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Spotlighting Nigeria's New Health Agenda: A Case Study on the Alignment of Global Health Initiatives with National Health Priorities Through the SRMNCAEH+N Lens

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ABSTRACT

Background: Alignment of global health initiatives (GHIs) with national health priorities is crucial for effective and sustainable healthcare interventions and strengthening health systems. Despite widespread recognition of this need, achieving alignment between GHIs and national priorities has proven challenging. The importance of addressing this challenge has led to a growing focus on GHIs alignment, evident in forums such as the Paris Conference in 2015 and the Lusaka Agenda in 2023. As Nigeria embarks on a new mid-term health agenda based on the sector-wide approach (SWAp), understanding the country-level implications of alignment becomes paramount. Method: This study utilized qualitative research methods to examine the issues affecting GHI alignment within the context of the sexual, reproductive, maternal, neonatal, adolescent, elderly, nutrition health plus nutrition (SRMNCAEH+N) program. Through 24 interviews and focus group discussions with key stakeholders including government officials, representatives of global health institutions, civil society actors, health workers, and community members, this research identified and validated six critical issues influencing GHI alignment at the country level. Result: The findings shed light on current practices, challenges, and recommendations, highlighting Nigeria's readiness to implement the new health agenda and SWAp effectively. The research identified and validated six critical issues influencing GHI alignment at the country level through the perspectives of diverse stakeholders. Conclusion: The paper underscores the importance of extensive stakeholder involvement, including communities, in achieving optimal alignment between GHIs and national health priorities. The

study's insights into the alignment dimensions of Nigeria's SRMNCAEH+N program reveal key areas for improvement and collaboration, essential for the successful implementation of Nigeria's new health agenda.

Keywords: Global Health Initiatives (GHIs), National Health Priorities, Health System Strengthening, Sector-Wide Approach (SWAp), Nigeria, Qualitative Research, Stakeholder Involvement, SRMNCAEH+N Program, Lusaka Agenda, Alignment Issues.

INTRODUCTION

Universal health coverage serves as the central tenet of global health, with the primary aim of promoting health equity across nations and individuals worldwide.(1) Critical in this quest are global health initiatives which emerged mid-twentieth century but have gained significant influence in the twenty-first century. The establishment of global health initiatives was first driven by humanitarian needs following the Second World War; however, the objectives of most global health initiatives have since morphed to organizing resources and commitments to confront global health risks, mitigate disparities within and between countries as well as strengthen health systems. This has involved integrating the efforts of organizations, individuals, ministries of health and other stakeholders to address emerging global health issues.(2)

Sexual, Reproductive, Maternal, Newborn, Child, and Adolescent, Elderly Health Plus Nutrition (SRMNCAEH+N) stands as a critical dimension of population health, carrying profound implications for the well-being and development of children, pregnant women, mothers, and adolescents on a global scale. These health considerations span across various life stages, encompassing the health needs of adolescent girls, women from pre-pregnancy to post-pregnancy, and the welfare of newborns and older children. Since the year 2000, there has been commendable progress in global population health, evidenced by a decline in maternal mortality, a reduction in the incidence of numerous infectious diseases, such as malaria, and an increase in global life expectancy. Among various programs, SRMNCAEH+N interventions continue to garner significant attention due to the high morbidity and mortality rates in low-resource settings, especially low- and middle-income countries (LMICs).

Over the last few decades, Global Health Initiatives have contributed to enormous progress in improving SRMNCAH+N outcomes globally. Prominent among them are the Global Fund to Fight AIDS, Tuberculosis and Malaria which reportedly has invested over USD 60 billion in saving up to 59 million people;(3) the Global Vaccine Alliance (GAVI) whose immunization programs have reportedly prevented 16 million future deaths;(4) and the Global Financing Facility (GFF) which a study indicates may save over 30 million lives by 2030.(5) Other initiatives include the US President's Emergency Plan for AIDS Relief (PEPFAR); US President's Malaria Initiative (PMI); and Global Polio Eradication Initiative (GPEI) and the Global Alliance for Improved Nutrition (GAIN) among others.(6) Together, these groups have contributed significantly to achieving great feats in global public health, including the elimination of smallpox and the eradication of the wild poliovirus among other achievements through the World Health Organization (WHO)'s expanded program on immunization (EPI). Before the establishment of the EPI program in 1974, less than 5% of children in resource-poor countries had received full dosage of vaccines against diphtheria, pertussis, tetanus, and poliomyelitis in

their first year of life. In less than half a century down the line, more than half of the children in these countries have access to lifesaving vaccines.(7)

Particularly in Nigeria, akin to many other African nations, the country has significantly benefited from international donor funds channeled through global health initiatives to combat infectious diseases and public health challenges.(8) Key contributors include the Global Fund to Fight AIDS, Tuberculosis, and Malaria; PEPFAR; PMI; and the GPEI. These initiatives have played a pivotal role in substantially reducing the prevalence of HIV, tuberculosis, malaria, and polio in Nigeria.(9–11) Notably, the Global Polio Eradication Initiative has supported the establishment of crucial infrastructure such as a laboratory network, emergency operations center, molecular laboratories, and has bolstered vaccination efforts.(12)

Similarly, the US President's Emergency Plan for AIDS Relief has been instrumental in addressing HIV in Nigeria, funding testing sites and laboratories, providing treatment for those living with HIV, and accounting for a substantial portion of the reported HIV spending in 2018. This focused approach on individual diseases has yielded some significant advancement in public health, with a decline in the prevalence of HIV and malaria nationwide, increased accessibility to testing and treatment, and the eradication of wild polio virus in 2020. The adaptation of these initiatives in the country's response to recent epidemic threats such the Ebola outbreak and the COVID-19 pandemic, has equally been credited to the importance of global health initiatives.(13)

However, as impactful as global health initiatives have been, achieving aid effectiveness has required the re-thinking the operations of global health initiatives.(14) This aim of this study, therefore, is to contribute to the growing conversation by analyzing pertinent GHI alignment issues in relation to Nigeria and other aid-recipient countries and spotlight insights that are specific to Nigeria with relevance to Nigeria's new health agenda and sector-wide approach.

Issues Affecting the Alignment of Global Health Initiatives

This study leverages an earlier rapid literature review by Aziza and Juliet, namely, 'Global Health Initiatives in Africa – Governance, Priorities, Harmonization and Alignment' in identifying key issues affecting GHI alignment with recipient countries' priorities.(6) After synthesis with additional information from Kristin and Nicholas' 'Out of Alignment? Limitations of the Global Burden of Disease in Assessing the Allocation of Global Health Aid' among others, 6 issues in total were identified as follows: governance structures; areas of support and prioritization practice; funding levels and modalities; alignment with national strategic plans and priorities; donor harmonization and coordination; and GHI contribution to stakeholder involvement. The issues are first broadly discussed with reference to Nigeria and other countries with similar contexts to offer a rich foundation for the study observations discussed later on in the article.

Governance Structures

Global Health Initiatives (GHIs) utilize various approaches to provide assistance in the countries they support. However, these organizations have been subject to criticism for their vertical governance structures.(15) The large variance in their leadership structures and the weak governance systems in many recipient countries make it nearly impossible for recipient countries to develop a unified framework for engaging these initiatives more predictably.(16)

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For example, The GAVI Alliance and the Global Fund exhibit contrasting decision-making structures: GAVI, by not having in-country secretariats, centralizes authority within its global body known as the Inter-agency Coordination Committee, while the Global Fund decentralizes power to country-level entities like the Country Coordinating Mechanism and local fund agents.(17)

In addition to the difficulties faced by countries in working optimally with the divergent forms of governance structures in global health initiatives, literature also suggests that GHIs operate in a top-down manner, with global-level decisions imposed by diverse boards comprising partners with varying backgrounds and perspectives.(18) However, recent events in the governance structure of the Global Financing Facility (GFF) may serve as a lesson for how global health initiatives can begin to address the issue of alignment in governance structure right from the top global-level. The Investors Group, a 32-seat multi-stakeholder group that includes financially and technically contributing donors, civil society, private sector, and recipient country representatives, recently increased the number of recipient country representatives from four to nine as part of its alignment reform.(19)

Furthermore, the Investors Group commissioned an independent review to clarify the roles of the TFC, the Secretariat, and the Investors Group itself, with the goal of improving effectiveness and accountability. The review resulted in a governance reform plan that was presented and approved in November 2019. This plan included refining the functions of the Investors Group, fostering joint ownership and alignment around country platforms and country-led investment cases, enhancing health financing support in countries, systematically reviewing GFF performance as a facility, and providing strategic advice to the TFC. The plan also established a co-chair function for a country representative and two standing committees, one on country engagement and the other on monitoring country progress. However, this reform does not affect the TFC. While representation of recipient countries has increased in the Investors Group, the TFC, as a decision-making entity, does not include representatives of recipient countries and civil society. This issue has been previously mainstreamed in an open letter by civil society to the GFF Secretariat prior to the 2018 replenishment where it was argued that the inclusion of recipient country representatives with equal voting rights in the TFC would ensure true ownership of GFF programs in line with the Paris Declaration on Aid Effectiveness.(20)

Areas of Support and Prioritization Practice

Although many communicable diseases fall within the SRMNCAEH+N spectrum, and many low-income countries suffer from high prevalence of infectious diseases, the emphasis of global health initiatives on infectious diseases even in the face of graver public health concerns, has raised many questions. For instance, a WHO study highlighted that HIV/AIDS received disproportionately greater support compared to other diseases, with 60% of GHIs targeting the trio of HIV/AIDS, tuberculosis, and malaria, and HIV/AIDS specifically garnering the most attention. Whilst the rationale behind the concentrated focus on HIV/AIDS may be justified by its historical impact on mortality and morbidity levels in sub-Saharan Africa, particularly before the advent of antiretroviral drugs, the continued large investment in this area is not reflective of the epidemiological trend in the region. Over the past decade, non-communicable diseases have consistently surpassed communicable diseases in the region.(21,22)

Another study by Dieleman and colleagues in 2014, comparing disease burden and development assistance for health in 130 low- and middle-income countries from previous years, revealed that HIV/AIDS received 45.9% while maternal, newborn and child health had 32% despite the latter accounting for more than fivefold of the former.(23) Besides the disproportionate attention from one disease to another, another aspect of concern is the apparent preference of GHIs with verticalization of individual diseases or package programs, over choosing to strengthen local health systems as a whole.(24) This behavior of GHIs to focus on specific diseases or services has been considered useful in its impact on spotlighting neglected diseases such as onchocerciasis, dengue, and trachoma, even when local stakeholders fail to prioritize these diseases. Specifically, in Nigeria which accounts for the largest cases of obstetric fistula globally, it has taken the support of the United States Agency for International Development (USAID)'s Fistula Care Plus (FC+) program to respond to the rise of the disease.(25)

Nevertheless, health systems strengthening is pivotal to achieving better health outcomes. The danger of a neglected health system became more glaring after the failure of some West African countries to limit the spread of Ebola Virus in 2014.(26) Gavi, for one, is seen to be addressing the challenge of health systems neglect by incorporating health systems strengthening as a core objective in its 2021-2025 strategy paper.(27) Although the evaluation of their health systems support is challenging since health systems strengthening investments are difficult to measure in relation to the organization's direct mandate.(28)

Another layer to the current issue is in the types of support rendered by global health initiatives. Notwithstanding the crucial roles that financial assistance plays in supporting global health objectives in countries, technical assistance is an equally important support option which is reportedly undermined by many GHIs.

Alignment with National Strategic Plans and Priorities

Many studies posit that GHIs are not totally aligned with their recipient countries' national strategic plans.(15,29,30) This concern is highly pronounced in Africa where global health initiatives have reportedly undermined local stakeholders.(31) Guided by predetermined agendas, GHIs have been spotted imposing restrictions on countries in their own national health programming decision-making. Pertinent examples are Global Fund's rejections of cross-cutting interventions from Uganda and Tanzania only to favor disease-specific proposals in 2002 and 2004 respectively.(6) However, a notable shift is emerging, exemplified by Lesotho's innovative approach to HIV prevention through voluntary medical male circumcision.(32)

Lesotho's strategy stands out as a compelling example of how countries can challenge the conventional structures of global health politics, typically dominated by experts and funders from high-income nations. In contrast to the traditional top-down approach, Lesotho's policymakers took a locally informed decision-making process. They consulted national statistics to assess the effectiveness of male circumcision as an approach to addressing the spread of HIV. This approach signifies a departure from the passive acceptance of externally imposed strategies. And it is similar to the engagement of traditional birth attendants in Nigeria's maternal and newborn health, exemplarily in the prevention of mother-to-child

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transmission of HIV/AIDS. This infusion of local, unorthodox strategy has proved impactful in stemming the HIV burden in Nigeria.(33,34)

In Nigeria, the National Strategic Health Development Plan (NSHDP) serves as a roadmap for the health sector to achieve the goals and objectives outlined in the National Health Policy. The plan is used to guide both national and subnational governments in prioritizing health sector initiatives. Additionally, it acknowledges and identifies critical actions that require collaboration or joint implementation with other sectors to effectively address the social determinants of health and advance health-related Sustainable Development Goals (SDGs).(35) There have been two consecutive plans, each lasting 5 years between 2010 and 2015, and 2018 and 2022 respectively. While the first plan was focused greatly on policy reforms such as the National Health Act which was passed in 2014, and primary healthcare reforms such as the Primary Healthcare Under One Roof Policy, the second plan set out to be more pragmatic in the sense that it sought to reduce out-of-pocket expenditure of Nigerians to 35%. While other gains were recorded, this pillar objective of the second plan was hardly achieved as the country still struggles with 78% out-of-pocket spending as of 2021.(36) The Lancet Commission concluded that the hampered implementation of NSHDP II was not only due to governance challenges, including a fragmented division of responsibilities among federal, state, and local governments but also the involvement of development partners in initiating certain policies through vertical funding which contributed to a sense of dis-ownership among national and subnational policymakers.(37)

Funding Levels and Modalities

There is compelling evidence suggesting that global earmarks and donor conditionality play a pivotal role in determining funding allocations, irrespective of a country's specific diseases, health needs, or priorities. A study conducted across Mozambique, Uganda, and Zambia serves as an illustrative case, revealing that the President's Emergency Plan for AIDS Relief (PEPFAR) consistently provided funding allocations at the same level in these three countries, disregarding differences in their epidemiological profiles and health systems.(38) This underscores the influence of external factors, such as global earmarks and donor conditions, in shaping the allocation of resources.

Moreover, insights from a report by McKinsey and Company suggest that countries with well-established integrated health plans, established funding mechanisms with donor participation, and clearly defined roles for central and district governments tend to interact more effectively with Global Health Initiatives (GHIs).(30) This implies that the ability of countries to secure funding may be contingent on their institutional readiness and capacity to adhere to predefined conditions and mechanisms set by donors. The burden of alignment in global health initiative financing is a complex issue. This is because many recipient countries often have weak governance systems that enable corruption and inefficiency while global health initiatives on the other hand are prone to exercising excessive powers that undermine the agency of local authorities.(16)

Another critical issue with money is funding modality. It borders on the efficiency of donor funds, the morality of power dynamics between funding entities and local stakeholders and the concern of ownership and sustainability of programs. The administration of funding for global health initiatives in Nigeria takes shape in various models – through governmental

organizations or structures such as grants to government agencies, use of basket funds, budget support, and direct facility funding; or non-governmental organizations (NGOs) often through competitive bids.(39)

Gavi, for example, operates a multi-phased co-financing arrangement for the purchase of vaccines for low and middle-income countries, including Nigeria. In this arrangement, Nigeria is currently undergoing an Accelerated Transition Phase, marked by a progressive rise in co-financing obligations as it moves closer to attaining full ownership during this transitional period. Gavi and the Global Fund often work based on the applications made by the ministries of health. The World Bank generally works with the ministries of finance, but they have also been recently spotted working with the National Primary Healthcare Development Agency (NPHCDA) on its Immunization Plus and Malaria Progress by Accelerating Coverage and Transforming Services (IMPACT) Project – the first phase of its Nigeria Improved Child Survival Program for Human Capital Multiphase Programmatic Approach (MPA).(40) GAVI once stopped its direct funding to Nigeria's national primary health care program in 2015 following findings of misuse of funds which was also related to the Global Fund and the country's AIDS control agency.(41,42) Although Gavi resumed its direct agency funding through the NPHCDA in 2016 after collaboratively implementing new accountability mechanisms within the agency,(43) accountability may continue to be a barrier to the widespread adoption of this method for all global health initiatives. For now, Gavi's co-financing tends to be thriving in Nigeria with increasing levels of national ownership, however, the same cannot be said of the country's basket fund with the United Nations Population Fund (UNFPA) for family planning commodities, due to low financial cooperation on Nigeria's part.(44)

Direct health facility financing (DHFF) is another viable means for global health interventions especially in last-mile programs such as performance-based health financing by the GFF in the democratic republic of Congo. Albeit effective this approach might be in mitigating bureaucratic bottlenecks, it is criticized as fostering inequity in the distribution of resources across facilities and communities.(45) DHFF paid to health workers who are engaged in global health initiatives have also been reported to be arbitrarily higher than government standards thereby posing an issue of labor inequity among health workers and discontinuity after the program cycle.(46)

Grants to NGOs are a significant portion of the competitive model of global health initiatives financing. They encompass funding to non-profit organizations such as civil society organizations (CSOs), as well as for-profit entities including academic institutions, research institutions and management consulting firms. For several years, both international and local non-governmental organizations (NGOs) have been working to improve the gaps in health service delivery, research, and advocacy through this type of global health financing. NGOs have demonstrated greater success and effectiveness in their efforts due to their adaptable planning and capacity to create projects focused on health education, health promotion, social marketing, community development, and advocacy that cater to the population.(47)

While the importance of NGOs is widely acknowledged, a USD 30 million grant by the President's Malaria Initiative to a consortium of America-, United Kingdom- and Australia-based organizations to support malaria control and elimination in African countries, raised concerns on the low level of involvement of local non-governmental organizations in this funding type.(48) Overall, besides recognizing the peculiarities of the various global health

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initiatives that make some funding methods more appropriate for some programs than others, it is also important to understand, particularly in Nigeria, current alignment efforts toward achieving equity, effectiveness, national ownership and accountability for resources.

GHI Contribution to Stakeholder Involvement

GHIs have shifted the perception that governments are solely responsible for health delivery by actively involving NGOs and CSOs in their programs.(49) Most GHIs also involve the private sector in their work using various strategies and mechanisms. For instance, PEPFAR prefers to channel its funds through international NGOs and CSOs rather than the public sector.(50) The Stop TB Partnership promotes inclusive governance that includes the private sector, and the GFATM's country coordinating mechanisms have private sector representation on their committees. GHIs have been successful in engaging a diverse range of stakeholders, including NGOs and faith-based organizations, enabling them to access financial resources directly.(51) Research in Malawi, Benin, and Zambia showed that the GFATM's funding opportunities strengthened public-private collaboration by allowing NGOs to establish umbrella organizations that channeled funds through principal recipients to sub-recipients.

Part of GFF's strategy is the establishment of multistakeholder coordination platforms for SRMNCAH+N in its program countries. The Nigeria SRMNCAEH+N Multi-stakeholders Partnership Coordination Platform (SRMNCAEH+N MSPCP) was launched in October 2020 and domiciled in the department of family medicine of the federal ministry of health.(52) The working document for the multistakeholder platform prescribed the membership of partner governments, academic and research institutions, adolescent and youth, donors and foundations, global financing mechanisms, healthcare professional associations, NGOs/CSOs, private sector and united nations agencies. And the aim of this platform is to "develop, implement and monitor" national SRMNCAH+N strategies, investment cases and financing strategies in line with the country's national plans. Not much is yet made public about the operations of this mechanism except that it was formed three years after the launching of Nigeria's investment case for RMNCAH+N which spans for a period between 2017 to 2030.(53)

Donor Harmonization and Coordination

The establishment of parallel and duplicative processes by various GHIs burdens countries, bypassing existing donor coordination mechanisms. Operations of GHIs may also result in competition for the limited skilled workforce, as they are often perceived as preferred employers due to lucrative remuneration and incentives.(14) Effective aid requires the harmonization of processes between donors and other partners at the country-level. Achieving harmonization entails coordination and alignment of efforts among various donors, international organizations, and local partners to ensure that aid activities are complementary, coherent, and collectively contribute to the recipient country's development goals. Since GHIs exert enormous influence on their recipient countries' health system, harmonization may help mitigate the systemic confusion that may arise from the multiple exertion of these various external forces in various directions.

Evidence suggests a positive trend in the harmonization of approaches within Global Health Initiatives (GHIs) over time. An exemplary case is the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFTAM), which, in 2004, demonstrated a pioneering move by permitting its funds to flow through Mozambique's Sector-wide Approach (SWAp), the common fund.(6) This

groundbreaking decision showcased how disease-specific programs could adapt and integrate with broader, harmonized approaches. Since then, the GFTAM's work on harmonizing donor support has equally been extended to Nigeria among other African countries, with GFTAM reaping benefits of expanded influence and acceptance in these countries. However, in Nigeria, little is known of the workings of these harmonized donor networks.

METHODOLOGY

Data Collection

We conducted in-depth interviews (IDIs), Key Informant Interviews (KIIs), and focus group discussions (FGDs) with participants purposively selected at national and state government levels, representatives of global health initiatives, civil societies that have implemented SRMNCAEH+N programs, and health facilities, to examine the prevalent practices and associated ramifications in the operations of GHI and SRMNCAEH+N programs in Nigeria. KIIs were conducted with program managers of government agencies at the national level. IDIs were conducted with civil society organizations that have implemented at least one SRMNCAEH+N program in the last two years. FGDs were conducted with the SRMNCAEH+N service providers at the health facility-level, including skilled birth attendants of all cadres, and routine immunization officers.

Fig 1: Map of Nigeria with study sites coloured in green.

The study sent out a total of 30 interview requests but achieved an impressive 80% response rate, with 52 respondents participating in the data collection process (see Table 1). The interviews were conducted over a two-month period in two key regions: the federal capital territory (FCT) and Lagos state, Nigeria (see Fig 1). The FCT represented participants at the national level, while Lagos state offered a subnational perspective, contributing insights relevant to local contexts. The data for this study was collected between 1st January 2024 and 31st January 2024.

Table 1: Study Participants

Respondent Categories	Definitions	Interview type	No. of interviews PER cadre	Number of respondents
Government	National Government Officials	KII	3	3
	State Government Officials	KII	5	5

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Global Health Initiatives	Reps of notable global health initiatives in Nigeria	KII	7	7
Civil Society	CSOs which have implemented RMNCAH at least one RMNCAH program in the last two years	IDI	5	5
Health Facility	Health workers who offer SRMNCAEH+N services at primary health facilities	FGD	2	16 (8 participants per interview)
Community	Locals who are members of the Ward development committees (WDC) in their communities	FGD	2	16 (8 participants per interview)
Total			**24**	**52**

Data Analysis and Validation

The primary data collected was followed with a mixed thematic analysis as transcripts were coded both inductively and deductively by two researchers independently and later collaboratively using the Dedoose software. The codebook can be found in the Table in S1 Table. The extracted themes and excerpts were further analyzed to generate preliminary results that were validated using a nominal group technique workshop with 25 participants. The validation participants were drawn from the same categories as the interviews, with the aim of interrogating the result in the data and effectively filling any persisting gaps.

This study utilized the Standards for Reporting Qualitative Research (SRQR) checklist in reporting the results.(54)

Ethical Consideration

The study obtained ethical approval from the Human and Health Services Secretariat of the Federal Capital Territory Human and Health Services Committee with approval number FHREC/2023/01/292/29-12-23. The authors complied with set ethical requirements by seeking and obtaining informed consent from all participants before every interview was conducted.

RESULT

The 6-pronged alignment considerations adapted for this study proved useful in x-raying the practices and challenges prevalent in the implementation of global health initiatives in Nigeria. The study is premised on the informed assumption that if the six areas of consideration under this study are addressed in terms of inputs from all relevant stakeholders, the outcomes of such efforts will be effectiveness, efficiency, equity, and sustainability. It was suggested at the validation engagement that sustainability should also be considered as an alignment issue. However, the study maintains that while sustainability is fit for an outcome-oriented consideration, the issues covered in this study are input-oriented, geared toward presenting stakeholders with actions that can produce sustainability among other outcomes.

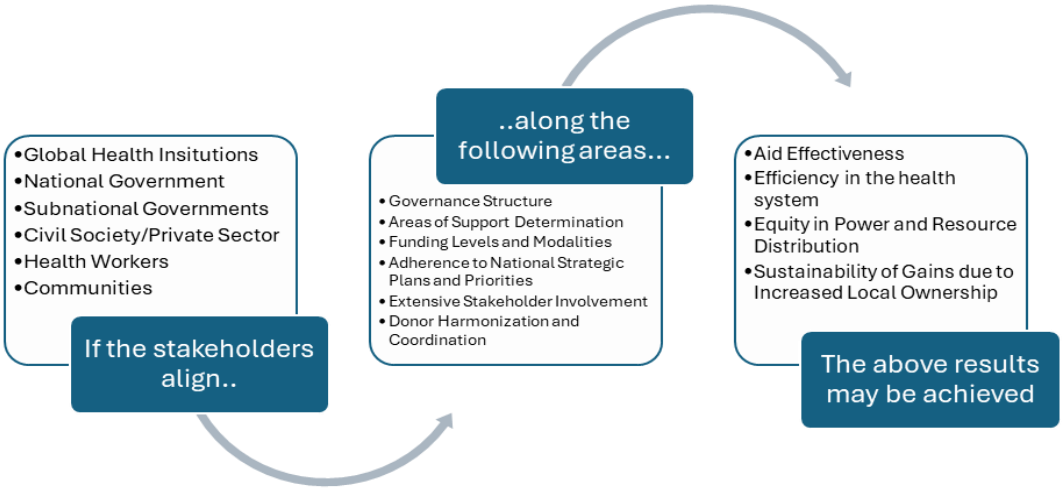

Fig 2: The Theory of Change Crystalized from the Study

Governance Structure

The issue of governance focused more on the aspect of GHI governance that directly affects their operations in Nigeria, rather than at the central realms of GHI governance. The study confirms that Nigeria's health system is experienced in either embedded GHI governance approach or a representative type.

According to one GHI respondent, there is a "*country coordination mechanism, that's CCM, it's chaired by the Honorable Minister of Health, and it has two vice-chairs, one from civil society, and I think one from the National Labour Congress. we have different people represented, the Secretary General of the Federation, we have our bilateral partners, the WHO, UNAIDS, etc*." This indicates how embedded the local governance of GHIs can be, whereas some other GHIs may only appoint local liaison officers or constitute a station in the country. Additionally, some GHIs utilize liaison officers and teams to implement programs and engage with local stakeholders, enhancing coordination and partnership-building at the grassroots-level. It is generally observed that the governance decisions are centrally decided and are uniform across all the countries where the GHI is present. This portends limited influence on the part of in-country stakeholders in determining the type of governance approach a GHI may employ.

Apart from people, GHIs have country strategy documents that guide their operations in Nigeria, outlining objectives, priorities, and stakeholder roles and are renewed periodically. "*We have a special GAVI board-approved strategy for guiding our investments in Nigeria. And those are reviewed on an annual basis with the government of Nigeria. So, we [have] what's called an accountability framework*," said another GHI respondent. In February 2024, UNICEF in Nigeria called for a one-day planning meeting with civil society organizations on setting priorities for 2024. [Unpublished event]. Such strategy papers are governance instruments that can provide opportunities for improved alignment among stakeholders.

However, challenges persist within this governance practice. Firstly, GHI governance in Nigeria is often limited in the area of human resources thereby leading to additional burden on the workforce. A health worker noted this when they said: "*When they come, they want us to work.*

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There's a lot of workloads on us. Because I think I know sometimes when they're having these programs, they only have little or no people to work with."

Secondly, there an inadequate entry management and communication strategy on the part of the national government, potentially leading to inefficiencies and gaps in coordination between GHIs and local health authorities. Speaking on the entry of GHIs in Nigeria, a subnational government official stated that there appears to be a framework but no strategy. A subnational government official pointed out that "*on the part of federal ministry of health that focuses on communication and all you know so, but I think there's a lot on paper, but we don't have a strategy*". During the validation exercise, this notion was clarified that though there is a dedicated desk office for the management of development aid in the Federal Ministry of Health, this desk office has not been functional.

Areas of Support and Prioritization

By examining how areas of support are identified and prioritized, there is a noted co-existence of government priorities and donor priorities. While the broad considerations of priority-setting by government stakeholders remain unclear, GHI participants were vocal about their priority-setting considerations, including gender, marginalized populations, const efficiency and evidence. "*For [us] there are some priorities that are mandatory. And so, one key one would be gender equality, and gender mainstreaming. And so, for every activity, be it health, economic growth, education, peace, democracy, governance, whatever it is, whatever it is, you know, we must mainstream gender*." Said a GHI respondent.

A youth organization respondent highlighted the limitations with government priorities, and said,

> *"adolescent girls and young women was [sic] never their priority, it was never their priority, nobody see Adolescent Girls and Young Women in terms of program for SRHR, GBV, economic empowerment, all those things were not their priority, the government wanted to submit procurement, wanted to submit different programs that will address other population, not the kids."*

Furthermore, they raised a suspicion that in some cases, prioritization tends to differ between them and government stakeholders due to the interference of personal interests. They stated an example that government stakeholders may prioritize the procurement that brings gain to the officers over addressing the most crucial needs of health consumers.

> *"You know, the best way to chop money, I'm using my own local words, the best way to chop money is procurement. So, rather than think of a pregnant woman… most of our people prefer procuring commodities that never get used. So, conflict of interest is one."*

According to a CSO representative, the views of external observers are crucial to articulating priority problems in the country's health system, however, there must be caution against overreliance on externally concocted solutions.

> *"Unfortunately, most of the time, maybe not in all cases, the, it is somebody far away that sees the problem, somebody far away conceived the idea of how to solve the problem, somebody far away puts the architecture together… Unfortunately, when an outsider sees your problem, he sees it from an angle. It is only you that can see the whole picture." (CSO representative).*

Respondents agree on the supremacy of primary healthcare as a priority program for the health sector while holding the views that prioritization can be better harmonized if all stakeholders agree on objective principles such as evidence and equity. After all, many respondents referred to the Paris Declaration on Aid Effectiveness as an aspiration GHI partnership in the country.

Funding Levels and Modalities

Funding levels, similar to governance, are subject to the availability of funds and other factors at the central realms of GHIs, with little influence on the part of recipient countries. However, funding modalities appear to be more flexible at country levels. In Nigeria, the funding modalities are faced with challenges of efficiency and utilization. Health workers complained that "*sometimes, we get all of these grants, and it doesn't flow down to the people in the local communities*." A GHI respondent also expressed the challenge that bureaucratic bottlenecks impede their utilization of available resources.

"*My recommendation is that the government should do more. The donor agencies, we are hearing. Yes. And with what they are bringing, they should invest more. They should step up*." A community member encouraged both government and development partners to increase funding volume to increase the last mile impact. Whereas a GHI respondent recommended a thorough resource mapping across government institutions and levels as well as development partners, to achieve greater efficiency.

Alignment with National Strategic Plans and Priorities

The national strategic plan is a compendium of country priorities, and it sharply differs from the areas of support analyzed above. While areas of support are specific to the operations of global health initiatives, the national strategic health plan is encompassing and runs mid-term. There is a general acceptance of the national strategic plan as guiding instrument for global health initiatives. The document is also adapted and implemented at the subnational level notably with support from global health institutions. A particular GHI reported to have supported states to adapt the national strategy:

> *"in these states, we work with state governments to adapt national strategies and guidelines that focus on these areas, you know, at PHC-level, as well as help them support them in instituting adequate referral networks between the primary health centers to secondary."*

A subnational government official also commented that they "tailor [their strategies] to recommendations from national [while the] national is tailored to the global health initiatives.

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The absence of a new comprehensive national strategic health development plan in the first quarter of 2024 since the last plan ended in 2023, is a challenge to planning GHI projects in the short term. One GHI respondent said

> *"The new administration has been changing the overall framework, right? So, at this moment, the country doesn't have an approved national health sector strategic plan."*

Another challenge noted is the low political prioritization of health care which affects the overall performance of the strategic plans.

According to the interviewed respondents, ensuring optimum level in the implementation of the country's national strategic health plan will require multi-level collaboration, bottom-up approach starting from the communities and greater country ownership.

"*The best way to achieve success in public health is to is to do something bottom up*." Said a national government official.

In terms of enforcing the alignment with national strategic plan, a representative of the civil society recommended strengthening the regulatory environment to enable government institutions effectively manage global health initiatives, however, there must be proactive checks on all opportunities for corrupt practices in the framework.

> *"So, to me, we need strong institutional arrangement on the part of government. But at the same time, we have to be very careful. We have seen [the] government against it. I think they are doing that. But of course, it's an opportunity for corruption. So, they try to tell partner, we want to see what you are doing and everything… To the extent that some of them will say, okay, whatever you want to do, we want to see it and everything. And why are they interested in that? They want to give you a local organization that is fronting for them. That they will be sending the money to and everything."*

GHI Contribution to Stakeholder Involvement

It is considered that there cannot be stakeholder alignment in the implementation of GHIs if participation is narrow. According to the respondents, GHIs have been instrumental in revamping the once-defunct multistakeholder platform. Now the platform encompasses the membership of government agencies, parliamentarians, development partners, civil society organizations (CSOs), and community-based organizations (CBOs) at national and subnational levels. One GHI respondent recounted that:

> *"… previously, there used to be the CTC, the Country Technical Committee, I think, which was basically at national, and these things were also duplicated at sub-national level. Somewhere along the line, it dropped off and it wasn't functional. But I think with a new head of Department of Family Health, this initiative was revamped, and the Coordination Platform was created, I think, in October 2020. A lot of partners actually came together to actually ensure that this was a reality. It has four sub-committees, which I think… are quite functional on their own…"*

This was corroborated by a national government official who extols the new multistakeholder platform for its broad-based participation from national government to community structures.

> *"There is also an overall coordination platform for SRMNCAEH+N, which looks at issues around coordination, advocacy, resource mobilization, technical quality, and the composition at that level involves the ministries, the relevant ministries, the line ministries, the academicians, professional bodies, media, philanthropists, CBOs, CSOs, faith-based organizations. We also have the representative of the National Assembly in the Government Forums."*

Apart from the multistakeholder platforms, GHI respondents mentioned their other unilateral efforts to include civil society actors as part of their global and decision-making and advocacy setup. "*GAVI, have what they call the GAVI CSO constituency, they're also at global level, at regional level, at country-level. These are CSO mechanisms that we are organizing our CSO advocacy*," said a GHI respondent.

However, challenges persist, such as inadequate funding for the Multistakeholder Coordination Platform, leading to fragmented coordination and duplication of efforts within GHI programs. Additionally, the vertical nature of GHIs and the non-involvement of health workers in decision-making tend to hinder integration at the grassroots level. One GHI respondent pointed out that while there is a vital need for global health initiatives to synergize, the country must be empowered to integrate the various health programs at the last mile.

> *"So far, oxytocin is not using the cold chain of NPHCDA for vaccines. Why not? So, I think we need to, when we are thinking how to harmonize the Global Health Initiatives in general, they are like something on a global level, how the fund streams are vertical, but as well, how their own national structures are fragmented, especially Nigeria."*

The limitations in the work of stakeholder platform are further compounded by limited data sharing practices and a lack of adequate community engagement. Overburdened health workforce and challenges in political coordination also add to the complexity. According to a subnational government official, the fragmentation negatively affects health consumers who

> "don't get services rendered because the focal persons, the healthcare workers, have gone for one training or the other, or they are chasing one report or the other to meet the demands of different implementing partners." The result of this on the community is captured in the frustration of one of the community representatives who said: "do your findings. You will be surprised that everywhere they'll ask, 'does this thing exists?' They don't know. They don't know. Because the impact is very minimal."

Also admitting to the negative impacts of fragmentation on the health system, a representative of GHI believes that the government and donor agencies are jointly responsible.

> *"Most of all our activities tend to be quite fragmented with a lot of duplication, and this is, I think, coming both from both government and donor side." (GHI respondent)*

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Despite these challenges, levers for improvement include an ongoing mid-term reviews of investment cases, growing awareness of the need for coordination, and the presence of community governance structures that offer opportunities for bottom-up coordination.

Per recommendations, A CSO respondents suggests that the best way to achieve alignment is to give equal attention to subnational alignment, "because if we align just at the federal level, things may not work." Another CSO respondent mentioned that many states in Nigeria have public-private partnership platforms such as state-led accountability mechanisms which can be leveraged for the establishment of coordination mechanisms at subnational levels. At the community level, a health worker hinted that have "*monthly meeting… with the community representatives*" after which they "*take that meeting minutes back to the local government authorities*." This presents an avenue to incorporate views and representatives from the community into the deliberations of the coordination platforms.

A national government official aligned with the thought of involving communities by charging that the demand side of the health system be incorporated optimally in working of the multistakeholder platform:

> *"I think there are gaps that need to be addressed. Most specifically, I think most of these interventions you see are more supply-side focused. So, you see a heavy presence of the supply-side actors in the in the way things are done in the way. These policies are developed but little or no involvement of demand side actors. And this is something that needs to be corrected, because on our road towards providing not only SRMNCAEH services, but a universal health coverage, the demand side is critical."*

All these key recommendations are made against the backdrop of the acknowledgment of the volume of resources and time required. Thus, a GHI respondent noted that mapping resources available from the government and partners is pivotal to efficiently maximize the multistakeholder platform.

> *"DPRS [should] actually conduct a resource mapping and expenditure tracking across at national level. With the resource mapping, you are able to see what partners are bringing to the table and where they plan to actually, what kind of activities they plan to do and where they plan to do them."*

Donor Harmonization and Coordination

Donor harmonization and coordination efforts among GHIs in Nigeria demonstrate progress. Financially, there is a reportedly growing conversation around adopting blended financing to support Nigeria on specific areas of the health system on a long-term basis. "*…In this last board meeting we have, there's what we call the blended financing, the blended financing, all the mechanism now where we can put in some money to help the country fix a long-time issue together with another bilateral partner*," one GHI respondent reported. They further hinted that blended financing is actively used in planning for malaria vaccine introduction in Nigeria.

Additionally, a new business model has emerged where GHIs negotiate geographical areas of focus in collaboration with the national government. This initiative arises from efforts to

mitigate duplication of programs within the same geographical locations as well as engender equity in the spread of development aid for health across the country. In a particular case scenario between Global Fund and PEPFAR, there is an interesting arrangement in which the Global Fund shrunk the number of its program states while PEPFAR takes others.

"*Global Fund used to have many states in Nigeria for implementation, but Global Fund has reduced itself to four, in terms of financing, well yes, Global Fund is investing billions of dollars, but they have reduced the number of states they take charge, and PEPFAR is also coming with its own chunk of funding, and they are saturating the rest of the states across the country*," reported a GHI respondent.

In addition to the harmonization reported in terms of financing and geographical planning, GHIs reported to sometimes execute programs jointly. In a particular program known as Partners of Global Fund through which a large-scale health commodity logistics project was recently implemented. "*So, for example, we are implementing Partners of the Global Fund. We have a service contract with them, and we have been upgrading 22 warehouses for drugs and medicines all across the country*." These dimensions of collaboration among GHIs is made possible through an umbrella forum known as Development Partners Group, a coordination and knowledge sharing platform "*where we share information with other partners on what we are doing, what the others are doing; and this allows us to, at a federal level, to align*," according to a GHI respondent.

Cross-Cutting Issue: Sector-Wide Approach

Perceptions regarding SWAp are generally positive, with optimism that it can positively impact Nigeria's health system and improve alignment among stakeholders implementing Global Health Initiatives (GHIs). This optimism is shared by civil society respondent who described it as an "*opportunity that they can align*" and a GHI respondent who referred to other countries whom they claim to have successfully implemented the approach:

> *"Looking at other countries that have been implementing sector-wide approach, like Bangladesh, this is something that has helped them reduce all the maternal mortality, child mortality, nutrition, address nutrition challenges, and all the indicators seem to be improving over the years. I know it's also happened in Ethiopia and Malawi. And Ethiopia, I think it's, I think it's, they've been doing it for the last, I don't know how many years now, and it seems to be working very well for them there."*

Many of the respondents offered recommendations on how it can achieve its set objective. A subnational government official advised that the success basic healthcare provision fund (BHCPF) should be studied and applied in SWAp implementation. "*We have like one point six million BHCPF enrollees covered. We have a lot of health care facilities that have received the existing basic health care provision fund. Let's hear from them what has worked*."

A GHI respondent sued that there is need for "*a common M&E framework*" while a national government official posited that the federal government "*need to really work together with the state*." Another GHI respondent emphasized "*strong quality assurance, quality of care, supervision mechanism, flow of funding, funding disbursements*" if the new approach must

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succeed. For the latter GHI respondent, funding availability is an anticipated challenge, however, according to them, if that and other concerns are addressed through collaborative efforts of all key stakeholders, SWAp may succeed.

DISCUSSION

Note that the study is broadly concerned with characterizing the implementation of GHIs in Nigeria along a selected number of alignment issues with the aim of influencing the current dispensation of health systems governance in the country. One of the most prominent issues is the determination of areas of support. GHIs have been previously well-criticized for imposing their priorities on the countries they work in. We noticed that this is changing as GHIs increasingly adopt the country-led prioritization approach. Most stakeholders agree that prioritization practice should be objectively determined based on evidence such as disease burden, cost-effectiveness, equity and risk ratio. The national strategic plan is the most common instrument of alignment among the stakeholders we interviewed. And the development of a new strategic plan is considered an opportunity to jointly operationalize this evidence- and equity-based prioritization principle.

Some of the existing mechanisms that can be leveraged for a broad stakeholder input include the multi-stakeholder platforms and the national council on health.(55) Already the ministry of health is seen to be reactivating these mechanisms through a multistakeholder compact agreement with GHIs and subnational authorities during its launch of a ministerial health agenda in 2023.(56)

A sector-wide approach (SWAp) was declared as the coordination approach for the new health agenda. Originally, SWAp was first introduced to health sector development in the last decade of the twentieth century, mostly in the wake of widespread fragmentation in donor-funded HIV/AIDS epidemic response in low- and middle-income countries.(57) It was designed to establish an environment for a more coherent government-led policymaking, financing, and institutional capacity building. Guy and Marcel articulate that SWAp possesses three important features that delineate from the traditional vertical programs approach. The first is that the approach assigns leadership to the ministry of health, without reservation on the leadership capacity, leadership changes and culture. The second is that SWAp emphasizes strengthening the health system through adaptation of management tools, improvement of implementation capacity and integration of health information systems – including monitoring and evaluation. Thirdly, SWAp requires pooling of resources between government and donor agencies to fund projects and activities of the ministry of health.(58)

In Nigeria where the approach is only making an in-road after over two decades of implementation across Africa, there is a noted general acceptance among stakeholders in Nigeria who spotted other countries such as Malawi and Ethiopia as having implemented it successfully. Indeed, SWAp has been credited with impact ranging from improving the identification of cost-effective list of essential services package in Malawi(59) to reducing out-of-pocket expenditure in Ethiopia(60) and enhancing the improvement of Bangladesh's health, nutrition, and population over a 15-year period of implementing SWAp.(61) At a global level, despite slow pace of noticeable progress, countries that switched from non-SWAp to SWAp are found to have reduced infant mortality rate by an 5.8% compared to countries that remain non-SWAp.(62) Notwithstanding the overwhelming argument for SWAp, the implementation of

SWAp cannot be said to be silver bullet as it took Bangladesh a series of iterations while in Ethiopia, SWAp is yet to receive the support of all the development partners despite significant progress over the years.

What is certain, however, is that Nigeria is not entirely new to the concept of SWAp from our 6 areas of consideration. The ministry of health is experienced in governing country mechanisms albeit a lot can be learned from the subnational on managing entry of global health initiatives and institutions. There has also been a measure of complementarity in the prioritization practice between the government and development partners. With the close involvement of development partners and communities in the design of subsequent national health priorities, the concerns of misplaced priorities and neglect of marginalized populations on the part of the government can be addressed.

The ministry is also experienced with various funding models and has expressed through the national health agenda its intention to operationalize the basic healthcare provision fund, the vulnerable group fund and decentralized facility financing. These funding mechanisms mostly promote decentralization which is a favoured approach among interviewed stakeholders for the financial management of global health initiative. Guy Hutton discovered there is a likelihood of countries that implement SWAp to also decentralize, and this has been emphasized by many studies as an integral component of SWAp since the approach is itself a product of a principle of decentralizing health programs from verticality to horizontality.(57,61,63)

The multistakeholder coordination platform, if provided optimal support, will provide an opportunity for the partners' coordination need for SRMNCAEH+N implementation in the SWAp regime. It interests the authors to see how the government and partners would navigate concerns around the unpredictability of national strategic plans. The presence of the development partners group and their stated commitment to the Paris Declaration on Aid Effectiveness are levers for Nigeria to enlist the widespread support of the major development partners in the country.

It is noteworthy that the recommendations of this study, from the call for increased participation of health workers and communities in the formation of GHI-country priorities, to the recommendations for a systematic decentralization of GHI governance to national and subnational authorities, are all in tandem with the position of important work by the Future of Global Health Initiatives (FGHI) consortium and its attendant Lusaka Agenda.(64) Although the FGHI study is scoped to examine the operations of GHIs globally, as well as proffer a clear pathway for change at that level, country-specific enquiries such as this present study are also important to enhance the appreciation of the peculiarities of individual countries and influence tailored alignment solutions.

This study was able to achieve its aim of x-raying the atmosphere of alignment among stakeholders implementing global health initiatives, from global health institutions to national government, to subnational government, civil society, health workers and communities. Notwithstanding, the study could have benefited from a larger pool of respondents who would have enriched the findings with more diverse and pertinent views.

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CONCLUSION

This study came at a historic turning point in Nigeria's interaction with global health initiative as the country transitions from the traditional vertical approach to a sector-wide approach. It helps to contextualize some issues that generally affect the implementation of global health initiatives in the Nigeria's context, while filling knowledge gaps on existing practices, challenges, perceptions, recommendations, and opportunities for the needed transition. It is hoped that stakeholders will use it as a part of landscape assessment to finetune plans and strategies for the ongoing strategic transition in the health sector. By addressing the identified challenges and leveraging key levers, stakeholders can enhance coordination, improve resource allocation, and ultimately contribute to improved SRMNCAEH+N and general health outcomes.

Declarations

Ethics approval and consent to participate: The study obtained ethical approval from the Human and Health Services Secretariat of the Federal Capital Territory Human and Health Services Committee with approval number FHREC/2023/01/292/29-12-23. The authors complied with set ethical requirements by seeking and obtaining informed consent from all participants before every interview was conducted.

Availability of data and materials: Data is not available to the public to protect the anonymity of participants, whose identifiable information may be present.

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Author Contributions

OP and OO contributed to the conceptualization, supervision, analysis while EJ, AT and SA contributed to data collection, analysis and review.

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