

# Executive Summary

## A Situational Analysis of the Neglected Tropical Disease Programme in Nigeria: A case study of Ogun and Kaduna states

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### Nigeria Situational Analysis | Executive Summary

2

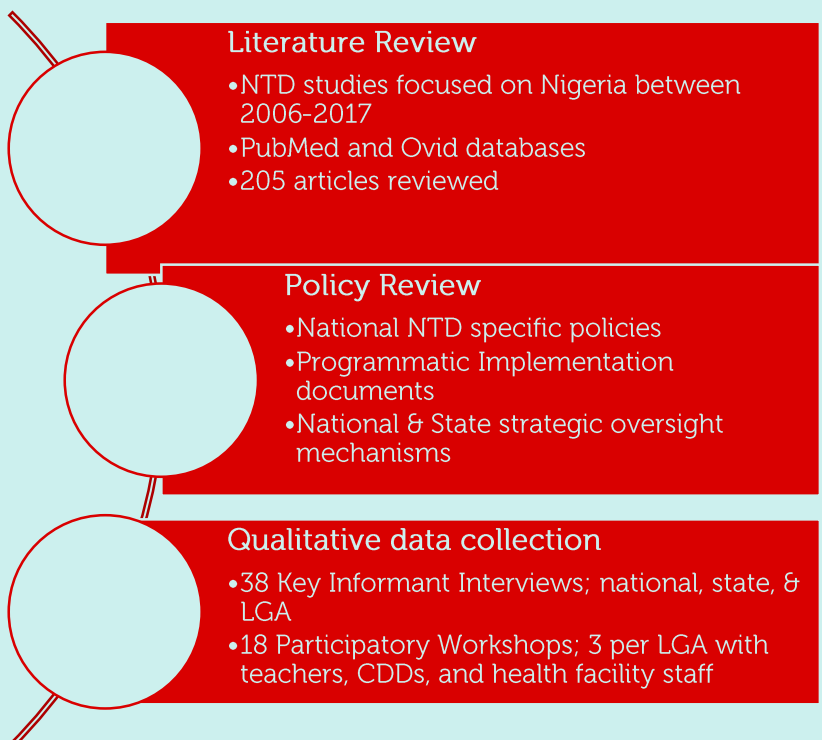
Nigeria has the largest burden of Neglected Tropical Diseases in sub-Saharan Africa, accounting for 25% of the continent's total Neglected Tropical Disease (NTD) burden<sup>1</sup>. The strategic goal of Nigeria's NTD programme is to progressively reduce morbidity, disability and mortality associated with these diseases using integrated and cost-effective approaches.

In 2012, the World Health Organization (WHO) released a roadmap for implementation aimed at 'accelerating work to overcome the global impact of NTDs'<sup>2</sup>. In line with the roadmap targets, coupled with country commitments following the 2012 London Declaration<sup>3</sup>, many endemic countries are striving to control and/or eliminate NTDs by 2020<sup>2,4,5</sup>. Nigeria's Master Plan for Neglected Tropical Diseases 2013-2017 was designed to achieve the WHO targets of controlling and eliminating specific NTDs by 2020 (NTD Master Plan, 2015).

The focus of control and elimination efforts has predominantly been the five NTDs that can be treated with preventative chemotherapy (PC), namely; onchocerciasis, lymphatic filariasis (LF), trachoma, schistosomiasis and soil transmitted helminths (STH)<sup>4,5</sup>. Despite this momentum, in many contexts there is a significant implementation gap between targets and slow progress to date<sup>4</sup>. To bridge that gap, it is now critical to understand factors that are hindering progress, and what can be done to scale up and speed progress toward these goals.

In 2015, the COUNTDOWN consortium, funded through the UK Department for International Development (DFID), was established with an overall goal of reducing mortality, morbidity, and poverty associated with NTDs<sup>6</sup>. The consortium is focused in four countries: Ghana, Cameroon, Liberia and Nigeria, and is conducting implementation research to address current NTD programme bottlenecks with a view to accelerate progress toward control and elimination of the PC NTDs.

COUNTDOWN conducted a mixed-methods situational analysis between February and April 2017. Kaduna and Ogun States were purposively selected for co-endemicity for four PC NTDs, and to ensure variation in programme support, progress to-date, and socio-cultural factors. Findings from a literature review, a policy review, and qualitative primary data were triangulated and synthesised to document the current strengths and weaknesses of the NTD programme in Nigeria and identify areas for future implementation research. A series of four briefs on the findings and recommendations of the study are available at <http://countdown.lstmed.ac.uk/>.





## Methods

### Situation Analysis Sites in Nigeria



**Kaduna State has a long history of INGDO implementation partners for NTD control, and higher levels of technical support and resources. Ogun has had inconsistent partner support and is just commencing its integrated programme.**

Three Local Government Areas (LGA) per state were purposively selected to achieve maximum variation in disease prevalence, programme impact (measured by geographic and treatment coverage), culture, and geography.

### Literature Review

To explore the breadth of literature relating to the PC NTDs in Nigeria, we searched for peer-reviewed theoretical and empirical literature through the PubMed and Ovid databases. Inclusion criteria were studies conducted and published between January 2006 (when NTD programme integration started) and April 20<sup>th</sup> 2017 (when the searches took place); focus on one or more PC NTDs in Nigeria; and the full text is available in English. Further details of the methodology and results are presented in the annotated bibliography, and a full list of citations is also available.

### Policy Review

Policies to be included in the review were identified through internet searches, key informant interviews, and snowballing. Each document was reviewed and grouped into a series of thematic areas linked to programme delivery. Documents were also reviewed as a set to understand how each linked together to shape a broad guidance framework for NTD programme delivery in Nigeria. The main output of this is a policy and programme governance summary.

### Qualitative Study

Key informant interviews were conducted with purposively selected stakeholders at the National, State and LGA levels. Informants included programme managers and coordinators; education secretaries; desk deworming officers; and directors at various levels in several state ministries (Local Government and Chieftaincy Affairs, Women's Affairs, Planning Research and Statistics, and the Universal Basic Education Board). Key informant interviews were semi-structured and covered topics including: job roles, successes and challenges of programme implementation, collaboration with other sectors, and recommendations for future areas of implementation research. Thirty-seven key informant interviews were conducted across the two states (13 Ogun; 18 Kaduna) and at the National level (6).

Stakeholder meetings that drew on participatory research methods were also held in each LGA. Three meetings per LGA were held: one with teachers, one with community drug distributors, and one with frontline health facility staff. Meetings included on average 15 participants from the specific cadre, who were further divided into smaller groups and asked to reflect on the strengths, weaknesses, challenges, and areas for future research for the NTD programme. Smaller groups then fed back to the plenary to allow for broader group dialogue and discussion. Nine meetings were held in each State.

All key informant interviews and stakeholder meetings were recorded with consent, the recordings were transcribed verbatim, and a sample were 'back translated' for quality checking. Data was analysed using a thematic framework approach. A coding framework was developed collaboratively amongst the research team and subsequently applied to the data independently by members of the research team, with some cross checking for consensus and quality. Once all data had been coded, similarities and differences within each code were looked for to develop thematic charts of the data. Once charting had been completed, the data was then discussed at length by the research team to bring clarity and meaning to descriptive and explanatory accounts of each emergent theme within the data set.

## Key Findings

Historically, the NTD programme in Nigeria operated as multiple distinct vertical disease programmes, but in 2006, a strategy for integration of the control programmes was adopted to achieve more effective and efficient implementation. The Federal Ministry of Health provides oversight and policies for endemic states, who implement the NTD programme. The implementation unit is considered to be the local government authorities at state level. **The findings presented here represent a high-level overview of the four thematic areas identified as critically important to the success or failure of NTD programme implementation in Nigeria.** While progress has been made, a number of barriers/challenges to sustaining progress and achieving goals have become apparent.

### 1. Financial and Non-Financial Resource Challenges

Financial support for NTD implementation varies between the states and leads to unequal progress toward elimination. There are variations in financial resources available for NTD programme implementation between the two states included in this analysis, and in state level financial commitments. **Budgeting without cost information creates a recurrent financing gap, while delays in the release of funds result in provider out of pocket expenditure.** Inadequate information on how much it costs to implement MAM has perpetuated funding gaps. The budgeting process does not evaluate programme costs; rather, an arbitrary percentage increment (based on the previous budget) is applied. To mitigate against delays, frontline programme implementers frequently utilise personal funds, especially in Ogun State. Similarly, allocations of medicines for the NTD programme are based on outdated population estimates projected from previous (2006) national census figures. At border communities or in locations where there are highly mobile populations, **populations shifts can result in a shortage of medicines in some communities, and an excess in others.** Transport delays from the central medical store to state level, as well as lengthy requisition procedures, also create drug supply chain bottlenecks that contribute to delays in drug distribution, and in some cases, medicine expiry. States that do not have implementing partner support for the requisition and movement of drugs may experience greater difficulty. In Ogun State frequent drug stock-outs and drug expiry meant that distribution could not take place.

#### Summary of Financial and Non-Financial Resource Challenges

<b>Financial support</b>	variations between the states , donor dependency
<b>Budgeting gaps</b>	unknown costs of MAM, arbitrary percentage increments
<b>Implementer Out of Pocket Expenditure</b>	inadequate funding and delayed fund release
<b>Difficulty in estimating population sizes</b>	old population figures, miscalculations
<b>Delays in drug supply</b>	logistical/transport challenges, drug wastage, expiration

## 2. Community engagement in neglected tropical disease treatment in Nigeria: Rethinking the needs of varying contexts

Community directed distributors in both Ogun and Kaduna States reported a reduction in community engagement and acceptance of MAM in recent years. They attributed it to the importance of other **competing community priorities including infrastructure, provision of food, safe drinking water, and fertilisers**. This suggests a need for collaboration with other sectors to increase community-level support for MAM. In communities where NTD morbidity prevalence was reduced due to frequent MAM cycles (a key programme success), communities perceive limited need for MAM interventions. In Ogun, medicine refusal is compounded by attribution of NTDs to non-medical causes and belief that traditional treatments were more appropriate. **Side effects, most commonly related to praziquantel (PZQ), also contributed to refusal, meaning the integration of PZQ into longstanding programmes could compromise the coverage with other medicines**. In Kaduna, intensive advocacy to community leaders and the use of pharmacovigilance guidelines have significantly reduced programmatic challenges and rejection of MAM. Successful community participation and ownership have so far been observed in the areas where there is continuous sensitisation of communities and where rural community structures are available for community mobilisation.

## 3. Human Resource Constraints affecting Community Directed Treatment: a challenging model for Nigeria's frontline workers

**Key principles of the Community Directed Intervention (CDI) model are no longer functioning. This impacts community acceptance, incentivisation and CDD motivation**. The NTD programme in Nigeria draws heavily on the CDI model originally developed for the onchocerciasis control programme. The cornerstone of CDI is that communities decide when, where, and how to distribute medicines. They use participatory meetings to select their own volunteers and are encouraged to provide incentives (financial or non-financial) at their discretion.

Training is currently cascaded from the state to LGA and then to community level; national guidelines suggest that training should occur annually and reach every Community Drug Distributor (CDD) and at least two teachers from each school. Current training duration is perceived to be too short and is described as non-standardised; a lack of clarity around treatment scenarios such as treating people with disabilities may result in unequal access to the programme. **The majority of teachers feel that MAM is a stressful responsibility; they consider it to be extra work without pay**. An insufficient number of teachers are being trained for school-based MAM. Those selected receive a transport allowance to attend training, but it is widely perceived that they are given incentives. This demotivates other teachers, results in overburdening of the trained teacher, and compromises programme delivery.

Key informants, CDDs, and health facility staff identified that CDD selection is now predominantly done by the village head or by health facility staff. Lack of community participation leads to a reduction in community ownership and contributed to a widely-reported perception that volunteers were incentivised or paid by the government. CDDs reported feeling poorly motivated and prefer to engage in other community-based programmes that incentivise them. Some reported that while incentives were decreasing, workload was increasing.

## Summary of Human Resource Constraints

Training challenges	short duration, content not standardized, some did not have training materials
Cascade training challenges	teachers and health facility staff did not feel ready to train others and took on more work themselves
CDD workload	difficulties in retaining and finding new CDDs increase their workload
Incentives	other health programmes offer incentives, inaccurate perceptions

#### 4. Expanding the National Coordination Platform to Reach Local Levels and Improve Partner Coordination

Coordination and partnership mechanisms are well defined at national level and are present or emergent at state level. Key informants reported that coordination at the National level is effective but varies at state level. Whilst informants reported that the Federal Ministry of Health is successful in interfacing with international partners, some responses emphasised a heavy involvement and reliance on the input of international actors. **Multiple donors present a risk of overreliance and challenges relate to varying donor requirements.** Programmatically, co-implementation occurs between the onchocerciasis and LF programmes, and the schistosomiasis and STH programmes due to similarities in drug regimens and target groups. However, challenges included a perception of job insecurity when programmes merge; lack of awareness of the need to harmonise activities; funding fluctuations; inadequate manpower; and a lack of engagement of senior stakeholders. Another key challenge was over-reliance on 'tacit knowledge' that can compromise continuity in programme delivery when there is staff turnover.

#### References

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