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## Key messages

- The national guideline on malaria-filariasis co-implementation in Nigeria is comprehended at all levels, but less so at the LGA and community levels than the state.
- Conversely, co-implementation was easier at the community and health facility levels than at the LGA and States levels.
- There is need for clearer definition and delineation of roles and responsibilities of team members for co-implementation to be better articulated.

## Introduction

Nigeria ranks third globally for lymphatic filariasis (LF) prevalence, with an estimated 66 percent of the population at risk. Some progress has been made on global efforts to eliminate LF by 2020 through mass drug administration (MDA), however, scale up of programmatic activities has been slow in Africa and there is a need for additional vector control strategies integrated with other diseases with similar epidemiology (e.g. malaria).

In 2013, Nigeria developed a National Guideline for Malaria and Lymphatic Filariasis Co-implementation. Malaria Consortium conducted an assessment to determine its usability by programme implementers in six local government areas (LGAs), one each from Ebonyi, Cross-river, Jigawa, Bauchi, Niger and Ondo states.

## Methods

- The guidelines were pilot tested to assess its clarity, structural flow, comprehensibility and usability for implementers at state, LGA, health facility and community levels.
- Trained field workers co-implemented mass administration of medicine (MAM) - mebendazole and praziquantel, and LLIN distribution in 24 communities across the six LGAs using the guidelines. Their perceptions were documented using data collection tools developed for this purpose.
- A mixed methods approach combining ethnographic techniques of observations, interviews as well as use of questionnaires to assess the usability of the guidelines in terms of clarity, comprehensibility and practicality of the instructions. The instructions covered planning and coordination, advocacy, mobilization, monitoring and supervision, logistics management and storage, budgeting and record keeping.

## Results

Results from the assessment showed that in all the states, implementers understood the guidelines **with varying need for explanation depending on the level of implementation**. Those at the state level were seen to better comprehend the guidelines than those at the LGA level and least so for those at the health facility/community level. The factors affecting comprehension included having prior access to the guideline to study it, understanding its purpose and at the community level, the language in which it was written.

Regarding practicality of the guideline, activity co-implementation was easier at the community and health facility levels in contrast to LGA and state levels. As responsibilities for service delivery and resources often overlapped at the community level, and as activities were often implemented for the communities themselves, there were fewer constraints at the community level in contrast to the state and LGAs where roles were more strictly defined.

At the LGA level, implementers expressed a lack of clarity about how to combine commodity estimation and ordering of supplies for LF and malaria. Defining who was responsible within a co-implementation plan needed further clarification, discussion and orientation of personnel at both state and LGA levels.

The processes described and the language used in the guidelines were found to be largely appropriate for its users, despite the small differences between states. Acceptance of the guidelines was universal among implementers at all levels.

However major constraints were found with the quantification of commodities for

both diseases and factoring in delivery lead times in supply ordering, harmonisation of data collection and reporting tools to aid co-implementation and delineation of personnel roles and responsibilities within the co-implementation plan.

**Table 1: Key findings across assessments domains**

Assessment domain	Findings
Comprehension of the guidelines by the implementers	Easily comprehended at the state level than LGA level and least so at the health facility and community levels
Structural design and user-friendliness of the guideline	Regarded as very easy to follow and use for teaching and planning co-implementation activities
Layout and appropriateness of the sequence of the steps in the guidelines	Having the right sequence and instructions presented step-by-step order was easy to follow
Practicality and feasibility of guidelines on co-implementation	Varied across levels; easier at health facility and community levels compared to LGA and state levels.



A community implementer interviewing a household

## Conclusion

The guidelines were found to be user-friendly, have the appropriate structure and instruction sequences for all levels. While the guidelines were comprehended better at higher levels of the health system, it was found to be more practical and feasible for implementation at the health facility and community levels.

Based on these findings, there is need for development and coordination of platforms, delineation and clarification of roles of implementers in MDA-LLIN co-implementation at all levels. Harmonisation of reporting tools, streamlined commodity logistics management at state and LGA levels, are also critical for the success of MDA-LLIN co-implementation.