Revolutionizing Healthcare Access: A Comparative Analysis of Drug Revolving Fund Schemes in Nigeria

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Background

Nigeria faces a staggering economic burden from malaria, with annual losses exceeding $1 billion and contributing to 27% of the global malaria burden. Traditionally, user fees have been used to finance healthcare access, however, this approach can be a barrier for low-income populations, hindering access to essential medicines, particularly for malaria control.

As international health funding declines, locally driven solutions like Drug Revolving Fund (DRF) schemes are crucial for sustaining healthcare access. This study offers insights into scalable healthcare financing solutions and examines the impact of DRF schemes on sustainable access to essential medicines, particularly for malaria control, across four Nigerian states (Kano, Nasarawa, Bauchi and Sokoto) by analyzing successful implementation in Kano and Nasarawa against challenges encountered in Sokoto and Bauchi.

Methods

A comparative qualitative analysis of programmatic data from the National Malaria Elimination Programme (NMEP) from Kano, Nasarawa, Bauchi, and Sokoto States. This included rigorous scrutiny of financial records, drug availability statistics, procurement data, and stakeholder reports. The qualitative analysis involved interviews with stakeholders to identify key success factors and challenges in DRF implementation.

Results

Kano & Nasarawa States:

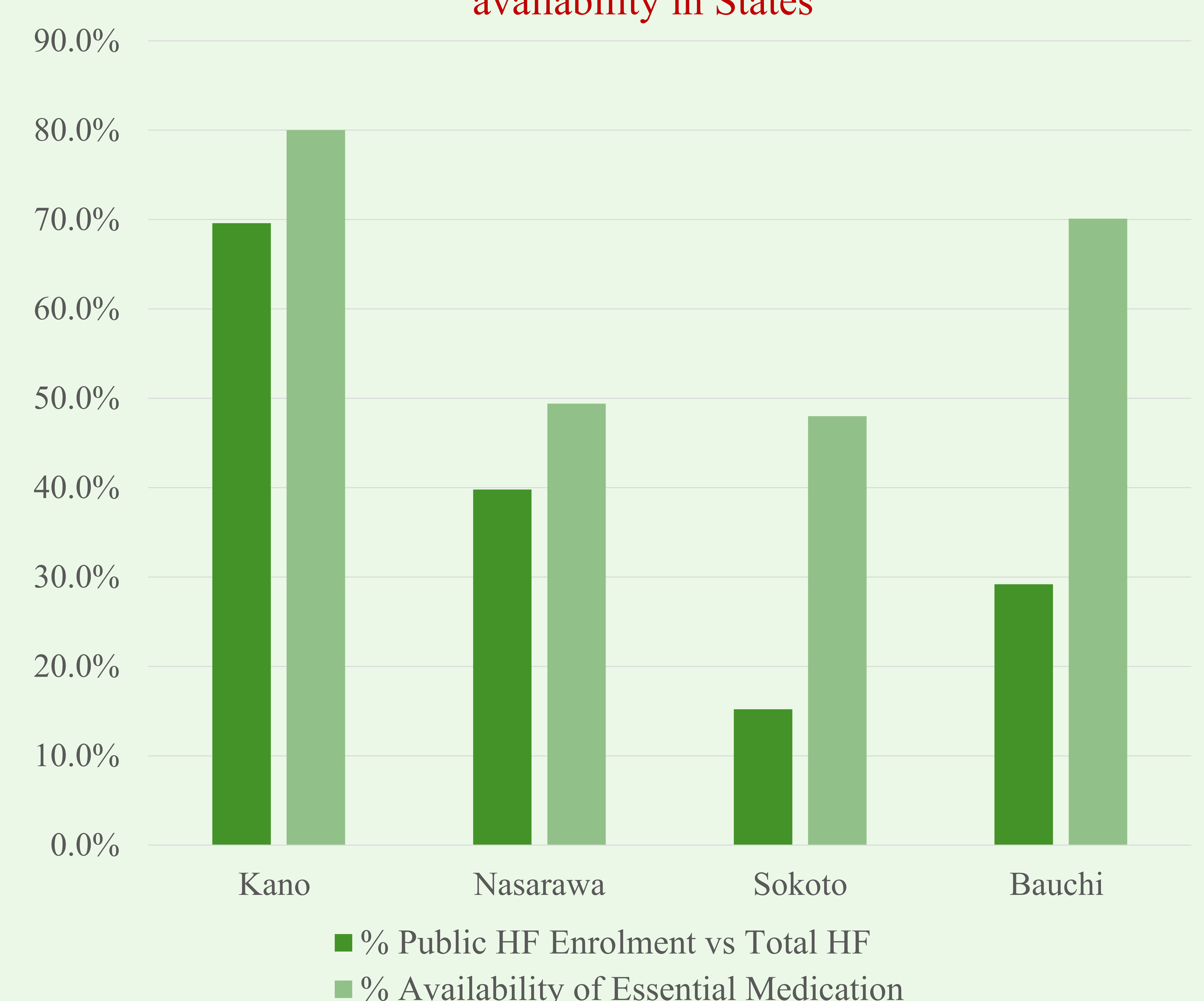
In Kano, the DRF's sustainable funding model and meticulous monitoring facilitated its success. The scheme was expanded to cover 890 public facilities, maintaining affordable uniform prices for medicines through a markup model that covers operational expenses. The Kano State Drugs and Medical Consumables Supply Agency ensured over 80% availability of essential medications, including malaria commodities. The established operational frameworks and governance structure with political buy-in were the backbone of the successes recorded. Lessons suggest that effective DRF programs require political buy-in, community engagement, and financial transparency to sustain affordable healthcare.

The success recorded with Nasarawa State DRF with technical assistance from the USAID/PMI GHSC-PSM project was due to the political commitment and buy-in for all operational frameworks and structures ab initio with robust monitoring, evaluation, supervision and sanctions (MESS) carried out by In-State-Team and Essential Drug Officers (EDOs); a concept borrowed from the Kano DRF. A total of 478 public health facilities have been enrolled to benefit from the DRF scheme within 2years of operation. Key learning includes strengthening staff capacity and institutionalization of loan recovery systems to ensure DRF sustainability.

Sokoto & Bauchi States:

For Sokoto State, the low commitment from state actors to have the DMMA governance structure and DRF operational guideline in place before the commencement of the state-owned centralized DRF affected the progress. Also, the pre-existing essential medicines replenishment system was not abolished nor properly integrated into the centralized DRF structure thus creating room for parallel operations at the beginning of the scheme. The state has 118 public health facilities enrolled in the DRF scheme. However, Sokoto has currently shown some level of commitment to the scheme with prospects of scaling up to 728 health facilities targeting 70% coverage

For Bauchi State, the operational framework and governance structure were in place but ownership by state agents was low coupled with delay in passage of the revised DMMA law and the release of funds for CMS and facility upgrades required for DRF optimization; Bauchi state has scaled up to 349 public health facilities in 3 years.



Conclusions and recommendations

Political willingness, clear policy guidelines, legislative expediency and collaborative governance structures are critical to the success of DRF schemes at the inception stage. They are also pivotal for effective implementation and sustainability, offering valuable lessons for healthcare financing and policy development. Uniform, affordable, carefully designed user fees with community participation across public health facilities within a geographical region will help address the challenges of misconceptions. A robust monitoring evaluation, supervision and sanction and upscale of activities by an established governance framework could help address challenges encountered at any stage of the DRF operation.

NATIONAL MALARIA ELIMINATION PROGRAMME
Federal Ministry of Health, Abuja

The National Malaria Elimination Programme (NMEP) in Nigeria is the body responsible for formulating and facilitating policy and guidelines, coordinate the activities of partners and stakeholders on malaria control activities, provide technical support to states malaria programs, LGAs and stakeholders; mobilize resources, monitor and evaluate progress and outcomes in malaria elimination efforts across the country.
Globally, millions of deaths attributable to malaria are still being recorded. The disease constitutes a huge epidemiologic burden in Africa and continues to cripple the economic development in the region. In Nigeria, the disease is responsible for 60% of outpatient visits to health facilities, 30% of childhood deaths, 25% of deaths in children under one year, and 11% maternal deaths.
The financial loss due to malaria annually is estimated to be approximately 132 billion Naira in the form of treatment costs, prevention, and the loss of man-hours. Malaria is a treatable and completely evitable disease.