

STANDARD CONCEPT NOTE

Investing for impact against HIV, tuberculosis or malaria

A concept note outlines the reasons for Global Fund investment. Each concept note should describe a strategy, supported by technical data that shows why this approach will be effective. Guided by a national health strategy and a national disease strategic plan, it prioritizes a country's needs within a broader context. Further, it describes how implementation of the resulting grants can maximize the impact of the investment, by reaching the greatest number of people and by achieving the greatest possible effect on their health.

A concept note is divided into the following sections:

- Section 1:** A description of the country's epidemiological situation, including health systems and barriers to access, as well as the national response.
- Section 2:** Information on the national funding landscape and sustainability.
- Section 3:** A funding request to the Global Fund, including a programmatic gap analysis, rationale and description, and modular template.
- Section 4:** Implementation arrangements and risk assessment.

IMPORTANT NOTE: Applicants should refer to the Standard Concept Note Instructions to complete this template.

SUMMARY INFORMATION			
Applicant Information			
Country	Nigeria	Component	Malaria
Funding Request Start Date	January 2015	Funding Request End Date	December 2016
Principal Recipient(s)	National Malaria Elimination Programme (NMEP); Society for Family Health (SFH)		

Concept note and grant duration: The funding request in this 3-year Concept Note (2015-2017) relates to a grant duration of 2 years (2015-2016). The current Global Fund (GF) malaria grants will be coming to an end in December 2014. Due to the size of the need related to maintaining current coverage for routine activities, the 2017 LLIN replacement campaigns, and the inability to cover both under the current allocation, GF agreed in March 2014 to allow Nigeria to apply its allocation request to a shortened grant period to 2015-2016. The plan is to place orders for the replacement campaign LLINs in 2016, based on commitments to VPP agents, expectant that the Global Fund will have another successful replenishment in 2017. These LLINs would arrive in 2017 for the campaigns.

Allocation and interim funding: In April 2013, the Global Fund announced an additional \$167 million of interim funding allocated under the New Funding Model (NFM) to Nigeria's malaria component for 2013-2014. In accordance with this allocation, the Country Coordinating Mechanism (CCM) submitted a request for \$153 million to replace LLINs through mass campaigns and \$14 million for the procurement of ACTs and RDTs. This request was approved and program implementation related to the campaigns has started.

A total sum of \$499,490,418 was allocated to the Nigeria malaria component in March 2014. Of this amount, \$167,000,000 is already committed to the LLIN campaigns and ACTs/RDTs, totaling 33% of the total allocation request. On top of this amount, there was a balance of \$16,228,854.34 from the existing Round 8 Phase 2 plus IF grant as at 31st December 2013, for a total of \$183,228,854.34 (please refer to "ANNEX 3 Nigeria Concept Note breakdown of \$183 million under the \$499 million malaria allocation" for details). The remaining amount allocated to support the Concept Note application for malaria is \$316,261,563.00 and is outlined in detail in the following.

Funding Request Summary Table



A funding request summary table will be automatically generated in the online grant management platform based on the information presented in the programmatic gap table and modular templates.

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A concept note outlines the reasons for Global Fund investment. Each concept note should describe a strategy, supported by technical data that shows why this approach will be effective. Guided by a national health strategy and a national disease strategic plan, it prioritizes a country's needs within a broader context. Further, it describes how implementation of the resulting grants can maximize the impact of the investment, by reaching the greatest number of people and by achieving the greatest possible effect on their health.

A concept note is divided into the following sections:

SECTION 1: COUNTRY CONTEXT

This section requests information on the country context, including the disease epidemiology, the health systems and community systems setting, and the human rights situation. This description is critical for justifying the choice of appropriate interventions.

1.1 Country Disease, Health and Community Systems Context

With reference to the latest available epidemiological information, in addition to the portfolio analysis provided by the Global Fund, highlight:

- a. The current and evolving epidemiology of the disease(s) and any significant geographic variations in disease risk or prevalence.
- b. Key populations that may have disproportionately low access to prevention and treatment services (and for HIV and TB, the availability of care and support services), and the contributing factors to this inequality.
- c. Key human rights barriers and gender inequalities that may impede access to health services.
- d. The health systems and community systems context in the country, including any constraints.

2-4 PAGES SUGGESTED

a. The current and evolving epidemiology of the disease(s) and any significant geographic variations in disease risk or prevalence.

Population at risk and prevalence

Malaria is endemic in Nigeria with 97% of the population of 170 million living in areas of high malaria risk and an estimated 3% living in malaria free highlands. Nigeria bears up to 25% of the malarial disease burden in Africa. Nigeria and the Democratic Republic of Congo together account for 40% of the 627,000 global estimated malaria deaths and 32% of cases (World Malaria Report, 2013 pg 64, attachment 1), making her one of the two countries with highest malaria mortality. Malaria-related deaths account for up to 11 % of maternal mortality, 25% of infant mortality and 30 % of under-5 mortality (NMSP 2009 -2013, pg 12, attachment 5). The disease overburdens the already-weakened health system with nearly 110 million clinical cases of malaria diagnosed each year. Malaria contributes up to 60% of outpatient visits and 30% of admissions (NMSP 2009 - 2013, pg 12, attachment 5). The 2010 Nigeria Malaria Indicators Survey (NMIS) revealed an average parasite prevalence of 42% among children below five years of age with zonal variations ranging from 27.6% in the South-east to 50.3% in the South-west zone (NMIS report 2012, pg 63, attachment 2).

Other than the 2010 MIS, there has not been a nation-wide point prevalence data estimates for proper comparisons of prevalence trends. There was also a decrease in malaria admissions, and a 27% reduction in malaria deaths in the same period (RIA 2014, pg 36, attachment 3). The NDHS 2013 also demonstrates 35% decline in all-cause mortality in children under five in the same period from 201 per 1,000 live birth in 2003 to 128 per 1,000 live birth in 2013 (NDHS, 2013; pg 19, attachment 4).

Malaria Transmission and Geographical Variation

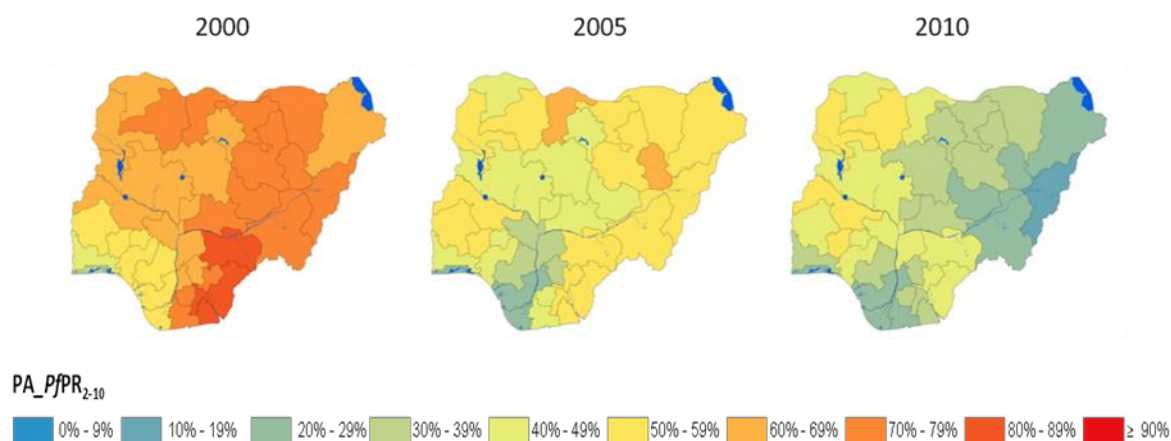
Nigeria has various ecological zones with vegetation changing from Sahel savannah in the far north followed by Sudan savannah merging into Guinea savannah in the middle belt, then Rain forest in the south and Mangrove forest in the coastal areas. In the northern part of the country, transmission is highly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

Epidemiological trends and implication for prioritization of available resources

There is evidence of some progress with respect to intensity of malaria transmission in Nigeria, over the last 15 years. Prior to 2010, it was estimated that approximately 30% of the population lived in

areas of high to very high transmission intensity and 67% in the moderate transmission zone (NMSP 2009 – 2013, pg 12, attachment 5). However, there is now evidence of a progressive divergence of in-country variation in malaria endemicity. Bayesian model-based geo-statistical methods were used to interpolate in space and time, age-corrected malaria point prevalence data in children 2-10 years old, to provide a prediction of malaria risk across Nigeria for the years 2000, 2005 and 2010 (Figure 1.1). As at 2010, 85% of Nigerians lived in areas supporting mesoendemic transmission, about 15% lived under conditions of hyper-holoendemicity and there are small pockets suggestive of hypoendemicity (Snow et al., 2013, pg 61, attachment 6). Although the basis for these changes may be multifactorial, they nevertheless mirror the period after the RBM Abuja declaration in 2000 and progressive increase in available resources and the large scale deployment of malaria control materials (LLINs and ACTs) in the country.

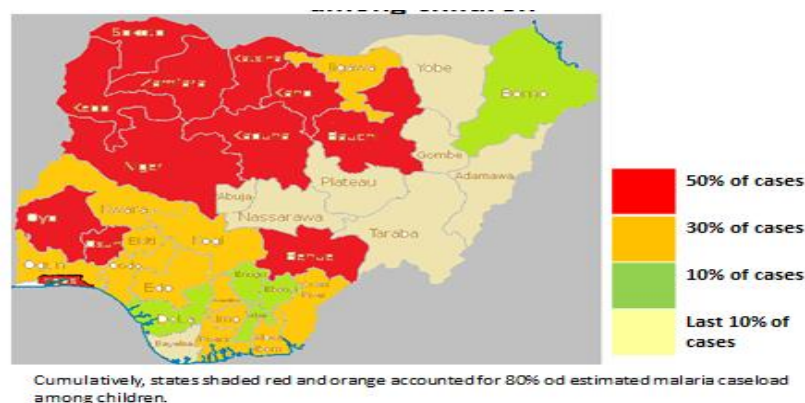
Figure 1.1: Possible Decline in Malaria Transmission Intensity During 2000-2010



Over the entire period 2000 to 2010 all states in the country may have witnessed a reduction in transmission intensity. *The modeled predicted percentage change from 2000-2010 exceeded 50% in 19 states* (Snow et al. 2013, pg 56, attachment 6). Despite significant changes in infection risks these states and those without a 50% decline all have *risks of infection that exceed 20% in 2010* but are all dramatically different from levels of infection risk in 2000 (Snow et al. 2013, pg 62, attachment 6). By implication the core malaria intervention strategies are still those of universal coverage for LLINs, ACTs and RDTs with other supportive interventions.

An analysis of the malaria caseload using the malaria transmission mapping estimates of $PfPR_{2-10}$, shows that 24 states in Nigeria bear 80% of the malaria burden as depicted in Figure 1.2. These 24-states are now regarded as high burden states (HB-States). *Although the malaria control strategies for all states in Nigeria remains essentially the same, i.e. universal coverage for core interventions, there is a rational basis to posit that in the face of resource challenge, the HB-States should, of necessity, be prioritized for deployment of interventions so as to ensure greater impact on malaria case load while not sparing any effort to consolidate on the gains made in the lower burden states by also sustaining their interventions.* This theme is expanded upon in section 3.

Figure 1.2: Distribution of Malaria Case Load in the Country Showing the Relative Contribution of the Different States



Malaria Parasites and Vectors

The dominant species of malaria parasites in Nigeria is *Plasmodium falciparum* (≈95%); which also occur as mixed species with other Plasmodium species; *P. malariae* (9.8%) and *P. ovale* (5.8%) and mixed infections (10.4%). The percentages of children infected with each plasmodium species in the absence of other species is: 84% with *P. falciparum*, 3% with *P. malariae*, and 2% with *P. ovale*. *Plasmodium vivax* was not identified in any of the cases (NMIS 2012, pg 66, attachment 2).

The major malaria vectors are the *Anopheles gambiae* complex (*An. gambiae* s.s. and *An. arabiensis*) and the *Anopheles funestus* group. These three species are widely distributed across the country, from the mangrove and coastal areas of the south to the Sahel savannah of the far north. Detailed disease epidemiology is contained in the NMSP 2014-2020 (NMSP, pg 29-33, attachment 7).

b. Key populations that may have disproportionately low access to prevention and treatment services and the contributing factors to this inequality.

In line with the Abuja 2000 declaration, Nigeria has adopted universal coverage for malaria services. Hence the approach to malaria intervention has been to reach the entire population with preventive, diagnosis and treatment commodities. Additional emphasis is placed on reaching children and pregnant women, who are more vulnerable to the disease, using the EPI clinics, ANC services and the schools to increase access to malaria related services. However due to the vastness of the country and other emerging social challenges, particularly insurgencies, there has been observable practical difficulties reaching some sections of the population. Thus key populations that may have disproportionately low access to prevention and treatment services include:

- i. **North Eastern Nigeria:** Due to challenges of insurgencies and the experience of attacking health workers as soft targets, there are now operational challenges for delivering malaria intervention services, especially mass campaigns in some states of this region of the country. There have also been a number of internally displaced persons whose relocations to other parts may affect the initial projections upon which planning for other states have been effected. The challenges posed from this region will be addressed on the basis of the different scenarios that come up and leveraging on available opportunities within the context of threats to life. It is also anticipated that current initiative of government will bring about lasting peace in this region of the country.
- ii. **Hard-to-reach rural communities:** On a general note the country has done remarkably well reaching the rural communities. In the DHS 2013, ITN ownership in rural households was 55.2% compared to urban households with 42% ownership. There are often some hard to reach rural communities for which very special measures including use of boats or camels are required (NDHS, 2013 pg 34, attachment 4). While these may be addressed in interventions delivered by campaigns, it may be a little more challenging to provide routine services in a more sustainable way. We estimate that areas with this type of terrain requiring very extreme measures for access should not exceed about 5% of the country and effort will always be made during micro-planning processes to ensure coverage of such communities.
- iii. **Nomadic population:** Nigeria has a significant population of nomads. Some end up being temporary settlers and integrated to local communities where they access available health services but there are the highly mobile nomads who traverse a great distance annually and do not have fixed locations, making them hard to reach. In addition, Akogun *et al.* 2012, noted that “the most important issues in health service utilization among nomads are the belief that fever is a Fulani illness that needs no cure until a particular period, preference for private medicine vendors and the avoidance of health facilities. Understanding nomadic Fulani beliefs about “*pabboje*” (*intermittent fever*) is useful for planning an acceptable community participatory fever management among them” (Akogun *et al.* 2012, pg 1, attachment 8).

c. Key human rights barriers and gender inequalities that may impede access to health services.

The Nigerian constitution guarantees fundamental human rights and equality for both sexes. There is a general commitment to the principle of non-discrimination as enshrined in Section 2 of the 1999 Constitution of the Federal Republic of Nigeria (Nigerian Constitution, 1999, attachment 9). Despite this Nigeria falls short of the desired result of giving males and females equal opportunity to advance socially, physically, educationally, politically and economically. Evidences abound that

several negative aspects of gender relations, such as gender-based division of labour, disparities between males and females access to power and resources, and gender biases in rights and entitlements, remain pervasive in Nigeria (National Gender Policy 2008 – 2013, attachment 10). This is further compounded by the discriminatory customary and religious practices.

The foregoing notwithstanding the implementation arrangement for the delivery of core malaria intervention services, which is based on the strategy of mass campaigns, free/subsidized drugs and supplemental targeted delivery through ANC and EPI Clinics in an effort to ensure universal coverage, will significantly prevent the aforementioned gender inequalities from exerting any negative effect regarding access to malaria intervention commodities and services.

d. The health systems and community systems context in the country, including any constraints

The Nigerian Constitution provides the administrative context for the organization of health services. It places health on the Concurrent Legislative List (Section 17(a) of the Part II of the Second Schedule of the Nigerian Constitution, 1999). See attachment 9. The public health system of Nigeria is divided into three tiers, each of which is associated with one of the administrative levels of government.

The Federal Government is responsible for tertiary health care and also formulates health policies through the Federal Ministry of Health. This level provides specialized services through the Teaching Hospitals, Federal Medical Centres, Specialist Hospitals and Medical Research Institutes.

The State Governments provide secondary health care through the state General Hospitals. The Local Governments Areas (LGAs) are generally responsible for primary health care services. Both the state and LGAs receive resources from the federation account, a percentage of which is expected to be dedicated to health. The Private Health sector is registered and supervised by the government. The private sector NGOs and local communities provide considerable services at all levels of health care.

Federal and State Ministries of Health have agencies and parastatals under them such as National Primary Health Care Development Agency (NPHCDA), National Agency for Food, Drug Administration and Control (NAFDAC), and State Health Management Boards etc. In the same regard, the Local Government Areas (LGAs) have the Ward Health Committees, Village Health Committees, Private Health Care Providers, and Traditional and Alternative Health Care Providers.

The Tertiary Level

The Tertiary Health Care is at the apex of the health care delivery. It consists of highly specialized services, which are provided by the teaching hospitals and other specialist hospitals providing care for specific groups of patients. These health facilities are largely provided by the Federal Government with every state having at least one Teaching Hospital or a Federal Medical Centre. A number of states and (to a much lesser extent) private hospitals are also providing tertiary health care.

From the Federal Ministry of Health directory of health facilities in Nigeria there were a total of 34,173 health facilities in Nigeria as at December 2011. Of this number 30,098 (88.1%) are primary health care (PHC) facilities, 3992 (11.7%) are secondary level facilities while 83 (0.2%) are tertiary facilities. More than 66% of the facilities are (public) government owned (Directory of Health Facilities in Nigeria, FMOH, 2011 pg 6, attachment 11). The table below shows the distribution of the health facilities by levels and ownership. With this distribution there are on the average 22 health facilities per 100,000 population in Nigeria.

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

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

Secondary Health Care Level

This level provides specialized services to patients referred from Primary health care level through outpatient services for medical, surgical, paediatrics, obstetric and gynaecological care and community health services. Secondary health care is available at each LGA as defined by the authorities of the state. Supportive services such as laboratory, diagnostics, blood bank, rehabilitation and physiotherapy are provided at the Secondary health care level.

Primary Health Care Level

The Primary Health Care level is designed to provide general health services of a preventive, curative, promotive and rehabilitative nature to the population. It is the entry point of the health care system. Provision of care at this level is largely the responsibility of the local governments with support of the state Ministries of Health and within the overall National Health Policy. Health facilities are static or mobile structures where different types of health services are provided by various categories of health workers. These health facilities are in different groups and called different names depending on the structure (building), staffing, equipment, services rendered and by ownership. Many terminologies have been used over the years including dispensaries, health clinics, health centres, primary health centres, maternities, health posts and comprehensive health centres. However based on the Ward Health System, the three recognized facility types are; (1) *Health Post* (2) *Primary Health Clinic* and (3) *Primary Health Care Centres* (Minimum Standards for Primary Health Care, 2011, pg 13, attachment 12).

Most private sector practitioners are located at this level but placed directly under the supervision of the Private Hospital Regulatory and Licensing Board. The Primary Health Facilities are designed to serve catchment area populations of about 10,000-30,000 people. Managerial system for a primary health centre at Ward level consists of the Ward Development Committee (WDC) co-managing with health workers and LGA PHC department. The composition, roles and responsibilities are well defined in the NPHCDA Manual on Minimum Standards for PHC in Nigeria.

Private Health System

The private health care system consists of formal tertiary, secondary, PHC health facilities, pharmacies as well as informal patent medical vendors (PMV) and drug sellers. The private sector comprising the not-for-profit and for-profit health facilities provides health care for a substantial proportion of the population. They account for 40% of registered health facilities especially at the primary and secondary health care levels. The informal private sector consists of about 120,000 PMVs and an unknown number of drug sellers (Private Sector Case Management Strategy, 2013, pg 14, attachment 13). Services provided by the private sector are either partially subsidized as in the case of some missionary health facilities, or not at all as in the case of individually owned clinics/hospitals. Their distribution therefore tends to follow a greater density in urban areas compared to rural areas except the informal PMVs and drug sellers (who often times) establish in rural areas as much as in urban areas.

An assessment carried out by the FMOH that included a household survey found that 56% of respondents who were ill in the previous two weeks purchased drugs from a private seller compared to 35% who obtained drugs from a public health facility. According to 2008 NDHS, 45% of the children below five years who experienced symptoms of fever and or an acute respiratory infection (ARI) received treatment from a health facility (NDHS 2008, pg xxvi, attachment 14).

Sixty-four percent of the population lives within 20km radius from a hospital. Urban areas are better served, as 78% of households are within 20km of a hospital compared to 58% in rural areas. Seventy-one percent of households are within 5 km of a PHC facility. Again urban areas are better served with 80% of households in urban areas being within 5km of a PHC facility whereas 66% have similar access in rural areas. Thirty-nine percent of households live in communities visited by a community health worker (CHEW) at least once a month. The average is similar in urban areas (43%) as in rural areas (38%) (NMSP 2009 – 2013, pg 10, attachment 5). With regard to health systems, the 2012 health systems report provides the basis of our analysis (NHSR 2012, pg 11, attachment 15). The report concluded that:

- 1) **Human Resources for Health (HRH):** Although great disparities exist across zones and across the rural-urban divide, the country has a good supply of Human resources for Health (HRH)

compared with other countries in the region. However, functional HRH planning and management units with sufficient personnel and adequate human resources planning skills within the SMOH and Federal level are generally not adequate.

- 2) **Health Financing:** Relative to its high burden of disease and large population, health financing levels in Nigeria remain low, on a per capita basis and as a share of the state government budget. At the Federal level, the budgetary allocations highlight systematic underfunding of capital projects. Data shows that relatively higher levels of financing are observed in states with significant donor presence, and even in these states, total health expenditure per capita is less than US \$4.00. The 2011 Nigeria Health Sector Report indicated that by 2011 the total budget allocation to health at the Federal level had increased by 67% from 2009 to 2011. Also the proportion of recurrent expenditure has increased from 67% in 2009 to 76% in 2011 (NHSR 2012, pg 53, attachment 15).
- 3) **Services Delivery:** The coverage of most key preventive and curative health services is relatively low in Nigeria. This is compounded by geo-political zone, rural-urban and socioeconomic disparities in coverage. Overall national hospital bed availability of 9.2 per 10,000 people is above sub-Saharan average of 5.6 per 10,000 people. But, this could be as low as 4.3 beds per 10,000 people in the North West zone. In 2011, increased access to healthcare was achieved through the provision of a wider range of basic, specialized and outreach healthcare services, with several hospitals vigorously pursuing community-based services (NHSR 2012, pg 50, attachment 15).
- 4) **Governance:** Governance across the health sector is very weak. For example, institutional arrangements for channeling advocacy and participation are not functioning well. There is significant variation on the level of effectiveness of SCH's across zones. Furthermore, there are few organizations that are informed and capable enough to link members of the public with providers and policymakers or engage with public officials in the establishment of policies, plans and budgets for health services.
- 5) **Health Information Systems (HIS):** HIS capacity across the country varies widely. Most states have limited budgets for HIS activities that provide adequate support for HIS. Few states have an adequate (well trained and sufficient resources with all positions filled) cadre of HIS personnel, particularly at state- and LGA levels. There is significant variation among states by level and type of available health information cadres.
- 6) **Pharmaceutical Management:** The pharmaceutical management system has mixed performance results. While the government has made tremendous progress in developing national pharmaceutical policies and regulations, implementation and enforcement of these policies lags far behind.

Community Health Systems: The framework for community health system is being developed. The Community Based Organizations (CBOs) provide community based prevention, sensitization & mobilization, demand creation, care and support, refer and follow up on cases. The CBOs are coordinated by the Lead NGOs at the zonal level, who are attached to private and secondary health facilities to work with Role model Mothers for access to commodities, increased active referrals and escort of clients to PHCs and secondary facilities. The CBOs link to Ward Health Development committees (WHDC) and health facilities facilitate demand creation and uptake of healthcare services. The CBOs conduct joint activities with the PHCs bi-annually in the Community System coordination meeting. The established structure for working with communities for malaria control is efficient but the current reach is low. There is the need to replicate this model in more Wards around the country especially in States where the malaria case loads are high.

Based on findings and recommendations from the Civil Society Constituency Coordinating Dialogue, the efficiency of the current model can be further improved. There is inadequate funding of community- level activities, as in many cases these are not costed and included in appropriations. These gaps can be seen in such areas as funded participation in monitoring activities; low access and inequality in service provision to populations in hard to reach areas such as the nomadic, residents of many rural communities, those with difficult terrains including those resident within riverine areas and those living on mountains. The poor Civil Society representation on decision making bodies have also limited the reflection of the realities of lives of many communities in programme planning and implementation as intervention models are often not contextualized to fit the

peculiarities of communities and Key Affected Populations such as the diversities in cultural, social and religious set ups of different communities. These hinder programmatic effectiveness.

Constraints

The Nigeria Health Sector Report (NHSR 2012, pg 63-64, attachment 15) highlights the following constraints:

- **Incomplete Data:** While the availability of national health data for monitoring the performance of the health sector has improved, routine HMIS data has a lot of **gaps especially at the state levels. In almost all the states of the federation, the NHMIS does not capture data from the private health facilities and some selected health facilities serving uniformed or military personnel. The data collection and transmission has also been affected by lack of tools as well as inadequate skills and capacity of NHMIS personnel at the sub-national levels to correctly use the NHMIS tools for proper data capture and management.** This reduces the usefulness of routine data and places a huge dependence on the periodic and expensive surveys which often do not occur in time for quick decision making. **In addition, poor and irregular data on government expenditure on health, especially disaggregated by programmatic and disease areas, makes planning and resource mobilization efforts difficult.**
- **Weak Capacity in Delivering Results:** Although the State Health Development Plans (SHDPs) are widely acknowledged as providing a useful framework for undertaking high impact health interventions within the specified timeframe, weak execution capacity at all levels continue to undermine potential of the health system. In addition, many states have not fully imbibed the technicalities of the operationalization of the annual work plans of their SHDPs, especially how to translate this into their day-to-day work.
- **Weak absorptive capacity/late release of funds:** At the federal level, despite an incomplete release of 89%, 59% and 61% of budgetary allocation in 2009, 2010 and 2011 respectively, utilization of the released amount stood at 50%, 98% and 67% in 2009, 2010 and 2011 respectively. This point to inadequate absorptive capacity. The late release of funds and long bureaucratic processes for approval and procurement of goods and services contributes to the inability to completely absorb released funds. This is rather unfortunate in the face of persisting stock-out of key medicines and other necessary supplies.
- **Poor Donor Coordination:** In as much as international donors are seen to be committed to the values and principles of the National Strategic Health Development Plan (NSHDP), as well being supportive of its implementation, most of their activities are still not harmonized on one-hand and then coordinated with the country systems on the other.
- **Deficit in HRH:** This is aggravated by high attrition and freeze on employment: Many states reported a freeze on employment which impact negatively on HRH availability in these states complicating an already dire situation. All have mal-distribution of even the insufficient numbers of health workers that they have. Health is a labour-intensive industry and services cannot be delivered until adequate numbers of health workers are employed and deployed.
- **Lack of Incentives and Sanctions for LGAs to Invest in Health:** LGAs across the country continue to be reluctant investors in the health of their people, in spite of the fact that the national health policy places on them the responsibility of planning and implementation of primary health care.

1.2 National Disease Strategic Plans

With clear references to the current national disease strategic plan(s) and supporting documentation (include the name of the document and specific page reference), briefly summarize:

- a. The key goals, objectives and priority program areas.
- b. Implementation to date, including the main outcomes and impact achieved.
- c. Limitations to implementation and any lessons learned that will inform future

implementation. In particular, highlight how the inequalities and key constraints described in question 1.1 are being addressed.

- d. The main areas of linkage to the national health strategy, including how implementation of this strategy impacts relevant disease outcomes.
- e. For standard HIV or TB funding requests¹, describe existing TB/HIV collaborative activities, including linkages between the respective national TB and HIV programs in areas such as: diagnostics, service delivery, information systems and monitoring and evaluation, capacity building, policy development and coordination processes.
- f. Country processes for reviewing and revising the national disease strategic plan(s) and results of these assessments. Explain the process and timeline for the development of a new plan (if current one is valid for 18 months or less from funding request start date), including how key populations will be meaningfully engaged.

4-5 PAGES SUGGESTED

Nigeria has developed a new National Malaria Strategic Plan for the period 2014-2020 that is at ensuring significant reduction in malaria burden towards per-elimination levels. See attachment 7.

a. The key goals, objectives and priority program areas.

The Vision is to have a MALARIA FREE NIGERIA.

The Mission is to provide equitable, comprehensive, cost effective, efficient and quality malaria control services ensuring transparency, accountability, client satisfaction, community ownership and partnership.

The Goal of this Strategic Plan is to reduce malaria burden to pre-elimination levels and bring malaria-related mortality to zero

The Objectives of the Strategic Plan are to ensure that;

- i. At least 80% of targeted populations utilize appropriate preventive measures by 2020;
- ii. All persons with suspected malaria who seek care in private or public health facilities are tested with RDT or microscopy by 2020;
- iii. All persons with malaria seen in private, public health facilities or by community agents receive prompt treatment with an effective anti-malarial drug by 2020;
- iv. At least 80% of the population practices appropriate malaria prevention and management by 2020;
- v. System is in place for timely availability of appropriate antimalarial medicines and commodities required for prevention and treatment of malaria in Nigeria by 2018;
- vi. At least 80% of health facilities in all LGAs report routinely on malaria by 2020;
- vii. To strengthen governance and coordination of all stakeholders for effective program implementation towards an 'A' rating by 2017 sustained through to 2020 on a standardized scorecard

Priority programme areas are:

Integrated Vector Management

- i. Use of Long Lasting Insecticidal Nets (LLINs)
- ii. Indoor Residual Spraying (IRS)
- iii. Larval Source Management (Larviciding and Environmental Management)

Chemoprevention (in target populations):

- i. Intermittent Preventive Treatment
- ii. Seasonal Malaria Chemoprevention

Case management;

- i. Diagnosis: Testing of all suspected cases of malaria before the institution of treatment at all levels of health care delivery in the country;
- ii. Use of quality assured artemisinin-based combination treatments (ACTs) for the treatment of uncomplicated malaria
- iii. Treatment of severe malaria with injectable artesunate

¹ Countries with high co-infection rates of HIV and TB must submit a TB and HIV concept note. Countries with high burden of TB/HIV are considered to have a high estimated TB/HIV incidence (in numbers) as well as high HIV positivity rate among people infected with TB.

Cross cutting supportive interventions

- i. Advocacy, Communication and Social Mobilization
- ii. Procurement and Supply Management
- iii. Health Information System, M & E and Surveillance
- iv. Programme Management

b. Implementation to date, including the main outcomes and impact achieved.

Table 1.2: Target and Outcome of Interventions

Intervention	Target (from NMSP 2009-2013)	Outcome
Indoor Residual Spraying	At least 80% of targeted population protected	About 1% of target population had IRS (MIS 2010)
Seasonal Malaria Chemoprevention		At the pilot stage
Intermittent preventive treatment in Pregnancy (IPTp) for Malaria	At least 100% of all women attending ANC receive IPTp by 2013	13% of pregnant women attending ANC that received at least 2 doses (MIS 2010)
Distribution of Long Lasting Insecticidal Nets	At least 80% of households with two or more LLINs/ITNs and 80% use by 2013	42% ITN household ownership and 29% use achieved (MIS 2010)
Diagnosis (RDT/Microscopy)	At least 80% of fever patients above 5 years attending health facilities receive a diagnostic test for malaria by 2013	28% of those with fever got tested by RDT/Microscopy. Testing rate (Routine data 2013)
Access to appropriate treatment	At least 80% of fever/malaria patients receive appropriate and timely treatment according to national treatment guidelines by 2013	6% access to ACTs among those had malaria 2 weeks preceding survey (NDHS 2013)
Advocacy, Communication & Social Mobilization	To reach by 2010 at least 80% of population (communities, families, care providers and health workers) through BCC for awareness and appropriate actions on malaria prevention and treatment and sustain through 2013	
Ensure timely availability of quality assured commodities for diagnosis, treatment and communication at all service points	To ensure the timely availability and appropriate use of safe, effective, quality antimalarial medicines and other health commodities and services at all levels of health care delivery system.	71% of health facilities reported no stock out of ACT (RIA 2014)
Reinforce the one-NHMIS model by re-defining and simplifying routine reporting;	Establish a sound and continuously updated database that monitors progress towards agreed targets and is used to effectively manage and adjust interventions based on evidence	56% of health facilities submitted their monthly reports in 2013

With regard to impact all cause under-5 mortality rate reduced from 157 in 2008 to 128 in 2013 per 1000 population (NDHS 2013, pg 19, attachment 4), 12.6% of children aged 6–59 months had hemoglobin measurement of <8g/dl (NMIS 2012, pg 60, attachment 2), malaria parasite prevalence in children under the age of five was measured (using slides) to be 42% according to the NMIS 2012. The Rapid Impact Assessment found the malaria test (slide/RDT) positivity rate to be 59% and the deaths due to malaria declined from 4.3/100,000 population in 2010 to 3.1/100,000 population in 2013 (RIA 2014, pg 37, attachment 3).

c. Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints described in question 1.1 are being addressed.

Progress is being made to overcome the constraints described in 1.1 and the following is the progress described by the JAR MTR report 2013, pg xiii-xvi, 65, 92-93, 129, attachment 16):

- **Incomplete Data:** In recent times, there have been a lot of efforts towards harmonization and roll out of the NHMIS across the country to address the gaps in routine data reporting both from the public and private sectors. One of such is the review and updating of the NHMIS policy in 2013 based on the

current drive of the country to ensure one pot of data for evidence-based decision-making. The country has now adapted one platform for electronic data capturing using the District Health Information System (DHIS) version 2.0; the roll out of which has commenced across the country with support from partners like GAVI, PMI/USAID, PRRINN-MNCH as well as GFATM. Progress made so far in strengthening the HIS include training of all LGA M&E officers and malaria focal persons in all 36 states and FCT on the newly harmonized HMIS tools; Training of state HMIS Officers, ATM M&E Officers & Immunization Officers on DHIS Vs.2.0 in the 22 states; provision of laptops and internet modems and printing and distribution of the NHMIS tools across the states. The FMOH, in a bid to address the gap in timely and regular availability of data on health financing, has signed an MoU with the National Bureau of Statistics (NBS), to activate the National Health Account with Technical Assistance from WHO. There are ongoing plans to institutionalize the NHA in terms of electronic data submission as well as streamlining the health financing indicators on the DHIS to have expenditure data captured correctly.

- **Weak Capacity in Delivering Results:** In the NFM, program implementers will be trained on the development of operational plans from their state specific strategic plans. The operational plans will provide a guide for program implementation, monitoring and evaluation.
- **Weak absorptive capacity/late release of funds:** there are ongoing efforts to strengthen the financial management systems at the national and state levels. Currently, there is a plan for ECOBANK/AfID to provide technical assistance and capacity building on financial management at the national and state levels.
- **Poor Donor Coordination:** The National Malaria Programme as part of the efforts to strengthen donor coordination has put in place a Technical Working Group Malaria (TWG-Malaria) which reports to the ATM task team chaired by the Honorable Minister of Health. The TWG constitutes of all partners implementing malaria programme in Nigeria with the NMEP serving as secretariat. They play an advisory role on malaria control activities at the national level.
- **Deficit in HRH:** Although there has been progress in this area there are there still remains big gaps in in terms of health workers at all levels of the health system. There are some areas of good progress including the adaptation of HRH policies and institution of HRH structures across the health sector, particularly at the federal level; where structures and systems for HRH are somewhat functional. However, the practice of HRH lags substantially behind the structures and systems so far established. The capacity for HRH planning, leadership and governance is generally weak.
- **Lack of Incentives and Sanctions for LGAs to Invest in Health:** LGAs across the country continue to be reluctant investors in the health of their people, in spite of the fact that the national health policy places on them the responsibility of planning and implementation of primary health care. Health financing strategies are being developed and implemented at federal, state and LGA levels across the country; however, in most cases, they are not articulated into a policy framework or strategy for financing health except in Lagos State.

d. The main areas of linkage to the national health strategy, including how implementation of this strategy impacts relevant disease outcomes.

The Federal Executive Council approved the most recent National Health Policy in 2005. This established the key principle that Nigeria would pursue a 'health systems strengthening' approach to improving health services and outcomes. The NSHDP was formulated in 2010, as a continuation of this effort. The NSHDP also served as the basis for preparing the Health Chapter in the Vision 20:2020, which set out the national economic and social investment priorities. Together the NSHDP and Vision 2020 map out the current national health policy targets and priorities. See attachment 17.

Of the 23 key Health Policy Targets (for the period 2010-2013) set down in Vision 20:2020, the efforts of the National Malaria Control Programme (NMCP), currently referred to as the National Malaria Elimination Programme (NMEP) will be central to the attainment of three of these:

- Increase the proportion of children under 5 sleeping under insecticide-treated bed nets from 5.5 in 2008 to 26.9 by 2013;
- Increase the per cent of women receiving intermittent preventive treatment for malaria during pregnancy from 6.5 per cent in 2008 to 60 per cent by 2013;
- Increase the proportion of children under 5 with fever who are treated with appropriate anti-malarial

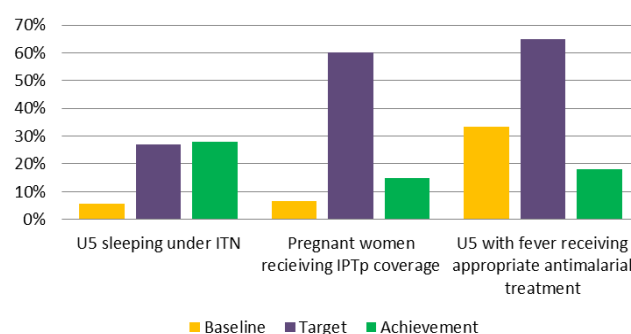
drugs from 33.3 per cent in 2008 to 65 per cent by 2013;

The NMCP has a key role to play in the attainment of at least 7 other targets. These include:

- Reduce under-five mortality rate from 157 per 1000 in 2008 to 103/1000 live births by 2013;
- Reduce infant mortality rate from 75/1000 live births in 2008 to 45/1000 live births by 2013;
- Reduce the maternal mortality ratio from the estimated 545/1000 live births in 2008 to 273/1000 live births by 2013;
- Reduce the number of health facilities experiencing stock-outs of key health commodities to 40 per cent by 2013;
- Increase to 60 per cent, the percentage of states with routine HMIS returns meeting minimum requirement for data quality standard by 2013;
- Increase to 60 per cent the percentage of states submitting timely disease surveillance reports by 2013;
- 50 per cent Reduction in counterfeit and fake drugs,

In addressing these targets, the Vision 2020 emphasizes thematic priorities which also apply to the National Malaria Elimination Programme. The Vision 2020 proposed 'investments' over the period 2011-2013 which include issues related to malaria. The figure below shows the current level of achievement of the targets.

Fig. 1.3: Country level of achievements versus NHSP targets



- e. **For standard HIV or TB funding requests , describe existing TB/HIV collaborative activities, including linkages between the respective national TB and HIV programs in areas such as: diagnostics, service delivery, information systems and monitoring and evaluation, capacity building, policy development and coordination processes. (DOES NOT APPLY TO MALARIA)**
- f. **Country processes for reviewing and revising the national disease strategic plan(s) and results of these assessments. Explain the process and timeline for the development of a new plan (if current one is valid for 18 months or less from funding request start date), including how key populations will be meaningfully engaged**

The malaria strategic planning cycle is aligned to the government finance year (January – December). The current Nigeria malaria strategic plan runs from 2014 to 2020. This plan has been developed in a participatory manner in line with the WHO recommendation for developing malaria strategic plans.

There was initial widespread input from states that formed the kernel of the Malaria Programme Review. Recommendations from the MPR formed a significant basis for the derivation of the objectives of the NMSP. Following the entry meeting of the thematic consultants; there were initial sub-committees set up to develop further specific objective areas. The output from the sub-committees led to the development of the zero draft of the document. Another broad-based stakeholder workshop, including representation from states and partners, was held to build consensus on the strategies, actions and performance targets. Several such meetings were organized at different stages of the document before a full meeting of the technical working group reviewed and finalized the NMSP 2014-20. The plan was further peer reviewed in a meeting organized by the World Health Organization and the Roll Back Malaria Partnership in March 2014 in Nairobi, Kenya. Comments received from all these meetings helped to further refine the strategic plan.

Costing of the strategic plan was done using the One-Health Planning and Costing tool following orientation processes that was conducted for the NMSP Team.

SECTION 2: FUNDING LANDSCAPE, ADDITIONALITY AND SUSTAINABILITY

To achieve lasting impact against the three diseases, financial commitments from domestic sources must play a key role in a national strategy. Global Fund allocates resources that are far from sufficient to address the full cost of a technically sound program. It is therefore critical to assess how the funding requested fits within the overall funding landscape and how the national government plans to commit increased resources to the national disease program and health sector each year.

2.1 Overall Funding Landscape for Upcoming Implementation Period

In order to understand the overall funding landscape of the national program and how this funding request fits within this, briefly describe:

- The availability of funds for each program area and the source of such funding (government and/or donor). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund).
- How the proposed Global Fund investment has leveraged other donor resources.
- For program areas that have significant funding gaps, planned actions to address these gaps.

1-2 PAGES SUGGESTED

- The availability of funds for each program area and the source of such funding (government and/or donor). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund).**

Table 2.1 The table shows costing for the full expression of quality demand as per the NMSP for the key interventions proposed to be financed in this Concept Note, according to the National Malaria Gap Analysis (Attachment 18). As noted, this Concept Note relates to the period 2015-2017 (proposing grant duration of 2015-2016); however US\$183,228,856 interim allocation was provided in 2014 and therefore included in the available funding presented below.

Table 2.1: Programme/Intervention Areas, Available Fund and Percentage Needs Financed

INTERVENTION AREAS	TOTAL NEEDS/ QUALITY DEMAND 2014-2017 (\$)	AVAILABLE FUND BY SOURCE		TOTAL AVAILABLE FUND 2014-2017 (\$)	GAPS/UNFUNDED QUALITY DEMAND 2014-2016 (\$)	PERCENTAGE NEEDS FINANCED
		EXTERNAL	DOMESTIC			
LLIN	\$1,144,042,661	\$333,586,973	\$33,687,226	\$367,274,199	\$776,768,462	32.10%
ACT	\$457,083,707	\$86,124,750	\$1,511,379	\$87,636,129	\$369,447,578	19.17%
RDT	\$620,049,768	\$46,223,946	0	\$46,223,946	\$573,825,822	7.45%
IPTp	\$39,475,305	\$752,400	\$1,242,395	\$1,994,795	\$37,480,510	5.05%
SMC	\$53,936,602	\$9,936,000	0	\$9,936,000	\$44,000,602	18.42%
Severe Malaria-Artesunate	\$57,135,463	\$12,271,150	\$782,975	\$13,054,125	\$44,081,338	22.85%
** iCCM	\$45,772,538	25792603	0	\$25,792,603	\$19,979,935	56.35%

**** The gap presented relates to 10 States proposed for iCCM implementation**

From the above, it is evident that given the level of funding available, none of the programmes / intervention areas is adequately resourced.

- How the proposed Global Fund investment has leveraged other donor resources.**

This table 2.2 shows the overall funding landscape for malaria control in Nigeria by funding source.

Table 2.2: Donor (Non-Global Fund) Resources for Malaria 2012-2017

FUNDING SOURCE	FUNDING PER YEAR					
	2012	2013	2014	2015	2016	2017
*USAID/ PMI Nigeria	\$43,600,000	\$60,100,000	\$73,200,000	\$75,000,000	\$70,000,000	\$72,733,333
**DfID/ Malaria Consortium (SuNMaP)	\$78,550,850	\$83,570,376	\$89,272,524	\$2,967,421		

***UNICEF(\$)	\$ 1,000,000	\$ 1,000,000	\$ 1,000,000	\$ 1,200,000	\$ 1,300,000	\$ 1,166,667
*WHO (RACe) UNITAID (Defeat & ISMO)		\$ 786,694	\$ 7,269,775	\$ 5,788,327	\$ 94,416	
**Gate Foundation/Malaria Consortium	\$ 40,477	\$871,222	\$607,672	\$ 174,968		
***Government of Nigeria	\$86,186,124	\$106,295,746	\$61,274,230	\$169,459,792	\$170,810,397	

Data Source and comments:

*Annual Malaria Operational Plan (MOP) for Nigeria. Available at www.pmi.gov. Data for 2017 was not available. However looking at the pattern of commitment between 2014 and 2016, an average of \$72,733,333 was assumed for 2017

**SuNMaP Programme Plan and Budget, 2014 (2014 budget includes commodities for 2015). The data include DfID, BMGF, CIDA& UNITAIDS commitment to AMFm of \$65m in 2012, \$70m in 2013 & \$70m in 2014 obtained from AMFm Secretariat NMEP.

***UNICEF/GON Cooperation Agreement. These exclude support to Government on iCCM. An average of \$1,166,667 assumed for 2017.

*2013 (Approved Programme expenditure); from 2014 (Programme Work Plan based on approved donor budget)

** Up to 2013 (Approved Programme expenditure); from 2014 (Programme Work Plan based on approved donor budget)

*** Please see details in Funding Model_Financial Gap And CPF_Table_en

Table 2.3: The leverage of the NFM allocation and above allocation requests on existing resources 2015-2016

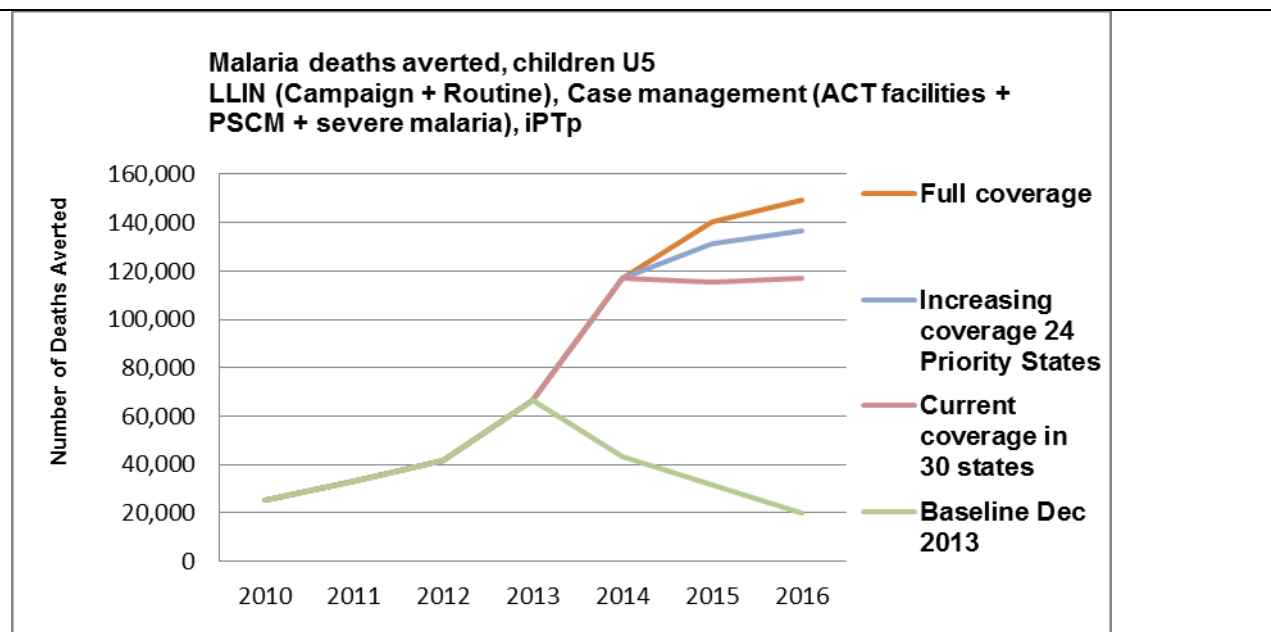
S/N	Intervention	Existing Government and donor resource available		Global Fund Allocation request		Global Fund Above allocation request		Overall contribution to National coverage *(DR+GR+TGFR)
		Total Amount (\$)	Contribution to National coverage	Total Amount (\$)	Contribution to national coverage	Total Amount (\$)	Contribution to national coverage	
1	LLIN (Routine)	94,206,613	18.50%	40,845,492	8.00%			
	LLIN (campaign)					111,474,803	21.90%	48.40%
2	ACT	18,000,000	7.50%	32,200,702	13.38%	76,455,774	22.30%	
	ACT Co-Payment			134,993,529	56.10%			99.28%
3	RDT	22,000,000	7.00%	32,355,303	10.30%	85,660,762	27.30%	44.70%
4	IPTp	0	0%	15,028,703	80.3%			80.0%
5	Severe malaria	7,235,391	24.00%	7,089,874	23.60%			47.60%
6	SMC	0	0.00%			9,263,259	34.80%	34.80%
7	iCCM	16,433,548	50.00%	1,219,577	3.70%	13,343,677	41.00%	95.10%

*DR Donor Resources; GR Government resources; TGFR The Global Fund Resources

The table above shows how the amount being proposed under the NFM would complement the existing government and donor resources. Please note this does not include existing resources for 2017, as the allocation/above allocation requests do not cover this period. In this current application, some states are presently supported by other donors and this overlaps with the 24 priority States. Of the 21 states supported by PMI and DFID, 16 overlap with the 24 proposed priority States. The projected overall existing coverage of the four proposed interventions (LLINs, ACTs, RDTs and IPTp) in these areas is estimated to be at 11% of the identified needs (average of percentage contribution to National coverage for these interventions in Table 2.3). The added investments from government and other donors bring coverage levels to about 48% of the total need for the priority states. Therefore this targeted cumulative funding ensures safe guarding the gains made and contributing to further reduction of the burden of malaria in the most high burden areas.

These funds together with the GFATM investment, as indicated in the chart below, will result in about 140,000 malaria deaths averted among children less than 5 years by 2016, given that it targets the areas with the highest burden, with full indicative funding.

Figure 2.1: Number of Malaria Deaths Averted Among Children U5 by Level of Coverage of Interventions



Source: Epi Analysis, 2014, attachment 19

C. For program areas that have significant funding gaps, planned actions to address these gaps.

In spite of the resources available through the GF, Federal Government, States, multilateral and bilateral partners, Nigeria still requires substantial amounts of funds to meet its full strategic plan need. Key areas of gap include vector control (continuous LLIN replenishment, IRS and LSM), increased diagnosis and treatment, strengthening of M&E and PSM and scaling up of other effective interventions such as IPTp, iccm and SMC.

In line with Nigeria's current strategic orientation towards malaria elimination, the country is embarking on a resource mobilization drive, and has developed a Business Plan for the exercise (Attachment 20). Advocacies would be paid to relevant government and private organizations using the revised Malaria Advocacy Kit, to improve funding, political and technical support for malaria control efforts. The FMOH plans to organize a National Malaria Forum in 2015, which will include local and international stakeholders, the academia, and research community. This inter-ministerial and broad-partnership discussion will include opportunities and challenges facing Nigeria as it embarks on malaria elimination. The FMOH is currently exploring opportunities for innovative financing mechanisms to improve funding for health. The planned Integrated Test, Treat and Larval source management (ITTLL) project of the GoN is aimed at mobilizing resources from the federal and state governments to address some of the identified gaps. To address the gap in LLIN replenishment in 2017, orders for the replacement campaign LLINs will be placed in 2016 based on commitments to VPP agents, expectant that the Global Fund will have another successful replenishment in 2017.

Other specific activities in this strategic drive will include:

- Effective engagement of the private sector for resource mobilization, such as the collaboration with Exxon Mobile for LLINs distribution and the Dangote Foundation, Malaria No More for community advocacy and uptake of interventions.
- As it relates to the sustainability of the gains from the PSCM, increased private sector participation in malaria program will be leveraged, both internally and externally to mobilize additional resources through the engagement of donors like PSHAN and Dangote. Further, it may be possible to raise resources from State and Local governments to implement demand generation campaigns among other programmatic interventions like increased regulatory monitoring efforts. More details on key concrete steps and suggested timelines towards sustainability are included in attachment 25.
- Targeted sensitization directed towards wealthy Nigerians to elicit their support for malaria programme
- Community participation and ownership

Funding Plan 2017

"This Concept Note covers the period of 2017, although the grant duration requested is for 2015-2016. The following presents the country's planning related to malaria funding for 2017:

- The Government of Nigeria and its states have committed \$401,544,419 for annual malaria funding in 2014-2016. Although concrete commitments have not been made for 2017, it is expected that this annual funding level will continue in 2017. It is expected that increased government resources will be leveraged as per activities noted above.
- Other domestic funding from private sector is expected to be leveraged as per activities described above (PSCM and sustainability).
- Partners: It was not possible at this time to get funding commitments from other partners for 2017. However, apart from World Bank, who will not be continuing their support to the malaria program, it is expected that PMI and SuNMaP will continue the current annual funding levels in 2017.
- Global Fund: To address the gap in LLIN replenishment in 2017, orders for the replacement campaign LLINs will be placed in 2016 based on commitments to VPP agents, expectant that the Global Fund will have another successful replenishment in 2017.

2.2 Counterpart Financing Requirements

Complete the Financial Gap Analysis and Counterpart Financing Table (Table 1, attachment 21). The counterpart financing requirements are set forth in the Global Fund Eligibility and Counterpart Financing Policy.

a. Indicate below whether the counterpart financing requirements have been met. If not, provide a justification that includes actions planned during implementation to reach compliance.

Counterpart Financing Requirements	Compliant?	If not, provide a brief justification and planned actions
i. Availability of reliable data to assess compliance	☒ Yes ☐ No	
ii. Minimum threshold government contribution to disease program (low income-5%, lower lower-middle income-20%, upper lower-middle income-40%, upper middle income-60%)	☒ Yes ☐ No	
iii. Increasing government contribution to disease program	☒ Yes ☐ No	

b. Compared to previous years, what additional government investments are committed to the national programs in the next implementation period that counts towards accessing the willingness-to-pay allocation from the Global Fund. Clearly specify the interventions or activities that are expected to be financed by the additional government resources and indicate how realization of these commitments will be tracked and reported

2-3PAGES SUGGESTED

The Government is committing an additional sum of Four Hundred and Fifty Six Million, Two Hundred and Seventy One Thousand, Two Hundred and Thirty Six US Dollars (US\$456, 271,236.00) to NMEP in the next four years on Integrated Test, Treat and Larval Source Management (ITTL) Project. This project has received due attention from the Presidency, States and FMOH. The project proposal has been accepted by the National Economic Council comprising the President of the Federal Republic of Nigeria, the 36 state Governors and the Honourable Minister of the Federal Capital Territory (FCT).

Consequently, National Economic Council (NEC) ad-hoc and Technical Committees chaired by the Executive Governor of Rivers State and Honourable Minister of Health respectively were constituted with the National Economic Council providing the Secretariat. The NEC Technical Committee is guiding the development of an implementation strategy for the project.

This commitment will be tracked through the National Health Accounts and Programme-specific budget and expenditures

c. Provide an assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures

Table 2.4: Assessment of the Completeness and Reliability of Financial Data Reported

Source of Revenue	Financial Data	*Completeness	*Reliability	Assumptions
Domestic Resources	Loan	2	2	Budget in Naira, converted to US Dollars at a rate of 157:1
	Debt Relief	1	2	Budget in Naira, converted to US Dollars at a rate of 157:1
	Government Revenue	3	3	The budget includes Government budgeted expenditure on programme implementation and Human Resources costs(salary & equipment) @\$42,802,547.37 per annum
	Social Health Insurance	0	N/A	N/A
External Resources (Non-Global Fund)	United State Government	3	3	Funding for 2012 - 2015 are based on approved budget while 2016 is indicative funding pending approval
	United Kingdom	3	3	Indicative budget subject to shifts across financial years. Funds converted from UK Pounds at the rate of 1.67909
	UNICEF	3	3	UNICEF / GoN Cooperation Agreement
External Resources (Global Fund)	Global Fund Grant-NMEP	3	3	The GF grant management letter
	Global Fund Grant-SFH	3	3	The GF grant management letter
Total Government Health Sector Spending	Loan	2	3	Budget in Naira, converted to US Dollars at a rate of 157:1
	Debt Relief	1	2	Budget in Naira, converted to US Dollars at a rate of 157:1
	Government Revenue	3	3	The budget in Naira converted to US Dollar @ exchange of N157 per \$1 US Dollar

***LEGEND:** Rated on a scale of 1-3 with 1 being the minimum score and 3 the maximum score

The table above assesses the completeness and reliability of the reported financial data. A tool which is similar to the above table was developed and sent to donor partners to affirm their commitments. The data quoted from donor agencies and the assumptions provided in the table were a result of the responses from each donor partner (Proof of funding commitment, Attachment 22). The reliability of the data was assumed to be strong if affirmative proof was received from the donor. A scale of 1 to 3, with 1 being the minimum score and 3 the maximum score was applied. The Government resources were based on the National budgetary allocations and other government resources such as the MDG and WB credits. The reported financial GoN data for 2012-2013 were based on actual expenditure as captured by the National Health Accounts. The 2015 – 2016 data were based on projections from the Health budget. It was also estimated that the ITTL project would span four years.

SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND

This section details the request for funding and how the investment is strategically targeted to achieve greater impact on the disease and health systems. It requests an analysis of the key programmatic gaps, which forms the basis upon which the request is prioritized. The modular template (Table 3) organizes the request to clearly link the selected modules of interventions to the goals and objectives of the program, and associates these with indicators, targets, and costs.

3.1 Programmatic Gap Analysis

A programmatic gap analysis needs to be conducted for the three to six priority modules within the applicant's funding request.

Complete a programmatic gap table (Table 2, attachment 3) detailing the quantifiable priority modules within the applicant's funding request. Ensure that the coverage levels for the priority modules selected are consistent with the coverage targets in section D of the modular template (Table 3).

For any selected priority modules that are difficult to quantify (i.e. not service delivery modules), explain the gaps, the types of activities in place, the populations or groups involved, and the current funding sources and gaps.

PAGES SUGGESTED – only for modules that are difficult to quantify

A programmatic gap table has been completed and detailed in section 3.2 addressing the needs for Vector Control (LLINs); Case Management (ACTs, RDTs and Injectable Artesunate for severe malaria); and Special Preventive Interventions (IPTp and SMC). In the programmatic tables, coverage targets were aligned with the NMSP (2014-2020), needs were estimated and funded commodities identified over the period of this proposal, in order to report on any gaps. Specifically for this section, three interventions which are difficult to quantify, have been included. These are Health Information System (HIS)/M&E, PSM and Programme Management. Below are explanations for the gaps, the types of activities in place, the populations or groups involved, and the current funding sources and gaps. In working out the needs, the detailed activities for each of these interventions were fed both into the One Health Tool and the National Malaria Gap Analysis (Attachment 18). The summary of the costs against the planned activities and available funds are presented to provide the gap for these interventions. Amount reflected as allocation from the indicative funding is according to availability of resources. Details of the activities requested to be financed under these modules are in Section 3.2.

- a. **HSS request under malaria CN and links to broader HSS request under HIV/TB CN:** GF funding for Nigeria cross-cutting HSS has historically mainly been budgeted under the HIV grant, The HSS request under the malaria CN is part of a broader HSS request, of which xxx will be requested under the HIV/TB CN expected submitted in August 2014. The broader HSS request under HIV/TB is expected to include activities/budget such as HMIS roll-out, additional funds for PSM supply chain integration and other activities – the gap analysis/costing related to these activities is still ongoing. The HSS gap analysis and allocation under the malaria CN is outlined below and in section 3.2. Please see relevant Annexes for the currently available detailed budgets. More details will be shared once available/with the HIV/TB CN **Procurement Supply Management (PSM):**

Activities: Activities planned under this module are aimed at integration of PSM across the three diseases funded by GFATM, other Partners and GoN, and also addressing malaria-specific PSM issues that will subsequently contribute to addressing **Objective 5** of the NMSP, to ensure the **“timely availability of appropriate antimalarial medicines and commodities required for prevention and treatment of malaria in Nigeria wherever they are needed by 2018”**. The key strategies for this objective are; (i) Strengthen procurement-related processes, (ii) Develop efficient distribution systems for antimalarial medicines and commodities (iii) Strengthen Logistics Management Systems (iv) Reinforce Policies on Quality Assurance and Pharmacovigilance (v) Operationalize and update where necessary existing policies for malaria case management in the private sector; (vi) Increase access to antimalarial prevention and management commodities in the private sector; through community outlets and other private health institution operating as PHC and (vii) Put in place regulatory requirements for distribution including storage and transportation of antimalarial products in the private sector.

Population: Although this intervention targets the delivery of malaria intervention commodities to every point it is needed, it will be prioritized in the CN as supportive activities to the places where the activities of the grant is focused. The total cost of PSM HSS need over 2 years is \$14,866,844 split into 60% in 2015 (\$8,920,106.4) and the rest in 2016 (\$5,946,737.6). A comprehensive gap analysis for 2017 is yet to be articulated by the PSM working group. Of the

\$14,866,844, this funding request will contribute \$3,808,061 to overall PSM integration while \$11,058,783 with 60:40 split in 2015 and 2016 respectively will be covered in the HIV/TB CN. An additional \$500,000 is earmarked for TA on PSM under this funding request for the two years with a 90:10 split; bringing the total PSM HSS contributed by this request to \$4,308,061. The \$3,808,061 is meant to address specifically, operational cost for Logistics Management Coordination Unit and LGA staff, and ICT requirements.

Table 3.1: Estimate of Funding Gap for PSM HSS (amounts in US\$)

PSM HSS Gap Analysis	2014	2015	2016	2017
*Total PSM HSS needs	N/A	8,920,106.4	5,946,737.6	N/A
Amount financed to be financed by HIV/TB CN	N/A	6,335,269.8	4,223,513.2	N/A
Final Gap (National)	N/A	2,584,836.6	1,723,224.4	N/A
Total Amount requested out of the malaria allocation per year	0	2,584,836.6	1,723,224.4	0
Grand Total Amount requested out of the malaria allocation	0	5,553,554		0

* Supply Chain Integration HSS budget_Jun2014 and NMEP_NFM Workplan_Final_07-07-14

b. Health Information System, M&E

Activities: These activities will support the implementation of Objective 6 of the NMSP which is to ensure that **“at least 80% of health facilities in all LGAs report routinely on malaria by 2020”**. The Malaria programme information system has been harmonized with the National Health Information Management System to minimize the use of multiple and parallel data reporting from health facilities.

Some of the key strategies articulated in the NMSP are (i) Strengthen routine data generation and flow from public/private facilities and community-based health providers for the NHMIS; (ii) Operationalize electronic database for malaria control using DHIS version 2.0; (iii) Strengthen human resources for monitoring and evaluation for ATM; (v) Strengthen routine monitoring and supervision; (vi) Strengthen Data Quality Assurance (DQA) at all levels of reporting; Develop and implement an Operations Research (OR) agenda for the Malaria Programme; (vii) Strengthen malaria surveillance coordination and linkages with National HMIS. Table 3.2 below details the gap and amount financed for this module. It is however important to note that the sum of \$612,087 is expected to be contributed to HSS with regard to NHMIS and DHIS roll out. The rest of the request will address programme-specific survey, monitoring and supervision.

Population: The health facilities are the Units of reporting

Need/gap and funding request: Table 3.2 below summarizes the gap as per the NMSP 2014-2020 and amount requested to be financed for this module. It is however important to note that the sum of \$612,087 is expected to be contributed to HSS with regard to NHMIS and DHIS roll out. The total cost/need in relation to the HMIS roll out as per the consolidated HMIS budget in the Annex (DHIS costing Nigeria revised_Jun2014) is \$14,179,389 split over 3 years – Global Fund will be requested to finance approximately half of this budget under the HIV/TB CN. The rest of the gap/request relates to programme-specific survey, monitoring and supervision, bringing the total M&E request to \$15,527,098.

Table 3.2: Estimate of Funding Gap for HIS M&E (amounts in US\$)

	2014	2015	2016	2017
*Monitoring and Evaluation (Programme)	7,707,504	5,414,584	4,789,584	7,082,504
*Research/Surveillance/Impact Assessment	13,248,075	12,143,683	12,080,353	12,382,307
*Total HIS M&E needs	20,955,579	17,558,267	16,869,937	19,464,811
*Amount financed	6,031,519	0	0	0
*Final Gap (National)	14,924,060	17,558,267	16,869,937	19,464,811
Amount requested out of the allocation		7,447,701	8,079,397	

*NMSP 2014-2020 (attachment 7, pg. 94)

c. Programme management

Activities: Activities have been identified to meet the National program management objective of the 2014-2020 NMSP **which is to strengthen governance and coordination of all stakeholders for effective program**

implementation towards an 'A' rating by 2017 sustained through to 2020 on a standardized scorecard.

The key strategies are (i) Strengthen programme coordination at national and sub-national levels; (ii) Improve unified annual operational planning; (iii) strengthen malaria resource mobilization and financial management mechanisms; (iv) develop a comprehensive strategy for private sector engagement; (v) strengthen human resource management to deliver malaria control/elimination interventions; (vi) Programme management and administration; (vii) Strengthen timely reporting of Malaria control activities at all levels and promote dissemination of all reports.

Population: Programme management focuses on the critical steps and approach expected of different stakeholders to take responsibility for planning, supervision, resource mobilization, capacity development and other management arrangements for efficient utilization of resources for effective programming.

Need/gap and funding request: Table 3.3 below summarizes the gap as per the NMSP 2014-2020 and amount requested to be financed for this module

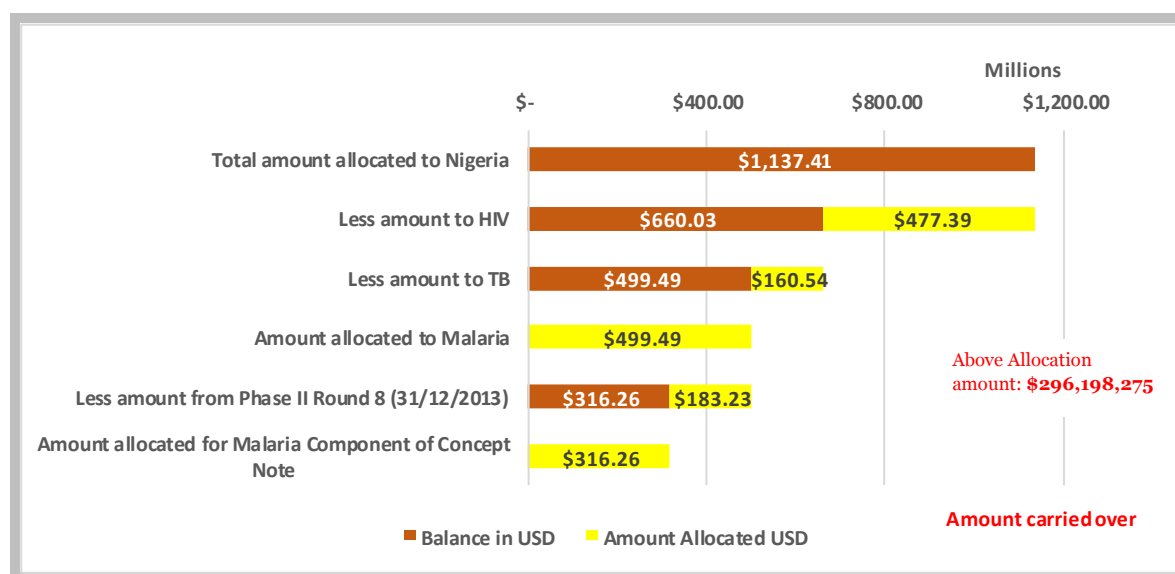
Table 3.3: Estimate of Funding Gaps for Programme Management

Programme Management	2014	2015	2016	2017
**Total Programme Management cost	62,780,800	66,410,282	65,719,762	64,011,341
Programme Management cost financed	46,266,251	43,763,390	43,763,390	43,763,390
Financial Gap	16,514,549	22,646,892	21,956,372	20,247,951
Amount requested out of the allocation { USD }	0	17,831,729	17,436,372	0

** This is summation of estimates for programme specific human resources cost, training, supervision and general programme management sourced from NMSP 2014-2020 (attachment 7 NSP, pg 94), Annex 1 to the letter of commitment from GoN on WTP and CF and historical data from PRs.

3.2 Applicant Funding Request

Provide a strategic overview of the applicant's funding request to the Global Fund, including both the proposed investment of the allocation amount and the request above this amount. Describe how it addresses the gaps and constraints described in questions 1, 2 and 3.1. If the Global Fund is supporting existing programs, explain how they will be adapted to maximize impact.

Figure 1.1: Country allocation of funds and amounts requested for malaria

a. Summary of Funds Allocated for Nigeria Concept Note

Figure 3.1 highlights the breakdown of the funds allocated to Nigeria and the distribution of the fund for the various disease components following the country dialogue. A total sum of **\$1,137,414,847.00** was allocated to Nigeria by the Global fund to support interventions in HIV, TB and Malaria. Following country dialogue in which the allocation to the various disease components was agreed upon, a sum of **\$499,490,418** was allocated to the malaria component. Of this amount, **\$183,228,855.00** was already available for Phase II of Round 8 Grant. Hence the amount allocated to support the Concept note application for malaria was **\$316,261,563.00** to cover implementation of some interventions from 2015-2016. However there is an estimated unspent balance of \$3.8m at the end of the current implementation period that will be carried over from 2014, thereby making the total amount available for the current application to be **\$320,081,933**.

As noted in Section 3.1, out of the total allocation for Nigeria, the country has allocated \$78,225,211 for cross-cutting HSS, of which \$9,882,028 has been proposed to be financed under the malaria component/allocation. Please see further details on this below.

b. Allocation and above-allocation request in the context of national programmatic gap

The total programmatic need has been reflected in the National Gap Analysis; Table 3.3 below describes the programmatic need in respect of drugs and other key commodities for implementation of malaria intervention for the period of 2015-2016 which amounts to **\$1,408,399,215**. Total commodity need financed is **\$153,533,937** leaving a gap of **\$1,254,865,278**. Thus the indicative fund/allocation of **\$316,261,563** represents about 22.5% of this sum. This is to be used to finance the cost of commodities and key supportive interventions. An additional sum of **\$296,198,275** is proposed for incentive funding/above allocation to prevent critical shortages in LLINs (for campaign in 2015 & 2016 in 6 out of the 17 eligible states), ACTs and RDTs to prevent shortages in public sector within the 24 priority states, iCCM and SMC.

c. Prioritization and rationale for the allocation and above allocation requests

The NMSP 2014-2020 reflects the aspiration of Nigeria to significantly reduce the burden of malaria to pre-elimination levels. To this end the NMSP has expressed the use of multiple proven interventions that assist the country to achieve this goal. The country size, population and the desire to massively scale-up deployment of various interventions has resulted in the country having a very large budget (more than \$1.5billion) over the two year period for which the concept note application is being made.

Table 3.4: Summary of Programmatic Commodity Funding Gap for the Key interventions

INTERVENTION	Resource	2015	2016	2017	Total
LLIN	Need	248,750,108	260,729,194	344,634,903	854,114,205
	Financed	50,619,807	43,586,807	8,421,807	102,628,421
	Gap	198,130,302	217,142,387	336,213,097	751,485,786
ACT	Need	117,996,543	122,722,602	120,201,882	360,921,027
	Financed	9,000,000	9,000,000	-	18,000,000
	Gap	108,996,543	113,722,602	120,201,882	342,921,027
RDT	Need	142,508,903	171,010,683	194,131,327	507,650,913
	Financed	11,000,000	11,000,000	-	22,000,000
	Gap	131,508,903	160,010,683	194,131,327	485,650,913
IPTp	Need	7,186,419	11,537,653	16,943,998	35,668,070
	Financed	-	-	-	-
	Gap	3,807,235	7,186,419	11,537,653	22,531,307
IRS	Need	87,606,562	181,640,018	276,444,828	545,691,408
	Financed	7,123,932	-	-	7,123,932
	Gap	80,482,630	181,640,018	276,444,828	538,567,476
SMC	Need	10,447,658	16,172,979	22,254,099	48,874,736
	Financed	4,968,000	-	-	4,968,000
	Gap	5,479,658	16,172,979	22,254,099	43,906,736
Severe Malaria/Artesunate	Need	14,749,568	15,340,325	15,025,235	45,115,128
	Financed	3,036,431	4,198,960	3,415,985	10,651,376
	Gap	11,713,136	11,141,366	11,609,251	34,463,753
Total Need		629,245,761	779,153,454	989,636,272	2,398,035,487
Total Financed		85,748,170	67,785,767	11,837,792	165,371,729
Total Gap		543,497,591	711,367,687	977,798,480	2,232,663,758

Allocation request prioritization: The considerations for prioritization of modules were burden of disease, attendant reversal of gains, ensuring programme efficiency as well as the drive to achieve impact. See section 3.3 for details. The following 6 modules have been prioritized for the allocation request in the following order:

- Vector Control (routine LLINs)
- Case Management:
- Specific Prevention Interventions
- Procurement Supply Chain Management
- Health Information System and M&E
- Programme Management

Above allocation request prioritization: The Country has prioritized the following modules for the above allocation request in the following order -Vector Control (campaign LLINs), Case Management (ACTs, RDTs and iCCM), and Specific Prevention Interventions (SMC). The need for replenishment of LLINs in 2017 was the rationale for the request for LLINs under the incentive fund. Furthermore, ACTs and RDTs covered under the allocation request are 27% and 16% of the total need in the 24HBS respectively. The above allocation request is therefore aimed at increasing the coverage to 45% and 56% respectively in view of the current strategic drive to scale up diagnosis before treatment. The huge gap presented for iCCM calls for extra resources. The above allocation request for iCCM is expected to cover 8 additional states in order to address these gaps. The inclusion of SMC is to contribute to the protection of 2,000,000 children less than 5 years living in the 9 sahelian eco-transmission zones as articulated in the NMSP. SMC is currently being implemented in 3 of these 9 states therefore; the above allocation request will scale up implementation to 6 States.

The Table 3.5 below summarizes the request for funds for the various interventions under the allocation and above allocation requests. Kindly note that IEC-BCC component for Vector Control, Case Management and IPTp has been pooled together in the last row of the table.

Table 3.5: The fund request to various interventions under the allocation and above allocation request

Interventions	Allocation		Above-allocation	
	2015	2016	2015	2016
CM (Facility-based treatment)	36,367,816	7,025,009	59,499,135	80,119,990
CM (Community case management)	91,407	-		
ICCM (HSS)	720,231	499,346	10,163,368	3,180,248
CM (Severe malaria)	6,199,884	889,990		
CM (Therapeutic efficacy surveillance)	1,503,389	-		
CM (Private Sector other)	8,892,028	7,655,325	6,870,610	6,045,043
CM(PSCM)	69,411,771	65,581,758		
VC (LLIN)	26,606,659	12,937,045	45,268,114	66,206,689.13
SPI (IPTp)	11,600,196	3,205,732		
SPI (SMC)			4,561,018	4,702,241
PSM(Operationalization of procurement and supply chain management system)	1,209,563	35,930		
PSM(HSS)	2,734,837	1,573,224		
HIS M&E	6,934,475	7,980,536		
HIS (HSS)	513,226	98,861		
Prog Management	17,831,729	17,436,372		
IEC/BCC (CM,VC & IPTp)	2,727,399	1,818,194.963	4,152,995	5,428,824
Totals per year	193,344,608	126,737,324	130,515,240	165,683,035
Grant Total	320,081,933		296,198,275	

Concept of High Burden States in prioritization of funds: For the purpose of this funding allocation and the resource profile at the time of application, it became necessary to examine distribution of disease nationally so that states with relatively higher burden of the disease can be prioritized for use of the available resources. The idea here is not to imply in any way that Nigeria has areas that are not in need of intervention, in fact, most states have >20% risk for malaria. However, a review of the epi-data did indicate that an analysis of the **malaria caseload** using the malaria transmission mapping estimates of PfPR₂₋₁₀, shows that **24 states in Nigeria bear 80% of the malaria burden** (Bob Snow report, 2013; Epi and impact analysis report, 2014). These are the states termed **higher burden or priority states** (HB-States) and they are so called for the purpose of the prioritization of fund from current indicative fund envelope (24 HB states, Attachment 24). The idea is that the population of these states will be directly factored into the proportion of the national gap to be addressed while also expecting that the impact of the investment of these funds would be higher in these states than the remaining 12+1states. However the needs of these other states must still be addressed outside the GF-resources so that gains remain consolidated and further impact achieved.

I. LLIN (Module: Vector Control)

I.a. Allocation funding request

The target of the country for LLINs is Universal coverage through mass campaigns and routine distribution of nets.

Routine distribution of LLINs is conducted through antenatal clinics and EPI clinics. However due to the relatively slow pace of uptake at these service points, additional distribution of LLINs through continuous channels is now being carried out through primary schools. To determine what amount of funds to be allocated to routine distribution of LLIN, an appraisal of GF contribution in the preceding year was made. In 2013 GF funded the supply of 3,500,000 nets representing 25.8% national need of 13,600,000.

An annual increase of 10% was decided for all routine commodities based on the assumption that acceptance and uptake will increase as we scale up BCC intervention. Allowing for an annual incremental factor of 10% over the preceding year, the ration of the need to be financed was placed as 30% of the total need in the 24-HB states. Hence **8,037,934** LLINs will be procured for routine distribution in 2015 and 2016 at a cost of **\$37,341,307**.

Table 3.6: Analysis of funds allocated for routine LLIN distribution

	2015	2016	Remarks
Total Population targeted for Routine LLINs in 36 states + FCT	16,859,304	19,073,553	
Total Population targeted for Routine LLINs in 24 HB states (public sector)	6,403,749	7,244,797	Represent 75% of total need
Total Population targeted for Routine LLINs in 24 HB states (private sector)	6,205,675	7,020,709	
Total number to be financed through concept note	3,581,216	4,456,718	30% financed. Consistent with historical contribution of 25% by GF to routine LLIN needs
Routine LLINs public sector	1,818,736	2,263,363	51%
Routine LLINs private sector	1,762,480	2,193,355	49%
Combined totals for 2015 and 2016		8,037,934	
Amount in USD		\$37,341,307	Includes PSM costs

I. b. Above allocation funding request

Mass campaigns in the HB-States: Due to the size and population of the country with the attendant challenge of being able to meet the national need of about 80,000,000 - 90,000,000 LLINs for coverage of 100% in a year of mass campaign, the country has adopted the rolling mass campaign approach. This approach takes into cognizance the years of previous campaign and uses this to plan for dates for replacement campaigns. Hence by the end of the 3rd year of distribution, the states in the first year would have been due for total replacement.

The current cycles of mass campaigns are in 2014, 2015 and 2016. The 2014 campaigns are ongoing and will cover 7 of the high burden states. For the outstanding campaigns for 2015-2016 the analysis is as follows:

- There are 17 states due for campaign in 2015-2016.
 - 9HB (Zamfara, Lagos, Kwara, Cross River, Benue, Edo, Imo, Ondo and Oyo) & 8 others
 - Of these 9HB, 3 states would be supported by other partners for campaign.
- We therefore propose that these states be covered through incentive funding as follows:
 - 6 HB states (2 in 2015, 4 in 2016)

The amount reflected in the incentive funding, based on the population of the selected states is worked as follows: Total LLINs needed in 2015 (8,367,489) and 2016 (12,237,835). In terms of cost the amounts are **\$45,268,114** and **\$66,206,689** respectively. Hence total allocation for LLIN in the incentive funding is **\$111,474,803**.

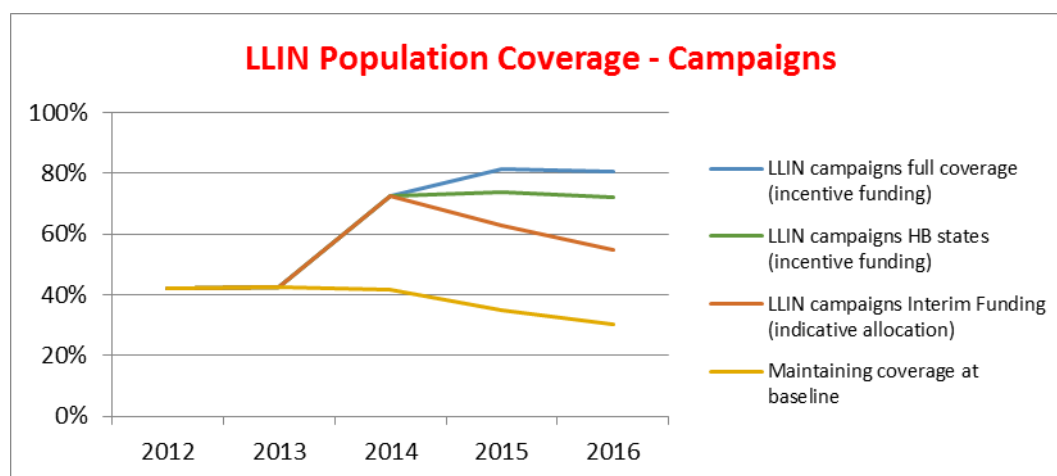
The graph and Table 3.7 below shows how the 2014 coverage would be maintained in 2015 and 2016 if the HB campaigns were covered, while it would even increase if the other states are included

Table 3.7: States scheduled for 2015-2016 LLIN mass campaigns

Sn	State	2015	2016	Supported by	Among 24 HB
1	Bayelsa	1,223,973			N
2	Benue	3,058,420			Y
3	Borno	3,115,913			N
4	Cross River	2,075,909		PMI	Y
5	Ebonyi	1,548,194		PMI	N
6	Enugu	2,361,131		SunMap	N
7	FCT	1,737,991			N
8	Kwara	1,718,741			Y
9	Lagos	6,648,748			Y
10	Taraba	1,653,228			N
11	Yobe	1,757,828		SunMap	N
12	Zamfara	2,404,595		PMI	Y
13	Abia		2,055,094		N

14	Edo		2,333,795		Y
15	Imo		2,995,118		Y
16	Ondo		2,569,138		Y
17	Oyo		4,339,784	PMI	Y

Figure 3.2: Coverage scenarios for LLIN



If additional 6 HB state campaigns are supported with GF incentive funding in 2015 for 8,367,489 nets and 2016 for 12,237,835 LLINs coverage is maintained at 72% by end 2016. When comparing incentive funding coverage with indicative funding coverage: 11% higher coverage in 2015, 17% higher coverage in 2016.

II. ACTs (Module: Case management)

II.a. Allocation funding request

The request related to ACTs is split into 3 major parts:

- ACTs provided through the private sector co-payment mechanism (PSCM) , (60% of ACTs request)
- ACTs for facility based implementation in both public and private sectors (35%)
- ACTs for iCCM and CCM in public sector (5%)

ACT Copayment for the Private sector: Nigeria successfully implemented the AMFm programme allowing for the availability of affordable quality assured ACTs in the private sector that constitute about 60% of the healthcare services in the country. To prevent an interruption in this system, DFID in 2014 provided US\$70,000,000 as copayment for ACTs to bridge the transition out of the AMFm. Henceforth, for 2015-2016, the sum of about US\$135,000,000 will be allocated to ACTs co-payment under the PSCM in the private sector. First Line Buyers (FLBs) that have signed Agreements with the PR for participation in the program will be able to access subsidized QA ACTs for distribution, with in-country distribution costs borne by the private sector and not the grant. This fund (US\$135,000,000) is split between 2015 and 2016 equally and will be at an 85% subsidy at the level of manufacturers, to pay for a total of 115,589,661 doses in 2015 and 2016, covering 80% of the estimated private sector need. The FLBs will provide the 15% balance for the payment of the ACTs at the point of procurement. See attachment 25 for details on the PSCM and sustainability plans.

Non Copayment ACT: ACTs for facility-based implementation will be distributed to the public and private health facilities, while ACTs and CCM will be delivered at the community level using integrated community case management and community case management of malaria approaches in two and 22 states, respectively. The sum of \$1,219,577 is allocated for iCCM to cover training of CORPs and other HSS activities, excluding the cost of ACTs. The allocation request for ACTs is **22,185,487 doses**. Overall this represents about 20% of the public sector need. Although most of the private sector need for ACT had been provided for under the copayment system, some amount of ACTs had to be allocated for the private sector PR. This is to enable the private sector PR have a platform to provide supportive supervision for quality of care in the private sector. Without the co-payment ACTs, the second PR would have been rendered redundant and this would adversely affect activities in the private sector.

II.b. Above allocation funding request

The overall funding for ACT in the public sector is significantly low; therefore additional 17,799,360 doses are to be requested for under the **above allocation request**.

Table 3.8 ACT need versus allocation and above allocation requests

Items		2015	2016	Remarks
COUNTRY TOTAL ACT need		117,996,543	122,722,602	LINE 56: From GA Tables
COUNTRY TOTAL ACT need (Public sector)		44,838,686	51,543,493	Lines 62 and 64 of GA Tables
COUNTRY TOTAL ACT need (Private sector)		73,157,857	71,179,109	Line 64 of GA Tables
Total Need - Public sector 24 HB		33,535,785	37,070,503	
Total Need - Private sector through PR for 24 HB		5,471,628	5,323,634	
Allocation request	Public sector (PR/facilities)	6,601,058	7,866,314	20% of need in 2015 and 21% in 2016
	Private sector (PR/facilities)	3,282,977	3,194,180	60% of need in both 2015 and 2016
	Private sector co-payment	58,587,153	57,002,508	100% total Co-payment need in the gap analysis
	Community -public sector	566,215	674,744	2% of need in 2015 and 2% in 2016
Above allocation request	Public sector (PR/facilities)	6,416,453	9,976,758	19% of need in 2015 and 27% in 2016
	Private sector (PR/facilities)	0	0	N/A
	Private sector co-payment	0	0	N/A
	Community-public sector	550,380	855,770	2% of need in 2015 and 2% in 2016
Total allocation request (Public and private through PR)		10,450,249	11,735,238	Covering 31% of total need in 2015 and 32% in 2016
Total allocation request (Private sector co-payment)		58,587,153	57,002,508	Covering 100% of country need in 2015 and 100% in 2016
Total above allocation request		6,966,833	10,832,527	Covering 21% of total need in 2015 and 29% in 2016

III. Rapid Diagnostic Tests (Module: Case management)

Good progress has been made in the number of suspected cases that received parasitological testing, especially in the use of RDT. The proportion of fever cases tested by RDT among Under-fives, as indicated increased gradually from 3.3% in 2011 to 21.2% in 2012, reaching 75.5% in 2013. Of the 7,584,700 RDTs utilized, 3.2% was consumed in 2011, 24.8% in 2012 and 72.0% in 2013 (Routine HMIS, FMOH 2013). Most (62.8%) of the confirmed uncomplicated malaria cases occurred in 2013 while the least (2.6%) was recorded in 2011. The same pattern is seen with the number of severe malaria cases in both Under-fives and those five years and above. A total of 1,290,719 cases of pregnant women with malaria were recorded between 2011 and 2013, the highest proportion (39.7%) being in 2013 (Routine HMIS, FMOH 2013). Available evidence also indicates that at the PHC levels compliance of health workers to RDT result is 82% (Mokuolu *et al.* 2013, NMEP RDT Implementation Research, pg viii, attachment 26). However, compliance at the private health facilities including PPMVs was >75% (REMEDI study, 2014, attachment 27). In the light of the foregoing RDT, has been prioritized for indicative and incentive funding in this concept note. Where applicable the principle is for the country to provide 3 RDTs for each ACT that will be used. Below is the summary of the needs estimates (as extracted from the gap analysis table) and allocation of funds.

Total RDT needs from Gap analysis table for 2015 and 2016 is 313,519,586 RDTs. The total need in the 24-HBS is 234,487,816 which is 75% of national need. A total of **119,954,542** RDTs have been requested in this concept note for the two years with their split indicated in Table 3.9. This represents 38% of national need and 51% of need in the HB states.

III.a. Allocation funding request: 34, 293, 780 RDTs are here for health facilities, community case management and iccm. Of these, 27,777,962 RDTs are allocated to the public sector and 6,515,818 RDTs for the private sector.

III.b. Above allocation funding request: The overall funding for RDT in the public sector is significantly low, therefore additional 85,660,762 RDTs are therefore included in the above allocation request. Of these, 72,745,109 RDTs

are allocated to public sector and 12,915,653 RDTs will be channeled through the private sector PR.

Table 3.9 RDT need versus allocation and above allocation requests

ITEM	2015	2016	REMARKS	
Total country RDT need	142,508,903	171,010,683	Line 94: From GA Tables	
TOTAL RDT NEED IN 24HBS	106,585,371	127,902,445	75% of Country Need	
Total quantity of RDTs requested in 24HBS (Factor of 1 ACT to 3 RDT)	52,251,246	67,703,296	119,954,542	\$187,657,839
Total ask under allocation	15,675,374	18,618,406	34,293,780	\$34,293,780.31
Total ask under incentive	36,575,872	49,084,890	85,660,762	\$85,660,762.07
Quantity of RDTs delivered through private sector	9,848,931	9,582,541	19,431,472	Reflected to determine sharing formula
Quantity of RDTs delivered through public sector	42,402,315	58,120,756	100,523,071	
Private sector / allocation request	2,978,321	3,537,497	6,515,818	Allocation
Public sector / allocation request	12,697,053	15,080,909	27,777,962	
Private sector / above allocation request	6,870,610	6,045,043	12,915,653	Above allocation
Public sector / above allocation request	29,705,262	43,039,846	72,745,109	

IV. Severe Malaria (Module: Case Management) – Allocation request

Consistent with the recommendation of WHO on the use of injectable artesunate for the treatment of severe malaria, Nigeria, in 2010, also revised the National Malaria Treatment Guidelines to reflect the adoption of injectable artesunate for treatment of severe malaria (Attachment 28). Partners, especially Clinton Health Access Initiative, UNITAID, MAPS, Malaria Consortium, and some state governments have collaborated with NMEP to scale-up access to injectable artesunate and ensure improved management of severe malaria. Currently active severe malaria intervention programmes are ongoing in 16-states (10 by CHAI, 3 by SuNMaP, and 3 by MAPS). Management of severe malaria is directly linked to the goal of achieving near zero mortality from malaria in Nigeria by 2020. Use of artesunate has been shown to have a 22.5% reduction in malaria mortality compared to quinine (AQUAMAT study, Lancet 2010, pg 1647, attachment 29). The implication is that with 100% access to injectable artesunate there is the potential for additional 150,000-200,000 lives being saved. The possibility of this impact is the basis for prioritizing injectable artesunate in the allocation of funds in this concept note, so that there could be an expansion of the states covered on severe malaria management. A total of 12,035,957 severe malaria cases are projected for the period 2015-16. About 9,001,943 of these are likely to occur in the 24-HBS. Costed need for Injectable Artesunate is **\$38,348,275.58** of which \$4,421,541(12%) is being requested in the indicative funding envelope. Table 3.10 gives the breakdown.

Table 3.10: Severe malaria treatment/ Injectable Artesunate needs vs allocation request

ITEM	2015	2016	
Severe Malaria Cases in the 37 states	5,899,827	6,136,130	Line 25: From GA Tables
Severe Malaria Cases for the 24 HB States	4,412,603	4,589,339	9,001,943
Total INJ ARTESUNATE Needed for 24 HB States (x3)	13,237,810	13,768,018	27,005,828
Total INJ ARTESUNATE Need for 24 HB States (USD) (Multiply No of cases by 1.42)	\$ 18,797,690.35	\$ 19,550,585.22	\$ 38,348,275.58
Total requested (12%)	\$ 2,184,238.67	\$2,237,302.89	\$4,421,541.55

V. Intermittent Preventive Therapy in Pregnancy (IPTp) (Module: SPI) – Allocation request

For 2015, 6.1m SP will be required while in 2016, 9,800,000 doses of SP will be needed to bring the total to 15,900,000 SP doses at a cost of **\$10,498,858** which has been prioritized for funding in this concept note. The deployment will be supported with appropriate BCC to ensure uptake while it is hoped that lessons will be learnt from future operation research to be carried out so as to further improve uptake.

Table 3.11: IPTp need vs allocation request

Item	2015	2016	Totals	Cost
Total SP needed for all states from GA	10,888,514	17,481,292	28,369,806	\$ 18,724,071.93
Total SP for 24 HBS	8,142,985	13,066,829	21,209,814	\$13,998,477.49
Total No of SP requested (75% of need)	6,107,239	9,800,122	15,907,361	\$10,498,858.12
Total No of PW in need of SP in HBS	2,714,328	4,355,610	7,069,938	

Total No of PW to be reached in HBS (75%)	2,035,746	3,266,707	5,302,454	\$14,805,928**
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**Total allocation requested including cost of capacity building for Health workers on IPTp

VI. Procurement and Supply Chain Management – Allocation request

The total request for PSM HSS and broader malaria PSM activities is \$5,553,554 (\$1,245,493 + \$4,308,061). Kindly note direct PSM costs related to e.g. distribution of commodities has been integrated in the Vector control, Case management and SPI modules as instructed. The budget requested for “operationalization of PSM” is \$1,245,493. This is to cover malaria specific PSM planning and coordination activities including Malaria Commodity Logistics System (MCLS) refresher trainings, PSM guideline development and other activities as outlined in Annex (NMEP_NFM Workplan_Final_07-07-14). The cost of ATM PSM HSS integration and technical assistance covered by the request is \$4,308,061. The \$3,808,061 is meant to address operational cost for Logistics Management Coordination Unit and LGA staff, and ICT requirements, and cover 27% of the total supply chain integration needs – please see detailed budget attached in Annex (NMEP Integration Costing budget_Jun2014).

VII. Health Information Systems and M&E – Allocation request

The total request is \$15,527,098. This is inclusive of: \$612,087 contribution in this concept note to HIS Health System Strengthening (HSS) including HMIS roll-out; routine reporting including sentinel site reporting, monitoring of/rapid service quality assessments, monthly cluster meetings at the HF levels to enhance data collection, support for data quality assurance (\$7,440,803); surveys including Rapid Impact Assessment in 24 states, MIS 2016, health facility assessment 2016, client exit interviews, program impact evaluation and operations research (\$5,062,273). \$1,450,055 is allocated to other M&E activities such as coordination meetings, revising the NMSP to align with the new NHSDP in 2016, re-training on HMIS tools, technical assistance for operations research (OR) and development of OR agenda.

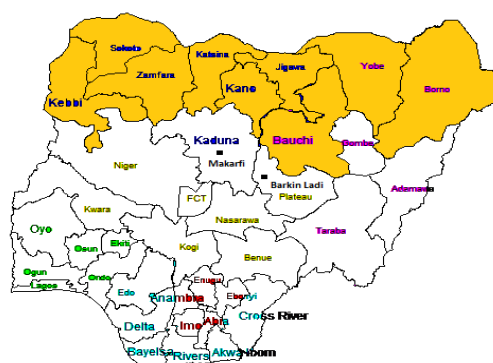
VIII. Program Management – Allocation request

The total request is \$35,268,101. Of these, \$22,600,951 is earmarked for the public sector and \$12,667,150 for private sector. The grant management accounts for \$33,714,953, while \$614,943 is for policy, planning, coordination and management and \$938,205 for training.

IX. Seasonal Malaria Chemoprevention (Module: SPI) – Above allocation request

SMC consists of providing three to four monthly courses of prophylactic or preventive treatment to children under-five during the long rainy season in recommended regions². SMC is highly effective: it has been found to prevent 75% of all malaria cases and 75% of severe malaria cases. If SMC is scaled up in the nine northern states - of which seven are part of the 24 high burden states - where it is deemed suitable³, it is estimated that it can prevent approximately 5.1 million malaria cases and 23,135 deaths among children under-five in 2014, and a total of 23,774 lives could be saved by 2015 (>45,000 deaths), the deadline for the MDG⁴.

Figure 3.3: Map of Nigeria showing states eligible for SMC



A total need **\$9,263,258** was derived for these 3 high burden States for 2015-2016, calculated based on the NMSP country targets and the assumptions given in the Country Gap Analysis Table. However, following careful consideration of the budgetary constraints, it was prioritized as an **Above Indicative Funding need**, and would be considered under the **Incentive Funding**.

² Sahelian sub-regions recommended for SMC are those with a clinical attack rate greater than 0.1 per transmission season in the target age group, or areas with >10 of 100 under-fives experiencing clinical malaria during the rainy season (WHO 2012).

³ Nigerian states that fall within World Health Organization's SMC areas include Kano, Jigawa, Katsina, Sokoto, Borno, Kebbi, Zamfara, Bauchi, and Yobe.

Table 3.12: Breakdown of funding request for SMC

Cost Category	Description	Assumptions	2015	2016
	Advocacy to State		\$50,610.01	\$65,100.86

3.3 Modular Template

Complete the modular template (Table 3, attachment 30). To accompany the modular template, for both the allocation amount and the request above this amount, briefly:

- a. Explain the rationale for the selection and prioritization of modules and interventions.
 - b. Describe the expected impact and outcomes, referring to evidence of effectiveness of the interventions being proposed. Highlight the additional gains expected from the funding requested above the allocation amount.
- a. Explain the rationale for the selection and prioritization of modules and interventions.

Selection of Interventions:

The country's malaria policy recognizes the use of a combination of proven interventions that work as enshrined in the NMSP 2014-2020. See attachment 7. The entire country need for malaria for 2014-2017 has been identified in the NMSP and enumerated in the Country Gap Analysis. For this funding request, due to funding limitations and a need to target resources to where it will achieve the most results, prioritization was considered in terms of geographical scope and spread of interventions. The rationale for this prioritization and selection of States has been elaborated in section 3.2.

Three interventions have been selected based on global best practices, the listed strategies in the NMSP, and in-country context and historical antecedents: LLIN (for vector control); deployment of ACTs and RDTs (for case management).

Prioritization of Modules:

Vector Control (LLIN): The use of LLIN is a highly effective tool for Malaria control when used regularly. Consistent use has been shown to reduce all-cause child mortality. Achieving universal coverage with mosquito nets is therefore the key strategy towards achieving high utilization rates and ultimately impact in terms of malaria burden. Consequently, Nigeria has prioritized the use of LLINs as a key strategy for malaria vector control in the country. See details in section 3.2c.

Case management (ACTs, ACT Co-payment, iCCM, CCM, severe malaria and RDTs): Parasitological diagnosis precedes treatment and ACTs remain the medicines of choice for treatment of uncomplicated malaria in line with national policy and guideline. RDTs have been deployed in phases to all states in Nigeria. The results of 2009-2010 DTET study attested to efficacy of ACTs and thus, their continuous use. Community case management has been proposed as an effort to improve rapid access especially in hard-to-reach areas to effective treatment. Community level services are envisaged at two levels. One, as a component of iCCM and two, as a standalone Community Case Management of malaria (CCM). The approach to iCCM is to leverage on states that are currently implementing iCCM under the RAcE and EU/UNICEF projects. On the other hand, CCM will be deployed in other states where iCCM is not currently being implemented in order to accelerate and improve access to malaria treatment.

The prioritization of the PSCM is aimed at building on the success of the AMFm implementation which has led to an increase in the availability of QAACs across all outlets (public and private sectors) and substantial price reductions, without evidence of profiteering in both rural and urban areas.

Injectable Artesunate for Severe Malaria was also identified as a complimentary high impact component to the Case Management intervention. Although malaria related mortality has fallen globally, Nigeria's malaria strategic goal to reduce U5 mortality to near zero underscores the need to improve on the management of severe malaria. Inj Quinine has traditionally been used by medical practitioners, and to consolidate the efforts to improve use of Inj Artesunate due higher number of deaths averted (AQUAMAT study, Lancet 2010, pg 1647, attachment 29). This module is one of those prioritized as NMEP intends to boost demand for Inj Artesunate over Quinine leveraging on the lessons learnt and spade work already done by other partners like Clinton Health Access Initiative (CHAI), Malaria Consortium and MAPS currently implementing this intervention in the country.

Special Preventive Intervention (IPTp) has been institutionalized and implemented as directly observed therapy during ANC. Paradoxically; there has been a relatively low coverage for IPTp compared to the high rate of ANC attendance. ANC attendance in the country ranges from 41% in the North West to 91% in the South East (NDHS 2013, pg 20-22, attachment 4), while the national IPTp coverage with Sulphadoxine-Pyrimethamine (SP) is about 15% (NDHS 2013, pg 35, attachment 4). Although this may easily suggest missed opportunities in using IPTp, it does appear that this experience is not unique to Nigeria and that the issues are not merely those of availability or the non-availability of SP. The foregoing

notwithstanding, it is not fully established in Nigeria that the core issue is non-use, hence the prioritization of this module to ensure availability of SP for IPTp as well as train health care providers on the delivery of IPTp as a core component of Focused Antenatal Care.

Supporting Interventions: For optimal uptake and quality of care, there reserves an absolute need to prioritize key supporting interventions such as BCC to improve demand and uptake of service/interventions; PSM to ensure a strong and sustainable procurement and supply chain; Program management and Health Information Management including M&E. These key supporting interventions constitute important elements of the six building blocks of a functional health system. It is therefore imperative that the grant contributes to strengthening the existing health system. As part of the HSS, selected cross cutting PSM and M&E activities will be integrated with other disease programmes such as HIV/AIDS and TB. The areas of integration were jointly identified based on priority and feasibility of implementation. See section 3.2c for details.

Derivation of Incentive Funding Budget

Finally, another weighting was done to derive a second adjusted Shared Cost % per module, for the extra funds that could be requested as Incentive Funding from the GF.

This was done by applying the Share Cost % to an estimated sum of \$271,000,000 (from a total of \$825,000,000 available for ATM for 39 countries in 'Band 1'). This reflects part of the "Budget that could be requested from the GF as an Incentive Funding Budget.

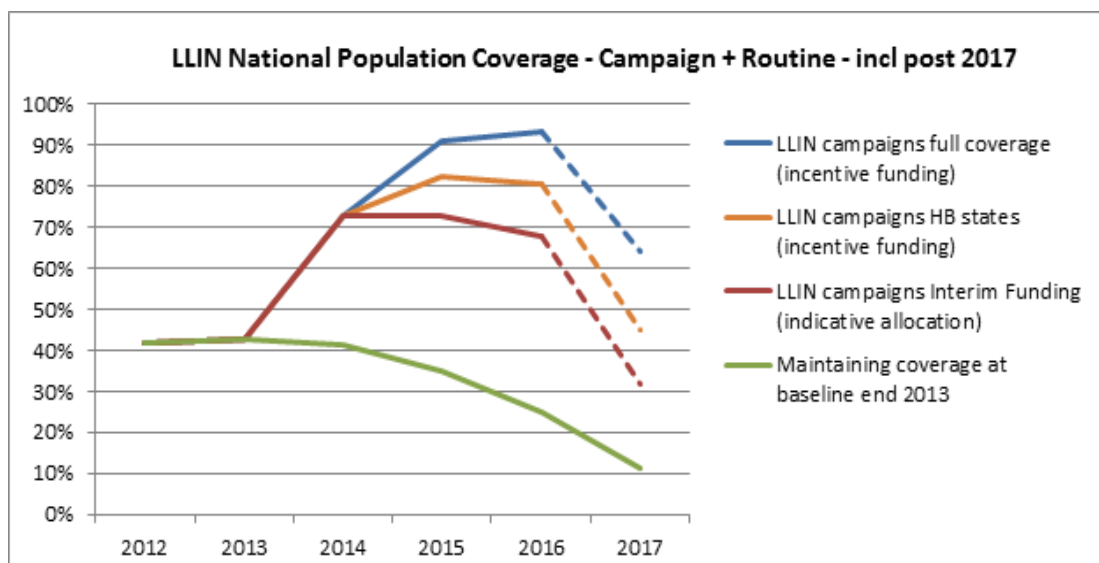
Please note that the funding being requested under the indicative window are core interventions that are aimed at meeting the needs in the 24 States, which make up 80% of the Malaria Burden in Nigeria.

b. Describe the expected impact and outcomes, referring to evidence of effectiveness of the interventions being proposed. Highlight the additional gains expected from the funding requested above the allocation amount.

The figures below describe the expected impact and outcomes of the interventions being proposed and the additional gains expected from the funding request above the allocation amount. **Figure 3.2** shows LLIN coverage levels that will be attained with Interim Funding under the current grant and with the investment under the proposed application. The LLIN coverage level will increase from about 70% in 2014 (with the IF) to about 92% by 2017 if the investment under the proposed application is focused on full coverage and to about 80% by the same year if focused on the 24 priority states. If additional 6 HB state campaigns are supported with GF allocation in 2015 for 8,367,489 nets and 2016 for 12,237,835 LLINs coverage is maintained at 72% by end of 2016. When comparing above allocation funding coverage against allocation, coverage there will be a resultant 11% higher coverage in 2015 and a further 17% higher coverage in 2016. If the above allocation request to cover all outstanding LLIN campaigns in 2015-2016 is granted (i.e. 11 states campaigns currently not covered in "other" states funded through incentive funding), universal coverage of 82% would be achieved in 2015 and remain at same level in 2016.

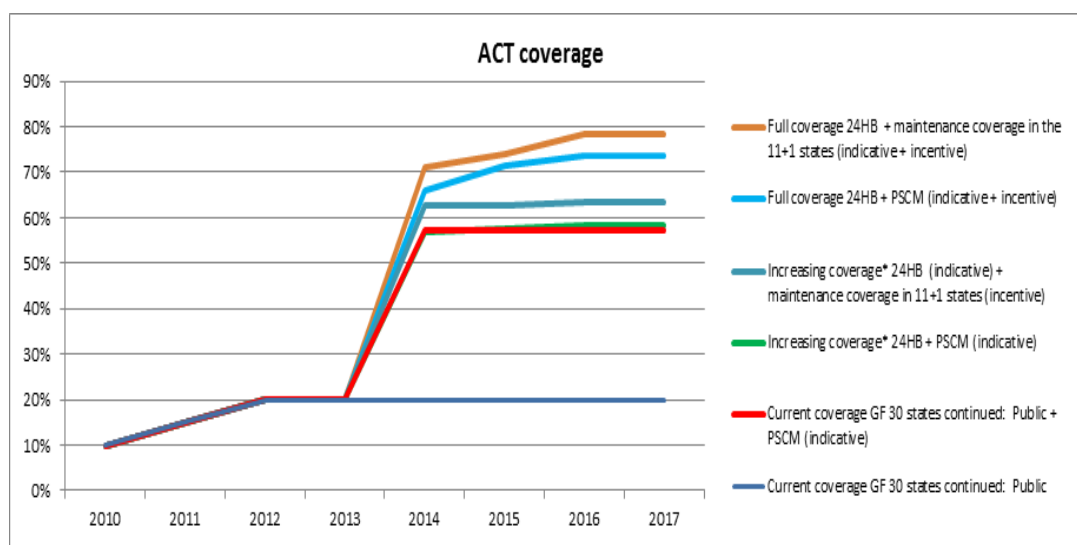
Figure 3.5 shows the coverage level of ACT that will be attained under different scenarios as well. The ACT coverage level will increase from about 70% in 2014 to about 80% by 2017 if the investment (allocation and above allocation) under the proposed application is focused at full coverage of the 24 HB states plus maintenance coverage in the remaining 11 plus 1 states and it will increase from about 65% in 2014 to about 72% by 2017 with full coverage of the 24HB with PSCM under the allocation and above allocation requests. An impact of the combination of interventions on mortality among children the under 5 years is shown on **Figure 2.1**. The investment under the current application together with existing investment will result in about 140,000 malaria deaths averted among children less than 5 years by 2016, given that it targets the areas with the highest burden, with full allocation funding (see various scenario):

Figure 3.4: Coverage scenarios for LLIN including post 2017



Source: Epi Analysis, 2014 (Attachment 19)

Figure 3.5: Coverage scenarios for ACT



Source: Epi Analysis, 2014 (Attachment 19)-4 PAGES SUGGESTED

3.4 Focus on Key Populations and/or Highest-impact Interventions

This question is not applicable for low-income countries.

Describe whether the focus of the funding request meets the Global Fund's Eligibility and Counterpart Financing Policy requirements as listed below:

- If the applicant is a lower-middle-income country, describe how the funding request focuses at least 50 percent of the budget on underserved and key populations and/or highest-impact interventions.
- If the applicant is an upper-middle-income country, describe how the funding request focuses 100 percent of the budget on underserved and key populations and/or highest-impact interventions.

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Target group/impact	Indicative allocation	Incentive funding
High burden geo areas	24 high burden States which represents 80% of the total malaria burden in Nigeria, including 10% increase of current level of GF support per year. - Northern states (Sahel and Sudan-Savannah eco-zones) accounting for 36.3% of the burden: will here specifically focus on women, who have less access to services in this area. - Within these 24 HB states, some have very poor knowledge about malaria (e.g. Kwara, Ondo, Kebbi, Lagos, Osun, Oyo). These will receive extra attention in BCC efforts.	12 + 1 states: existing GF routine commodity support in 11 + 1 states, all endemic regions with $Pf\ Pr_2 > 20\%$, proposed to be maintained via incentive funding;
Rural areas/community level	- Community Case management strengthened and iCCM in 2 states: Niger (RACe) and Kebbi (UNICEF). - Participatory inclusion of Role Model Caregivers and ward health committees; as recommended by community consultation process. - CBO/CSO capacity strengthening.	iCCM in 8 states: Abia (RACe) and Adamawa (UNICEF); Akwa Ibom, Benue, Katsina, Ogun, Oyo, Sokoto
Pregnant women/IPTp	- IPTp - Distribution of routine LLINs to pregnant women (as in Phase 2)	
Children	- Facility-based distribution of routine LLINs to under-fives. - School-based LLIN distribution (using lessons learned from Phase 2). - BCC interventions to intensify their focus on children especially for ACTs and RDTs.	- SMC in 3 of the 7 targeted HB states
LLINs – campaign and continuous distribution	Continuous LLIN distribution in 24 high burden states	- LLIN campaigns in 6 of the 24 high burden states, due in 2015: Lagos, Benue, Zamfara, Ondo, Imo and Kwara
Treatment	- ACT distribution in both private and public facilities in 24 high burden states. - Private sector co-payment and supporting interventions to ensure more demand to private sector for ACTs. - ACSM directed towards enforcement of ban towards monotherapies.	
Diagnosis	- Distribution in both private and public facilities in 24 high burden states. - ACSM directed towards changing national policy to allow PPMVs to handle RDTs.	

SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT

4.1 Overview of Implementation Arrangements

Provide an overview of the proposed implementation arrangements for the funding request. In the response, describe:

- a. If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector Principal Recipient(s)).
- b. If more than one Principal Recipient is nominated, how coordination will occur between Principal Recipients.
- c. The type of sub-recipient management arrangements likely to be put into place and whether sub-recipients have been identified.
- d. How coordination will occur between each nominated Principal Recipient and its respective sub-recipients.
- e. How representatives of women's organizations, people living with the three diseases, and other key populations will actively participate in the implementation of this funding request.

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a) If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector Principal Recipient(s)).

Nigeria will continue to use the dual track implementation arrangement (Government and Non-Government Sectors), which has been adopted by the CCM before the commencement of Round 8 grants implementation. The same approach was adopted for implementing the Interim Grants currently running. Through the dual track system, PRs focus on the public and private sectors based on their competencies. Previous implementation arrangements have demonstrated the effectiveness of such a dual track arrangement in reaching the target populations. The implementation of activities through SRs will also be dual track.

b) If more than one Principal Recipient is nominated, how coordination will occur between Principal Recipients.

In order to provide for smooth implementation of this funding request, the existing Memorandum of Understanding (MoU) between the Malaria PRs, that clearly define roles and responsibilities of each PR and areas of collaboration will be revised and updated not only to address any changes in implementation resulting from this new NFM grant, but also to capture and define emerging areas not previously covered in the implementation arrangements. The existing coordination framework of the CCM will provide guidance to the PRs, through the quarterly PR Forums, the interactions with LFA all provide the CCM the opportunity to oversee grant implementation and provide oversight and stewardship. A platform for PR-PR coordination exists, in the form quarterly meetings, aimed at experience sharing, resolution of bottlenecks and harmonization of efforts during implementation. This will be maintained and strengthened. In addition the Malaria Technical Working Group (TWG) and its sub committees (ACSM, Case management, IVM, M&E, PSM, Programme management) would be strengthened to carry out the coordination at the service delivery levels. The Malaria TWG is part of a Ministerial Task Team on AIDS, TB and Malaria.

c) The type of sub-recipient management arrangements likely to be put into place and whether sub-recipients have been identified.

The SRs on the current grant will be re-assessed to select the ones to implement this funding request along with new ones, where necessary. A transparent process, will be employed, including a call for expression of interest, review of submissions, shortlisting of qualified organizations, assessment of pre-selected organizations and final selection. A Joint Programme Implementation Assessment has been commissioned to identify lessons learnt from the current implementation arrangements which will inform modifications to the implementation of this request.

Sub-grant management arrangement will include development and signing of an MoU between PRs and SRs. Existing sub-grant management documents will be updated to include relevant arrangements in the current grant. Workplans, based on the implementation arrangement, and performance frameworks will be developed with clear indicators and milestones for monitoring SR performance. Approval of disbursement requests from SRs will be based on pre-determined conditions, which will include but not limited to delivery on targets, submission of timely and accurate financial and activity reports, etc.

Other arrangements will include continuous on-the-job supervision and mentoring, PR/SR forums to review status and address challenges on grant implementation, follow up on spot checks conducted on the SRs by LFA, CCM and Internal Auditors, quarterly/periodic data quality assessments and performance based disbursements. Positioned at the State levels, these SRs will provide capacity building, supply chain management, data collection, collation and transmission. They will also undertake on-the-job mentoring, supervisory site management and carry out social mobilization activities under the grant in both the private sector and public sectors according to the PR they are affiliated to. On a regular basis, SRs financial systems will be audited and the outcome of such activities will be used to ensure prudence and accountability. Internal control systems of the PR will also be used to regularly conduct spot-checks on SRs as well as provide follow up on the results of LFA spot-checks on SRs.

d) How coordination will occur between each nominated Principal Recipient and its respective sub-recipients.

The pre-existing sub-grant management manual that clearly describes roles and responsibilities of PRs and SRs in programme implementation will be reviewed and updated. This document will further provide guidance on programme activity reporting; modalities for engagement of, or collaboration with, any third party during implementation; and accountability of funds disbursed to the SRs. The sub-grant manual will be disseminated to all participating SR staff and will form part of the grant documentation. A grant agreement will be signed between PR and SRs and will outline implementation and disbursement modalities, budget and conditions precedent for the sub-grant.

The PR will use a quarterly PR-SR retreat as a coordination platform to resolve SRs' implementation challenges, provide feedback on performance, share best practices and lessons learnt among SRs. It will also be a capacity building forum to ensure that the SRs capacity is strengthened continually for programme implementation. The PRs will also regularly conduct mentoring and monitoring visits to the SRs and service providers so as to identify gaps in programme implementation and proffer solutions where necessary.

The internal control systems of the PR will regularly conduct spot-checks to the financial systems of the SRs to detect any anomalies as well as follow up on the issues arising from the LFA spot-checks. Issues detected will be followed up to a logical conclusion. On an annual basis, every SR will be audited by capable audit firms and reports shared with LFA and the GF secretariat. Problems arising from data management at SR levels will be logged, tracked and resolved through the joint track system. When this is not completely resolved, issues will be followed up during supervisory and monitoring visits.

e) How representatives of women's organizations, people living with the three diseases, and other key populations will actively participate in the implementation of this funding request.

Umbrella bodies of CSOs, FBOs, and Women groups/organizations were involved in the development of this concept note and will participate actively in its implementation. It is noteworthy that some of these umbrella bodies/organizations are implementers of the current grant. These organizations will continue to coordinate implementation of community sensitization, mobilization activities and outreaches to key affected populations including women, children and migrant groups. The choice of states to be assigned to SRs will be based on their area of strength and coverage of their network. The operation of the SRs will be guided by the ACSM Strategic Framework and Implementation Plan (Attachment 31).

4.2 Ensuring Implementation Efficiencies

Complete this question only if the Country Coordinating Mechanism (CCM) is overseeing other Global Fund grants.

Describe how the funding requested links to existing Global Fund grants or other funding requests being submitted by the CCM.

In particular, from a program management perspective, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities.

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The CCM is currently overseeing a number of Global Fund Grants as indicated in the Table 4.1 below. With respect to Malaria, the country is currently implementing the Round 8 phase 2 and Interim Funding with a total value of US\$392,168,360 for the period, September 2011 – December 2014. This is split between SFH (US\$ 177, 846, 360) and NMEP (US\$ 214, 322, 000). The grant covers malaria prevention with LLINs; diagnosis with RDTs/microscopy and treatment with ACTs; BCC and HSS in 36 States plus FCT for the private sector (SFH) and same interventions in 29 states plus the FCT for the public sector (NMEP).

Table 4.1: Portfolio of GFATM grants in Nigeria and overlap with NFM

GRANT NUMBER	PRINCIPAL RECIPIENT (PR)	YEAR							
		2009	2010	2011	2012	2013	2014	2015	2016
NGA-H-NACA	National Agency for Control of AIDS (NACA) (HIV)								
NGA-H-ARFH	Association For Reproductive And Family Health (ARFH) (HIV)								
NGA-H-SFHNG	Society for Family Health (SFH) (HIV)								
NGA-T-ARFH	Association For Reproductive And Family Health (ARFH) (TB)								
NGA-T-IHVN	Institute of Human Virology Nigeria (IHVN) (TB)								
NGA-809-G11-M	Society for Family Health (SFH) (MALARIA)								
NGA-809-G14-M	National Malaria Elimination Programme (NMEP) (MALARIA)								
NFM	New Funding Model (NFM) Allocation								

As at January 2014, a total of US\$ 208,939,494 had been expended leaving a balance of US\$183,228,866. By December 2014, it is forecasted that US\$ 179,408,486 of the available US\$ 183,228,866 will have been disbursed leaving a balance of US\$3,820,370 available for reprogramming into the first NFM implementation period.

As shown above, of all the Global Fund grants being implemented, the only grant this NFM is programmatically linked to is the Round 8 Phase 2 & interim malaria grant, currently being implemented by NMEP and SFH. From this ongoing grant, there is US\$ 183,228,855 in the pipeline, which adds to the US\$ 316,261,563 being requested under the NFM application to bring the total funding envelope under the NFM to 499,490,418 for its indicative application. The pipeline amount is already committed to programme activities and had been discussed earlier in the concept note under Section 3.

Therefore under this Concept Note, the country is requesting for US\$316,261,563 in new funding, and the grant implementation will commence on January 1, 2015 and end in December 31, 2016. The funding being requested for will build on the gains of the current grant in the following ways:

- In terms of trained personnel, both PRs will use existing trained personnel at the Federal, Organizational, State and LGA levels to implement the activities of the grant. Refresher trainings will be used on basis of need to maintain optimal service delivery. Training documents and job aids developed from the previous grant will be used to conduct such training activities as well as improve implementation capacities at the service delivery points.
- The current grant covers 29 states and the FCT in the public sector and 36 states and FCT for the private sector; however, the grant being sought for will focus on the highest burden states, which has been established to be 24. Findings from the epi-analysis and other relevant findings will guide the deployment of effective interventions to these states.

- c) The M&E Plan will be used to guide monitoring of this grant. Structures and systems such as the District Health Information System (DHIS), trained personnel, data tools, and data collection will be deployed in this grant to contribute to timely and quality data. See attachment 32.

Lessons learned from the implementation of the Round 8 grant and key findings and recommendations of a Joint PR Programme Review carried out this year will be used to inform implementation arrangements for this grant. For example, availability of operational costs for LLIN mass campaigns ensured the smooth implementation of the campaigns; continuous LLIN distribution through schools and communities has increased the access to LLIN to populations that do not patronize health facilities and institution of RDT outreaches with supportive BCC activities led to increase in informed demand for diagnosis (RDT) among patients.. Moreover, a literature review on use and non-use of LLINs in Nigeria carried out in R8 provided some insights into the reasons for low utilization of LLINs. An operations research now commissioned to be conducted in the country will include a BCC messages mapping and meta-analysis; which will be directed at answering questions such as 'What is the difference in the net culture between the northern and southern regions of Nigeria?' and "Is there an association between message exposure and/or frequency with net use across regions?' It is designed to provide evidence that will aid in the development of an improved strategy to promote net/LLIN use.

The HSS component including capacity building, M&E, LMIS and facility upgrade under the Malaria funding request has been streamlined to ensure that there is no duplication of activities. In the case where same activities are being considered across the ATM, there is a mechanism (CCM oversight) to ensure that the services are not provided for the same group of persons in the same states or communities.

4.3 Minimum Standards for Principal Recipients and Program Delivery

Complete this table for each nominated Principal Recipient. For more information on minimum standards, please refer to the concept note instructions.

PR 1 Name	National Malaria Elimination Programme (NMEP)	Sector	Public
Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a crosscutting health system strengthening grant(s)?	☒ Yes ☐ No		
Minimum Standards	CCM assessment		
1. The Principal Recipient demonstrates effective management structures and planning	The National Malaria Elimination Programme (NMEP) is headed by a Director who is under the guidance and supervision of the Top Management Committee (TMC) of the Federal Ministry of Health headed by the Honourable Minister of Health. This committee serves as the Governing Board; it meets monthly to review progress and address challenges on Malaria and other Programmes under the Ministry. The NMEP has a Global Fund Programme Management Unit, which provides, guidance, strategic direction and coordinates with Branches of NMEP namely Case Management, PSM, IVM, M&E, ACSM and Programme Management towards implementation of Global Fund		

	grant. Internal coordination is achieved through monthly meetings of all heads of Branches Chaired by the National Coordinator and through internal circular. The Programme coordinates Sub-Recipients through quarterly PR-SR meetings and through official communications on management actions and monitors their activities through quarterly supervision. Coordination with Partners is achieved through quarterly meeting of the Programme Technical Working Group (TWG) and monthly meeting of its sub-committee. The TWG offers technical support to the Programme. The grant implementation plan is derived from the National Malaria Strategic Plan and is jointly prepared by relevant stakeholders.
2. The Principal Recipient has the capacity and systems for effective management and oversight of sub-recipients (and relevant sub-sub-recipients)	NMEP is supported by the Global Fund Programme Management Unit headed by a Programme Manager. NMEP has about 100 staff (about 80 are technical and 20 supportive staff). Two of the six head of Branches under the Programme are two Directors, three Deputy Directors and one Assistant Director in the Federal Civil Service. There is a dedicated finance and internal audit unit with full complement of staff to the grant. Internal coordination is achieved through monthly meetings of staff Chaired by the Programme National Coordinator and through internal circular. The Programme coordinates Sub-Recipients through quarterly PR-SR meetings and through official communications on management actions and monitors their activities through quarterly supervision. Coordination with Partners is achieved through quarterly meeting of NMEP Technical Working Group (TWG) and monthly meeting of its sub-committee.
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud	The pre- and the post- audit processes are in place to ensure accountability and transparency. Quarterly audits and review of Financial Books to review the FMS and Internal Control systems are undertaken.
4. The financial management system of the Principal Recipient is effective and accurate	The FMS of NMEP is under the headship of the Head of Finance who works with the Finance Manager, Project Accountant and accounts officers. This unit is guided by The Finance and Accounts Policies and Procedural Manual. Job descriptions and reporting lines are adhered to, ensuring smooth day to day operations. Regular meetings are conducted among staff of the unit. Recently, tools to ensure proper retirement of advances have been designed and implemented. Importantly, books are kept up to date, with regular oversight/supervisory to SRs.
5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products	The Federal Medical Stores in Oshodi is the central warehouse used by NMEP; the regional warehouses are the respective states' medical stores. The State warehouses have challenges in terms of infrastructure, staffing capacity, inventory management practices as well as in ensuring coordinated distribution of commodities. Part of the planned HSS budget under PSM will address these weaknesses. The supply chain integration work is annexed to this concept note to provide detailed information. It is expected that gradually, a smaller number of integrated warehouses will be managed under a Public-Private Partnership arrangement to ensure efficiency under the PSM integration arrangement across malaria, HIV/AIDS and TB. . Due to the expansive nature of the country and needs for malaria spread across the country, State warehouses may still be used as break-bulk shipment points thus reducing the time required to store commodities in them. NMEP

	will also strengthen its logistics management capability to oversee these operations by deploying qualified and competent Logisticians in all States. Currently, adequate security measures are in place at the central warehouse using private security guards while Nigeria Civil defense personnel will be used at the State warehouses for security purposes.
6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment/program disruptions	Commodities are distributed from the Federal Medical Store to the States Central Medical Stores (CMS) using the Third Party Logistics Providers (3PLs). Distribution from States to Health Facilities is carried out by the SRs as the States with exception of some states where GF/NMEP and PMI have had collaboration and PMI has provided distribution services using their 3 rd Party Logistics providers. Distribution thus has had challenges previously associated with underfunding as well as inefficiencies. To improve this, all the commodities will be distributed using 3 rd Party Logistics providers to be contracted by NMEP. It is noted that the existing 3PLs contracts (for National to State Distribution) have expired and , NMEP is currently carrying out a new contracting process to engage new 3PLs for both central to States, and States to health facilities, with provisions to ensure that the performance of the 3PLS are measured from time to time. In actual fact, this is also one of the areas where the Supply chain integration will be working on to integrate distribution with other disease programmes and partners to ensure efficiencies are generated. The availability of 3PLs with adequate capacity and provision for performance management will ensure continued and secured supply of health products to end users.
7. Data-collection capacity and tools are in place to monitor program performance	The harmonized NHMIS data capturing tools are used in the Global Fund supported facilities. Data retrieval forms are available to collate health facility data at the Local Government level, which is aggregated at the states level. There are SOPs that guide data management at all levels. Data Quality Assessments checklists are used to validate data at sub-national levels.
8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	Data is submitted to the LGA M&E Officer on a monthly basis from health facilities in the first week of each new month using the NHMIS monthly summary form. LGA focal persons collate the data in the data retrieval forms and submit to the states in the second week of the new month. The states' M&E officers review the data and send same to the national level (NMEP) electronically. DPRS is currently training LGA staff on the use of DHIS 2.0 tool, and NMEP intends to train the malaria programme staff at all levels before the end of 2014 so that data can be acquired from the national instance. The current reporting rate on the national instance is 44%.
9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	Quality standard requirements for commodities are set by the National Agency for Food and Drugs Administration and Control (NAFDAC). NAFDAC ensures that these requirements are met for food and drug commodities. The National Institute for Pharmaceutical Research and Development (NIPRD) and the University of Lagos, Idi Araba Lagos conducted quality assurance testing for Health products. According to the stipulations of the Quality Assurance Systems and Capacity specified in the Global Fund Guide to Procurement and Supply Plan, PR has through a transparent process engaged TUV SUD PSB Pte Limited Singapore, an ISO/WHO certified laboratory for quality control

	testing of ACTs. TUV SUD PSB Pte Limited Singapore has conducted sampling and testing for ACT in Nigeria and will continue through the phase 2 of the project. NMEP plans to extend the contract of this organization.
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4.3 Minimum Standards for Principal Recipients and Program Delivery			
Complete this table for each nominated Principal Recipient. For more information on minimum standards, please refer to the concept note instructions.			
PR 2 Name	Society for Family Health	Sector	
Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a cross-cutting health system strengthening grant(s)?		☒ Yes ☐ No	
Minimum Standards		CCM assessment	
10.The Principal Recipient demonstrates effective management structures and planning		The PR has a core program management unit headed by a Director and five other managerial staff at the headquarters. This unit has successfully managed the Round 4 Phase 2 as well as the Round 8 Phase 1 GF Malaria projects. The program unit provides strategic direction and interfaces with program support units which provide specialized services for all the projects in the organization. The support units include finance, procurement, HR and Admin, research and Monitoring and Evaluation, Behavioral Change Communication, Corporate communication and Field Operations. Field Operations has a complement of staff specifically dedicated to the implementation, supervision, monitoring and evaluation of the GF project. The Field Operation staff provides direct implementation as well as oversight to SR implementation in specific states.	
11.The Principal Recipient has the capacity and systems for effective management and oversight of sub-recipients (and relevant sub-sub-recipients)		The PR program management unit headed by a Director provides strategic direction to the project, feedback to the PR executive management and Board, clarifications to GF and LFA, seamless interface to support units in the PR system. Management arrangement with SRs is as in the SR grant agreement and details provided by the regularly updated sub grant management manual. PR has designated this Directorate to Global Fund grants and it's responsible for the coordination of GF activities. Within the Directorate are two Divisions – Global Fund Malaria and Global Fund HIV. These are directly in charge of implementing the specific programmatic interventions within the PR system. The interventions adopted and planned by the Divisions are implemented in the field through the Field Operations Directorate to which all staff outside the headquarters report. Directly supporting the Division are the Procurement, Finance and Accounts, BCC, M&E and Sales/Distribution Units. These units support all SFH programmes in an integrated manner and leverage the experiences and strengths of the various Departments and Divisions to provide efficient services	
12.The internal control system of the Principal Recipient is effective to prevent and detect		Internal control systems of the PR provide spot checks, mentoring, capacity building and follow up on audit issues raised within the SR systems. Management letters are used to communicate progress and status of implementation to SRs while PR/SR fora are used to provide	

misuse or fraud	feedback, mentoring and capacity building. The PR internal control system is well set up and functional.
13.The financial management system of the Principal Recipient is effective and accurate	PR Finance and Accounts Division have evolved over time with a team of twenty eight chartered accountants (including fellows of the Institute) and thirty two other experienced non chartered accountants. The Finance Division is headed by the Chief Finance Officer who reports to the Managing Director and followed by the Finance Director, two Deputy Directors, three Assistant Directors and other project Finance Staff. The accounting system runs on SAP integrated ERP system and the accounting policy is maintained on modified cash basis. The Accounting Division has been able to manage several multilateral (Global Fund, DFID, USAID, WHO) and other donations from organizations such as Bill & Melinda Gates, University of California San Francisco, etc. The Accounting Division has supported the Program unit and provided timely accurate financial information that enables seamless management of the programs. In particular, they have ensured proper budget and budgetary controls and followed up with timely burn rates analysis. Other areas the Finance Division has been of immense value to PRs program management include: • banking, ensuring that funds are not commingled, • Audits, ensuring that there is no qualified report , • Vendor management, timely payment of invoices • Statutory payments, withholding taxes, PAYE tax, national Housing Fund etc • MIS, management of sales and stock movements • Territorial /Finance Functions; accounting for funds disbursed to branch offices Because of the peculiarities of each donor funding, the Finance and Accounts Units is divided into Project Units with senior qualified accountants managing the accounting function of each unit and specializing in the various donor requirements.
14. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products	SFH has a 7,500sqm warehouse located in Ota, Ogun State. This warehouse which effectively commenced full operation in May 2013 has a storage capacity of 18,500 cubic meters. It is from this warehouse that every stage of its supply chain is managed and monitored. The supply chain management system at the warehouse is fully integrated with the upcountry third party sites-the MDS (Manufacturers Delivery Services) which is a privately owned warehousing and logistic facilities. PR utilizes about 22 of the MDS depots to make its commodities available to all it's over 60 wholesalers and 16 regional offices spread across the country. PR also engages the services of some registered haulage companies in making sure that its commodities are delivered timely to all the 22 MDS depots. The central warehouse also serves as a staging area for product repackaging as most commodities from the donors are received in bulky packs and broken into smaller and convenient packs. The breaking of bulk into smaller packs will include providing additional information such as user guides in local language, pictorials and demonstrations which benefits the user. Reminders of next injectable appointments are also included to assist users of injectables remember their appointment days. These repackaging activities are carried out by over 350 temporary staff mainly young people who live in the local communities.

	Also within the warehouse, certain commodities like the Gold Circle condoms undergo Batch by Batch quality assurance (QA) test by trained Laboratory assistants from the Federal Ministry of Health (FMoH). Only batches that pass this external evaluation are permitted to be repackaged for subsequent redistribution. Within the warehouse, commodities are stored in line with the recommended storage conditions which vary from one commodity to the other. Two cold stores measuring about 2,000sqm are dedicated for storage of temperature regulated commodities. They are often equipped with thermometers and Hygrometers for monitoring of temperature and relative humidity respectively. The warehouse manages the inventory of commodities and other materials using a robust enterprise resource package that allows for online real-time inventory recording
15.The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment/program disruptions	There are relatively significant challenges to distributing goods in Nigeria, primarily centered on poor infrastructure and the inadequate availability of reliable trucks. These factors can create an unpredictable transportation schedule and cause delays in commodities reaching the end-users. PR tries to limit these potential issues by using only nationally registered transporters, keeping its own fleet of trucks in case of an emergency, and investing in transportation insurance. A yearly procurement with staggered delivery times is already instituted and running. PR will maintain a minimum of three months' and maximum of six months' stock supply in the warehouses, and a just-in-time delivery system with a maximum lead time of one week for facilities where SRs are to deliver commodities. An additional obstacle in the distribution of ACTs and RDTs is the inadequacy of proper cold storage systems at the state level. SFH will continue to collaborate with MDS to ensure that renovated and demarcated areas in the warehouses maintain the standard storage conditions. These warehouses are strategically placed so that the wholesalers and SRs in each of the states can access them in a timely manner. This is to ensure that ACTs and RDTs are not en route for prolonged periods of time in un-refrigerated vans. Special cool transportation for RDTs has been put in place to ensure that the commodities are moved under standard conditions. With the downstream distribution of RDTs and ACTs, a checklist of criteria for selection of participating health facilities will include availability of an appropriate storage system and also that quantities supplied are in volumes that can be managed by the facility. The private sector component of the malaria treatment and prevention objectives will be nationwide in reach. Transportation contracts are competitively bided out every two years and transporters contracted on a yearly basis. Currently, there are five transport companies used by SFH third party logistics companies. PR also has a fleet of 3 trucks, which will be used for any urgent or unscheduled transportation needs at the state level. All detailers are provided with SUVs to push products in their designated states as well. All commodities (LLINs, ACTs and RDTs) procured under the Grant will be delivered to the PR central warehouse in Ota, Ogun State before they are sent to the 21 MDS depots. The private sector health commodities will be stored centrally upon customs clearance. Commodities will be delivered to the regional level (MDS depots), state level (SRs and wholesalers), and local levels (clinics and other points of sale) on demand. PR works with designated transportation agents to move the ACTs from the central level to the MDS depots. All deliveries

	to the MDS will be based on push and pull strategy. If any MDS depot requires an extraordinary delivery, PR will use one of its trucks to deliver the product. Sales to wholesalers and SRs are conducted on a rolling basis.
16. Data-collection capacity and tools are in place to monitor program performance	Responsible for the GF Malaria is an M&E manager, two Monitoring and Evaluation Senior Officers and a database officer. They are responsible for the continuous retrieval, collation, analysis and storage of data. They facilitate the harmonization of M&E processes, activities, data reporting and dissemination through the M&E working group of the Roll Back Malaria Partnership of Nigeria. Data collection and collation which is an integral part of the system is done using two basic primary tools developed by the National programme: the Health facility form and the community level forms. These tools have been harmonized into one summary tool which is used both in the private and public health facilities. These tools have been deployed by all SRs to their various participating facilities to facilitate data collection, collation and analysis. Data is collected at the community level (Private facilities) and collated at the state level and this is further transmitted to the SFH HQ. At the state level, the SR shares the data with the State RBM monthly. All data collected is based on agreed national indicators, data collection instruments and reporting formats as indicated in the national M&E framework and plan. The PR conducts Quarterly Data Quality Assessments to verify all indicators. The Data from the Private Sector is shared with the NMEP during PUDR reviews. PR uses the District Health Information System for management and tracking of routine data from the facilities. The monthly health facility form and the Logistics Management Information System form (LMIS) are entered into the DHIS database. The DHIS is a tool for collecting, validating, presentation of and analyzing aggregate statistical data
17.A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	PR uses the District Health Information System for management and tracking of routine data from the facilities. The monthly health facility form and the Logistics Management Information System form (LMIS) are entered into the DHIS database. The DHIS is a tool for collecting, validating, presentation of and analyzing aggregate statistical data.
18. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	The National Agency for Food and Drugs Administration and Control (NAFDAC) is responsible for the national quality control system. It ascertains the quality of all products before they can be registered and imported into the Country; thus only products registered with NAFDAC will be procured under the GF Malaria grant. Health products procured for part of Phase 1 were previously subjected to a QA testing conducted by National Institute for Pharmaceutical Research and Development (NIPRD) and University of Lagos, Idi Araba Lagos. The QA protocol is based on ISO 17025 certified guidelines. According to the stipulations of the Quality Assurance Systems and Capacity specified in the Global Fund Guide to Procurement and Supply Plan, PR has through a transparent process engaged TUV SUD PSB Pte Limited Singapore, an ISO/WHO certified laboratory for quality control testing of ACTs. TUV SUD PSB Pte Limited Singapore has conducted sampling and testing for ACT in Nigeria and will continue through the phase 2 of the project. PR will extend the contract of this organization to cover future phases till an alternative competent laboratory is available locally

4.4 Current or Anticipated Risks to Program Delivery and Principal Recipient(s) Performance
a. With reference to the portfolio analysis, describe any major risks in the country and implementation environment that might negatively affect the performance of the proposed interventions including external risks, Principal Recipient and key implementers' capacity, and past and current performance issues. b. Describe the proposed risk-mitigation measures (including technical assistance) included in the funding request.
1-2 PAGES SUGGESTED RISKS AND MITIGATING MEASURES The country has developed a risk management plan (Attachment 33), which identifies risks at different levels namely, country and PR/SR levels. Highlighted below are some of the identified risks and mitigating measures planned and currently being implemented in specific programme areas. The table below presents a synopsis of the major risks, the mitigation measures and the key TA needs. CROSS CUTTING FINANCE: Significant work has been undertaken by the Global Fund and respective PRs to strengthen financial procedures and operating culture within the NMEP and SFH. A number of key initiatives implemented to mitigate financial risk include: - Non Retirement of advances: PRs across the portfolio were carrying historically high balances of unretired advances which exposed grant funds to the risk of theft or misappropriation. Malaria PRs have policy and retirement procedures to administer management of advances, which includes a 14 day retirement timeframe. An advance register is maintained, monthly ageing analysis conducted and remedial action is to be taken against institutions and staff who fail to comply (suspended disbursements, pay reductions etc.) - Price fixing and procurement procedures lacking transparency: Preferred supplier agreements have been negotiated for air travel ticketing and petrol. Fuel cards are in use with specified fuel stations. - Cash management and forecasting: Cash reconciliations are now to be undertaken on a monthly basis. PR's provided quarterly cash balance updates to the Global Fund and submit quarterly variance analysis (budget vs actual) as a pre-requisite to cash tranche release. - Asset Management: Fixed asset register is requested to be maintained. An LFA review is conducted on a semi-annual basis. PR SPECIFIC FINANCE SFH - The PR has generally performed well in the financial management of the grant. The PR continues to make good progress against issues such as external audit process and recommendations, challenges with monitoring of assets/inventory and tracking of budget expenditures. - Current absorption rate needs to be addressed including delays to implementation resulting in a high cash balance being carried through 2 consecutive quarters. The Global Fund has advised the PR to strengthen the working partnership between Finance and Programs department to understand the reasons for delayed implementation and address identified bottle necks. The PR will utilise available management tools, such as [monthly /quarterly] Variance Analysis to identify SDAs and cost categories which require specific attention. NMEP - Strengthening of the NMCP financial management system through restructuring, recruitment of qualified finance and internal audit staff, strengthening of the internal audit function, and ongoing reviews: - The PR has historically experienced significant issues in relation to the financial management of the grant including: accounting and use of accounting software, quarterly and annual reporting, external and internal audits, and SR financial management & oversight, but has made significant progress during the first half of 2014 in strengthening its Financial Management Systems capacity, with particular focus on the financial control environment. - The NMEP financial management system underwent a number of reviews and restructuring in 2013 with the objective of having a robust financial management system. There had been challenges experienced by the Finance department, especially in areas of staff capacity and competence and consistent adherence to procedures and application of controls, however, recent recruitments of a qualified accountant to head the finance unit and one additional staff to support the internal audit unit has helped to strengthen the control environment in NMEP. - The new National Coordinator has demonstrated strong commitment and leadership to address the recommendations and requirements made by the Global Fund, resulting from ongoing reviews to

date. The National Coordinator is at the forefront of implementing the necessary changes in the Global Fund project unit.

- Technical assistance and capacity building initiative covering the PR/national and state levels:

The Global Fund has been conducting dedicated outreach to mobilize Financial Institutions active in the countries where the organization operate to provide financial assistance and service-in-kind contributions to strengthen financial management capabilities of their implementers, extract more value from every dollar invested and infuse best practices to foster sustainability in our programs.

Ecobank Nigeria is entering into a partnership with The Global Fund that will seek to strengthen the financial management capabilities of Nigerian Principal and Sub-Recipients through the provision of Technical Assistance and Capacity Building expertise and services. Through a partnership with Accountants for International Development (AFID), ECOBANK, will leverage information and analysis undertaken by the Global Fund and Local Fund Agent on the Nigeria portfolio to design and implement a project plan over the remainder of 2014 calendar year.

As the Malaria portfolio is going through renewal under NFM, the objective is to prioritize key PRs and SRs within this portfolio. Risk-weighted Analysis has been undertaken by both ECOBANK and the Nigeria Country Team, which fed in to the development of the final list of SRs to receive Technical Assistance and Capacity Building which will be focused on the following areas:

- Budgeting, Forecasting, and Variance Analysis
- Software and accounting procedures
- Financial Reporting (Process, templates etc.)
- Cash and Treasury Management (FX and Cash management, including advance management)
- Process, Procedures & Non-Compliance (General)
- Audit (Internal / External)
- FMS and HR Structure/ Issues
- SR Oversight
- Payment Modalities (Cash, Bank & Mobile, credit cards)
- Asset Management

The project plan has been co-developed by the GF Nigeria Finance Specialist and ECOBANK. Implementation will commence the first week of July and is anticipated to run through to the end of current implementation period.

PSM: Procurement through Voluntary Pooled Procurement (VPP). The LLINs will be delivered to state level and in a phased approach to decrease congestion at the port and decrease other logistical challenges related to in-country transportation, as is being done for the other LLINs procured through Phase 2 funding delivered to state level and which has shown good results. Recent efforts to improve the VPP arrangement and collaboration between the PRs and the VPP implementers has resulted in improved delivery planning in Phase 2 – this will be key in planning the arrival of the LLINs at the LGA level, which has been indicated as paramount in previous campaigns;

- Timely identification and contracting of logistics agents as in past campaigns;
- The PR has built on lessons learned from overall campaign management and BCC activities which have fed into the current and future campaign planning and preparation. LLIN tracking tools have been developed

COUNTRY LEVEL				
Functional Area	Risk Identified	Triggers	Risk Rating	Mitigation Measures
Security	Security challenges and threats in the north eastern states	Poor education Poverty Ignorance Terrorism	High	a) Advocacy to states to increase funding for education and on poverty eradication programmes b) Government set up ad-hoc committees for continuous negotiations and dialogue with the concerned groups/bodies Intervention of regional and international governments c) Declaration of force majeure by PRs under the circumstances where the risk of

				implementation can no longer be managed or mitigated
Election	Uncertainties around upcoming elections in 2015	Political differences Acceptability of election results	Medium	Education of the electorates and politicians by Independent Electoral Commission (INEC) and the National Orientation Agency Transparency and accountability by INEC in the conduct of and management of the results of the election will go a long way to douse tension.
PR/SR LEVEL				
Functional Area	Risk Identified	Triggers	Risk Rating	Mitigation Measures
Programme	Reduced staff strength	Inadequate staffing Inadequate capacity for grant implementation	Medium	Engagement of new staff; the planned recruitments exercise to be expedited LFA's capacity assessment to identify the capacity gaps and training needs of staff of NMEP and recommend appropriate staff circulations and training to address the risk Work plans would be introduced for all technical units (Finance, M&E and PSM) and staff assigned where appropriate to specific tasks and responsibilities. Demonstration of ability to carry out these tasks would be evaluated via performance management system. There would be regular supervision and follow up sessions within the technical units to assess weekly progress against tasks and provide support where necessary.
Programme	Inadequate follow-up of SR management and capacity building plan Weak coordination	Poor quality reporting from SRs; Poor coverage / oversight of SRs; Multiple activities occurring simultaneously.	High	Reporting template to include activities on SR management; Risk management plan to be incorporated into the original proposal; Quarterly PR/SR coordination meetings; SR focal points in NMEP to report on SR management to supervisors (reporting template); Regular spot checks on the SR including state SRs by the PR; Follow-up on GF SR spot checks to be included in SR capacity building/oversight plan; Internal Auditors to regularly check on the implementation of the SR capacity building plan; SR focal points in each team (PM and technical teams) to meet/exchange on regular basis on their states.
Programme	Delayed implementation of planned activities	Late release of funds; Lack of readiness of relevant stakeholders; Frequent impromptu meetings/compulsory engagements	High	Ensure prompt request for and release of funds; Plan all meetings ahead and minimize impromptu ones disrupting planned activities.
M&E	Poor capacity for M&E at sub-national level in terms of quality and quantity.	Poor political will/support for M&E; M&E low on state priority list; - Inadequate training; Skill gaps among M&E	High	Advocate for political support for M&E at State and LGA levels; Refresher training for newly posted staff; Advocate for commitment from govt. to retain trained staff in M&E even if such is relocated from one facility/LGA to another

		officers at National level		
M&E	Sub-optimal Data quality Assurance mechanism	Lack of updated Standard Operating Procedure for Data Management and Data Quality Assurance Tools; Lack of printed Standard Operating Procedure for Data Management	High	Update SOP and DQA tools; Print and distribute SOP
PSM	Stock out; overstock; expiry	Attrition of skilled personnel; Inadequate data for consumption based forecast; Varying reviewing periods; Uncertain/erratic supply of health products	Very High	PRs should buy into the ongoing harmonization and strengthening of the LMIS; Strengthening of the LMIS through quarterly PSM monitoring and supportive visits to States; Regular availability of data capturing tools at the sub-National level; "Broadening of training to involve more health personnel using the harmonized LMIS and provision for refresher training; Advocacy at all levels" Implementation of robust LMIS for informed forecast; Use of Harmonized LMIS; Optimization of the distribution of Health products. Integration of the distribution of antimalarial commodities with commodities from other health programmes
PSM	Poor-quality product	Poor infrastructure; Non availability of storage equipment in storage facilities (ACs, etc); Unavailability of standard operating procedures manual (SOP)	Very High	HSS Improvement for stores/ hire private warehouses where necessary; Develop SOPs and implement them;
PSM	Losses (pilferages, damages, expiry)	Poor inventory management system; Inadequate security measures	Very High	Roll out Harmonized LMIS and Supervision
Finance	Cash & Treasury Management	High level of Advances; Poor Documentation	High	Enforcement of retirement, e.g recover from staff salary; Blacklist staff with unretired advances; Use of internal auditor to identify non retirements on a regular basis and to escalate to senior management; Staff with unretired advances would not be paid for new activities; Proportion of advances (75%) to be released to staff , while 25% balance attached to retirement of advance.
Finance	Transaction Processes	Non-Retirements of advance payments made to non-NMEP staff for field work outside Abuja; Bulk Cash Payments	High	Payment for field work by non-staff are to be made by NMEP finance officers on collection of financial receipts and other means of verification; Collation of bank details of non NMEP staff to enable direct payment; Insurance cover of staff; Provide additional security at the paying venue (e.g mobile police); Improved mechanism for disbursement; Payment to service providers such as hotels and travel agents to reduce bulk payments/cash
Finance	Low Burn Rate	Delay in retirement	Mediu	Aging analysis on advances; Regular follow up

		of advances (Both Staff and Project); Inadequate documentation without supporting documents; Delay in procurement and payment for commodities through VPP; Poor planning; Delays in approvals from the GF; Delays in approval and payment process within the NMEP; Late Expenditure Reporting	m	on outstanding retirements; Strict adherence to policies and procedures; Use of internal audit to enforce established procedures; Enforce retirement of outstanding funds with adequate supporting documents before further advances are given; Long outstanding unretired advances should be deducted from staff salaries; Timely communication about delays to GF; Early assessment and signing of agreements between the PR & SRs to reduce the time-lag between grant signing between the PR and GF and implementation by the SRs; Proper planning
Cross Cutting	Weak Coordination	Vertical programmes Inadequate funding Poor implementation of coordination framework	High	Coordinated planning and implementation of programmes and activities Provision of adequate funding for coordination activities Regular coordination meetings
Cross Cutting	Inadequate staff capacity	Non-availability of structured training plan Inadequate funding	High	Appropriate training for Programme staff
TA Needs				
1. TA to build capacity of relevant staff on risk management 2. TA to support development of sustainability plans/strategies for increasing state Government financing for malaria 3. TAs to support Quantification, Data Management; Integration of Supply Chain & Pre-qualification of laboratory				
Performance of the PRs has consistently shown improvement by the public sector (a performance of C, B2 & B1 for Periods 10, 11 & 12 respectively) while the private sector achieved A2, A2 & B2 for the corresponding period.				

CORE TABLES, CCM ELIGIBILITY AND ENDORSEMENT OF THE CONCEPT NOTE

Before submitting the concept note, ensure that all the core tables, CCM eligibility and endorsement of the concept note shown below have been filled in using the online grant management platform or, in exceptional cases, attached to the application using the offline templates provided. These documents can only be submitted by email if the applicant receives Secretariat permission to do so.

- ☑ Table 1: Financial Gap Analysis and Counterpart Financing Table
- ☑ Table 2: Programmatic Gap Table(s)
- ☑ Table 3: Modular Template
- ☑ Table 4: List of Abbreviations and Annexes
- ☑ CCM Eligibility Requirements
- ☑ CCM Endorsement of Concept Note