21

DEVELOPMENT ASSISTANCE FOR BUILDING INSTITUTIONAL CAPACITY

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In their quest to mount effective responses to the HIV epidemic, countries often face the challenge of ensuring that development assistance supports the capacity building of local institutions. "Development assistance" in this context refers to the transfer and use of resources to achieve and sustain effective programs that offer HIV prevention, treatment, or care, or that mitigate the impact of the epidemic on families, communities, and sectors of the economy. The scope of this definition includes institutional development, capacity utilization, improvement of the country's knowledge base for HIV/AIDS control, official development assistance, and development assistance for health (1).[1] "Institutional capacity" refers to the organized skills, systems, and components required to mount effective HIV/AIDS control initiatives in Nigeria.

For years a global debate has raged about the conditions under which development assistance can be effective. Considerable evidence has accrued that development assistance works best in the pres-

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[1]According to the definition by the Development Assistance Committee of the Organisation for Economic Co-operation and Development, "official development assistance" includes grants and loans to developing countries and territories, with the promotion of economic development and welfare as the main objective, and on concessional financial terms. "Development assistance for health" is broader than "official development assistance"; it includes nonconcessional loans from development banks and funds from private foundations and nongovernmental organizations that contribute directly to the promotion of development and welfare in the health sector in developing countries. (WHO Commission on Macroeconomics and Health, 2002)

ence of strong policies and effective institutions (2), and yet development assistance can also help to nurture effective institutions. A more recent study suggests that development assistance engenders success in countries with weaker policy environments; the authors found that higher-than-average short-impact aid to sub-Saharan Africa raised per capita growth rates by half a percentage point over the growth that average aid flows would have achieved (3). The basic result depends on neither the recipient's level of income nor the quality of its institutions and policies; the authors found that short-impact aid causes growth, on average, regardless of those characteristics. The authors also found evidence that the impact on growth tends to be greater in countries with stronger institutions or longer life expectancies. This debate contains a circular element, in that development assistance may strengthen institutional capacity yet may not be forthcoming in the absence of a certain level of institutional capacity. The future of the market for development assistance continues to be a matter of intense discussion (4).

Data on health expenditures and aid dependency reveal that Nigeria spends less on health than is average for low-income countries. Nigeria also receives less foreign aid than is average for low-income countries, both in per capita terms and as a percentage of gross national income (5). (See Table 21-1.)

A full understanding of development assistance and sustainability in Nigeria would require analyses of domestic objectives, resource commitments, the structure and function of institutions, relationships among local and international institutions, past and current resource needs, allocations and expenditures, and projections of future resource requirements. Unfortunately, the lack of accurate and reliable data on yearly allocations to—and expenditures on—HIV/AIDS control in Nigeria and the difficulty in obtaining data in a timely fashion prohibit a quantitative analysis of HIV/AIDS financing in Nigeria in this chapter. We place emphasis, therefore, on the qualitative aspects of development assistance and sustainability. The absence of valid quantitative data limits the discussion to institutional and organizations aspects. Yet this limitation itself helps to identify the critical need for government to ensure that information on the main sources and quantities of public expenditures and development assistance for HIV/AIDS is available in the public domain.

THE NIGERIAN RESPONSE TO HIV/AIDS

The National HIV/AIDS Strategic Framework

In 2000, Nigerian President Olusegun Obasanjo formed both the Presidential Committee on AIDS—comprising ministers from all sectors and the president as chairperson—and the National Action Committee on AIDS (NACA). NACA, in turn, prepared the country's HIV/AIDS Emergency Action Plan (HEAP), which received approval in 2001 for a three-year period (6). HEAP was the first countrywide strategy providing a multisectoral framework for the control of HIV/AIDS in Nigeria. With approximately 700 performance indicators emerging from various interest groups, it was an ambitious document. Unfortunately, its weak strategic focus limited its potential as a framework for coordinating development assistance. Compounding this problem was the challenge of coordination among the various governmental levels—federal, state, and local—and their agencies.

Table 21-1. Selected Data on Health Expenditure and Aid: Nigeria and Low-Income Countries

	Aid Dependency		Health Expenditure			
	Aid per capita, in US$ (2002)	Aid as % of gross national income	Total % of gross domestic product (2001)	Public % of gross domestic product (2001)	Public % total (2001)	Health expenditure per capita, in US$ (2001)
Nigeria	2	0.8	3.4	0.8	23.2	15
Low-income countries	12	2.7	4.4	1.1	26.3	23

Source: World Bank, World Development Indicators, 2004.

A review of HEAP began at the end of 2004, with the intention of developing a new National HIV/AIDS Strategic Framework for 2005–2009. The strategic framework was developed in partnership with many stakeholders. In line with the internationally endorsed approach of "The Three Ones" (one national strategic framework, one national coordination body, and one monitoring and evaluation system), development agencies reached consensus about the need to work on this single national strategic plan.

The strategic framework is set within the context of the National Economic Empowerment Development Strategy (NEEDS), which is Nigeria's framework for poverty reduction. NEEDS sets the stage for coordination of strategies toward the achievement of Nigeria's long-term vision for economic development. States have been developing their own strategies, known as SEEDS, and HIV/AIDS has been mainstreamed into both NEEDS and SEEDS.

National Action Committee on AIDS

NACA was envisioned as a multisectoral mechanism that could coordinate the country's HIV/AIDS response rather than as an implementing agency. The committee includes representatives from the public sector, the private sector, nongovernmental organizations (NGOs), faith-based organizations, and networks of people living with HIV/AIDS. NACA members meet regularly; the committee also has a secretariat that serves as its technical and management arm.

A credit from the World Bank provided funds to strengthen both the NACA secretariat and a National Project Team (7). While this was useful in view of the complexity of program coordination and management, it has become clear that two parallel structures were being developed. Confusion arose about roles and responsibilities, as well as the appropriateness of the structure and system in relation to needs. Under a consultancy financed by the Department for International Development (DFID), the coordinating structures of the national response were assessed, and a restructuring plan was formulated through a long participatory process. This involved bringing the National Project Team and NACA together, ensuring better clarity in job descriptions, terms of reference, and "measurable deliverables" for each staff member. The restructuring plan requires new staff and changes in the functions of some of the existing staff. Some new staff members have been recruited, and the transition into the new re-engineering plan was slated for completion in 2005.

If the National Assembly passes an enabling law, NACA will transition into an agency, in line with the National Policy on HIV/AIDS that the president launched in 2003 (8). This law, which had not been

passed as of late 2005, would give NACA a legal mandate, a formal budget line, and greater protection from potential political interference if future leaders are less committed to the HIV response than current ones. The underlying assumption is that a suprasectoral body such as NACA would enable the country to mount a more effective response to HIV/AIDS than would a strengthened ministry of health. This assumption is plausible, but there is no cross-country evidence to support it.

State Action Committees on AIDS

State and local action committees on AIDS—the SACAs and the LACAs—are responsible for spearheading the multisectoral response to HIV/AIDS at the state and local levels. In principle, the roles of the SACAs and the LACAs resemble that of NACA at the federal level in that they provide coordination and oversight.

Between 2000 and 2002, all states but one inaugurated a SACA. In 2003, NACA commissioned a review of the SACAs, showing that some were active, with 40% of all SACAs meeting at least four times a year (9). Others, however, appear to exist in name only. Ten SACAs have at least one full-time staff member, yet only seven states have a SACA office. The equipment available to SACAs is extremely basic, with only nine SACAs even having access to a telephone. Two states in particular—Lagos and Plateau—appear to have vibrant and functional SACAS. Lagos State took early action to establish its HIV/AIDS coordinating body and received assistance from local and external sources. Plateau State also benefited from external assistance, including direct support from the AIDS Prevention Initiative in Nigeria (APIN). In the case of Plateau State, APIN funded the development of a statewide action plan for HIV/AIDS control.

The role of the SACAs appears poorly understood in many states. While 81% of SACAs have terms of reference, in most cases those terms were adopted from recommendations that NACA sent, without any adaptation or consideration of local context. In some cases, the terms of reference are not fully understood; 58% of the SACAs view their role as being directly responsible for implementing the state response rather than merely providing coordination and oversight.

A number of factors have contributed to the SACAs' confusion about their roles and responsibilities. First, the SACAs have often taken their membership from people within line ministries and civil society organizations (CSOs) who are themselves directly responsible for implementing activities. Therefore their role within the SACA is confused with their role outside the SACA. This staff mix of membership carries risks, as it is difficult, and a potential conflict of interest, to be both the implementer and the overseer. NACA recommends that the SACAs have senior representation by policymakers at the state level rather than representation from the desk officers or those directly responsible for daily implementation. Some SACAs argue that desk officers understand best what is happening and what needs to be done. Ultimately the decisions about SACA membership rest with the chairman of the SACA, the state governor.

Second, because the SACAs play key roles in providing oversight for development assistance within the states, they tend to maintain a tight control of resources by directly implementing the HIV/AIDS programs themselves. Given the complexity of large-scale implementation, the SACAs do not have the capacity to mount responses to the depth and breadth needed. Therefore, the SACAs need to be empowered to identify the priorities for action, allocate the responsibilities to various implementing agencies such as line ministries and CSOs, and then oversee and monitor the implementers.

And third, in reality many governors are too busy to attend all meetings, and the responsibility of chairing the SACA is often delegated to someone in the governor's office. In 2003, the health commissioner served as the SACA chairman in 40% of the states. While the health sector is a key component of the HIV/AIDS response, the risk to one line ministry holding the chairmanship is that it may compromise the multisectoral philosophy of SACAs. It is important to note, however, that expectations of a large-scale multisectoral approach are unrealistic in the short term; even more modest interventions in the health sector tend to be weak. Therefore, it is pragmatic to start with core health sector functions in HIV/AIDS control, particularly when the capacity for larger multisectoral approaches is poorly developed.

Another challenge the SACAs face is the fact that many development agencies bypass them. In addition, some line ministries represented within the SACA will implement activities without the knowledge of the SACA. No systematic study of the reasons for this has been undertaken. Among the possible causes are the real and perceived weaknesses of many SACAs, including the perception that they might serve more as bureaucratic obstacles than as facilitators.

While many SACAs report having a workplan, few are implementing those workplans to the degree originally intended. SACAs cite a lack of resources as a principal reason; many would argue, however, that a lack of capacity and political will is equally at fault. During 2004, the number of states benefiting from World Bank assistance increased significantly. Workplans within 16 states are therefore beginning to have additional resources made available, and 15 states have shown a noticeable increase in activity. APIN has provided technical assistance to enable SACAs to develop state-level programs of action in Oyo and Plateau States. Most SACAs would benefit from capacity building to enable them to gain a greater understanding of their important role of coordination and oversight rather than direct control and implementation. This capacity building needs to be linked to the development of budget lines for HIV at the state level, together with strategies for coordinating external development assistance.

Local Action Committees on AIDS

Nigeria has 776 local governments, and a SACA review in 2003 estimated that more than 500 of those had established LACAs, only 134 of which are considered active (9). This represents 17% of all local governments. Even those described as "active" often cite a lack of funding and an inadequate capacity.

The local government response desperately needs strengthening if Nigeria is to reach most of its citizens with HIV/AIDS messages. In 2004 NACA promoted the development of HIV/AIDS information centers to be managed by staff members from local governments. Each center is intended to provide a local information resource, materials, and such commodities as condoms. The information would be available both to the general public and to the line departments, NGOs, and other CSOs. These centers

may eventually be used for voluntary counseling and testing (VCT) as well. The first stage, however, is to build the capacity of a core group of local government staff.

If Nigeria is to provide an effective grassroots response to the HIV/AIDS epidemic, it will be in part through the strengthening of the local government sector. Given the huge number of local governments, and the lack of capacity at that level, these fortifying efforts will require a substantial increase in resources and effort.

Other Coordinating Agencies

In recent years, Nigeria has developed a number of HIV/AIDS coordinating groups that represent the interests of various key constituencies. Nigeria has an active UN Expanded Theme Group, established in 1996, which meets bimonthly and represents development partners, government agencies, and CSOs. Among the many groups and networks that exist or are emerging are the Donor Coordination Group; the National Assembly Response to HIV/AIDS, which has participation from both the senators and representatives; the Civil Society Consultative Group on HIV/AIDS in Nigeria, or CISCGHAN, which provides a voice and capacity building for NGOs and community-based organizations throughout Nigeria; and the Network for People Living with HIV. The recently formed Nigerian Business Coalition for AIDS has members representing some of the largest businesses and multinational companies working in Nigeria. The country has many active Muslim and Christian groups, with the Interfaith Coalition on HIV/AIDS taking on an ever-expanding role. While the proliferation of actors indicates increasing activities, the strategic relevance and technical quality of their work have yet to be documented systematically.

THE RATIONALE FOR DEVELOPMENT ASSISTANCE TO SUPPORT INSTITUTIONAL CAPACITY

Despite the president's strong commitment and leadership in the national response to HIV/AIDS, one of the country's constraints has been its limited *organized* capacity to address the epidemic. This limitation has been recognized for both the suprasectoral coordination functions and the health sector. For example, in addition to funding shortfalls at the National AIDS and STDs Control Program (NASCP) of the Federal Ministry of Health (FMOH), the "managerial, organizational, logistic, and technical capacities within NASCP are inadequate to coordinate so many players and programs in a country of this size and complexity" (10). The situation analysis further noted a "clear and urgent need for institutional capacity strengthening as a pre-requisite to ensuring leadership of the health sector response" (10).

The rationale for external development assistance in HIV/AIDS control is multiple. The immediate purpose would be to support locally led efforts to control the epidemic. In the short term, since HIV spreads across national boundaries, it has the potential for negative externalities beyond the confines of a particular country. In the medium- to long-term, not only would an uncontrolled epidemic have a large and negative impact on the Nigerian economy, but it could also reduce the inter-generational transfer of human and intellectual capital. With Nigeria's share of the regional population and economic output so significant, an unraveling of the Nigerian economy and social structure could have a negative impact on much of West Africa, including its security. Finally, achieving one of the targets of the Millennium Development Goals on HIV/AIDS—to have halted and begun to reverse the spread of HIV by 2015—would be impossible in West Africa without successful efforts in Nigeria. The HIV epidemic also has direct and indirect impact on many of the other Millennium Development Goals.

THE TYPES OF DEVELOPMENT ASSISTANCE REQUIRED

Financial

The level of development assistance per year to Nigeria is unknown. NACA, the body responsible for coordination, has not developed any publicly available documentation that provides the full picture of development assistance for HIV/AIDS control in Nigeria. This is due in part to difficulties the committee has encountered in collecting data from some development assistance sources. Public sector data on financing the HIV response are spotty.

Determining the amount of financial resources allocated to HIV/AIDS is complex because of its multisectoral nature. For example, resources allocated to NACA and the SACAs, or reported by these committees, is not a good proxy for the total allocation, as most resources are allocated directly to the implementing agencies. Therefore resources allocated and used by line ministries, NGOs, and private agencies often go through neither NACA nor the SACAs, and these organizations rarely receive full information about the allocations. At the same time, it seems unnecessary to spend a great deal of public sector resources on coordination of private sector efforts *if* those private sector efforts are effective and working.

In addition, the amount of development assistance from the international community is difficult to estimate due partly to the lack of coordination of information and partly to the large discrepancy between planned and allocated budgets. This is particularly true of two of the largest international HIV/AIDS funders—the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria—in which the actual allocation per year is less than 20% of that planned. In addition, the resources the private sector has made available to HIV/AIDS are unknown and largely uncoordinated. The same is true for the financing from private individuals, foundations, charities, and faith-based organizations.

Despite the lack of data, it seems likely that, until recent years, the government has underfunded the country's HIV/AIDS control effort. In a 2003 survey, 78% of the SACAs reported that their lack of financial resources had prevented them from implementing their workplans (9). Most had long since exhausted the 2 million naira that NACA had sent in 2002. While this allocation was well intended, it led to the impression in some states that the state-level HIV/AIDS response—included the SACAs—would be federally funded. It has taken some time for the states to realize that they must take the HIV epidemic seriously by allocating adequate resources to state-led activities.

At the federal level, NACA has received government resources. The FMOH also has received substantial federal funding to implement its antiretroviral program (850 million naira in 2003 and 2004) (11),

resulting in one of Africa's largest publicly funded antiretroviral programs, with approximately 14,000 people on treatment. This program has been clouded, however, by the slow release of government funds and the oversubscription for treatment. Overall, inadequate planning and management resulted in interruptions of treatment for many patients at the end of 2003.

The picture is mixed at the state level. Some state governors have begun to take the epidemic seriously, allocating resources to control efforts. After a slow start, for example, 16 states have now committed counterpart funding of US$100,000 for the World Bank-assisted HIV/AIDS project. Most of these financial pledges followed the elections of new state governors in 2003, which may signal a new commitment to the epidemic. In addition, some states have dedicated additional resources to procure antiretrovirals.

At the local level, the lack of funds is cited as a critical reason activities have been hampered, not just for HIV/AIDS services, but for all services. Even so, the local government level is considered the main source of service delivery.

Another crucial funding issue has been the need for greater information collation and transparency of allocations and expenditures. Enhanced information will enable better planning and more directed and focused support.

One important development in 2005 was the creation of a single workplan construct for NACA and each state SACA. NACA and the SACAs are encouraging all partner agencies to declare their funding commitments and incorporate their activities into the workplans. For the first time, NACA and the states may be able to assemble a comprehensive picture of the activities being undertaken within their constituencies and therefore be able to coordinate efforts. The Nigerian government, the World Bank, and UN agencies have become the first to incorporate their activities into these plans, and bilateral organizations have begun to come on board.

Organizational and Individual Capacity-Building

Probably as important as direct financial assistance, the national, state, and local government HIV/AIDS response requires development assistance in terms of capacity building of individuals and institutions. Capacity development needs to be considered in broad terms, including ensuring the existence of functional organizational structures, physical infrastructures, functional systems, and a fit between the functions to be performed and the individuals assigned to perform those functions.

The skill areas required to tackle the full complexity of the HIV/AIDS epidemic also are extensive, from basic science to biomedical and clinical research, and from policy development to management and service delivery.

CURRENT DEVELOPMENT ASSISTANCE RESPONSE TO HIV/AIDS

External Development Assistance

The major multilateral sources of external development assistance include the World Bank (through a credit of US$90.3 million) and the Global Fund (through grants of US$41.7 million to scale up the government's antiretroviral treatment program, US$27.4 million for PMTCT, and US$1.7 million for the civil society response, all of which were signed in 2003). The major bilateral sources include the governments of the United Kingdom (through DFID-financed programs); the United States (through the President's Emergency Plan for AIDS Relief and projects funded through USAID); Canada; and Japan. United Nations agencies have provided assistance, both under the umbrella of UNAIDS and individually; examples include UNICEF, the United Nations Development Programme (UNDP), and the World Health Organization (WHO).

A major challenge for Nigeria is the effective coordination of international development assistance in a way that encourages the implementation of programs supported by external funders at the same time that it avoids gaps among those programs and a wasteful duplication of efforts.

Development Assistance for NACA

Several development agencies—including the World Bank, DFID, the UN system, and the U.S. government (through the POLICY Project)—have provided support for NACA since its inception. Neither the Revenue and Expenses Statement for NACA nor the full scope of development assistance for HIV/AIDS control is in the public domain. Since 2003, at the request of the Nigerian government, development partners have made significant efforts to strengthen NACA, by funding the appointment of senior staff, for example, and by furnishing the new NACA offices. While NACA does have a budget line, which has risen in recent years, NACA depends heavily on external development assistance, raising questions about the extent to which the country is fulfilling its basic responsibilities of financing its coordinating body. Enhancing NACA's ability to coordinate an effective countrywide response to HIV/AIDS will require significant development assistance.

Development Assistance for the SACAs and the LACAs

In recent years, a number of development partners—including the World Bank, UNDP, DFID, APIN, and the U.S. Centers for Disease Control and Prevention—have been working with the SACAs to develop workplans. While an encouraging 75% of all states have workplans, in reality only 26% are implementing those workplans. A lack of funding is a common reason cited for failure to implement a workplan.

The World Bank-assisted project has established offices in 16 states, yet many of these are new, and they must build their own capacity before they can provide significant support to their partners.

Development Assistance for CSOs

The burgeoning civil society response to HIV/AIDS in Nigeria has begun to develop strategies for capacity building and coordination. The social marketing program, supported by DFID and USAID, is an exception in having national coverage, a strong capacity, and a long track record in awareness raising and condom marketing.

The faith sector, which delivers an estimated 40% of all health care in some states, also has huge potential. The Christian Health Association Nigeria, or CHAN, a 30-year-old network with 358 health

institutions and more than 4,000 health facilities, runs 120 VCT centers and provides antiretrovirals in ten facilities. These drugs are provided on a fee-for-service basis with little financial support from the government.

The private sector response to HIV is poorly coordinated, and little is known about its financial allocations. NACA established a Business Coalition on AIDS in 2003, however, and some businesses—notably UNILEVER, Coca-Cola, and Chevron—have well-documented workplace policies.

By the second quarter of 2005, the World Bank-assisted project had committed more than US$18 million to more than 550 CSOs, including networks and coalitions, NGOs, community groups, faith-based organizations, workers' unions, professional associations, and private sector groups. Anecdotal claims of the impact of the scale up of civil society financing have been considerable. There has been no publicly available review or assessment, however, of the strategic relevance or technical quality of activities being undertaken by CSOs and the business sector.

Development Assistance for Substantive HIV/AIDS Control Programs

Most agencies in the United Nations have engineered specific responses to HIV. UNAIDS, which coordinates the UN system's contribution to HIV/AIDS, has actively supported the expansion of Nigeria's HIV response in line with the principle of "The Three Ones." Since this principle was adopted only as recently as April 2004 (12), it is too soon to determine its impact on HIV/AIDS control in Nigeria.

UNAIDS also supports the WHO in its efforts to expand access to antiretrovirals and to pursue the 3 by 5 Initiative, whose goal is to place three million HIV-infected people in resource-poor countries on antiretroviral treatment by the end of 2005. The WHO has been a key stakeholder, supporting ministries of health at both the federal and state levels and working with the FMOH in a national situation analysis and development of a health strategic plan. The WHO, which has offices in all states, maintains a focus on building capacity, as well as surveillance and strategic planning.

UNDP conducts a US$7 million project (2003 to 2007) aimed at building the capacity of eight states. It has a strong multisectoral focus and has been at the forefront in helping states mainstream HIV into SEEDS. The United Nations Population Fund has a US$40 million budget (2003–2007) for population, development, advocacy, reproductive health, and HIV. It has assisted in establishing VCT centers in 15 states and commodity procurement and distribution. UNICEF is working to scale up the PMTCT program in six states. It also has a large HIV program with the National Youth Service Corps. The International Labour Organization has been active in supporting HIV/AIDS workplace policies. UNIFEM, or the United Nations Development Fund for Women, has played an important role in ensuring that women have a voice and in mainstreaming gender issues into the National Strategic Plan.

The World Bank has provided a US$90 million credit facility to build the capacity of both individuals and institutions to enable an effective architecture for a substantial and scaled-up HIV response. Credit resources are also being used to scale up the public sector response at the federal, state, and local government levels. An HIV/AIDS Fund has been established at the federal and state levels for civil society funding. Implementation of the World Bank–supported program has been slowed by such factors as delays in the initiation of activities at the state level, organizational arrangements at the federal level, and the complexity of the project structure.

The major bilaterals working on HIV in Nigeria are the U.S., British, and Canadian governments. As mentioned earlier, the U.S. government has given Nigeria HIV/AIDS support through the President's Emergency Plan for AIDS Relief. The plan is to work with many partners, including national and international groups, to strengthen government systems, with a substantial scale-up planned over the five years of the project; US$34.5 million was budgeted for 2004.

During its long relationship with Nigeria, DFID has provided substantial funds aimed at strengthening NACA. DFID also funds a £52-million social marketing project with the Society for Family Health that increases access to commodities, particularly condoms.

The Canadian International Development Agency (CIDA) has a Can$4.8 million project over five years to provide resources to CSOs, with a specific focus on gender and human rights and a geographic focus along some specifically defined transport routes and junction towns. CIDA also provides funds to UNICEF and the WHO. Other bilaterals, including the Japanese International Cooperation Agency, are discussing their involvement with Nigeria.

Two U.S. foundations—the Ford Foundation and the Bill & Melinda Gates Foundation—also have provided major assistance. The Ford Foundation has supported a number of CSOs and provided funds to the Nigerian Institute of Medical Research (NIMR) to establish a reference laboratory and clinical research center. The Gates Foundation–funded APIN works in Lagos, Oyo, Plateau, and Borno states, with an emphasis on knowledge-based aspects of virologic and epidemiologic surveillance, program design, capacity building for the SACAs, targeted support for CSOs, equipment and training of key personnel in laboratories, support for PMTCT programs, and selected operational research projects. APIN has also supported a range of federal-level activities, including national HIV serosurveillance and a capacity-building program focused on the social and economic aspects of the HIV/AIDS epidemic.

CHALLENGES TO DEVELOPMENT ASSISTANCE FOR BUILDING INSTITUTIONAL CAPACITY IN NIGERIA

A Late Start

Until democratic elections in 1999, Nigeria was largely isolated from the international community. Efforts to develop a comprehensive response to the HIV/AIDS epidemic began only in 2000, and many working in the field have encountered a steep learning curve since then. Initially, the response focused on sensitization, enlightenment, and awareness raising; only recently has there been a shift toward behavioral change communication, care and support, and impact mitigation.

As discussed earlier, NACA, the SACAs, the LACAs, and other coordinating structures are mostly new, and in many areas, they have yet to fully understand their roles and responsibilities. Building their institutional capacity will require significant support. At the same time, there has been a mismatch

between the availability of private-sector planning, marketing, and management skills applicable to HIV/AIDS program management, and the persistently weak capacity of the health sector to manage effectively a countrywide HIV/AIDS control effort.

A Weak Health System

The health system is only one component of an effective HIV response, yet it is arguably the most important. Today, Nigeria's health care system is weak, particularly at the primary health care level. Indicators for some of the most basic of health services, such as immunization, are among the worst in the world (13), and in 2000, Nigeria's overall health care system performance ranked 187th among the 191 member states of the WHO (14).

The national response to the epidemic is therefore faced with the additional challenge of providing HIV services within the context of an already strained system. Effective use of additional resources will be possible if the underlying system is strengthened concurrently with increasing attention to HIV/AIDS. If this does not happen, the additional resources being earmarked for HIV/AIDS activities risk the development of a distorted health system. This could easily happen if human and other resources become directed toward HIV and away from other core health services, further straining an already weakened system. At the same time, care must be taken to avoid a simplistic view that a perfect system must be in place before the epidemic can be controlled. Some activities, such as behavior change communications and condom distribution, are less demanding of a strong health system than others, such as large-scale antiretroviral treatment programs.

A Lack of Systematic Documentation

One of the greatest challenges facing government and development partners working to curb the epidemic in Nigeria is the limited availability of information on what exactly is happening. Many individuals have tacit knowledge of the status of HIV/AIDS control, but little of this information has been documented systematically. This is particularly true at the state level, where few SACAs have full information on the activities within their state or updated documentation. The result of this lack of information is poor coordination. This is particularly serious given the inadequacy of local and external resources. In 2004, Nigeria launched its national monitoring and evaluation system, the Nigerian National Response Information Management System, or NNRIMS. This system is essential for collecting information on the services being provided. NACA also has plans to work with the states on developing a situation analysis of HIV initiatives throughout the country. This enormous undertaking is needed to enable prioritization of activities both geographically and thematically.

The Need for Sustained Support, Supervision, and Monitoring

The SACA review that NACA commissioned in 2003 found that while many states had developed action plans, few had implemented them (9). The support for implementation therefore remains a challenge. There has been an assumption that once an action plan was developed, implementation would follow. Without significant additional resources, support for skills development, supervision, and monitoring, however, implementation is unlikely to occur. This is because the skills needed to develop workplans differ from those required to implement programs. In addition, resources do not necessarily flow, just because there is a workplan, and with so many priorities competing for resources, it is not surprising that some important issues fall off the agenda.

A Complex Epidemic Requiring a Multisectoral, Multipartner Response

Mounting an effective multisectoral HIV response requires the mobilization of all relevant sectors of government and civil society. This mobilization presents an enormous logistical challenge, not only in ensuring that all actors understand their roles, but also in building their skills, coordinating their efforts, and monitoring their impact. This challenge, though not unique to Nigeria, is particularly difficult given the country's size and diversity.

Nigeria's Image of Corruption

In 2004, Transparency International ranked Nigeria as the third most corrupt country in the world (15). Although this finding was not based on HIV/AIDS program management, the country's overall poor ranking probably decreases the amount of resources it can attract. The federal government is taking measures to address issues of corruption, to strengthen financial management systems, and to improve accountability and transparency.

CONCLUSION

This chapter, although exploratory in nature, helps to identify key issues that require action by the leading federal agencies working on HIV/AIDS. Specifically, NACA must address issues of policy formulation and coordination across sectors without engaging in program implementation. NACA and the SACAs should *support* efforts of multiple institutions rather than seeking to *control* them. These committees should be limited to convening sessions on the formulation of evidence-based policies; serving as clearinghouses of information on programs, including findings from routine and special studies, particularly those dealing with the impact of HIV/AIDS control; facilitating consultations among sectors; disseminating information, including that on resource mobilization and allocation; offering federal- and state-level advocacy; and, in the case of NACA, providing external representation in non-specialized fora that deal with continental or global issues on HIV/AIDS. These committees should also eschew coordination as an end unto itself and avoid the temptation to seek control of specific activities of program funders and managers.

Other specific recommendations include:

- **Distinguish between the means and the end.** The goals of HIV/AIDS control in Nigeria must be differentiated from the means of achieving them. A multisectoral approach is useful not as an end unto itself, but as a means to reaching the goals of preventing transmission, treating and caring for those

already infected, and mitigating the impact of the epidemic. To this end, it is critical that measurable results be defined as the centerpiece of HIV/AIDS control. This approach would also help to clarify the roles of different actors.

- **Strengthen coordination systems.** The distinction between control and coordination must be clarified at the national and state levels. The lack of coordination is hindering the extent to which development assistance can be allocated and used effectively. Better coordination will ensure that the existing resources are channeled to priority activities and geographic areas with greatest need. All development partners have a responsibility to work with the existing structures — such as NACA and the SACAs — and empower them with the skills to coordinate activities effectively. The SACAs should not misinterpret this statement to mean that the resources should be channeled through them for implementation. This approach would not be appropriate, and when this situation arises, development agencies should invest resources in the capacity development of SACAs to ensure they understand their role as coordinators — rather than controllers or implementers — of activities.
- **Ensure transparency in reporting.** If Nigeria is to improve its image and attract additional resources, all coordinating structures and implementing partners must strengthen their reporting practices, particularly through transparency in financial reporting. All development partners must, in turn, insist on good and transparent reporting and provide technical assistance when a lack of expertise is the reason for inadequate reporting.
- **Develop outcome-driven budgets and plans.** The development of program budgets that are guided by desired outcomes and that take into account implementation constraints is essential. These budgets would include local and external financial sources on short-, medium- and long-term bases as inputs into discussions on the sustainability of HIV/AIDS control in Nigeria. A system of HIV/AIDS accounts at the federal and state levels would be particularly useful in this regard. It is important that these accounts be available in the public domain.
- **Enhance systems through technical assistance, skills building, and other support.** Nigeria needs additional financial resources for HIV/AIDS control. Yet financial resources alone will not solve the HIV/AIDS problem; skills building is also needed in evidence-based approaches to program design, implementation, monitoring, and evaluation.
- **Combine short-term goals with long-term sustainability.** Developing separate programs focused on HIV/AIDS, without full consideration of the broader health system, runs the risk of either creating an unimplementable dream or further undermining the weak health system. At the same time, it is important to take a pragmatic rather than ideological approach to the problem. A binary approach to policy analysis — such as "vertical programs" versus "integrated programs" — will not resolve the HIV/AIDS problem in Nigeria. In the short- to medium-term, the country most critically needs efforts that are highly effective in curbing HIV transmission and in caring for those already infected. At the same time it is essential to improve service delivery systems in all key sectors relevant to HIV/AIDS control.

Although the root causes and impacts of the HIV epidemic extend well beyond the health sector, much of the burden of diagnosis and treatment falls on that sector. Hence, the FMOH should both assume major leadership responsibility for addressing HIV/AIDS and receive the resources to meet that responsibility. Both the FMOH and NACA should work toward transparent planning, including the regular publication of the sources, amounts, and uses of development assistance for HIV/AIDS in the country. External partners should, in turn, support rather than supplant local leadership and plans.

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