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VIEWPOINT

Improved Domestic Funding Enhances the Sustainability of HIV/AIDS Response in Nigeria

Babayemi Oluwaseun Olakunde, MBChB, MPH, Chinwendu Daniel Ndukwe, MBBS, FWACP
Abuja, Nigeria

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INTRODUCTION

Following the first AIDS case reported in 1986, which heralded the HIV burden in Nigeria, a national response was initiated to address the HIV scourge. Although the HIV/AIDS epidemic grew in the early years, the past decade has witnessed a stabilized epidemic.[1] As a result of the well-coordinated multisectoral response approach, the prevalence rate (from sentinel surveillance) declined from 5.8% in 2001 to 4.1% in 2010.[2] Financing, an integral element of the response has been critical to the significant gains experienced to date. As of 2012, the total HIV/AIDS expenditure from all sources was estimated at US $577.4 million.[3] However, with dwindling of donor funds sustainability (the capacity to maintain program services at a level that can provide ongoing prevention and treatment for a health problem after termination of major financial, managerial, and technological assistance from an external donor)[4] of these achievements has come under serious threat, necessitating exigent mitigating measures.

This article briefly looks at recent efforts by the federal government of Nigeria (FGN) to address the brewing risk to its HIV/AIDS response. It highlights the progress in increasing domestic HIV/AIDS funding and the paradigm shift in implementation to foster ownership and sustainability of the HIV/AIDS response.

SKEWED FUNDING LANDSCAPE

HIV financing in Nigeria is pluralistic but broadly categorized into domestic and external (international) sources. In contrast to the domestic funding which includes the public and private sources, the external support has been more substantial and relatively stable.[3,5] A review of the national expenditure from 2009 to 2012 shows that the public funding varied between 17.7% to 25.2%, whereas the international funding varied between 74.7% and 82%.[3,5] Private funding sources within this period ranged from 0.5% to 1.6%. In absolute figures, HIV spending by public sources ranged from about US $97.8 million in 2009 to about US $123.0 million in 2012.[3,5] HIV expenditure by international sources steadily increased to US $445.2 million in 2012 from US $317.2 million in 2009.[3,5] Evidently, HIV financing in Nigeria is heavily donor dependent.

External funding remains critical to many HIV programs in low- and medium-income countries. In 2012, about 51 countries including Nigeria depended on international sources for >75% of their HIV-related expenditure.[6] Sources of external funding in Nigeria include bilateral contributions, multilateral agencies, and international nonprofit and for-profit organizations, with the bilateral donation accounting for the largest contribution.[2,4] The 2 major donors are the US President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Other notable donors include the Department for International Development, the World Bank Multi-country AIDS loans, the Bill & Melinda Gates Foundation, the Canadian Agency for International Development, and the United Nations Agencies.[7]

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From the National Agency for the Control of AIDS, Abuja, Nigeria. Address correspondence to O.B.O. (bolakunde@naca.gov.ng).

However, the recent global economic meltdown has continued to affect external support, resulting in dwindling of donor funds for HIV/AIDS.[8,9] Evidence from Nigeria reveals that although funding from external sources is increasing, the rate of increase is on the decline. Analysis of the external sources from 2009 to 2012 shows a steady decline in the percentage increase from about 17% to 8.2%.[10] PEPFAR Nigeria's total annual budget has gradually been dipping since 2012.[11]

The increasing systematic redesign of donor supported programs is arguably further suggestive of dwindling donor funding. For example, PEPFAR has had a major implementation shift in its support for HIV prevention, treatment, care, and support programs in Nigeria. In the country operative plan for 2014, an active scale-up was limited to only 8 states, while the remaining states were categorized as maintenance states without active demand creation outreach and community-based activities.[12] Additionally, support for certain laboratory investigations such as complete blood count, chemistry, chest x-ray, hepatitis B surface antigen testing, and urinalysis were withdrawn.

Given the degree of reliance on external funding, this downward trend in support portends crisis for the national response and has brought to the fore the imperativeness of increasing domestic funding toward sustainability of the HIV/AIDS response.

RENASCENT DOMESTIC FUNDING

The pledge by many countries in the United Nations 2011 Political Declaration on HIV and AIDS to intensify efforts to eliminate HIV has led to increased political commitment toward country ownership, efficiency, and sustainable financing.[13] Among the resolutions was the commitment to close the global resource gap by scaling up new, voluntary, and additional innovative financing mechanisms.[14] Consequently, a growing number of countries are exploring innovative funding channels for their HIV programs.[13,15]

It was estimated that 50% of domestic funding of HIV services (in addition to the external sources) is required to achieve universal access to HIV prevention, treatment, care, and support in Nigeria by 2015.[16] As noted earlier, the total share of government contributions to HIV/AIDS expenditure has been <30%. Recognizing the huge existing gap in domestic support and service provision, and to demonstrate his political commitment, the former president of Nigeria, Dr. Goodluck Jonathan in 2013 requested the development of a 2-year action plan that would bridge the gap and accelerate key service implementation toward the achievement of universal access by 2015.

The President's Comprehensive Response Plan (PCRP) is a 2-year plan in the first phase of the longer-term sustainability strategy of the FGN.[16] The PCRP was designed with the objective of addressing financial, health-system, and coordination challenges to the HIV/AIDS response. A matching grant model with the federal and state governments providing resources to the pool in a 50/50 ratio was proposed for the investment. If fully implemented, the proportion of domestic funds investment in HIV/AIDS response will increase to 60%. Overall, the plan aims at ensuring Nigeria takes a greater ownership for a sustainable HIV/AIDS response.

Federal government funding of the PCRP for 2014 and 2015 was provided through the Subsidy Re-investment and Empowerment Programme (SURE-P) under the social safety net programs. SURE-P is driven by the resources that accrued to the government as savings from the partial removal of fuel subsidy and the goal is to accelerate economic transformation through investments in critical infrastructural projects and provision of social safety net program that targets the poor and vulnerable.[17]

In summary, the FGN, from savings through policy reform, gained and allocated additional funding for its domestic support of the HIV/AIDS response. Savings from processes or program reforms have been used in countries like South Africa and Swaziland to scale-up HIV coverage.[13]

PARADIGM SHIFT IN IMPLEMENTATION APPROACH

With the available SURE-P fund for the PCRP, the FGN has adopted implementation strategies that will promote greater responsibility and ownership of the HIV/AID response. Firstly, the government opted to investing directly in HIV treatment, care, and support services. Hitherto, the country did not have such services designed, implemented, and solely funded by the government. Government's expenditure has largely been on human resource, program management, administration,[3,5] and procurement of drugs and commodities to support other donor-funded HIV programs. Country ownership is a key step to sustainability.[18]

Secondly, the adopted implementation approach involves the use of State Ministry of Health

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(SMOH) to coordinate, monitor, and supervise the implementation of the government-owned HIV treatment, care, and support services. This is a complete departure from the conventional use of nongovernmental organizations (NGOs) by donor partners for implementation of HIV services. The NGO-centered approach has been associated with drawbacks that undermine the public health system.[19]

The decision on the approach and roll-out plan followed a series of consensus building and multistakeholder engagement. For the first phase of the program, PEPFAR in line with its plan for advancing country ownership, agreed to transition its supported sites in 2 high-burdened states (Abia and Taraba) to the FGN. The selection of the 2 states had followed a methodical process taking into consideration the available funds, HIV service gap, existing level of partner support, and geopolitical balance.

The FGN is now responsible for the treatment, care, and support of about 35,000 people living with HIV (PLHIV) following the seamless transition from PEPFAR to FGN. The government-funded HIV/AIDS program also aims to scale-up by initiating new 15,000 HIV-infected people on treatment and provide 10,000 women with Prevention of Mother-to-Child Transmission of HIV services over a year. The FGN support includes laboratory monitoring and active demand creation, which were discontinued by PEPFAR in those 2 states.

(DIS)TRUST IN GOVERNMENT-SUPPORTED PROGRAMS

The bold move by the FGN toward sustainability of the HIV/AIDS response has received positive reviews. However, a few observers remain critical. They have argued speciously that the FGN is inexperienced and lacks the requisite expertise to manage HIV programs. It has also been posited, rather ironically, that the investment might not be sustainable given the vagaries of government policies. The issues of corruption and the possible mismanagement of the funds have also been vehemently raised. Undoubtedly, these perceived uncertainties about the program might affect uptake and delivery of services by the clients and health care providers respectively.

The management of the HIV program is not entirely new to the FGN. Before the advent of PEPFAR in 2004, the FGN was responsible for treatment, care, and support of about 5000 PLHIV.[20] Also, the National Agency for the Control of AIDS (NACA), entrusted with the coordination of the funds, has been in the forefront of donor-fund coordination and HIV programming in Nigeria. NACA has been a principal recipient of the Global Fund HIV/AIDS grant and has successfully coordinated the implementation of the fund for HIV/AIDS services. The technical expertise to efficiently manage the fund is certainly not lacking. Although the agency performs the overall coordination of the program, SMOH is responsible for coordination of the implementation at the subnational level. Nonetheless, acknowledging the novelty of the task to the SMOH, provisions were made for technical support in the early phase of the program through the state NACA liaison officers embedded in the 2 states.

The growing political commitment of the FGN to HIV/AIDS is reflected by the increasing effort toward achievement of the universal target. The promulgation of the PCRP and the recent launching of the National eMTCT Operational Plan 2013-2015 clearly demonstrate a consistency in the government's commitment. This unique commitment has been reinforced by the release of some funds for implementation. The FGN has taken the first committed step to ensuring a perpetual ownership pathway, with a full understanding of the implications. An attempt at reversal of the funding support can jeopardize treatment outcomes of >35,000 PLHIV in the 2 states.

Finally, transparency and accountability is a key fundamental aspect of the program. In line with the underlying guiding principle, a robust system for monitoring the budget, disbursement, and expenditure is in place. This involves committees that perform oversight at different levels to ensure appropriate and efficient use of the resources.

CLOSING OTHER GAPS

The funding projections for HIV/AIDS in Nigeria have demonstrated that a huge investment will be required to meet the universal access by 2020. For example, on antiretroviral therapy, the investment required will increase from US $2.3 billion in 2015 to US $2.9 billion in 2020.[10] This level of funding will require a considerable domestic investment.

A robust policy on domestic funding has become imperative for investment in the HIV/AIDS response. A clear framework to improve the resource mobilization, efficiency, and accountability is required. Other financing mechanisms such as a health insurance

scheme, HIV/AIDS-dedicated taxes, and levies should be considered. The private sector remains largely untapped and a public–private partnership should be explored to bridge the huge financial gap. Support of domestic funding needs to be all inclusive and must be a shared responsibility between the 3 tiers of government. Nonetheless, external donors still have a significant role in funding HIV/AIDS programs.

Aptly, there has been a call for a coherent global framework for health financing capable of securing efficient, equitable, sufficient, and sustainable funds to achieve universal coverage.[21] A revision of the current approach to health financing in domestic financing as well as the joint financing of global public goods for health, and external financing has been recommended. This will involve addressing key challenges with health financing such as mobilization of resources, pooling of funds, spending, and accountability.[21] In line with this and of huge relevance is a universal framework for health-financing research. It is important to develop a global research agenda to inform policies toward sustainable funding. This should include the development of a framework for methodologies, assessments, and analyses in health-financing research.

Beyond funding, donor-supported HIV/AIDS programs have had mixed effect on Nigeria's health system.[22] Thus, addressing other elements of the health system is crucial to the sustainability drive. The challenges with human resource for health in terms of quantity and quality need to be tackled at all levels of care by the appropriate tiers of government. This will involve looking at the issues of recruitment, training, retention, distribution, and motivation. The health management information system needs to be strengthened to ensure timely collection, collation, analysis, dissemination, and use of reliable data. This should include building the capacity and infrastructure for electronic data reporting. The current procurement and supply chain system, described as not sustainable as it is run by a consortium of foreign technical organizations supported by donor grants needs to be restructured.[22]

With adequate support, the use of SMOH for coordinating implementation has the potential to strengthen ownership and sustainability. However, it is important to determine the cost effectiveness of this approach. Furthermore, it is critical to assess the quality of care in government-supported facilities in terms of structure, process, and outcome. Evidence and the lessons learned from this approach can inform possible expansion.

CONCLUSION

Against the backdrop of dwindling donor support for HIV, the improved domestic funding and implementation approach for provision of HIV services by the FGN is a right step toward sustainability of the HIV response. Closing the funding gap will involve shared responsibility and exploring other financing mechanisms.

Dealing with other system issues and restoration of public confidence in government-supported programs is crucial to the success of the government-funded HIV/AIDS program.

Development of a universal framework for health-financing research is essential to support the push toward global sustainable health financing.

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