Political economy analysis for malaria programming in Nigeria

AUGUST 2021

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UKaid disclaimer: This material has been funded by UK aid from the UK government; however, the views expressed do not necessarily reflect the UK government's official policies

Summary

This political economy analysis (PEA) was undertaken for the Support to the National Malaria Programme in Nigeria 2 (SuNMaP2) and National Malaria Elimination Programmes to gain a better understanding of government stewardship, the prioritisation and allocation of public funding, decision-making processes in the country's health systems and the role of the private sector. The objective of the PEA is to have a shared understanding of the political and economic contexts for decision-making about policies and implementation in the malaria elimination subsector of the Nigerian health sector and its impact on performance. The study used a mixed-methods approach that included a desk review; mapping of key stakeholders and institutions; and collection of primary data through key informant interviews and focus group discussions (FGDs).

Key findings

Lack of political commitment to the malaria response presents constraints in attaining targets on malaria elimination in Nigeria.

The current structure and placement of the malaria programme is suboptimal and, therefore, limits the capacity of the malaria programme to effectively engage through a sector-wide approach for effective implementation especially for cross-cutting interventions.

Health is not seen as a priority — neither politically nor by citizens. There is, therefore, a need to create awareness on the right to advocate for health as a fundamental right and political priority. This should involve engagement of civil societies to support advocacy approaches, demanding accountability and raising awareness.

Politicians need to be better informed and educated about health and economics, as well as the importance of fostering healthy communities and the consequent effect on economic growth.

Domestic financing support for malaria is inadequate and there is high dependency on donor funding. Over the years, many health programmes have been heavily funded by donors supporting programmes on malaria, tuberculosis (TB), HIV etc. Although donor support is important, this is mostly unsustainable and has debilitating effects on programme continuity. Consequently, the government deprioritises funding for health programmes including malaria. However, with recent reprioritisation of donor support, there is an increasing threat to the management of health programmes and its effect on mortality and morbidity.

Systemic and functional challenges present constraints for malaria programming. These include:

- Poor coordination of platforms that enable effective engagement with other sectors and programmes and more integration with other units, such as primary health care. This also includes poor coordination with the private sector, which is key to supporting and providing needed services to malaria programmes
- Inadequate and poor capacity of human resources affects access to quality care and health services
- Poor supply chain management processes; commodity management in malaria programming remains a major cause for concern due to poor coordination that results in weak accountability for supplies and stock-outs

- Limited capacity to engage in advocacy and behaviour change communication. The PEA identified this as a key barrier to effective engagement with government authorities to negotiate needed reforms for malaria programmes.

We have applied the PEA as a tool to unpack the politically and economically related factors that are key to scaling up malaria programming, and to identify those factors that impede its progress. The analysis should help the programme identify how it can promote positive change towards a sustainable national programme and which approaches may be effective in giving malaria greater importance on the policy agenda.

Introduction

Political economy analysis (PEA) has been defined as an assessment aimed at understanding the political dimensions of any context and actively using this information to inform policy and programming. Politics is the formal and informal way through which contestation or cooperation occurs in a society. Political processes are dynamic and occur at all levels of society. PEA involves looking at the dynamic interaction between structures, institutions and actors (stakeholders) to understand how decisions are made.[1]

PEA is being used increasingly as a key tool to understand governance, how decisions are made and implemented, and what drives health systems organisation, priorities and performance. It aims to situate development interventions within an understanding of the prevailing political and economic processes in society — specifically, the incentives, relationships, distribution and contestation of power between different groups and individuals. PEA can help projects to be more effective by identifying political, economic, social and cultural factors that drive or impede reforms, and to use these findings to inform, design or adapt programming. When purely 'technical fixes' alone are not meeting expectations, a PEA should also help to understand:

- political and economic approaches to programming: why change is/isn't happening
- where positive change is emerging and why
- what those with power want (or don't want)
- how, where, why and when to improve programmes, what should be done and who should do so
- how to achieve better outcomes (technically sound, politically possible)
- how to identify a set of feasible recommendations to address or mitigate against the challenges.

The overall purpose of PEA for malaria programming is to have a shared understanding of the political and economic contexts for decision-making about policies and implementation in the malaria elimination subsector of the Nigerian health sector and its impact on performance.

The PEA focuses on gaining a better understanding of government stewardship, the prioritisation and allocation of public funding, decision-making processes in the country's health systems and the role of the private sector. This analysis should help the programme identify how it can promote positive change towards a sustainable national programme and which approaches may be effective in giving malaria greater importance on the policy agenda.

Rationale for political economy analysis for malaria programming

The original interest in PEA arose from the realisation that highly technical (usually input-based) development programmes often did not work well. In particular, donors would rally around a reform process, providing technical advisers and funds, only to see the planned changes stall and disappear. This would usually be written off as a lack of 'genuine political will'. PEA is the attempt to find out what is really going on in a situation, what lies beneath the surface of the immediate problem (for

[1] Department of Foreign Affairs and Trade, Australia. Political economy analysis: Guidance note. Australia: DTAF; 2016.

example, whether competing interests exist).[2] According to the World Health Organisation (WHO), incorporating PEA into health financing reform processes can help policy makers develop more effective approaches to navigate political challenges that arise when introducing policy change.[3]

The Nigerian National Malaria Strategic Plan (NMSP) 2014–2020 had the ambitious aim of achieving pre-elimination status and reducing malaria-related deaths to zero by 2020. Although the aim was not achieved, there was a substantial reduction in the prevalence of malaria from 42 percent in 2010 [4] to 23 percent in 2018 [5]. Despite this progress, malaria remains a major public health problem, with 97 percent of Nigeria's population at risk from the disease. Intervention coverage is still low for the most vulnerable groups, and access is inequitable. Children and pregnant women are the most at-risk populations and regional variations exist, with the northwest region having the highest prevalence and the south the lowest.

The Nigerian National Health Account 2017, estimated total expenditure on malaria at N1.9 trillion ($5.3 billion) with out-of-pocket (households) payment accounting for 78 percent of all malaria spending.[6] This expenditure represents 44 percent of the current health account in 2017. Government's contribution to malaria prevention and treatment totalled 18 percent, with federal government contributing 12 percent, state government five percent and local government 1 percent. Donor contributions to malaria control spending in 2017 are estimated at approximately four percent.[5]

The scale-up of malaria control in Nigeria so far has generated significant results from implementing 'low-hanging fruit' interventions, such as universal distribution campaigns of long-lasting insecticidal nets (LLINs). However, resource constraints present a serious challenge to both maintaining and progressing malaria control and elimination. A 2012 systematic review of malaria resurgence events in 61 countries showed almost all events were attributed at least in part to the weakening of malaria control programmes, primarily due to resource constraints.[7] More recently, the World Malaria Report of 2017 and 2018 also shows a resurgence that could be attributed to reduction in donor funding for malaria in Nigeria over the same period. Thus, it is important that the federal and state governments commit to ensuring improved domestic resources in order to achieve sustainable malaria control.

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[2] Whaites A. Beginner's guide to political economy analysis (PEA). United Kingdom: National School of Government International; 2017.
[3] WHO. Addressing the political economy of health financing reform. [no date; cited 2021 Aug 23]. Available from: https://www.who.int/activities/addressing-the-political-economy-of-health-financing-reform. world_malaria_report_2013\en\ 2021.
[4] Nigeria MDGs Information System.
[5] National Population Commission (NPC), Nigeria and ICF. Nigeria demographic and health survey 2018. Abuja and Rockville, Maryland: NPC and ICF; 2019.
[6] Federal Ministry of Health. National health accounts 2017: Technical report. Abuja: FMoH; 2019..

Purpose of the study and methodology

The overall purpose of this PEA is to have a shared understanding of the political and economic contexts for decision-making about policies and implementation in the malaria elimination subsector of the Nigerian health sector and its impact on performance.

PEA is based mainly on a qualitative research methodology that identifies the relevant set of stakeholders, outlines the broad areas of enquiry and explores how the influence of key actors and institutions shapes the context for implementation. This study used a mixed-methods approach that included:

- A desk review of secondary data from reports, media, relevant national documents, SuNMaP2 documents, publications on political economy of health in Nigeria, World Bank and WHO, as well as other relevant publications was carried out to identify and describe the current political and economic context of the SuNMaP2 programme and inform the research design.
- In-depth interviews with key informants and FGDs were carried out at federal level and in the six SuNMaP2-supported states. The sample frame for key informants included: the elected and non-elected political leaders with direct and indirect influence on the health sector; legislators involved in budget-making and oversight; sectoral technical mandate managers; policy makers; agents of relevant departments and institutions; providers of services; clients; non-governmental organisations (NGOs); traditional authorities; religious and faith leaders; development partners; the private sector and interest groups.

Political economy analysis for malaria programming approach

Over the past decade, donor agencies and development organisations, aware that their efforts have often been compromised by ill-informed or simplistic assumptions about country context and sectors, are increasingly using PEA as a key tool to understand governance, how decisions are made and implemented and what drives health systems organisation, priorities and performance.

The PEA approach involves a pathway of change outlining a sequence of events, leading to a particular desired outcome. See Figure 1 below.

Figure I: Political economy analysis pathway of change diagram

Update existing and if necessary source new PEA

Iteration cycle 1

Iteration cycle 2

use PEA to unpack issues, understand root causes of blockages; Map and group issues according to root causes

PLAN IMPLENT

OBSERVE

REFLECT

PLAN IMPLENT

OBSERVE

REFLECT

Validate, challenge and/or adapt the project Theory of Change and Logframe

Problem Driven Iterative Adaption (PDIA) to plan and implement Political Economy Analysis (PEA) informent activities

The PEA for malaria was adapted to inform the Department for International Development (DFID)-funded SuNMaP2 programme on a strategic approach to improve the effectiveness of the National Malaria Elimination Programme (NMEP) by generating evidence on a situational analysis of government stewardship, philanthropic and private sector engagement and fiscal space analysis as key drivers of the country's health systems. The programme also assessed its progress on capacity development, transition to the NMEP and State Malaria Elimination Programmes (SMEPs) and mentoring of sustainability of malaria in NMEP and SMEPs. This presented an opportunity to identify where opportunities and barriers to sustainability and policy reform exist; how the programme can promote positive change towards a sustainable national programme, and which approaches may be effective in giving malaria greater importance on the policy agenda.

This analysis should then inform health-systems strengthening activities and the type of approach that will be used, with a focus on strengthening capacity and sustainability for malaria control in Nigeria, when DFID funding ends.

Many of the objectives of the SuNMaP2 programme imply institutional and cultural change and shifts in power dynamics, which are at the core of PEA. SuNMaP2 is interested in understanding how power, interests, incentives, values, beliefs and ideologies of different individuals and groups — at national and subnational levels — shape the context for implementation of the malaria elimination programme at federal level and in SuNMaP2-supported states.

Political economy analysis conceptual framework

The conceptual framework draws elements from the DFID,[8] Edelman[9] and Fritz et al,[10] as shown in Figure 2.

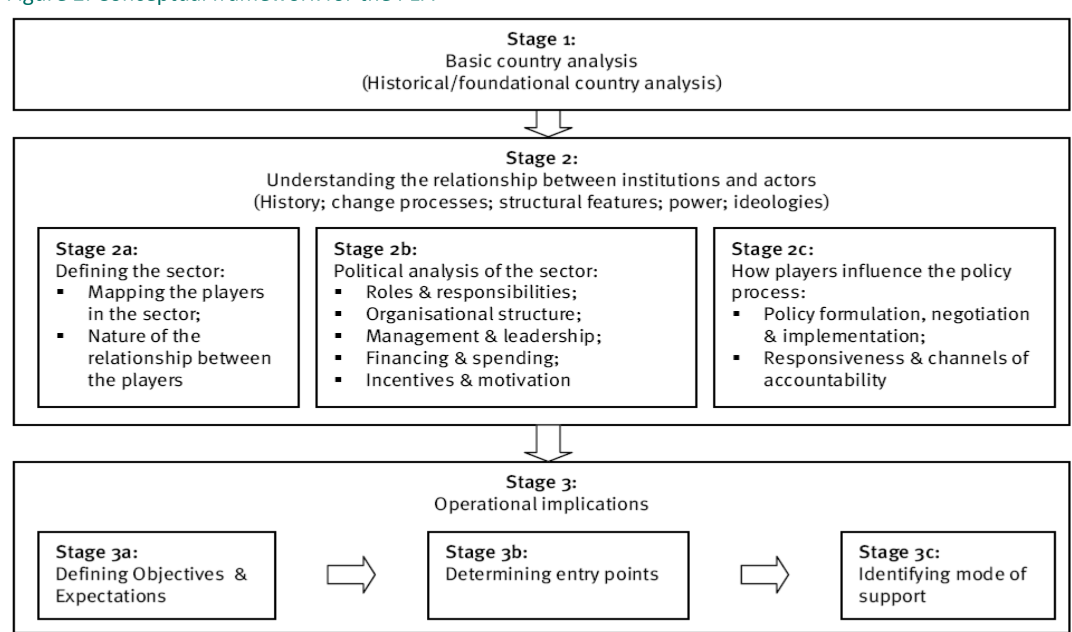
The PEA drew on available resources that could provide the necessary country-level analysis with more specific analysis from the data collected in the SuNMaP 2-supported states and from federal level stakeholders.

[8] DFID. Mapping political context: Drivers of change. Overseas Development Institute (ODI); 2009.

[9] Edelman D. Analysing and managing the political dynamics of sector reforms: A sourcebook on sector-level political economy approaches. Working Paper 309. London: ODI; 2009.

[10] Fritz V, Kaiser K, Levy B. Problem-driven governance and political economy analysis: Good practice framework. Washington, DC: World Bank; 2009.

Figure 2: Conceptual framework for the PEA



Applied political economy in the health sector involves the interrogation of perceived and actual power relations between key actors that directly or indirectly influence the allocation, distribution and utilisation of finite resources, or have the potential to do so. Statistical quantitative methods do not sufficiently allow for the exploration of why the cause and effect of those power relations exist, and how. As such, qualitative methods will form the mainstay of this study.

Therefore, data and information relevant to ascertain the PEA for malaria programming was extracted through primary and secondary research methods.

Results

Guided by the conceptual framework, the study findings were contextualised through a thematic analysis of 10 broad areas relevant to the PEA of the malaria elimination programme at the federal level and in the SuNMaP2-supported states. These areas were: governance, policy and leadership; health financing and resource allocation; health prioritisation; cross sector collaboration; health work force and quality; delivery systems and supply chains; advocacy and behaviour change communication; private sector involvement; civil society involvement and evaluation and adaptation (use of data and evidence for policy and planning).

Federal and state levels key findings

Although specific issues emerged from each of the 10 areas, there were also some important cross-cutting issues that were common to, or influenced by, all of the thematic issues.

1. Governance, policy and leadership

> "*People seem comfortable with the malaria story — there is an emotional acceptance and understanding regarding the importance of addressing malaria but in the end, they don't put their money where their heart is."* (Stakeholder)

Lack of political commitment and the knowledge of the importance of engaging with stakeholders with political influence contributes to impeded progress on attaining goals for malaria elimination.

High-level advocacy has been lacking and is critical for visibility and attention to malaria programming. Politicians and governors can influence priorities and budget once malaria is high on the political agenda and seen as politically attractive.

> *"Budget allocation really depends on who is sitting at the helm of affairs at state level."* (Stakeholder)

The malaria programme is not structurally well positioned
Although the NMEP leadership is technically competent, it is limited by bureaucracy, the programme not being structurally well positioned and by having four levels of reporting before the Minister of Health. It was reported that only the Ministry of Health (MoH) is involved in the NMEP, whose coordinator is not empowered to call on other ministries (this is also reflected in the lack of cross-sectoral collaboration of the NMEP and SMEPs). Compounding this is the view that the NMEP appears detached from the Federal Ministry of Health (FMoH); there is also a disconnect with other relevant departments and agencies that includes the hospital management board, the Food and Drug Administration, the MoH, the National Health Insurance Scheme, public financing systems and communication agencies.

2. Health financing and resource allocation

> *"Health has low political priority — no demands or expectations from the population."* (Stakeholder)

A cross-cutting issue for health programmes is that health is not seen as a priority — politically or by the citizens — and citizens need to be sensitised about their right to advocate for health as a fundamental right and political priority. Health is seen as a humanitarian issue by the political class

and there is no real demand or expectation for health services by the population — as illustrated by Nigeria's poor health indicators, despite several years of economic growth.

Politicians need to be better informed and educated about health and economics
Key informants emphasised the need to address poor understanding of health economics and the relationship between healthy communities and economic growth (stability). Improved knowledge of financing and advocacy strategies is essential, as well as ensuring there are improved National Health Account reports from the Department of Planning Research and Statistics, which is required for key decision-making processes.

An integrated health systems approach is needed
The issues and challenges with leadership at the federal level are not unique to malaria; the same issues occur in many programmes. These include challenges in mobilising domestic resources for health programmes; accountability issues; inadequate attention etc. Key non-state actors expressed concern and the need for a health systems approach that harnesses the overall health financing needs rather than individual diseases and programmes. This, however, required support and commitment from an effective political system as a key enabler.

Domestic financing support for malaria is inadequate and dependent on donor funding
Many health programmes have been heavily funded by donors over many years and, as a result, infrastructure has been created around these programmes, e.g. malaria, TB and HIV. Although donor support is important, it polarises the system. Consequently, the government allocates funding to other sectors. However, as donors increasingly become fewer, the challenge persists on how to change the narrative and increase the government's commitment to health.

Key informants were unanimous in voicing that the country needs to allocate resources to encourage increased involvement in decisions on national priority, but several current issues need to be improved. The allocated budget release is poor and counterpart funding for Global Fund (GF) programmes is not released, accompanied by inadequate commitment at state level for co-financing.

Illustrative examples

Jigawa: There had been significant improvements in the quality of financial management marked by a major increase in the health budget and good performance in budget execution, until recently. The overall health budget was 10 percent — 12 percent for the last three years — and in 2019, only 3.8 percent of the health budget was for malaria. Although the state governor and the local government levels have committed to support the malaria programme, to date, the programme is almost entirely donor funded.

Kaduna: The PEA findings showed that all malaria interventions in the state are 100 percent donor driven. This means that the state has no budgetary allocation or any support directly

focusing on malaria elimination or reduction, despite the strong focus on improving primary healthcare in all political wards in the state.

Kano: The state has made a considerable effort to secure funding for the SMEP. This is evidenced by the dedication of 15.7 percent as health sector budget (this is above the WHO/African Union Abuja Declaration of 15 percent of the annual budget to health), and there are also efforts to ensure extra-budgetary allocation to the malaria elimination programme through Kano State Health Trust Fund, the Drugs & Medical Consumable Supply Agency, Saving One Million Lives (SOML) and the Health Contributory Scheme, among others. However, at the local government, the majority of the key stakeholders stated a need for more funding for the malaria elimination programme, as most local government areas (LGAs) depend on donors, especially GF for LLINs, drugs and testing kits.

Katsina: Malaria elimination in the state is currently funded wholly by international donor organisations with little or no support from either state or local governments in Katsina state. More funds will be set aside for malaria eradication programmes after obtaining approval from the state governor.

Lagos: The state government is committed to funding malaria programmes that are beyond the scope of donor agencies' support. In the last few years, the state received support from projects funded by the Foreign, Commonwealth & Development Office (FCDO), such as SuNMaP and SuNMaP2.

Yobe: The current leadership has shown commitment in terms of providing an allocation of about 12 percent for the health sector in 2020; however, to date, this has not been implemented and funding has not been released. Moreover, it transpired that over 50 percent of the funds that were released were for infrastructure rather than for service delivery or strengthening the quality of human resources for health. The disparity between leadership commitments in providing the required allocation of funds and the lack of demonstrable action could be attributed to the state's reliance on donor funding, e.g. from the World Bank assisted by the SOML programme and the Nigerian State Health Investment Project. There is a potential adverse effect on sustainability due to over-reliance on a single funding stream that may decline when donor support is no longer available.

3. Health prioritisation

> *"Relevant to other sectors, the health sector is relatively well allocated — what we need to focus on is the efficiency in the use of resources available to the health sector."* (Stakeholder)

There is insufficient advocacy from the political class and those who influence them at the federal and state level, resulting in low prioritisation of malaria interventions.

Illustrative examples

Jigawa: Governors' personal interests, working styles and resources can influence health priorities and whether reforms are initiated and funded. Access to governors by politicians or senior officials, through formal or informal means, is important to ensure support for adaptations that may be needed for an effective, sustainable SMEP.

Kaduna: The government consistently emphasised the need to prioritise education and health, especially during campaigns. Judging by the policy goal direction of the government, malaria is not a priority. In addition, interventions that have counterpart funding get more attention from the government.

Kano: The state government has prioritised healthcare financing through budgetary and extra-budgetary allocation by setting up agencies that could pull funds from the state, LGAs and private sector to ensure proper and adequate funding for the health and malaria control programme in the state.

Katsina: Malaria programmes are affected by weak presence as a policy priority — lacking policy prominence, bureaucratic power and budgetary allocation.

Lagos: The PEA study has shown that Lagos state incorporates a group of strong and resilient political actors who are effective change agents and are willing to maintain a stable political stance and environment. Importantly, the study has shown that there is effective political will from the state government, the local government chairpersons and other critical key stakeholders interested in public health — who believe that the cause for malaria elimination is a justifiable one, along with corporate responsibility of all stakeholders. Interviews with key

informants and FGDs confirmed that healthcare and health sector funding are at the top of the state'spriority list.

Yobe: There is little evidence that the technical leadership at different levels has put any effort into engaging political leaders on the need to fund the health sector.

Prioritisation is based on evidence, communication and advocacy efforts
The bulk of the federal health budget goes to tertiary care as well as the National Primary Health Care Development Agency (NPHCDA) for immunisation and services at the primary healthcare (PHC) level, where the need is perceived to be greater. Health priorities are related to the level of advocacy, communication and evidence as well as taking the right messages to politicians. Priority setting and budget allocation for malaria are the primary responsibility of the FMoH.

Advocacy to influence politicians and national assembly for malaria has been weak
Respondents were unanimous in their opinion regarding the lack of advocacy by the malaria programme and its partners to engage politicians and the national assembly.

> *"Malaria is not a high priority and apart from World Malaria Day, you hear nothing about it in the media."* (Stakeholder)

The issue of health economic understanding was re-emphasised and it is clear that politicians' interests can make or break programmes.

4. Cross-sector collaboration

Vertical silos of health programmes and conflicting messages from donors on integration into primary healthcare or focus on high burden diseases
The key message is that there is a crucial need to move from the vertical, donor-driven programmes towards better integration with PHC and cross-sectoral collaboration. Malaria, HIV and TB are vertical programmes and there is little or no cross-collaboration, even with other relevant ministries. Most of these programmes are managed vertically, both in terms of structure and funding, and this is seen as a major barrier to the development of sustainable national and state malaria elimination programmes.

Illustrative examples

Jigawa: It was observed that the working synergies between the various government ministries and departments have many gaps in terms of interagency collaboration on malaria. We found that the Ministry of Environment is not involved directly in the policy formulation for the malaria

programme in the state. This shows that multi-sectoral collaboration is a major challenge in the state as ministries, such as that of the environment, are relevant to the success of the programme.

Kaduna: The state has over 50 development partners working in and supporting different sectors with 40 intervening in the area of health and five working towards the reduction and elimination of malaria in the state. However, the presence of the multiple development partners does not translate into maximum performance. Despite recording some successes, progress has remained slow.

Yobe: Malaria programming is mostly conceptualised and planned centrally without necessarily involving local and community stakeholders. Verticalisation of the structure of the malaria programme is a key problem.

More integration with PHC/NPHCDA

The NPHCDA is expected to deliver a sizable portion of malaria interventions — but at present, the collaboration is not very effective.

"*The current disjointed investments across states are not working, there is a need to bring implementation of programmes to the PHC platform.*" (Stakeholder)

There are opportunities for the malaria programme to take advantage of the fact that the PHC sector is also focused on the community and to move from the malaria-specific community health workers to a more integrated approach to help address barriers to access to services.

5. Health work force and quality

> *"There is a need to improve the provider's behaviours in order to ensure public trust."* (Stakeholder)

Major gaps in health services and materials remain

The challenges of inadequate human resources cut across the whole of the health sector and are not limited to malaria programmes. However, it was reported that there is a limit to what the FMoH can do about the inadequacy of staff across the country due to the federal structures and architecture of the Nigerian health systems.

Human resources are not equitable across states

Human resources are not equitable across the states, with the lowest in the northeast. Moreover, the issue of vertical programmes also leads to compartmentalisation of health workers, which

aggravates the human resource problem. In general, health workers are perceived to have good skills and task shifting was recommended as a way to address the lack of a trained workforce.

Concerns about the health service providers in the public sector's behaviour were raised as *"inputs do not guarantee good service*", and it is perceived that, as the private sector providers receive better incentives, they tend to have better attitudes.

Illustrative examples
Jigawa: The challenges reported by earlier studies still remain in terms of human resources — the state still suffers from a shortage of skilled professionals — service delivery, oversight, monitoring and effective use of data.

Kaduna: For the health sector to function optimally in Kaduna, the health system would require about 16,000 health workers. Currently the state has 5,251 health workers, just about one-third of what is needed. In addition, personnel often decline deployments to rural communities and prefer to work within the state capital or other urban centres.

Lagos: The state health workers are well motivated, though staff numbers are declining due to migration outside the country.

Yobe: There is a strategy to increase the number and quality of lower cadre healthcare workers, midwives and nurses through the state's policy Human Resources for Health Policy (supported through the FCDO-funded Women for Health programme).

6. Delivery systems and supply chains

Multiple players in supply chain management; lack of cohesion and supply chain related interventions are mostly donor driven and dependent
The issue of over-reliance on donor driven programmes also affects the malaria supply chain. Logistics and commodity management in the malaria programme remain a major cause of concern, with different models resulting in problems in reconciling consumption with the supply chain. In some states, like in Jigawa and Lagos, there are two systems side by side: on the one hand, for example, USAID and the GF procure commodities and Axios distributes to health facilities; on the other hand, the drug revolving fund (DRF) system, where state central medical stores (CMS) procure drugs, sells them at subsidised rates and recycles the funds.

Problem with inadequate supplies of rapid diagnostic tests, quantification of malaria commodities

> *"If there is no product, there is no programme. It is critical that funding for the procurement and distribution of drugs becomes timely and predictable."* (Stakeholder)

Malaria commodities are of high market value and it was reported that accountability and management have been difficult. In all states, rapid diagnostics test supplies were reported to be inadequate and other malaria commodities were often out of stock. This points to a fundamental problem with the current system for quantification and forecasting. At the federal level, more than 80 percent of the NMEP budget is used for malaria commodities. Stakeholders are of the opinion that the NMEP needs to be more proactive and insist on the appropriate commodities and funding for efficient supply chain management.

Partnerships with the private sector for supply, procurement and distribution

> *"Our problem is that we do not persevere, we do something and at the first setback, we abandon it and move to another strategy."* (Stakeholder)

The DRF system is used in those states not supported by donors, and findings from Lagos, Jigawa and Sokoto provide good examples of how this system can be efficient. There is a need for a strategy for DRF schemes that are competitive with retailers, manufacturers and states to be linked together to drive down the cost of malaria commodities. Likewise, to improve distribution of malaria commodities from the CMS, it is suggested that government should partner with the private sector to set up efficient push systems to improve processes for ordering, tracking and delivery.

Opportunity to collaborate with the Governor's Forum
There is an opportunity here for the NMEP to collaborate with the Governor's Forum, which is responsible for the implementation of the Basic Health Care Provision Fund, and explore how malaria can be streamlined into it. Perhaps anti-malaria availability could be used as a marker to define functionality of any PHC.

States should drive the use of bed nets with minimal support from federal government and donors
There are reports that nets are used for non-medical purposes and that culture and beliefs affect usage of bed nets from state to state. These are issues that need to be addressed through behaviour change communication, which can be coordinated at state level. Therefore, the responsibility for net distribution by states, with minimal support from federal government and donors, was strongly encouraged. Distribution by NGOs and private entities can be supported by faith-based organisations at the state level. The issue of provision of nets can also be linked to state leadership and governance, where support for malaria is seen as politically important.

7. Advocacy and behaviour change communication

Health communication is fragmented; legislators and politicians hear the strongest voices
One clear message throughout this PEA is that the NMEP and partners are not doing enough to advocate for malaria issues to political stakeholders, legislators and the media. Communication is key and implementing partners supporting malaria programmes, as representatives of the people, need to engage with legislators to improve programme awareness and oversight. Better communication tools that can educate stakeholders and show that malaria is a priority health

problem should be developed. For example, a cost-benefit analysis in terms of national savings and direct-cost impact on the economy would be effective.

Malaria partners need to develop a framework for key messages that would be delivered to appropriate stakeholders. Advocacy guidelines should also be developed which should include a clear definition of success.

Illustrative examples

Jigawa: Although communication and sensitisation on health — particularly malaria — was reported to be effective at the LGA level, advocacy and mobilisation of resources are not being addressed at state level. Civil society organisations (CSOs) seem to be involved in raising awareness and in assisting insecticide-treated net/LLIN distribution.

Kaduna: There are vibrant and numerous CSOs/NGOs involved in health interventions in the state. They contribute immensely in awareness raising and support advocacy and mobilisation. Although there are no malaria champions in the state, the governor's wife and the deputy governor have previously been named as ambassadors during commodities distribution.

Kano: Some civil societies work with government and donors to ensure the effective delivery of malaria commodities, consumables and public enlightenment. In addition, CSOs have also been able to hold the government accountable and to push for more funding for the malaria control programme.

Katsina: On the service delivery side, politicians' commitments are centred on the distribution of patronage rather than broader provision of public goods; while on the demand side, citizens only respond to commitments that they believe are credible.

Lagos: The social media space is known to be lively and actively trending, with various platforms being used to engage the governance and policy makers in the state. Twitter handles and Facebook pages are all used to generate conversations around good governance principles and practice. There is strong presence of large faith-based religious institutions in Lagos state, with vibrant state chapters in the large city that are willing to be engaged.

Yobe: There is little evidence that the technical leadership at different levels has put any effort into engaging political leaders on the need to fund the health sector.

The population needs to be empowered to recognise health as their right: *"Without doubt, the civil society needs to be re-positioned for accountability and community advocacy."*
Malaria is often considered to be anormal situation, a recurring disease people see as common — hence, it is often not taken seriously. There is a level of complacency about the disease so the population needs to understand that they can, and should, demand health as a right.

Advocacy through the media needs to be funded
It was pointed out that advocacy through media outlets needs to be funded. "*The media in Nigeria is dominated by politics and now by COVID-19."* Journalists are poorly paid and make money through paid assignments; communication strategies to promote programmes need to take this into account.

8. Private sector involvement

The private sector needs coordination to be effective
Unlike some other disease programmes, there are no malaria champions at national or state level. Some private sector foundations, companies and individuals support malaria control efforts — the Dangote Foundation being the most visible and involved at present, both at the national and state levels.

For private-sector providers, support to supply free commodities and the implications for the commercial market are issues that need to be addressed if they are to play a greater role. The leakage of free commodities from the public sector compromises private-sector investments. However, respondents agree that the capacity for the NMEP to develop robust public private partnerships needs to be strengthened.

Private sector should be involved at the beginning of planning — not as an afterthought — so they know what is expected
The private sector should be more involved, particularly in the planning stages of malaria programming. They need to know what gaps they can fill and what the expectations are. The incentives and motivation for the private sector need to be clearly understood and taken into account.

9. Civil society involvement

> *"Civil societies in Nigeria are no longer active like in the military era, they are not holding us and the partners to account anymore. This for me is important for our system to grow and to keep us on our toes."* (Stakeholder)

Voice for malaria is needed: "*They should demand accountability and represent the voice for quality service, service coverage and promote use of services*."

Unlike HIV/AIDS, malaria does not have a strong civil society group or voice. Although the Civil Society for Malaria Control, Immunization and Nutrition (ACOMIN) is known for its links to malaria, it is perceived to be focused on GF project implementation rather than acting as a voice on broader malaria programming. Lessons from the polio response have been mentioned by several respondents: *"Nigeria also needs to create a sense of urgency for malaria elimination leveraging on the momentum created by the polio elimination."*

Nigeria's budget preparation involves a public platform for all sectors. This presents an opportunity for civil societies to engage relevant committees and make a case for malaria. However, ACOMIN and other civil society groups are unable to function without donor support, and this has implications on the sustainability of their roles.

The Health Reform Foundation of Nigeria is an example of a good CSO that has pushed for some changes in the health sector; but, at present, malaria is not one of their focus areas.

10. Evaluation and adaptation (use of data and evidence for policy and planning)

Relevance for planning and policy

Though data and information on malaria are used to the greatest extent possible for planning and policy revision, financial data are poor and not usually shared. However, concerns have been raised on quality of data and the applicability of global models to the Nigerian context. Respondents expressed concern over reliance on survey data that may not be reflective of evolving situations, and on reliance on WHO's approach for programme modelling, which may not be as effective in some cases.

Sustainability

PEA presents valuable findings and evidence on key issues relating to programming and is instrumental in instituting reforms, including decision-making and policy reviews. Findings from the PEA for malaria programming highlight strengths and gaps while recommending key mitigation strategies. The PEA can, therefore, be adapted for annual and mid-term reviews as a supplementary tool for harnessing and conducting robust analysis in relation to the political and economic impacts of malaria programming. It can be used in addition to other systemic reviews to present holistic findings and inform more strategic planning.

Recommendations

Studies on PEA have noted that while approaches and findings differ based on country context, there are key strategic factors to be considered. These are governance structures and systems; stakeholder engagement processes; other systematic functions such as supply chain; and human resources.

The PEA for malaria programming takes into account a robust mix of approach and methodology, thereby ensuring quality and validation data and information collated during the process. The PEA is, however, an exercise with a finite duration. As a result, findings may be limited due to certain externalities. Key recommendations to consider for a PEA process include:

- **Sensitivity of the subject matter**: PEA data and information extraction involves accessing highly sensitive materials, including budgets and political reports. Hence, careful judgement is required on the feasibility of accessing and utilising applicable materials and complying with governing laws on information sharing of sensitive materials. The PEA should be conducted in close collaboration with relevant governing bodies to provide guidance on accessible applicable data. Analysis of findings should be validated for verification and acceptance of outcome by key stakeholders.
- **Adaptability of approach**: Defining the PEA approach to inform methodology and reporting of findings is key to effective management of the assessments. The PEA for malaria programming methodology was adapted from the Fritz et al PEA conceptual framework. However, findings have been contextualised based on key thematic areas relevant to health systems and programmes. This presents an appreciable analysis relevant to context and applicable for informing necessary reforms.
- **Analysis and reporting period**: PEA revolves around certain dynamics that evolve over time. Key to this is the political space and economy. Hence, it is necessary to conduct a PEA within a 'safe period' to ensure findings are reflective of the situation at the time of study. A key limitation to this study included impacts of the COVID-19 pandemic on the assessment approach, which included engagements with stakeholders. Management of this challenge through efficient and viable alternative methods such as virtual engagement has proved to be effective and instrumental to the timely conclusion of the analysis — thereby limiting potential risk of presenting skewed findings as a result of unforeseen systematic changes.

Lessons learnt

The success of the PEA could be attributed to the participatory process, which involved collaboration with the NMEP and FMoH. This was important as relevant materials were accessed and proper guidance was received on managing issues pertaining to sensitivity whilst conducting the study.

The PEA approach was built around a conceptual framework and methodology. This included desk review and stakeholder engagement. The study was conducted in 2020 during the COVID-19 pandemic. This presented setbacks for stakeholder engagement. However, alternative means of engagement via virtual platforms were leveraged, which was instrumental to ensuring discussions were held with key individuals. While this measure proved efficient in engaging with stakeholders, other planned assessments through site observation and field visits were not feasible, which limited findings relating to the outcomes of desk research and stakeholder discussions.

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