HARM REDUCTION FINANCING LANDSCAPE ANALYSIS IN NIGERIA

HARM REDUCTION INTERNATIONAL

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Harm Reduction International (HRI) is a leading non-governmental organisation (NGO) dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. We promote the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies. The organisation is an NGO with Special Consultative Status with the Economic and Social Council of the United Nations.

Research and analysis for this report was carried out by Henry Okiwu, in consultation with Catherine Cook and Gaj Gurung.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AUPA	African Union Plan of Action for Drug Control
AYP	Adolescent and Young People
BHCPF	Basic Health Care Provision Fund
BMPHS	Basic Minimum Package of Health Service
CAC	Corporate Affairs Commission
CAMA	Company and Allied Matters Act
CCM	Country Coordinating Mechanism
CLM	Community-Led Monitoring
FCT	Federal Capital Territory
FGoN	Federal Government of Nigeria
FMoH	Federal Ministry of Health
FRA	Fiscal Responsibility Act
FSP	Fiscal Strategy Paper
GDP	Gross Domestic Product
GF-NFM	Global Fund New Funding Model
GNI	Gross National Income
HIV	Human Immuno-deficiency Virus
IBBSS	Integrated Behavioral and Biomedical Surveillance Survey
KP	Key Population
MAT	Medication Assisted Therapy
MTEF	Medium-Term Expenditure Framework
NACA	National Agency for the Control of AIDS
NAHI	National Aligned HIV/AIDS Initiative
NAIIS	National AIDS Indicator and Impact Survey
NASA	National AIDS Spending Assessment
NAC/ NCH	National AIDS Council/ Nation Council on Health
NDCMP	National Drug Control Master Plan
NDLEA	National Drug Law Enforcement Agency
NEPWHAN	Network of People Living with HIV/AIDS in Nigeria
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme

NiBUCCA	Nigeria Business Coalition Against AIDS
NSF	National Strategic Framework
NSP	National HIV Strategic Plan
NSP	Needle and Syringe Programme
OSGF	Office of the Secretary to the Government of the Federation
PEPFAR/COP	Presidential Emergency Fund for AIDS Relief/ Country Operation Plan
PHC- UOR	Primary Health /Under One Roof
PLHIV	People Living with HIV
PWID/PWUD	People Who Inject/ Use Drugs
SRHR	Sexual and Reproductive Health Services
SUD	Substance Use Disorder
TWG	Technical Working Group
UNAIDS	Joint United Nation Agency on AIDS
UNODC	United Nation Office on Drug and Crime
USAID	United States Agency for International Development

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EXECUTIVE SUMMARY

The state of the health system of a country is a reflection of the premium its government places on the health and well-being of its citizenry. Health being a key parameter for measuring development of nations varies from one country to another. The 3 main sources of health funding Nigeria are government, donors and private out-of-pocket expenditure. The national health insurance coverage is low as it is limited to those in public service while the Basic Health Care Provision is not enough to bridge the funding gap.

The health system in Nigeria is over-burdened and weak. This is largely due to limited funding consequent on dwindling government revenue and inability of the government to diversify from its oil dependent economy. The health sector allocation is less than 5% of total GDP falling short of the Abuja declaration in which the government commited to a 15% allocation to health two decades ago. The allocation of available health resources is skewed towards secondary and health system at the expense of the primary health care which is closer to and meant to serve over 130 million poor Nigerians (Multi Poverty Index, National Bureau of Statistic 2022) especially key and vulnerable population who cannot afford health services.

People Who use drugs, Sex Workers and Men who have Sex with Men constitute about 3.4% of Nigeria population contributes to 32% of HIV together with their partners, hence; are considered as key population. According to UNODC Drug Use Survey 2018, 14.3 million people (age 15-64 years) which represents to 14.4% drug use prevalence is about 3 times the global drug use prevalence of 5.6%. HIV incidence among people who inject drugs is 9%, while the HIV prevalence is 10% (IBBSS 2020) which is about 7 times higher among the female sub-population as documented in Integrated Behavioural and Biological Surveillance Survey (IBBSS 2014).

The growing HIV epidemic among people who inject drugs is due to criminalization of drug use and the enforcement related punitive measures leading to unintended consequences to people who use drugs. The associated societal stigma, gender and human rights violation (in family, community, public and health settings) seemed normalized and under reported. These factors drive people who use drugs underground making them unable to be reached with available services. This is contradicting the provisions of the constitution which supports individuals to seek health services as a fundamental human rights. It guarantees right to life, right to dignity of the human person, right to personal liberty, right to freedom of expression and right to peaceful assembly and association which empowers Non-Governmental Organizations or any agency in Nigeria to provide health services.

There exist laws and policies that guide the national HIV response and harm reduction program which was approved in 2019. The national strategic plan and other guidelines recognized people who use drugs as a key population and as such meaningfully involve them in policy formulation, program implementation and coordination platforms or decision making. Unfortunately, the unmet health needs of people who use drugs are growing, despite USD 2.1 billion reported donor spending on HIV between 2015-2018. Of this spending, just USD 44 million went to key population programmes, representing 2% of the total expenditure (NASA, 2019).

It is to this end that Harm Reduction International commissioned YouthRISE Nigeria to conduct a landscape analysis to assess the state of harm reduction program funding in

Nigeria. The findings of the desk review and community consultation process in addition to the recommendations will inform future policy advocacy efforts.

The Nigerian government should:

- Go beyond approval: prioritize and commit to funding the implementation of harm reduction programmes in Nigeria;
- Decentralize health expenditure that is skewed to tertiary and secondary facilities with a focus on primary health care targeting vulnerable populations that will benefit the most;
- Improve the social accountability mechanism that will support the delivery of harm reduction services;
- Strengthen measures for communicating results of health sector budget performance with consideration for development of detailed periodical budget reports at both the national and sub-nation levels;
- Sustain coordination of the harm reduction response in Nigeria;
- Integrate harm reduction services into the health insurance and provision of complementary tax finance schemes to ensure the inclusion of people who use drugs into UHC efforts.

Technical partners should:

- Strengthen the capacity of civil society to advocate for increased domestic funding of harm reduction services;
- Support development of policy guidelines that support implementation of harm reduction programmes.

Donors should:

- Improve funding of harm reduction and integration of harm reduction into community-led monitoring of HIV programmes in Nigeria;
- Increase funding of harm reduction programmes in Nigeria for scale up and coverage.

Civil society should:

- Document evidence from current harm reduction impact with support from donors;
- Use available evidence to advance policy and stakeholder engagement to advance advocacy for increased domestic funding of harm reduction programmes in Nigeria;
- Explore the window of opportunity on the National Strategic Plan development and Global Fund NMF4 processes to prioritise harm reduction programmes for government funding;
- Push for integration of harm reduction into ongoing community-led monitoring of HIV programmes and produce periodical monitoring reports;
- Strengthen partnerships for implementation of harm reduction programmes in Nigeria;
- Mobilize resources from the government and other sources to support delivery of harm reduction services.

SECTION 1: INTRODUCTION

Nigeria, located in West Africa, is a lower-middle-income country (GNI: 2,100 per capita, Atlas method[1]). With a current population estimate of 219,243,344 (population demographics: 49%and 51% male[2]), it is Africa's most populous country. Nigeria is ethnically and culturally diverse, with 36 states plus the Federal Capital Territory (FCT) and is divided into six geo-political zones.

Nigeria has abundant natural resources, with oil being the leading source of income. Though the country has the largest economy in Africa (according to the Gross Domestic Product (GDP) rebasing in 2014), it is facing significant economic challenges in recent years, ranking 161st among 189 countries on the Human Development Index (HDI) in 2019.[3] About 40% of the population live below the poverty line, and 25% are classified as vulnerable.[4] The increasing spate of violence, banditry, and insecurity has produced the worst humanitarian crisis in Nigeria's history, with an estimated 8.4 million people requiring humanitarian assistance in 2022, and the Northeast of the country being the worst-hit.[5] The deplorable security and socio-economic situations are fueling drug use and the HIV epidemic, with huge implications for its weak and overburdened health system.

An estimated 14.3 million (14.4% of the population) 15–64-year-olds use drugs in Nigeria.[6] This figure is about three times greater than the global average of 5.6%.[7] The 2020 Integrated Behavioural and Biomedical Surveillance Survey (IBBSS 2020) reported a 10.9% HIV prevalence rate among people who use drugs, which is high compared to the 1.3% prevalence rate among the general population, according to the National AIDS Indicator and Impact Survey (NAIIS).[8]

Also, people who use drugs (with an estimated population of 227,068[9]) and other key populations (KPs) constitute about 1% of the adult population in Nigeria, but they contribute as much as 23% of new HIV infections.[10] Together with their partners, KPs account for 3.4% of the adult population and 32% of new HIV infections.[11] The relatively higher prevalence among KPs is exacerbated by unsupportive cultural beliefs and practices, societal and religious biases, stigma and discrimination, and punitive national laws.

To address drug use, the HIV epidemic, and other blood borne infections, the federal government approved the implementation of comprehensive harm reduction in 2019, including needle and syringe programmes (NSP), medication assisted therapy (MAT), and naloxone, all of which were lacking in the previous HIV response. The pilot was conducted in three states

1 World Bank, 2017 data https://data.worldbank.org/country/Nigeria
2 2020 Spectrum data, 2019
3 United Nations Development Programme (UNDP). 2020. Human Development Report 2020: The Next Frontier: Human Development and the Anthropocene. New York
4 National Bureau of Statistics. 2019 Poverty and Inequality in Nigeria. https://nigerianstat.gov.ng/download/1092
5 UN Office of Coordination Humanitarian Affairs. About OCHA in Nigeria. https://www.unocha.org/nigeria/about-ocha-nigeria
6 National Drug Use Survey Report. https://www.unodc.org/documents/nigeria//Drug_Use_Survey_Nigeria_2019_BOOK.pdf.
7 World drug report. United Nations Publication. 2019
8 Federal Ministry of Health Nigeria & NACA. National HIV/AIDS Indicator and Impact Survey, Report 2018.
9 PEPFAR Nigeria. Country Operational Plan 2020
10 Federal Ministry of Health Nigeria & NACA. National HIV/AIDS Indicator and Impact Survey, Report 2018
11 National Agency for the Country of AIDS (NACA 2017)

and the FCT, and harm reduction services are currently being scaled up with funding support from the Global Fund and ViiV Healthcare. Therefore, there is no better time than now to conduct this landscape analysis, as it will serve as a baseline to measure future investment in harm reduction programmes in Nigeria.

1.1 Landscape analysis objectives

1. To assess the domestic funding of harm reduction programmes in Nigeria;
2. To gather evidence to advance advocacy for increased domestic funding of harm reduction programmes in Nigeria.

1.2 Methodology

The landscape analysis used a qualitative method, which involved conducting a desk review of available literature, policy, and legal documents, as well as carrying out a community consultation for the landscape analysis of harm reduction programme processes in Nigeria.

The community consultation targeted networks of people who use drugs and other key population-led networks that include harm reduction within their work; community-based and civil society organizations that are involved in the harm reduction response at national or subnational level (including those providing services and those involved in advocacy); and representatives from the government, coordinating agencies, and technical partners.

The consultation was conducted primarily via email with follow-up phone call interviews using a structured and open-ended questionnaire with the consent of interviewees. The responses were transcribed and thematic analysis of the outcomes was conducted, which subsequently informed the development of this report.

1.3 Study limitations

Some of the study limitations were as follows:

1. This report was based on available budgetary data and information from national budgets only, due to the lack of evidence at the subnational level.
2. There is limited data and information on domestic funding of harm reduction programmes in Nigeria, with the exception of the fiscal year 2022 budget, as the programme is relatively new, having only been approved in 2019. Evidence provided in this report was based on budgetary expenditure for the HIV service package, excluding NSP and MAT (otherwise known as Opioid Substitution Therapy (OST)), for the period 2015-2018 as contained in the National AIDS Spending Assessment (NASA) report, 2019.
3. Available budget performance and NASA reports are not detailed, data is not disaggregated based on programme thematic areas and target population. Data is available on key populations, but there is no specific data on KP typologies in order to ascertain budgetary expenditure for people who use drugs programmes.

SECTION 2: OPERATIONAL LANDSCAPE

2.1 Legal and policy environment for CLOs, CBOs, and CSOs

The Nigeria Drug Law Enforcement Agency Act (NDLEA Act 1989) mandated the Agency to control the national drug response in collaboration with the Ministry of Health addressing the public health and treatment related issues to drugs. The NDLEA approach to drug control is primarily based on enforcement. The Act criminalises the use of hard drugs (cocaine, LSD, heroin, or any other similar drugs) and stipulates a jail term of 15-25 years for drug-related offences such as drug use, possession, and trafficking. The law runs contrary to the debate on the issue of drug policy on the continent, as evidenced by the African Union's (AU) Plan of Action on Drug Control (AUPA 2013 -2017), which states: "Drug Control practice in Africa has tended to focus more attention on supply reduction, this plan proposes to restore the balance and pay greater attention to health and other social consequences of drug use, while not neglecting law enforcement approaches." However, the Act is one that very much focuses on law enforcement at the expense of health and social initiatives.

Some of the shortfalls of the law include:

1. Lack of clarity on the definition of "any other similar drugs" controlled by the legislation;
2. The Act's stated aim is to "enforce laws against the cultivation, processing, sale, trafficking, and use of hard drugs". Again, there is no legal definition as to what constitutes a "hard drug";
3. Repeated sections that deal with same activities. For example, Section 19 replicates the offence of possession already contained in both Section 11(d) and Section 20(1)(c); it is unclear how prosecutors or police would determine the charge;
4. Another point of confusion is the offence of buying a controlled drug as outlined in Section 11(c); it is unclear whether the act of buying would include people who are purchasing drugs for their own personal use;
5. Finally, the Act seems to be silent on the issue of access to medicines which are classed as controlled drugs.[12] The Single Convention on Narcotic Drugs 1961 creates an obligation for member states to ensure access to essential medicines that are also controlled by the treaty, including opioid analgesics. It is unclear from the Act how Nigeria is meeting this obligation.

The above provisions contradict the Nigeria Constitution which provides the legal framework for individuals to access health services as a fundamental human right, and empowers non-governmental organisations (NGOs) or other agencies in Nigeria to provide these health services. Section 1(1) of the 1999 Constitution states that "the Constitution is supreme, and its provisions shall have binding force on all authorities and persons throughout the Federal Republic of Nigeria". Section 1(3) further highlights the superiority of the constitution: "if any other law is inconsistent with the provision of this Constitution, this Constitution shall prevail, and that other law shall to the extent of the inconsistency be void". It is important to note that

12 Analysis of Nigeria Drug Law Enforcement Agency Act, YouthRISE Nigeria & Release Drug 2018.

the entrenchment of human rights in the Constitution did not create them, instead it protects and guarantees them from undue interference and enables their assertion.

Hence, the right to life, the right to dignity of the human person, the right to personal liberty, the right to freedom of expression and, more importantly, the right to peaceful assembly and association. Section 40 of the Constitution of the Federal Republic of Nigeria provides, amongst other things, that: "Every person shall be entitled to assemble freely and associate with other persons, and in particular he may form or belong to any political party, trade union or any other association for the protection of his interests". These provisions are the basis of NGO operations in Nigeria.

Section 17 affirms respect for equal rights, obligations, and opportunities, as well as respect for the sanctity of the human person and dignity, including people who use drugs.

In the context of harm reduction and NGO operations, section 16 stipulates that CLOs, CBOs, and CSOs can only be registered by the Corporate Affairs Commission (CAC), but only the Federal Government reserves the right to register business names under prescriptions of the Exclusive Legislative list, 2nd schedule, part 1 item 62 (f). This implies that all registration of business is under government regulation and does not limit registration of organisations.

Moreover, drugs and poisons are in the exclusive legislative list. Therefore, only the Food and Drug Services (FDS) of the FMoH is the Competent Narcotic Authority (I) to procure, store, and distribute controlled medicines (especially those for substance use disorder treatment) under 2nd schedule, part 1 item 21.

Other available laws serving the same purpose are the Company and Allied Matters Act (CAMA) 2004, which supports the establishment of CAC; the National Planning Commission Act of 2013, which provides renewable clearance certificates to NGOs; the Terrorism (Prevention) Act of 2012, which determines what is freedom of speech and hate speech; the Money Laundering Prohibition Act 2012; and the Companies' Income Tax and Tax and Levies Acts of 2007 and 1998, respectively.

The National Drug Control Master Plan (NDCMP) recognises the need for FMoH and NACA to establish models for comprehensive, accessible, affordable, and evidence-based HIV prevention, treatment, and care services for people who use drugs, with a focus on those who inject.

Despite these laws, several bills have been proposed at the National Assembly between 2014 and 2017 recommending the need to set up another agency – the NGO Regulatory Commission – with the authority to renew licenses of all NGOs, oversee receipt of grants, and give approval for expenditure with 18 months' term for any NGO that default. This is evidence of the conflicting or parallel laws and the hostile working environment in which NGOs operate in Nigeria, as well as the failed attempt to control, to create bureaucracy to limit their operations, and weaken their accountability function. These are attempts by the government to control the activities of NGOs that failed due to civil resistance but attest to the hostile working environment.

Currently, harm reduction services, such as needle and syringe programmes, are provided on the basis of public health to reduce harm, morbidity, and mortality related to drug use. People who use drugs continue to face harassment, abuse, and exploitation from law enforcement, while intervention sites are subject to raids and service providers are at the risk of being

arrested during the process. Representatives of CLOs, CBOs, and CSOs (e.g. people who use drugs and their network leadership) are meaningfully involved in decision-making processes at all levels, and sometimes play a lead role in the national technical working group meetings, state steering committee, policy development meetings, national surveys, Global Fund KP Core group and PEPFAR community consultations. People who use drugs self-identify within this coordinating structure and play a lead role in their CBOs and network, the KP Secretariat, GF KP Core Group, and PEPFAR community consultations.

The FMoH and the National Agency for the Control of AIDS (NACA) lead the health and multi-sectoral HIV response. NACA is situated within the Presidency, reports through the Office of the Secretary to the Government of the Federation (OSGF), and is accountable to the National AIDS Council.

2.2 Policy framework and mechanisms for social contracting of CLOs, CBOs, and CSOs for harm reduction

Social contracting is defined by the Global Fund as a mechanism that allows for direct flow of funds from the government to CSOs to implement specific activities.[13] In Nigeria, the mechanism for social contracting includes grants, procurement, and contracting. These mechanisms are guided by a legal framework that includes the Health Policy Act 2007, the Financial Act 2020, and the Public Procurement Act, which guides the purchase of goods and services being implemented by the Bureau of Public Procurement (BPP) with oversight by National Council on procurement.

However, there is no social contracting mechanism between the government and CSOs in the HIV space as HIV programmes are donor-driven. For the donor-funded HIV and recent harm reduction programmes, the sub-granting process started with a call for applications, was followed by submission of a detailed proposal and budget breakdown of how cost will be applied, then was subject to a technical or expert review. An assessment of successful organisations is done with a national tool to determine the capacity of the organisation to successfully implement the grant and identify areas where support can be strengthened. Other eligibility criteria considered are evidence of registration, security approval from the anti-fraud/graft commission and whether the organization has been audited. Implementation of harm reduction programmes is relatively new and, as such, is not being funded by the government. ViiV Healthcare provides direct contracts to local organisations in tranches prior to project implementation, while the Global Fund adopted the umbrella grant model in which funds are disbursed to the primary recipient – usually a local or international CSO registered in Nigeria – for onward disbursement to others (sub-recipient (SR) and sub-sub-Recipient (SSR).

Moreover, one of the challenges identified in the national HIV response (including the KP programme) is the inability of NGOs to influence and monitor the government budget, despite their strength in programme implementation and advocacy. This is largely due to the limited capacity of parallel laws and legislations, and lack of disaggregated data and transparency around the government budgeting process.

13 Social Contracting, Global Fund 2017.

2.3 Integration of harm reduction in health and HIV planning processes at national and sub-national levels

Harm reduction programmes are reflected only in the HIV response and not in other health responses. The National HIV and AIDS Strategic Plan (NSP 2017 – 2021) is structured into five thematic areas that address cross-cutting issues including harm reduction. The document emphasized the need for "key populations and vulnerable populations to adopt risk reduction behaviors" and safe injection by 2021; and, as such, the need to advance the facilitation of harm reduction strategies for people who use drugs was a key recommended intervention in this regard'. The National Strategic Plan (NSP) is costed at the national and sub-national levels, while harm reduction is reflected in policy documents guiding the provision of HIV services for KPs and adolescents and young people (AYP), as well as the recent guidelines for NSP and MAT.

On the other hand, the national health policies, such as the National Health Act 2014, do not explicitly focus on the provision of harm reduction services to people who use drugs in Nigeria, but provide exemptions from payment for health services by vulnerable groups such as women, children, older persons, and persons with disabilities (but not people who use drugs).

The National Health Insurance Scheme (NHIS) superintended by the National Health Authority (NHA), listed identification and screening of Brief Intervention and Referral (SBIRT) for substance use disorder (SUD) as one of the services under the Basic Health Care Provision Fund (BHCPF), as seen under section 4.14.1 (8) iv. This means that harm reduction services, including screening for dependence and addiction, should be provided to beneficiaries at a 10% subsidy for consultation and medicines should be prescribed in primary health centers (in accordance with the principle of Primary Health Care Under One Roof -PHCUOR) and secondary health facilities as part of Basic Minimum Package of Health Services (BMPHS). Unfortunately, this is not the case.

Screening for Hepatitis B Surface Antigen (HBsAg) and testing for HIV and Tuberculosis, which are all essential components of harm reduction, are also listed under all primary and secondary level health care services.

Moreover, a resolution of the National Council on Health in 2018 mandated that all tertiary health facilities should provide services for SUD aimed at addressing physical dependence, social problems, risky use, and impairment as a result of drug misuse. In terms of health financing and budgeting, the most recent fiscal health budget (2022 budget details of the FMOH) has 20 million Naira (or about USD 40,000) approved for the finalisation of the National Health Policy on Substance Abuse, Alcohol and Suicide Prevention and Management Policy. The National Council on Health and AIDS, the Technical Working Groups on HIV and Harm Reduction (NTWG-HIV, & NTWG on Harm Reduction), as well as the Steering Committee are existing platforms for decision-making at both the national and sub-national levels.

CLOs, CBOs, CSOs, and their network provide programmatic evidence for policy guidance and are meaningfully involved, without any significant barriers, in the policy development process, implementation of harm reduction programmes, mobilization of people who use drugs for service uptake, and related advocacy efforts.

SECTION 3: CURRENT LEVELS AND SOURCES OF HARM REDUCTION FUNDING IN NIGERIA

The federal government of Nigeria approved the implementation of core harm reduction services (NSP, MAT, and Naloxone) in 2019.[14] This was followed with the implementation of a pilot needle and syringe programme in four states between 2020 and 2021. The outcome of the pilot informed scale-up of harm reduction services in three states for 2021 focal year (October 2021 –September 2022). There are ongoing efforts to further scale up harm reduction services in four additional states (a total of seven out of the 36 states plus the FCT) in the current project cycle. The provision of harm reduction services is supported by investments from the Global Fund and ViiV Healthcare, but the coverage remains low for the moment.

The implementation of the NSP pilot is supported by Global Fund in three states Abia, Gombe and Oyo and Open Society Foundation (OSF)/AIDSFONDS in the Federal Capital Territory. To scale up harm reduction services, an estimated GBP 601,375 was invested by ViiV Healthcare for implementation and coordination of its gender responsive harm reduction programme in the first year.

Table 1: A table of Harm Reduction Program funding in Nigeria highlighting contribution of Global Fund & ViiV Healthcare in FY 22.

	Global Fund	**ViiV HealthCare**
NSP Pilot	Amount= NA 2020 (3 states)	Amount =NA 2021 (1 State)
Harm Reduction Scale up 2022	USD 1,956,569.58 National Aligned HIV/AIDS Initiative (NAHI) in seven states	GBP 601,375 Gender Responsive Harm Reduction Program in three states
Duration	2021-2023	

The approved cost for the Global Fund supported harm reduction intervention was USD 1,956,569.58 under the National Aligned HIV/AIDS Initiative (NAHI) for the period covering 2021-2023. Under the NAHI project, harm reduction is embedded into existing HIV programmes as a gap filling measure in seven out of eight PEPFAR states. Since NSP service commodities are not an allowable cost by PEPFAR, the Global Fund money is used to purchase needle and syringes in PEPFAR project states.

The Nigeria HIV response is donor-dependent with donor support accounting for 85.4% of total HIV expenditure in 2007 compared to the public sector contribution of 15%. Domestic funding increased to 27.07% in 2014, compared to the international contribution of 70% for the same year. The total expenditure for HIV was USD 299,246,295 in 2007 and USD 632,378,599 in 2014.[15]

14 Nigerian government accepts needle exchange pilots. AIDSFONDS (March 4, 2019).
15 National Agency for the Control of AIDS (NACA). National AIDS Spending Assessment (NASA) for the Period 2013 - 2014. Abuja, Nigeria: National Agency for the Control of AIDS (NACA), Abuja, Nigeria; 2015

Table 2: Summary of HIV budget expenditure vs investment in KP programme between (2015-2018)

Year	Total HIV budget expenditure (USD)	Investment on/ allocation to key population program per source (USD) at national level				
		Public	Private (Business Coalition on HIV)	International funding sources	Total expenditure per year	% contribution of total expenditure
2015	501,763,459	10,198,792	6,544	619,454	10,824,790	2.16%
2016	553,039,153	328,146	433,563	487,336	1,249,045	0.23%
2017	560,296,398	109,317	91,808	19,860,637	20,061,762	3.58%
2018	532,371,499	11,208,005	907	695,122	11,904,034	2.24%
Total	**USD 2,147,470,509**	**USD 21,844,260**	**USD 532,822**	**USD 21,662,549**	**USD 44,039,631**	

Note: Data extracted from National AIDS Spending Assessment 2019 (NACA & UNAIDS)

The above table shows that prior to the approval of the harm reduction programme in 2019, out of the total HIV expenditure of USD 2,147,470,509 between 2015-2018, a paltry sum of USD 44,039,631 was expended on the KP programme. This represents an average rate of 2% HIV budgetary expenditure compared to 60%-80% investment on HIV treatment, care, and support services for the general population of people living with HIV (PLHIV) during the same period.

The HIV response efforts in Nigeria continue to be almost fully dependent on international donors, with PEPFAR and the Global Fund accounting for 67% and 15% respectively of about USD 532.4 million reported HIV spending in 2018.[16]

In addition, donor investments account for 98% (PEPFAR 82% and GF 16%) of the HIV-related commodities expenditure at a cost of USD 126M in 2018 and USD 181.6M in 2017, while 2% of commodities investments are funded domestically.[17]

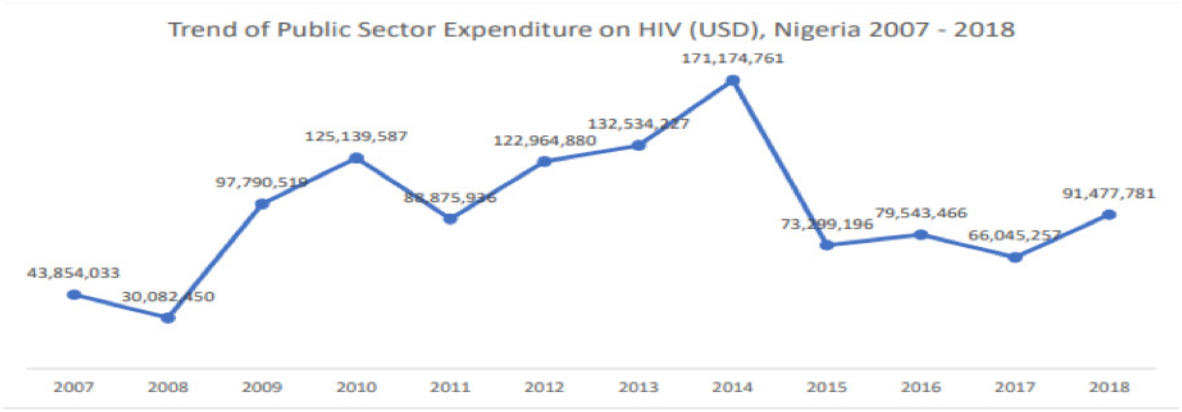
Presently, there is no account of domestic harm reduction funding since there has not been any commitment in this regard. Even the implementation of the National Drug Control Master Plan (NDCMP 2021-2025), which includes harm reduction as a strategic pillar, is not operationalized due to little or no funding commitment by the government over the years. There is no benchmark to measure changes or fluctuations in harm reduction funding in Nigeria, as the programme is in its second year of implementation (amid 20.52% inflation rate as of August 2022 which was not factored into the budget) and in limited scope, but it is expected that development partners will include harm reduction in their transition plan as in the case of HIV funding. For example, some ART sites being supported by the Global Fund and PEPFAR/ USAID have been transitioned to government.

16 National Agency for the Control of AIDS, '2019 National AIDS Spending Assessment Report'. (Unpublished Draft).)
17 PEPFAR COP 2019, Nigeria.

3.1 Domestic public financing for the harm reduction response

Evidence from the qualitative information gleaned from the community consultation affirmed that aside from the conventional HIV programme, core harm reduction services such as MAT, NSP, and naloxone are not funded by the government at the moment, as per the submission above. The reason can partly be attributed to the refusal of appropriation committees of the government to approve budget proposals from the public health department of the FMOH on the grounds that international donors are providing funding support for the sector. It may also be due to the perceived indifferent stance of political leaders when it comes to implementation of harm reduction. For instance, the National Drug Law Enforcement Agency Act still criminalises drug use. Arbitrary arrests, harassment, exploitation, and raids of intervention sites occur frequently, and negative societal perceptions of people who use drugs still persist.

Figure 1: Trend of Public Sector expenditure on HIV (USD) Nigeria 2007-2018



Despite the decline in public sector HIV expenditure from USD 171,174,761 in 2014 to USD 73,297,196 in 2015 (with an increase to USD 91,477,781 in 2018), the total annual budget appropriated for the health sector is less than half the World Health Organization's recommended 15%.

In terms of allocation efficiency, there is no specific information on the harm reduction programme as it is new. However, in the 2016 budget, out of total of N28.65 billion allocated to health sector to execute its capital projects and programmes, only N18.47 billion was released and N15.57 billion utilized (67.3%) by the end of the fiscal year. This the lowest capital budget execution rate at the federal level due to poor government commitment which is reflected in low health sector budget and non-prioritization of national HIV response budget for timely disbursement.[18] The dwindling gross domestic income and continued budget deficit resulted in a decrease in total health expenditure by individual out-of-pocket and pooled spending mechanisms. This means that Nigeria will continue to struggle to manage its health system, thereby making the dream of achieving sustainable health care financing and universal health coverage (UHC) a mirage.

There is coordination among international donors in Nigeria and CLOs, CBOs, and CSOs are receiving funds directly under the ViiV harm reduction project. There are also primary (FHI360), sub (Society for Family Health (SFH)), and sub-sub (CLOs, CBOs, and CSOs) recipient relationships under the Global Fund/PEPFAR funding mechanism. The key stakeholders

18 Ministry of Budget and National Planning, 2016.

in this regard are UNAIDS, USAID, UNODC, FMoH, NACA, NDLEA, civil society, and key population organizations and networks.

3.2 Existing analyses on the resources required to fund harm reduction at national or sub-national level

As previously mentioned, the challenge of resource allocation is perennial and not peculiar to health sector funding alone. The harm reduction programme is relatively new, and the government has not yet shown any commitment in funding it. Hence, there is no basis for an analysis of harm reduction resources in terms of gaps and allocative efficiency. The CSOs, CLOs, CBOs, and networks of people who use drugs have limited or no information to refer to in this regard, and the networks of people who use drugs have limited capacity and resources to engage in budget tracking or the development of reports. The ongoing National HIV Strategic Framework and Plan development process presents opportunity for costing of harm reduction services at both national and sub-national levels in the short term. Data from the National Health Accounts in 2016 shows that 67%, 26%, and 7% of government health spending took place at the federal, state, and local levels, respectively.[19] No programme specific data or information was provided. Prior to 2018, analysis of spending in the HIV and AIDS landscape between 2015 and 2018 showed that it has been skewed in favour of PLHIV, accounting for 60% of expenditure in HIV and AIDS, while about 2% of the spending was allocated to key populations - with people who use drugs as a subset. Data from PEPFAR COP 2019 and the NASA report covering 2015-2018 (developed by NACA in partnership with UNAIDS) have been highlighted in the table above.

Criminalization of drug use in Nigeria by the NDLEA Act 1989 remains a huge challenge due to stigma, gender and human rights violations associated with enforcement of the law. This in turn drives people who use drugs underground, thereby making it difficult to reach them with available services.

It is therefore important to increase the harm reduction package of services being provided to people who use drugs, with emphasis on the optimization of Hepatitis and Tuberculosis testing and treatment, SRHRs, naloxone services and community distribution, as well as the provision of safe spaces and empowerment of people who use drugs. It is pertinent to track current harm reduction funding and gather evidence to inform future advocacy efforts aimed at mobilizing resources and ensuring government commitment to funding harm reduction services in Nigeria. The outcome of NSP pilot was documented and NSP is prioritized by the Federal Ministry of Health led by Technical Working Group on Harm Reduction and monitored through quarterly progress and review meetings.

3.3 Existing prioritization processes and mechanisms for improving efficiency in national or subnational program planning and resource allocation

The public sector budget is guided by economic targets, expenditure levels, revenue projection, and the financing plan. The government developed a Fiscal Strategic Paper (FSP) and Medium-Term Expenditure Framework for 2023-2025 in line with Fiscal Responsibility Act (FRA2007),

19 National Health Account Report, Federal Republic of Nigeria, 2017.

with input from stakeholders before approval. These fiscal documents serve as a framework for budget development. Sectoral and health budgets are prepared based on the programmes prioritized by the health ministry in conjunction with technical partners and international donors and are submitted for final political approval before budget implementation. There are also mechanisms for monitoring the budget, development of performance reports, and revenue chart of accounts in the public sector. Meanwhile, available budget reports are based on macro-economic parameters and not on specific programmes, such as harm reduction.

Within the International Funding such as the Global Fund and PEPFAR, the existing prioritization processes and mechanisms for improving efficiency in national or subnational programme planning and resource allocation include:

- The Global Fund Concept Note development process, especially for the ongoing New Funding Model (GF-NFM4 3-year framework) process led by the CCM;
- The USAID-CDC grant making process;
- PEPFAR community consultations and COP development;
- Development and costing of the National Strategic Plan;
- The KP secretariat (the Umbrella body of all key population networks in Nigeria); and
- The GF-KP core group.

The process for development of the National Strategic Plan starts with review or assessment of past strategic plans with evidence gleaned from the review used to inform development of future plans. The process entails development of a framework by a team of experts and zero-draft development for input by expanded stakeholders, which is followed by further community and sub-national consultation for additional input, as well as its finalisation, costing, and operationalisation by all stakeholders. There is a need for CSOs to build their capacity and gather evidence to advocate for increased funding of harm reduction and to monitor budget performance for accountability. The CLOs, CBOs, and CSOs do have a voice in the national processes through their respective network and the umbrella network of all KP groups and the GF KP-Core Group.

SECTION 4: OPPORTUNITIES FOR HARM REDUCTION FUNDING WITHIN THE BROADER DOMESTIC HEALTH FINANCING ENVIRONMENT

The coordination platforms such as the technical working group, KP networks, and KP Core Group present opportunity for budget advocacy in both the public and private sectors (through the Nigeria Business Coalition Against AIDS-NiBUCCA) in favour of prioritization of harm reduction funding for domestic financing in Nigeria. Provision of HIV services under the National Health Insurance Scheme was recently approved, but harm reduction services are not covered under the scheme except for related services such as hepatitis, HIV testing, and ARVs. However, opportunity exists at the subnational level as states are in the process of implementing their Health Insurance Scheme and their ongoing efforts to expand the scope of the insurance scheme as the coverage is low. Also, participation of CSOs in drafting of the legislative bill and policy development process. These processes present opportunities for advocacy.

Further opportunities for budget advocacy for resources to be allocated to the harm reduction component of the broader KP programme include:

- The current public sector 2023 budget development process;
- USAID-CDC grant making process for HIV funding;
- GF-NFM4 discourse, consultations, and concept note development;
- ViiV Heathcare scale up of harm reduction;
- PEPFAR grant making process for the new project cycle; and
- Development of the National HIV Strategic Plan.

4.1 Community and civil society monitoring of harm reduction funding

Tracking of harm reduction funding is not included in the maiden edition of the Community-Led Monitoring (CLM) for HIV funds which was launched in 2021 and implemented by a network of PLHIV in Nigeria (NEPWHAN) through the National Agency for the Control of AIDS with support from United Nations Joint Program on HIV/AIDS (UNAIDS). The CLM framework for monitoring on accountability mechanisms, to improve service and quality of delivery in Nigeria, focuses on increasing literacy and expanding engagement among stakeholders, whilst addressing issues of stigma, discrimination, and human rights violations among the community of PLHIV (including adolescent girls and young women and key populations). However, there is opportunity for integration of harm reduction funding in the current CLM framework, as the initiative is expected to be replicated in other communities and monitored by their respective community organisations. Besides the report on the official launch of CLM, the performance report on the process in the last one year was not available during the period of this engagement.

SECTON 5: RECOMMENDATIONS

To circumvent some of the challenges highlighted in this report, the following recommendation highlight specific actions required by the government, technical partners, international donors, and civil society aimed at improving domestic funding for harm reduction programmes in Nigeria:

The Nigerian government should:

- Go beyond approval: prioritize and commit to funding the implementation of harm reduction programmes in Nigeria;
- Decentralize health expenditure that is skewed to tertiary and secondary facilities with a focus on primary health care targeting vulnerable populations that will benefit the most;
- Improve the social accountability mechanism that will support the delivery of harm reduction services;
- Strengthen measures for communicating results of health sector budget performance with consideration for development of detailed periodical budget reports at both the national and sub-nation levels;
- Sustain coordination of the harm reduction response in Nigeria;
- Integrate harm reduction services into the health insurance and provision of complementary tax finance schemes to ensure the inclusion of people who use drugs into UHC efforts.

Technical partners should:

- Strengthen the capacity of civil society to advocate for increased domestic funding of harm reduction services;
- Support development of policy guidelines that support implementation of harm reduction programmes.

Donors should:

- Improve funding of harm reduction and integration of harm reduction into community-led monitoring of HIV programmes in Nigeria;
- Increase funding of harm reduction programmes in Nigeria for scale up and coverage.

Civil society should:

- Document evidence from current harm reduction impact with support from donors;
- Use available evidence to advance policy and stakeholder engagement to advance advocacy for increased domestic funding of harm reduction programmes in Nigeria;
- Explore the window of opportunity on the National Strategic Plan development and Global Fund NMF4 processes to prioritise harm reduction programmes for government funding;
- Push for integration of harm reduction into ongoing community-led monitoring of HIV programmes and produce periodical monitoring reports;

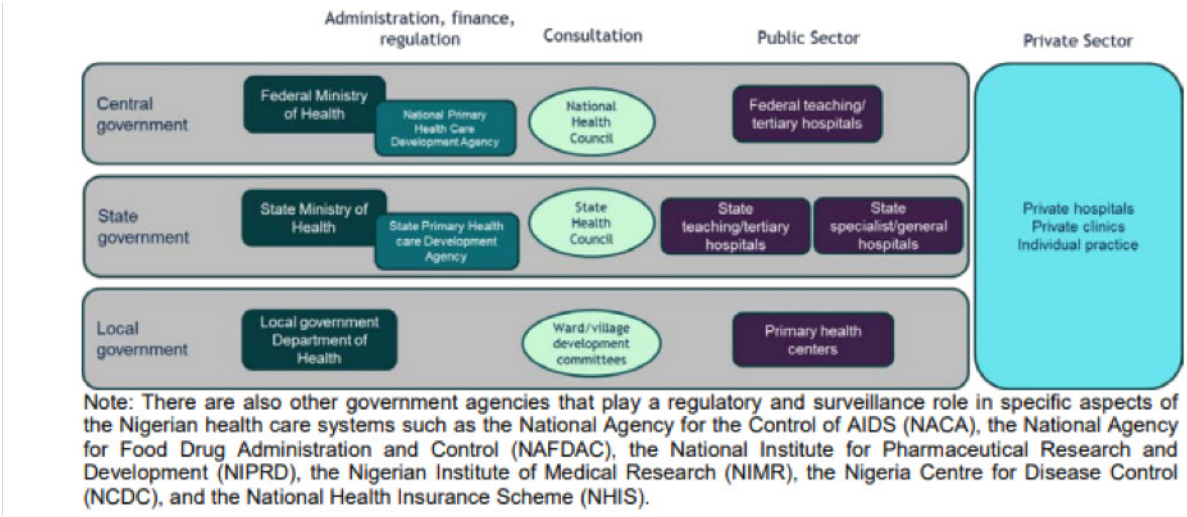
- Strengthen partnerships for implementation of harm reduction programmes in Nigeria;
- Mobilize resources from the government and other sources to support delivery of harm reduction services.

APPENDIX

List of community, civil society, and stakeholder consultation participants

SN	Name	Title	Organization/ Individual	Organization type (CLOs, CBOs, CSOs)
1	Nigeria Network of People Who Use Drugs (NNPUD)		Organization	CLO
2	Good Health and Hope Organization (GHHO)		Organization	CBO
3	Greater Women Initiative for Health and Rights (GWHIR)		Organization	CBO
4	Drug Harm Reduction and Advocacy Network (DHRAN)		Organization	CLO
5	Life Advancement Project Initiative (LAPII)		Organization	CBO

Figure 2: Governance structure of health service delivery in Nigeria



Note: There are also other government agencies that play a regulatory and surveillance role in specific aspects of the Nigerian health care systems such as the National Agency for the Control of AIDS (NACA), the National Agency for Food Drug Administration and Control (NAFDAC), the National Institute for Pharmaceutical Research and Development (NIPRD), the Nigerian Institute of Medical Research (NIMR), the Nigeria Centre for Disease Control (NCDC), and the National Health Insurance Scheme (NHIS).

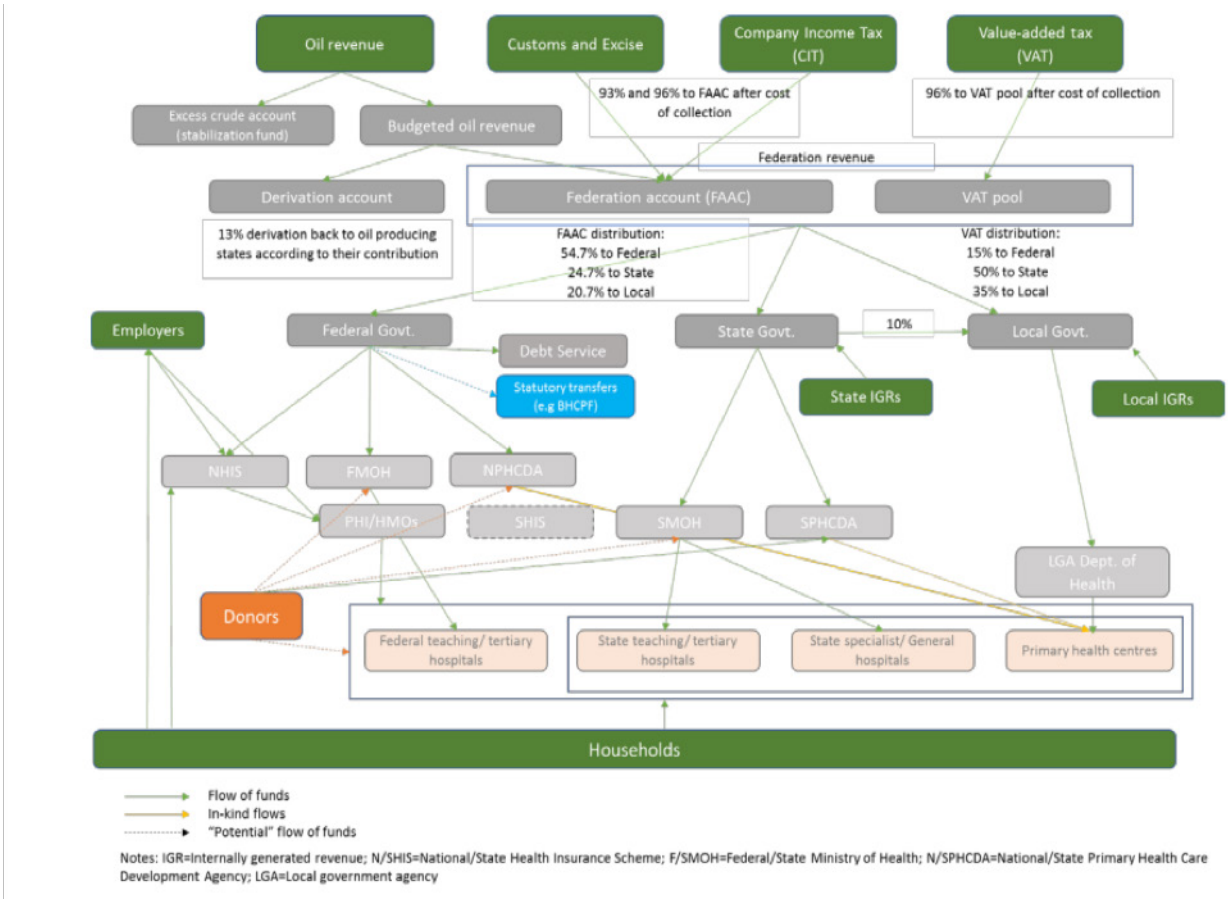


Figure 4: Basic Health Care Provision Fund and National Health Insurance Scheme

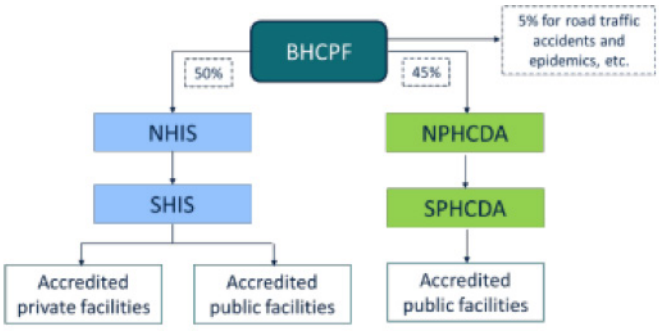


Table: NNHIS versus BHCPF

	NHIS	BHCPF
Legislation	• National Health Insurance Scheme Decree No. 35 of 1999	• National Health Act of 2014
Benefits	• Comprehensive covering inpatient and outpatient services (including dental, provision of lenses, cancer treatment and renal dialysis) at primary, secondary and tertiary level facilities	• Package of 56 essential interventions covering 60 percent of the disease burden: Antenatal care (16 interventions), delivery (6 interventions), postnatal care (9 interventions), child health (19 interventions), adult malaria (1 intervention), non-communicable diseases (1 intervention), and family planning (5 intervetions)
Coverage	• Intended to cover all Nigerians although because participation is voluntary only 4.2 percent of population currently covered, mostly civil servants	• Intended to cover all Nigerians • Will initially focus on rural pupulation only (~60 percent of population)
Source of financing	• Contributory scheme (premiums from employers, employees, and households) with Federal, State, and Local governments meant to set up an fund to pay premiums on behlaf of vulnerable groups however this has not materialized as participation is not mandatory (see Table 4)	• Non-contributory scheme • Predominantly tax-based (i.e., no less than 1 percent of the consolidated revenue fund) plus contributions from States, and others (including donors, private philanthropists) • To date, the BHCPF has not been funded
Financing channel	• Demand-side financing only, reimburses providers for providing health care services	• Demand-side financing (through the NHIS gateway, providers are reimbursed for providing health care services) • Supply-side financing (through the NPHCDA gateway, facilities receive funding to fund operating costs)
Provider payment arrange-ment	• NHIS pays capitation payments to primary health care and fee-for-service for secondary care • NHIS payment is in addition to budget in-kind support, and users fees that public facilities receive	• Proposing to bundle payments and reimburse based on number of patients seen and quantity of services provided

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