 2024 (Annex 26).

Public Private Partnership (PPP): Leveraging the corporate social responsibility (CSR) of private companies and organisations to fund malaria related interventions (e.g. ongoing partnership with the Nigeria Liquefied Natural Gas (NLNG) Company, to support interventions towards the elimination of malaria on the Bonny Island in Rivers

State, South-South geopolitical zone of Nigeria, that is estimated to cover 350,000 persons), and galvanising private sector support for malaria through the Corporate Alliance on Malaria in Africa (CAMA).

Efforts are also ongoing to support the local production of malaria commodities; the NMEP is engaging with local manufacturers for the production of WHO-approved LLINs in Nigeria.

Another challenge to sustainability is the concentration of management of donor funding for HIV, TB and malaria at the Federal level of Government and by international NGOs (INGOs), to the exclusion of the Government institutions and structures, particularly at the State level. There is an urgent need to decentralise the implementation arrangement of health programmes from the Federal level with minimal role for the States, using Government institutions with the statutory mandate for the programmes. The current arrangement makes the States view the programmes as owned by the DPs and the INGOs implementing the programmes, and thus providing minimal or no opportunity for their participation: reversing this trend will encourage and empower the States to take ownership of their programmes and responsibility for their citizens. The change in implementation arrangements proposed in this grant will address this by giving direct responsibility to the States to manage their programmes. The Lagos example has shown that this strategy works, and the State Approach is also showing great potential in this regard. In the long term, State ownership will also empower the States to include these services in the benefit packages of their social health insurance schemes which is fast picking up across the country. This way, funding for these diseases from all sectors will increase and become more predictable, and thus more sustainable.

8. Projected Need for Programme Revisions (Reprogramming)

Malaria

Expected documents, evaluations/reviews, surveys or other relevant information	Expected availability (month, year)
NMSP	December 2020
Periodic review of NMSP	June 2023
Malaria Indicator Survey (three- yearly)	2020
Rapid Impact Assessment (two-yearly)	2022
Antimalarial drug TES (conducted at two-yearly intervals per site but rotational across zones – hence annual with alternate set of sites each year)	Annual
Insecticide Resistance Monitoring	Annual
Planned/Ongoing pilot studies: New nets study (2020); IPTi, Community IPTp (TIPTOP, 2022); malaria vaccine, Rectal Artesunate (CARAMAL, 2020)	Varied

RSSH

Expected documents, evaluations/reviews, surveys or other relevant information	Expected availability (month, year)
National Strategic Health Development Plan, 2018-2022	Mid-term review in 2020
National Health Insurance Law	Ongoing review will produce a new law expected to rapidly improve coverage
National Health Act, 2014	Operationalised through the BHCPS and support to SHISs
National HF Survey and SMART Survey	2020 and 2022
MICS	2020 and 2023
<i>(Insert additional lines as needed)</i>	

9. Matching Funds (if applicable)

This question should only be answered by applicants with designated matching funds, as indicated in the allocation letter.

Describe how the programmatic and financial conditions, as outlined in the allocation letter, have been met.

[Applicant response]

NOT APPLICABLE

Annex 1: Documents Checklist

Use the list below to verify the completeness of your application package.

<input checked="" type="checkbox"/>	Funding Request Form
<input checked="" type="checkbox"/>	Programmatic Gap Table(s)
<input checked="" type="checkbox"/>	Funding Landscape Table(s)
<input checked="" type="checkbox"/>	Performance Framework
<input checked="" type="checkbox"/>	Budget
<input checked="" type="checkbox"/>	Prioritized above allocation request (PAAR)
<input checked="" type="checkbox"/>	Implementation Arrangement Map(s) ³⁴
<input checked="" type="checkbox"/>	Essential Data Table(s) (updated)
<input type="checkbox"/>	CCM Endorsement of Funding Request
<input type="checkbox"/>	CCM Statement of Compliance
<input checked="" type="checkbox"/>	Supporting documentation to confirm meeting co-financing requirements for current allocation period
<input type="checkbox"/>	Supporting documentation for co-financing commitments for next allocation period
<input type="checkbox"/>	Transition Readiness Assessment (if available) NOT APPLICABLE
<input checked="" type="checkbox"/>	National Strategic Plans (Health Sector and Disease specific)
<input checked="" type="checkbox"/>	All supporting documentation referenced in the funding request
<input type="checkbox"/>	Health Product Management Tool (if applicable)
<input checked="" type="checkbox"/>	List of Abbreviations and Annexes

³⁴ An updated implementation arrangement map is mandatory if the program is continuing with the same PR(s). In cases where the PR is changing, the implementation arrangement map may be submitted at the grant-making stage.

Annex 2a: List of Abbreviations

AA	Artesunate Modiaquine
ACOMIN	Association of Civil Society Organizations for Malaria, Immunisation and Nutrition
ACPCR	Adequate clinical and parasitic cure rates
ACSM	Advocacy, communication and social mobilisation
ACT	Artemisinin-based combination therapy
AL	Artemether Lumefantrine
AMFm	Affordable Medicines Facility-malaria
ANC	Antenatal care
AOP	Annual Operational Plan
ART	Antiretroviral therapy
ATM	AIDS TB Malaria
BA/BE	Bioavailability/Bioequivalence
BCC	Behaviour change communication
BEmONC	Basic emergency obstetrics new-born care
BHCPF	Basic Health Care Provision Fund
BMPHS	Basic Minimum Package of Health Services
BOD	Burden of disease
CAMA	Corporate Alliance on Malaria in Africa
CARAMAL	Community Access to Rectal <i>Artesunate</i> for Severe Malaria
CBA	Community Based Associations
CBHIS	Community Based Health Insurance Scheme
CBHCS	Community-based health care services
CBO	Community-based organisation
CBW	Community-based worker
CM	Country Coordinating Mechanism
CHAI	Clinton Health Access Initiative
CHEW	Community Health Extension Workers
CHIS	Community Health Information System
CHW	Community Health Influencers, Promoters, Services programme
CHIPS	Community Health Influencers, Promoters and Services
COE	Challenging operating environment
CORPs	Community oriented resource persons
CRS	Catholic Relief Services
CRV	Civil Registration and Vital Statistics
CSO	Civil society organisation
CSR	Corporate social responsibility
CSS	Community system strengthening
DFDS	Department of Food and Drug Services (FMOH)
DFID	Department for International Development
DRF	Drug Revolving Fund
DHIS	District Health Information System
DHP	Dihydroartemisinin-Piperaquine
DHPRS	Department of Health Planning, Research & Statistics, FMOH
DP	Development partner
DPRS	Department for Planning Research and Statistics
DQA	Data quality assurance
DRF	Drug Revolving Fund
EOC	Emergency Operations Centre
EPI	Expanded Programme on Immunisation
EPHS	Essential package of health services

EQA-PT	External Quality Assurance - Proficiency Testing
ERC	Research Ethics Review Committee (WHO)
FBO	Faith-based organisation
FCT	Federal Capital Territory
FMOE	Federal Ministry of Education
FMOH	Federal Ministry of Health
FMOWSD	Federal Ministry of Women Affairs and Social Development
FP	Family planning
GAC	Grants Approval Committee
GBV	Gender-based violence
GDP	Gross domestic product
GF	Global Fund
GON	Government of Nigeria
HBHI	High Burden High Impact
HCF	Health care financing
HDCC	Health Data Consultative Committee
HDGC	Health Data Governance Council
HDI	Human Development Index
HF	Health facility
HIS	Health information systems
HJFMRI	Henry Jackson Foundation Medical Research International
HMIS	Health Management Information Systems
HMO	Health maintenance organisation
HRH	Human resources for health
HRV	Human rights violations
iCCM	Integrated Case Management of Childhood illnesses
ICT	Information communication technology
ICT4D	Information Communication Technology for Development
IDA	International Development Association
IDP	Internally displaced person
IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations
IMCI	Integrated management of childhood illnesses
IMSV	Integrated Monitoring and Supervisory Visit
IPC	Interpersonal communication
IPTp	Intermittent Preventive Treatment in pregnancy
IR	Insecticide resistance
IRM	Insecticide resistance monitoring
ISS	Integrated supportive supervision
ITN	Insecticide-treated nets
IVM	Integrated vector-control management
KAP	Knowledge attitude practise
LGA	Local Government Area
LGHAMT	Local Government Health Authority Management Team
LLIN	Long lasting insecticidal nets
LMCU	Logistics Management and Coordination Units
LMD	Last Mile Delivery
LMIC	Lower middle-income country
LMIS	Logistic Management Information System
M&E	Monitoring and evaluation
Mal-RMNCAH	Malaria-Reproductive, Maternal, New-born, Child and Adolescent Health
MC	Malaria Consortium
MDAs	Ministries, Departments and Agencies (of the Government)

MFO	Mixed function oxidases
MICS	Multiple Indicator Cluster Survey
MLSCN	Medical Laboratory Science Council of Nigeria
MNCH	Maternal new-born child health
MOU	Memorandum of Understanding
MPR	Malaria Programme Review
MSH	Management Sciences for Health
MSP	Minimum health service package
MSSV	Mentoring and supportive supervisory visits
NACA	National AIDS Control Authority
NASCP	National AIDS and STDs Control Programme
NAFDAC	National Agency for Food and Drug Administration and Control
NAIIS	Nigeria HIV/AIDS Indicator and Impact Survey
NAPHC	National Action Plan for Health Security
NARHS	National HIV and AIDS and Reproductive Health Surveys (
NCD	Non-communicable disease
NCDC	Nigeria Centre for Disease Control
NDHS	Nigeria Demographic and Health Survey
NDR	National Data Repository
NEMA	National Emergency Management Agency
NGO	Non-government organisation
NHA	National Health Act
NHFA	National Health Facility Assessment
NHFR	National Health Facility Registry
NHIS	National Health Insurance Scheme
NHLMIS	National Health Logistics Management Information System/NAVISION
NHMIS	National Health Management Information System
NHP	National Health Policy
NHREC	National Health Research and Ethics Committee
HNRHIS	National Human Resources for Health Information System
NIMR	Nigerian Institute of Medical Research
NIPOST	Nigerian Postal Service
NIPRD	National Institute for Pharmaceutical Research and Development (
NLNG	Nigeria Liquefied Natural Gas
NMDR	National Malaria Data Repository
NMEP	National Malaria Elimination Programme
NMSP	National Malaria Strategic Plan
NNHS	National Nutrition and Health Survey
NPHCDA	National Primary Healthcare Development Agency
NPSCMP	National Products Supply Chain Management Programme
NSCIP	National Supply Chain Integration Programme
NSHDP	National Strategic Health Development Plan
NTBLCP	National Tuberculosis and Leprosy Control Programme
NUC	National Universities Commission
NURTW	National Union of Road Transport Worker
OPE	Out-of-pocket expenses
OTSS	Online training and supportive supervision
PAAR	Prioritised Above Allocation Request
PBO	Piperonyl butoxide
PCR	Polymerase chain reaction
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHC	Primary health care
PMI	President's Malaria Initiative

PPMV	Patent and Proprietary Medicine Vendors
PPP	Public-private partnership
PQ	Pre-qualified
PR	Principal Recipient
PSCM	Private Sector Co-payment Mechanism
PSCM2	Procurement and supply chain management
PSM	Procurement supply mechanism
QMS	Quality Management System
QOC	Quality of care
RBM	Roll Back Malaria
RDT	Rapid Diagnostic Test
RSSH	Resilient and sustainable systems for health
SBC/C	social and behaviour change / communication
SDG	Sustainable Development Goal
SEMA	States Emergency Management Agency
SFH	Society for Family Health
SHIA	State Health Insurance Agency
SHIS	State Health Insurance Scheme
SMART	Standardised Monitoring and Assessment of Relief and Transition
SMC	Seasonal malaria chemoprevention
SMOE	State Ministry of Education
SMOH	State Ministry of Health
SMOWASD,	State Ministry of Women Affairs and Social Development
SOP	Standard operating procedures
SP	Sulfadoxine-Pyrimethamine
SPHCDA	State Primary Health Care Development Agencies
SR	Sub-Recipient
SP/SPAQ	Sulfadoxine-Pyrimethamine + Amodiaquine
SSHIS	State Social Health Insurance Scheme
SWOT	Strengths, Weaknesses, Opportunities and Threats
TA	Technical assistance
TBA	Traditional birth attendant
TES	Therapeutic Efficacy Studies
TETFUND	Tertiary education Trust Fund
TOR	Terms of Reference
TOT	Training of trainers
TRP	Technical Review Panel
TSO	Technical Support Organisation
TWG	Technical working group
UHC	Universal health coverage
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
U5MR	Under-five mortality rate
VHC	Village Health Committee
VHW	Voluntary health worker
WDC	Ward Development Committee
WHO	World Health Organization
ZTO	Zonal Technical Officers

10. Annex 2b: List of Annexes

Annex	Document Title
1	GF Document Checklist
2a	List of Acronyms
2b	List of Annexes
3	National Malaria Strategic Plan 2014-2020
4	Nigeria Demographic and Health Survey 2018
5	Malaria Programme Review 2019
6	National Malaria Elimination Programme/World Health Organisation Stratification Map 2020
7	Malaria Quality of Care Guidelines
8	Breakthrough ACTION Report 2019
9	Integrated Case Management of Childhood Illnesses Report 2019
10	Community Health Influencers, Promoters, Services Programme (CHIPS) Guidelines
11	Basic Health Care Provision Fund (BHCPF)
12	Severe Malaria Study Report (NMEP 2020)
13	CARAMAL Interim Report 2019
14a	ACT-RDT Market Transition Plan (NMEP 2019)
14b	REPORT ON PRIVATE SECTOR ACT ASSESSMENT
15	NMEP Position Paper on Private Sector Response
16	TIPTOP Project Interim Report
17	NMEP-SMC Implementation Report 2019
18	ACOMIN Report 2019
19	Independent Evaluation of Social and Behaviour Change Communication Scale up Activities Gombe 2019, Blake and Harper Report
20	Mal-RMNCAH-N Framework, FMOH
21	National Strategic Health Development Plan (NSHDP-II) 2018-2022
22	RSSH Principal Recipient Progress Report 2019
23	Report on Stakeholders Meeting on HMIS/LMIS Data Triangulation, 7-8 August 2019
24	Nigeria Health Systems Programmatic and Financial Situation Analysis February 2020
25	List of Relevant Policies and Plans
26	Overview of Nigeria's Health System
27	Different Actors at Different Levels of the Nigeria Health System
28	NMEP-SMEP Meeting Report
29	National Supply Chain Strategy
30	Procurement and Supply Chain Management Stakeholders
31	Nigeria Roll Back Malaria Annual Report 2004
32	NMEP Preliminary Report of Therapeutic Efficacy Studies 2018
33	National Health Accounts 2017
34	NAFDAC Strategic Plan for Rapid, On-the-Spot Field Detection of Substandard and Falsified (SF) Medical Products using the Truscan Device in Nigeria.
35	NAIIS Malaria Reanalysis Report
36	Malaria Implementation Map
37	Malaria: Roles and Responsibilities of PRs and SRs
38	Malaria: Criteria for Selecting States as Sub-recipients
39	Process Evaluation on LLIN Campaign and Continuous Distribution in Nigeria
40	Efficiency Analysis of Donor-Funded Malaria Interventions in Nigeria (LLIN distribution)
41	NMEP ABC Analysis Report Summary
41a	World Bank IDA Credit for Nigeria Immunization-Plus and Malaria Progress

41b	Notification of World Bank Board Approval –IMPACT Programme
42	Islamic Development Bank Support to Malaria Elimination Nigeria
43	RISK MANAGEMENT TABLE - MALARIA PROGRAMME IMPLEMENTATION RISKS
44a	Malaria Principal Recipient Organogram - NMEP
44b	Malaria Principal Recipient Organogram – CRS and SRs
45	National Health Facility Survey Report 2016

