

Malaria Hyperendemicity: The Burden and Obstacles to Eradication in Nigeria

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Abstract

Malaria deaths and cases have been common among people living in tropical climatic countries like Nigeria, Ghana, Uganda, Tanzania, Mali, etc. Malaria is one of the leading causes of deaths in Nigeria and every person in Nigeria experiences at least three episodes of malaria sickness every year. Many efforts in the past to reduce malaria incidence and burden to patients have not proven successful as resistant strains of mosquitos emerge. Malaria incidence in Nigeria has risen to a hyper-endemic level over some decades whereas countries like Algeria, Morocco and Argentina etc. have controlled and eradicated malaria by following international intervention programs by the World Health Organization and similar agencies. Malaria is of public health concern in Nigeria. Through a review of literature and lived experiences, the author identified and discussed the political and biosocial contexts: ecological, economic, communication, and infrastructural conditions that pose challenge to eradication programs. Recommendations were made to set up surveillance and monitoring system, restructuring the funding and management system, improving community partnership, and promoting health education.

Keywords

Health Challenge, Malaria, Eradication, Control, Structural Violence, Biosocial, Nigeria, Hyperendemicity

1. Introduction

Nigerians have lived with and died from malaria for decades. Malaria is a disease caused when an infected female Anopheles mosquito bites a person. It is a common disease among people living in tropical climate countries like Nigeria, Ghana, Uganda, Tanzania, Mali, etc. Malaria affects people living in poor environmental

conditions and who lack the resources for preventive and curative cares. While countries like Algeria, Morocco and Argentina etc. have controlled and eradicated malaria by implementing intervention programs and guideline from the World Health Organization and similar agencies, the incidence of malaria is still very high in Nigeria. Certain individual, government, and environmental factors in Nigeria are responsible for the persistent high level of malaria cases and death in the population. For instance, the adoption of Neoliberalism in Nigeria in the 1980s stalled rural infrastructural development, imposed high taxes, caused mass unemployment and the decay of social services. The state of primary healthcare in Nigeria, for example, is deplorable and dysfunctional making it very difficult for people to access healthcare when sick and for effective community health education outreach to be implemented. This article discussed the biosocial and political contexts that hinder malaria eradication efforts in Nigeria and recommended some measures than can be implemented to achieve success in malaria eradication and elimination efforts.

2. Literature Review

Malaria is a mosquito-borne infectious disease transmitted by the bites of female *Anopheles Mosquitoes*, which thrive in temperate and tropical climates. Mosquito bites to humans transmit a parasite known as *Plasmodium Falciparum*. Climatic conditions in Nigeria make malaria bites and transmission of the parasite very common and pose health burden to the people. Hyperendemicity refers to the persistent high levels of malaria sicknesses in the Nigerian environment. Regular occurrences of malaria cases, deaths and disabilities are abnormally high and impact majority of Nigerian population negatively. Malaria is not only hyper endemic in Nigeria; it is the same across all African countries. In Nigeria, for example, it is a leading cause of death and sickness and accounts for 20% of mortalities [1]. Among the major reasons for the increase in malaria disease are the presence of drug resistant species of the vector mosquito, the preponderance of enabling environments such as poor living conditions, and the inadequacy of primary health infrastructure to treat the disease [2]. Malaria sickness and burden have posed great threat to the global population that the World Health Organization (WHO) raised it to the level of public health concern and designed a framework for global malaria control, elimination and final eradication. But while some countries like Algeria and Argentina have been certified free of malaria by the WHO by applying these strategies, Nigeria has totally failed due to some systemic constraints.

2.1. Constraints to Malaria Control and Eradication in Nigeria

Malaria eradication program in Nigeria is faced with several constraints such as poor living environmental conditions, the lack of basic sustainable infrastructures, underfunding of the health structure, limited access to healthcare, program inconsistency and lack of oversight [3] [4]. Other constraints are posed by

political, social and economic structures of Nigeria and the inadequate efforts to educate the public.

2.1.1. The Impact of Lack of Basic Living Infrastructure to Malaria Exposure and Disease

About 97% of Nigerians live under poor environmental conditions that expose them to greater risks of malaria [5]. For instance, rural residents are faced with the lack of basic sustainable infrastructures such as clean water, electricity, good sanitation and housing, motorable roads, job opportunities, and accessible primary healthcare facilities [4]. These conditions expose the poor to disease vulnerability and low-living standards. The inability of government to provide services that support the most vulnerable deepens the health disparity gap between the privileged and the less privileged. Living closer to bushes, farms, or pond water sources encourage mosquito-causing malaria to breed while poverty and limited access to healthcare pose challenges to seeking a timely care. These conditions are common in Nigeria and other African countries and hence the increase in burdens and malaria related morbidity. Reports show that African countries carried 93% of 213 million global malaria cases, and accounted for 90% of the 216 million of malaria cases and deaths [1] [6]. Again, the 2017 World Malaria Report [1] indicated that the Sub-Saharan Africa carried 80% of the 445,000 global deaths from malaria. It is on record that Nigeria alone accounts for 27% of all the global cases, according to the report.

2.1.2. Inadequate Funding of the Health Sector and Impact on Health Behavior

Insufficient funding of the health sector is of the major problems affecting health delivery and access to care in the African region. To address this problem, the African countries *Abuja Declaration* of 2001 [7], set a target to allocate at least 15% of their annual budget to improve the health sector as the World Bank had recommended that countries allocated at least 5% of GDP to the health sector. Only a very few African countries have reached any of these goals. A World Bank report showed Nigeria's percentage of GDP allocated to the health sector in the following years as: 3.30% in 2010; 3.36% in 2012, 3.35% in 2016, and 3.76% in 2017 [8]. The allocations are insufficient to sustain the population and the health system in Nigeria and has constantly manifested in the poor performance of the health system. Poor funding of the health system has skyrocketed out-of-pocket expense for health care up to 77% in 2017 [9], which is a real constraint when seeking care. High out-of-pocket expenses cause patients to delay or not seek healthcare. A high out-of-pocket expense increases patients' health burden and generally impacts their attitude to use healthcare facilities. Nigeria is among the countries in the African region with very high out-of-pocket health expense (see **Table 1**). Inadequate investment in the health sector has affected Nigeria's ability to pursue a comprehensive malaria control and eradication program at both national and local levels. Equally, poor funding has impact on quality local health facilities and services, availability of staff to educate, engage

Table 1. Out-of-pocket payments as a share of total health expenditure for the African region.

	Less than 20%	20% - 40%	More than 40%
2001	Namibia, Botswana, Mozambique, South Africa, Angola, Seychelles, Madagascar, Swaziland (8 countries)	Algeria, Rwanda, Malawi, Cape Verde, Ghana, Lesotho, Zambia, Gambia, Ethiopia, Liberia, Equatorial Guinea, Mauritius, Uganda, Mauritania, (14 countries)	Sao Tome and Principe, Niger, Kenya, Congo, Tanzania, Eritrea, Burundi, Guinea-Bissau, Benin, Comoros, Mali, Senegal, Chad, Gabon, Central African Republic, Burkina Faso, Nigeria , Togo, DRC, Cameroon, Côte d'Ivoire, Guinea, Sierra Leone (23 countries)
2005	Namibia, Seychelles, Botswana, Malawi, Mozambique, Swaziland, Rwanda, South Africa (8 countries)	Madagascar, Ghana, Gambia, Cape Verde, Angola, Algeria, Zambia, Ethiopia, Lesotho, Senegal, Liberia, Sao Tome and Principe, Mauritania, Equatorial Guinea, Tanzania, Burkina Faso, Comoros, Burundi (18 countries)	Congo, Mauritius, Kenya, Uganda, Niger, Benin, Guinea-Bissau, DRC, Mali, Eritrea, Chad, Gabon, Togo, Central African Republic, Nigeria , Cameroon, Sierra Leone, Côte d'Ivoire, Guinea (19 countries)
2010	Seychelles, Namibia, Botswana, Malawi, Tanzania, Mozambique, Swaziland, Lesotho, South Africa, Angola (10 Countries)	Algeria, Rwanda, Equatorial Guinea, Gambia, Cape Verde, Zambia, Ghana, Madagascar, Comoros, Senegal, Liberia, DRC, Burkina Faso, Ethiopia, Burundi (15 countries)	Niger, Kenya, Mauritania, Benin, Togo, Gabon, Uganda, Mauritius, Eritrea, Mali, Congo, Sao Tome and Principe, Nigeria , Central African Republic, Guinea-Bissau, Cameroon, Chad, Côte d'Ivoire, Sierra Leone, Guinea (20 countries)

Source: https://www.afro.who.int/sites/default/files/2017-06/state-of-health-financing-afr_0.pdf.

community in the required behavioral change of applying preventive measures and seeking proper care.

2.1.3. Political, Social, and Economic Perspectives of the Problem

The Nigeria that exists today was initially separate independent ethnic and geographical areas before the British amalgamation in 1914. The Amalgamation, which was for the economic and political expansion of the Great Britain, merged the South and North of the River Niger into an entity known today as Nigeria. The amalgamation was a forced union of politically, culturally, and religiously different ethnic regions north and south of the River Niger for the benefits of Great Britain. It was not fashioned to enable nation building and has never been. Rather, it fueled ethnic tensions due to marked differences in the culture, religion, judiciary and education as well as land tenure systems between the North and South of Nigeria [10]. British Government support for the North to hold political power perpetually, and to advance Northern Islamic Caliphate agenda across the country in disregards to the Christians and traditional beliefs of other ethnic groups in Nigeria [11]. Such crisis and the demands for a better governance led to a military coup d'état that resulted in a Civil War, 1967-1970. The war otherwise known as the Nigeria-Biafra War destroyed the newly built infrastructures after the independence especially in the then Republic of Biafra, the battlefield of the war. During the war, most health facilities were targeted and bombed because they housed sick civilians and soldiers. These facilities have not been rebuilt to this date. In the North, low levels of literacy, culture and religion impacted people's ability to accept modern medicine or respond to civiliza-

tion. The absence of health facilities in the South translated to poor health outcomes. However, government tried to offer free and subsidized health services to the people in order to lessen hardship on the people. So, in 1986, the Babangida Administration established the Directorate for Food, Roads, and Rural Infrastructure (DFFRI). This program was to mobilize rural population to achieve sustainable development, improve food production, and encourage agro-business. This program hardly took off before Nigeria was forced to adopt the western style neoliberal economic policy otherwise known as the Neoliberalism. *Neoliberalism*, a socio-political agenda of the West for global economic dominance forced Nigerian government to relinquish its people-centered social and economic responsibilities to market forces [12] [13]. The Neoliberal social and economic plan stalled all people-centered efforts towards rural development in Nigeria and instead introduced hardships and widened gap in infrastructural development between urban and rural communities. The Neoliberal ideology, a conceptual idea from David Ricardo and Adam Smith, is based on free market autonomy and allocation of resources. Given her poor levels of social and economic underdevelopments, Nigeria was not ready to compete for essential services in the globalized market recommended by the agents of neoliberalism [14]. Adopting neoliberalism had serious negative impacts on the Nigerian population in accessing essential services including healthcare and basic needs. Indeed, Neoliberal plan eroded almost all aspects of government responsibilities to the citizens of Nigeria, increased hardships and imposed high taxes and levies on the people [12]. The structural adjustment and economic reforms associated with the neoliberal agenda badly affected the socio-economic and living standards of the people as well their ability to seek for care when sick. Such pains from government actions and inactions is endemic in Nigeria and was a trigger for the recent October 2020 National Youth Uprising in Nigeria tagged #Endsars, which is a metaphor for bad and oppressive government.

2.1.4. Biosocial Analysis of the Health Challenge

Global health practitioners and experts believe that disease cure and prevention should be approached both from biologic and social dimensions. The society, political economy, history, culture and the social environment, all have impacts on the nature of disease, population health and their access to healthcare [15]. As mentioned earlier, Nigeria's natural climate and geographical locations in the rainforest zone is prone to mosquito bites which cause malaria. Also, limited and dysfunctional health facilities in the places where the vulnerable population live pose a problem to seeking care in a timely manner and receiving preventive education. Nigeria's climatic condition of high temperatures and heavy rainfalls encourage mosquito breeding and malaria [16], as well as increase mosquito population and transmission dynamics [17]. These conditions promote mosquito bites and malaria transmission year round especially to people living in swampy and unhygienic environments. Commonly, people who live around bushes, shallow wells or ditches and surrounded by litters of bottles, plastics, broken contain-

ers of sorts are more susceptible to mosquito bites and malaria disease. Flooding and erosions induced by poor road constructions cause pools of stagnant water to collect near homes, markets, schools or community centers, thereby providing additional breeding sites for mosquitos [18]. In some places, the pools of water remain until the dry season to serve as source of water supply for the people and also breeding grounds for mosquitos which bite people as they come to collect water for use.

2.1.5. The Implications of the Social Environment and Socio-Economic Status to Malaria Diseases

The environment in which people live and their economic status have effects on malaria control and eradication in Nigeria. Poverty or economic capacity affects people's ability to seek protective measures against malaria such as sleeping under insecticide treated nets, using indoor residual spraying, proper housing and seeking curative measures in a timely healthcare [19] [20]. People in overcrowded and poor sanitary living conditions are more prone to mosquito bites and malaria disease than people living in well-planned urban environments. Hence often, malaria is referred to as a disease of the poor and underserved. Disparity in the living environment between the rich including senior government officials and the poor, who form the majority of the population is very remarkable. There is a tendency to create a better living environment with public health facilities where government officials and the rich live than extending to the rural population. According to the World Health Organization [21] poverty creates ill-health because it forces people to live in poor environments with no access to decent housing, clean water and proper sanitation and thus expose them to many types of illnesses. Also, studies show that human life expectancy is determined among other factors by the conditions of their living environment, per capita income, health expenditure, access to physicians and the degree of social and economic development in the country [22]. Therefore, the context for the control, elimination and eradication of malaria in Nigeria should be set in understanding the roles of the socio-economic factors. As far as the high political class and the highly connected live in the best areas of the cities and have access to the best healthcare overseas and in Nigeria, there is no urgency to improve health services or social development infrastructures. These social and economic disparities posed a threat to any efforts to prevent or control malaria.

2.1.6. Systemic Structural Violence that Challenge Malaria Eradication

Certain government actions or inactions have contributed to Nigerian people's susceptibility to malaria disease burden and sickness. From the colonial era to independence and to date, Nigeria's failure to implement a sustainable socio-economic agenda to uplift her growing population has impacted the health and wellbeing of the people. Government's lack of political will to maintain equity and justice in the distribution of basic amenities gradually imposed hardships on the people as they become structurally limited to the extent of their access to the basic needs of life. Structural violence arises when government actions or inac-

tions impact negatively on the life and enjoyment of the people to the extent that they accept the conditions as normal while undergoing pains and hardships. Structural violence are barriers posed by social, economic, institutional, environmental, legal and or/political factors that prevent people from reaching their full potentials [23]. It can be viewed as a social arrangement that put individuals and populations in a harm's way, because social and economic arrangements in the organization are so structured that they impact the people violently and disadvantageously. In Nigeria, government neglect of developmental infrastructure, the absence of basic living amenities, deliberate denial of opportunities to certain ethnic groups, marginalization and militarization of certain regions are all signs of violence to the people [24] [25]. Such embedded violence in the social and political system in Nigeria has perpetuated suffering and inflicted pains, hardships, frustrations, and posed a restrain to the health of the people. Logically, people who struggle with poverty and hunger will give priority to food than to buying bed nets for preventive measures or going to a health center when sick. This is the situation with many people in Nigeria and actually not a surprise that malaria cases and deaths are on the increase yearly.

2.1.7. Nigeria's Dysfunctional Health System Poses a Challenge to Malaria Eradication

The Nigerian national health system is dysfunctional and characterized by problems such as 1) lack of clear referral link between healthcare systems, 2) ill-equipped health facilities, 3) inadequate funding for the primary health delivery system 4) paucity of funded health research, 5) shortage of doctors at primary health facilities, 6) absence of equitable health insurance system, 7) poor surveillance and data collection system; 8) and the lack of sustainable malaria control programs etc. [3] [4] [26] [27]. The decay and malfunctioning of the health system are major reasons certain health behaviors such as self-medication, delayed treatment, and for increased deaths from malaria related sicknesses. According to Jones & Williams [28] health behaviors are not simply a function of knowledge or beliefs but are also modified and constrained by the social, cultural, economic, and political restrictions or contexts in which they occur. Within the Nigerian health system, there is no health insurance program for most of the people, especially, the rural and underserved, which translates into a huge out of-pocket expense for seeking care. In addition, the absence of a qualified physician and shortage of drugs at a closest primary healthcare facility, which is common in Nigeria, constitute a constraint to access treatment in a timely manner.

3. Disease Burdens of Malaria

Malaria presents health, social, and economic burdens to the majority of Nigerians. According to the WHO Malaria Report [1], Africa accounts for 90% while the Sub-Saharan Africa has 80% of global malaria cases and deaths. According to

studies, malaria disease burden is high among under-5 year children, pregnant women, the elderly population, and people of lower socio-economic status [29] and also on poor rural residents who are unable to seek care or acquire preventive insecticide treated bed nets [6] [30]. Infested pregnant mothers are at the risk of frequent maternal illness, chronic placental parasitaemia, neonatal mortality and delivering low-birthweight babies as a result of *Plasmodium falciparum* infection [31]. Newborn babies and infants less than 12 months old do not have adequate protective immunity against malaria and their risks of malaria increase as they play outside and without clothes on or left unattended. International travelers and tourists from mosquito-free countries are equally at great risk because they lack the immunity from malaria. This therefore, underscores the need for global eradication of malaria because it is not only a health threat to those living in tropical or poor environmental conditions, but also to travelers or business executives from malaria free countries.

Malaria is a taxing disease with serious symptoms such as fever, severe headaches, loss of appetite resulting in malnourishment, general weakness, bitterness in the mouth, etc. According to the US Centers of Disease Prevention & Control [32], severe and frequent episodes of malaria can affect vital organs in the body and cause complications such as acute kidney injury, severe anemia, hyperparasitemia, metabolic acidosis etc. Besides, malaria also imposes social and economic burdens on the individual, family, relations, and community [33]. According to Tabbabi, malaria has both direct costs associated with actual prevention and treatment; and indirect costs from loss of income due to absenteeism and low productivity. According to the author, children suffering from malaria will skip school, while their parents lose substantial income staying at home and taking care of the sick child. For poor families and marginalized populations, the burden of malaria means a choice between meal and treatment, use of herbal or unproven cure methods due to limited income [4] [28]. Poor households with low levels of income are more likely than the rich households to experience poor health outcome from malaria, have limited access to health care, and suffer from poor nutrition and the risk of other health complications or death [29]. Socially, malaria sickness brings pains to the family, and to close relations as health and sickness are shared values in a typical Nigerian community.

4. Addressing the Barriers to Malaria Elimination

For Nigeria to progress in the control and eradication of malaria, it should implement a combination of measures that include mosquito avoidance, improved access to diagnostics and treatment, health education and promotion and community partnership. The National Health Insurance program enjoyed by the Formal sector (public service, organized private sector and the armed services) should be extended to other citizens of Nigeria. As a necessity, Nigeria should focus on improving population health and wellness by investing in rural socio-economic infrastructures and should abandon the neoliberal agenda which puts

health care in the marketplace. The poor often are less educated and unemployed and consequently lack the ability to pay out-of-pocket for high costs associated with frequent malaria illnesses. Studies show that willingness to pay (WTP) is closely related to socioeconomic status which is a major health determinant [34] [35]. Socioeconomic status has serious impacts on health and wellness and access to healthcare especially for low-income households as the ability or willingness to pay for goods and services is a function of personal income which directly determines the demand for such goods and services. Consequently, the abilities of households to pay for preventive and curative services of malaria are essential to malaria eradication and elimination.

Nigeria should also follow diligently the World Health global strategies for malaria eradication. The World Health Organization's *Global Technical Strategies to Eradicate Malaria* recommends the following: 1) universal access to malaria prevention, diagnosis, and treatment, 2) accelerate efforts toward malaria elimination and attainment of free status, and 3) transform malaria surveillance into a core intervention [1]. In order to accomplish the above, current Ward Health Delivery System practiced in Nigeria should be re-energized, properly funded, and managed by an independent body for proper accountability and oversight.

4.1. Proper Staffing and Training of Ward Health Staff

The Ward Health System practiced in Nigeria uses the electoral wards as the basis of its operational units for primary health delivery. Therefore, it should be strengthened by employing qualified staff at all levels and providing them training to enhance their skills in malaria eradication strategies. Ward health system staff should be trained to acquire skills for health needs assessments, planning and implementing health promotion programs, advocacy, data collections, management and program evaluation, and trained in theories and models of program implementation, collaboration and community building, leadership models, school health promotion etc. In addition, every ward or set of wards should have a physician to cater for local population health needs.

4.2. The Role of Primary Health Delivery Trust Fund (PHTF)

Funding and finances for primary health delivery should be carefully mapped out and sanctioned against any misappropriation or mismanagement. Since local governments get monthly allocations from the Federal Government, therefore, a mandatory percent of their allocations should be deducted at source and deposited into a fund which may be known as Primary Healthcare Trust Fund [PHTG, 3]. PHTF is an innovation that ushers in a social change whereby the funds allocated for primary healthcare delivery will be out of the reach and control of any local government chairman and shield the funds from any state government interferences. It will ensure that allocated funds are directed to services that will benefit the target populations and address local health problems.

Additionally, implementing this approach ensures that State Governments

mandatorily allocate a percentage of their monthly federal allocations directly to the PHTF to enable a robust public health program at all ward levels in the local government. The trust fund should be managed by a regional board selected from both the public and private sectors which will also appoint local board for each or a set of local government primary health systems. The regional board will be responsible for all funds allocations, disbursements, hiring of physicians, procuring and supplying drugs, and general oversight. The local boards should have the duties to 1) manage specific local funds, 2) manage and supervise local health delivery systems, 3) develop and implement malaria eradication programs and treatment plans, 4) hire and retain health professionals and administrative staff, 5) maintain health facilities, 6) and report to the regional board 7) perform other functions as deemed necessary. Members of the local board will also be selected from the communities, community leaders, health professionals, ward staff, and senior staff from the local government.

4.3. Empowered and Engaged Grassroots through Health Education and Promotion

Furthermore, there is a great need to educate, engage, and empower the grassroots to embrace any behavior change relevant to achieve malaria interventions and eradication. To truly conquer malaria, we need a comprehensive approach that includes vector control measures and early diagnosis and treatment, especially at the village level, remarked WHO Director-General, Dr. Tedros Adhanom Ghebreyesus [36]. Therefore, for Nigeria to achieve the World Health target strategies under the Ward Health System, emphasis should be placed on preventive measures and improved access to medical treatment. Every ward should commit to health promotion and education programs to increase awareness of malaria prevention measures; promote community participation and adherence to evidence-based strategies such as the use of Insecticide Treated Bed nets (ITNs) and indoor residual spray (IRS). Insecticide treated bed-nets (ITNs) will prevent mosquitos from biting and transmitting malaria to humans, whereas the IRS will kill mosquitos already in the rooms and prevent biting and transmitting diseases [1].

4.4. Strengthened Ward System of Health Delivery

The Ward System of Healthcare was adopted to use the electoral ward as the basic operational unit for PHC service delivery, but most of them lack the basic or essential facilities and equipment to operate. The government should strengthen the ward system by adequately equipping, staffing, and funding health facilities and as well provide regular training for staff to update knowledge and skills. In the absence of a national insurance scheme for the rural population, every local government should have the autonomy to work out an equitable or affordable service fees to be paid by patients to sustain the health program. In an effort to support lowered out-of-pocket expenses for health services, community and

youth volunteers could be used for minor services such as clerical work, routine cleaning, and security etc. Student volunteers from higher institutions could be used for data collection, advocacy, fundraising or sensitization through education and communication campaigns for malaria eradication [37]. Leadership can be enhanced by involving leaders of local business stakeholders, which will in turn encourage their employees to patronize the local health facilities.

Furthermore, another important strategy to sustain the program could be improved intersectoral collaboration. Inter-sectoral action for disease prevention was emphasized in the 1978 Declaration VII (4) of the World Health Organization *Alma Ata Declaration* [38] as the working together between the health sector and other sectors, including the at-risk populations. This collaboration makes for better interactions between the health staff, policy makers and community. In addition, it motivates people to take control of their health challenges and participate in the recommended behavioral changes that contribute to the problem-solving agenda [32] [39]. This will provide the needed local capacity to implement a planned roadmap towards malaria eradication. By engaging communities in the malaria eradication program plan, it becomes possible to extend the education and intervention practice to hard to reach places and enable people to change their behaviors or attitudes to malaria control by being part of the implementation.

5. Conclusion

Malaria eradication should be seen as project that demands immediate attention. This means that the government should provide adequate financial and human resources to supplement international support for eradication program. Therefore, a separate funding allocation and management for the health sector will help promote continuity, accountability, improve grassroots outreach, intervention and engagement. Nigeria should set up and implement a functional malaria surveillance system to collect data on malaria cases and monitor eradication progress. Malaria can only be eradicated in Nigeria when the government feels committed to it as a national responsibility. Malaria hyper-endemicity is a major public health crisis that requires government's deliberate and consistent efforts to follow recommended strategies to eliminate and eradicate malaria in Nigeria and save the people from deaths and malaria associated health consequences.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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