HP+ POLICY *Brief*
December 2019

User Fees for HIV Care Services in Nigeria

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Objective

To address the perennial challenge of out-of-pocket expenditures hindering access and adherence to care in Nigeria for people living with HIV, the director-general of the National Agency for the Control of AIDS (NACA) set up an Expanded Theme Group in February 2019. The group brought together prominent stakeholders, including development partners such as U.N. agencies, the World Bank, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), and civil society. The aim of this group was to make recommendations on how to reduce and/or eliminate user fees in HIV service delivery. With direction from this meeting and PEPFAR, the U.S. Agency for International Development (USAID) in Nigeria engaged Health Policy Plus (HP+), a project funded by USAID and PEPFAR, to assess the prevalence, magnitude, and types of direct fees and indirect costs incurred by people living with HIV in select states in Nigeria. The end use of the findings is to inform PEPFAR and USAID priorities.[1] HP+ undertook this study in May 2019, and collected data across four states (Akwa Ibom, Kano, Lagos, and Rivers). This policy brief shares the results of the study, summarizes the context of user fees for HIV care in Nigeria, and outlines recommendations to be explored with key stakeholders.

Context: HIV and User Fees in Nigeria

In 2018, PEPFAR, the Global Fund, the World Health Organization (WHO), and UNAIDS supported Nigeria in completing the Nigeria AIDS Indicator and Impact Survey, a population-based survey that produced new and detailed data on the country's HIV epidemic. The survey estimated the national prevalence of HIV at 1.4 percent for people between 15 and 49 years of age (with female prevalence at 1.9 percent and male prevalence at 0.9 percent), with a total estimated 1.9 million people living with HIV in the country. The survey also identified seven states now considered high-prevalence, including Akwa Ibom and Rivers. While antiretroviral therapy (ART) coverage in Nigeria has markedly improved in the last few years, only 47 percent of people living with HIV are currently receiving ART and unmet need is particularly high among younger population groups (NACA, 2019a).

As part of its strategy to achieve a key HIV target of "enabling people living with HIV to receive quality HIV treatment services," NACA's current strategic interventions are comprehensive and focus on expanding access to ART in high-prevalence states, implementing WHO's recommended "treat all" policy, and

[1] Elimination of "all formal and informal user fees in the public sector for access to all direct HIV services and related services" was named as a "minimum requirement" for Nigeria under its *Country Operational Plan 2019* (PEPFAR, 2019, p. 28).

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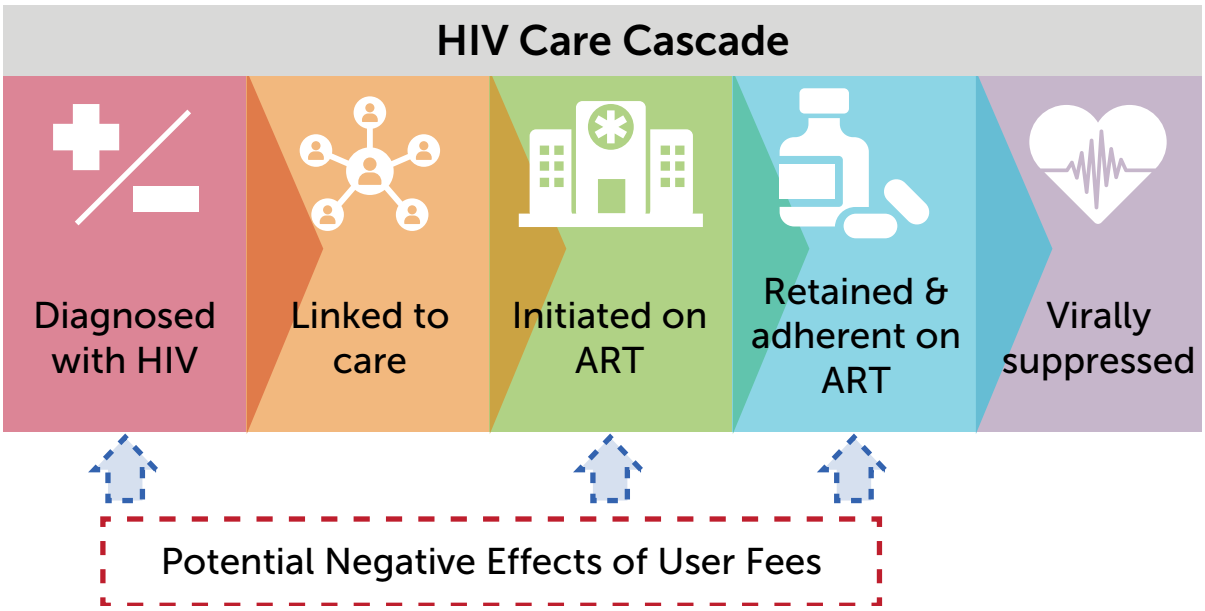
scaling-up nationally identified differentiated models of patient-centered care (NACA, 2019b, pg. 22). Various development partners—including PEPFAR, the Global Fund, and the government of Nigeria—are financing national-level above-site efforts to combat the HIV epidemic, providing support to designated health facilities to ensure that antiretroviral (ARV) drugs, CD4 count tests, viral load tests, and HIV rapid test kits are available free of charge to patients.

However, there has been evidence in recent years that health facilities are charging careseekers fees for different types of HIV-related services and products. For example, Onwujekwe et al. (2016) measured out-of-pocket spending for outpatient HIV service visits in 2013 and found that patients spent per outpatient visit an average of US$2.11 on medical expenses and user fees, US$3.05 on transportation, and US$0.90 on purchasing food. Ndukwe et al. (2018) measured out-of-pocket spending for HIV services in 2011, finding that people living with HIV spent an average of US$528 per year. Etiaba et al. (2016) estimated that people living with HIV in Nigeria spent per outpatient visit an average of US$0.87 on medical expenses, US$3.93 on transportation, and US$0.60 on food purchases for outpatient visits. Depending on their magnitude and prevalence, these fees can potentially impact the health-seeking behavior of people living with HIV, especially the more socioeconomically vulnerable. Patients may be scheduling fewer visits to facilities, skipping regular check-ups, and subsequently increasing the risk of non-adherence to ARV treatment or other adverse behaviors (see Figure 1).

Figure 1. Critical Points in the HIV Care Cascade that can be Negatively Impacted by User Fees



The HP+ study added to this literature by measuring the prevalence and magnitude of user fees, as well as indirect costs faced by people living with HIV seeking HIV care in Nigeria (Dauda et al., 2019). The study provides a more detailed description of the type of user fees, by categories of charges, by type of service received, and type of payment made at PEPFAR-supported facilities. Of 645 people living with HIV interviewed, 25 percent reported paying at least one direct user fee for HIV care services. Among those who paid, the fee represented on average 92 percent of their daily income. Indirect costs (transportation and time spent) represented 89 percent of their daily income. The study further identified the prevalence of charges that could be considered informal (see Box 1).

User fees and indirect costs represent a financial barrier that can affect the number of people seeking HIV care or staying on ART, thus putting at risk any policy or program that aims to

improve Nigeria's overall HIV cascade (Roberts et al., 2018). NACA and PEPFAR have signaled that the overall elimination of user fees should be prioritized by federal and state authorities.[2] Elimination of user fees across all facilities may have to be preceded by a greater allocation of funds for HIV programs at the state level or other forms of prepayment schemes such as social health insurance. The findings from the HP+ study will inform policy directions moving forward.

Box 1. What are Informal Fees?

Informal fees are patient charges for what should be free service items (funded by the government of Nigeria or external donors), such as:

- Antiretroviral prescription or medication
- CD4 count test
- Viral load test

Landscape: Legal, Regulatory, and Health Financing

In Nigeria, a user fee policy was introduced within the framework of the Bamako Initiative of revolving drug funds as a way of financing the government's health services. The implementation of this policy became important following the structural adjustment program and macroeconomic reforms implemented in the 1980s. With financial and technical support from WHO, UNICEF, and the U.K.'s Department for International Development, the user fee policy aimed to ensure a steady supply of essential drugs, prescribed under generic names, at affordable prices (Olukoshi, 1993; WHO, 2011). However, the introduction of this policy was subjected to criticism as it was predicted to increase economic, financial, and even cultural barriers to the provision of healthcare in Nigeria. At the same time, it was argued that the policy would reduce budget deficits for the national health system while improving utilization of services by diminishing "frivolous" consumption of health services (John and Stanley, 2014; Uzochukwu et al., 2002). This debate took place in a context of lack of affordable health insurance schemes, the non-mandatory nature of the National Health Insurance Scheme, and the overall lack of knowledge or awareness about health insurance among formal and informal sector workers in Nigeria (Gustafsson-Wright and Schellekens, 2013).

In December 2016, the government of Nigeria launched a Fast-Track plan using domestic resources to maintain 60,000 people living with HIV on treatment and to ensure that an additional 50,000 access treatment each year. By the end of 2017, the National Economic Council of Nigeria proposed a resolution (not yet approved) through which 0.5–1.0 percent of the monthly federal funding flow to states (via the Federation Account Allocation Committee) would be earmarked for financing the implementation of HIV programs. This significant increase in state budgeting for HIV is expected to partially alleviate the current financial constraints among some primary care facilities that may be under pressure to charge user fees to cover current costs. People living with HIV from lower socioeconomic backgrounds would benefit the most from the removal or reduction of user fees.

In this context, it is important to explore the potential role that could be played by the Basic Health Care Provision Fund and national and state health insurance schemes. The Basic Health Care Provision Fund has three gateways of operation—the National Primary Health Care Development Agency gateway, the National Health Insurance Scheme gateway, and the Emergency Medical Treatment gateway. The National Primary Health Care Development Agency gateway has been designed to strengthen the delivery of primary care services across the country through supplementing funds required for activities, including the improvement of facilities, procurement of basic supplies, and community outreach and health promotion

[2] The *Country Operational Plan 2019* letter calls on the PEPFAR/Nigeria team to "support the rollout of the nation's new health insurance system to eliminate formal and informal user fees" (U.S. Department of State, 2019, p. 1).

activities (Federal Ministry of Health et al., 2018). The National Health Insurance Scheme gateway is designed to contract a Basic Minimum Package of Health Services for Nigeria that covers maternal and child health interventions, non-communicable diseases, and malaria. These two fund gateways can influence user fees for people living with HIV at the primary healthcare level in a number of ways. Additional money for the provision fund may remove the need of facilities to charge patients user fees to cover operational costs. A greater number of adequately funded facilities would be able to provide better HIV care, eliminating the need for some people living with HIV to travel for care. Facilities that are properly stocked with basic supplies would be less likely to make patients buy and pay for their own supplies in order to receive a service. Finally, coverage of prevention of mother-to-child HIV transmission in the basic minimum package will ensure that these services are provided at no charge to HIV-positive pregnant women.[3]

The national and state health insurance schemes are mechanisms through which predictability of financial costs due to health events is ensured. If health insurance schemes cover HIV care services (including diagnosis, ART, and treatment of opportunistic infections), integration of HIV services under those schemes will lead to reduced user fees for people living with HIV as the facilities are reimbursed through the respective health insurance schemes. Depending on the policies set forth by the states, coverage of these services can also eliminate user fees in public facilities where no balance billing may be applied, given that the reimbursement covers the full cost of service provision. Reduction of user fees at private for-profit facilities is expected when services are covered through health insurance schemes.

Findings on Current User Fees in Nigeria

Overall Design and Implications

In May 2019, HP+ implemented a descriptive cross-sectional survey of facilities in the states of Akwa Ibom, Kano, Lagos, and Rivers. Within these four states, HP+ randomly selected 31 PEPFAR-supported healthcare facilities that were providing HIV care and treatment services with a minimum patient volume of 20 patients per day. HP+ surveyed between 15 and 20 patients at each of those facilities during their visits for HIV care (totaling 645 patients) and complemented such information with brief close-ended interviews with two healthcare providers from each of those 31 facilities. Information collected from patients included expenses incurred during their current or last facility visit for HIV care, socioeconomic and demographic characteristics, transportation costs, travel time, and time spent at the facility. Providers were asked about the types of user fees that the facility usually charged.

Key Findings

The study found that 25 percent of patients reported paying at least one direct user fee for HIV care services during their last visit to a healthcare facility (see Table 1). Prevalence of direct fees was higher among poor patients, at 27 percent. Overall, prevalence was highest in Rivers (55 percent) and lowest in Kano (6 percent). The average amount spent on direct user fees among patients who reported incurring a fee was 1,235 Nigerian naira (NGN) (US$3.40). Direct fees were more prevalent among three services: HIV testing, ARV medication, and regular visits for HIV treatment, where 43 percent, 20 percent, and 19 percent of patients seeking those services, respectively, paid. In terms of indirect costs, respondents spent an average of 619 NGN (US$1.70) on transportation, and 3.9 hours in time expended in travel and receiving the service at the facility.

[3] Interventions covered under the basic minimum package for prevention of mother-to-child HIV transmission are HIV testing and counseling for all pregnant women, ART for mothers and newborns, and infant feeding counseling.

Table 1. User Fee Study Findings

Category	Poor Sub-Sample	Total
Direct fees (prevalence)	27%	25%
Direct fees (in mean NGN)	NGN 1,270	NGN 1,235
Direct fees (as percent of daily income)	170%	92%
Total time spent (hours)	3.9 hours	3.9 hours
Total indirect costs (transportation and time)	NGN 844	NGN 1,191
Total indirect costs (as percent of daily income)	113%	89%
Total direct fees and indirect costs (if incurring both)	NGN 2,104	NGN 2,508
Total direct fees and indirect costs (as percent of daily income)	281%	187%

Financial burden as a proportion of the average daily income represented by user fees and indirect costs is significant, according to the study results. The average amount spent per patient on user fees per visit is equivalent to 92 percent of average daily income; among the subset of poor patients, user fees were equivalent to 170 percent of daily income. Across the sample, total indirect costs per patient were equivalent to 89 percent of the average daily income.

Patients who reported making a payment for a specific HIV service were asked what the direct fee covered. The study found that the type of fees patients incurred can be broadly grouped into "allowable charges" and "informal charges." Allowable charges are fees that facilities can charge their patients, such as hospital registration fees, consultation fees, and fees for the diagnosis and treatment of opportunistic infections. "Hospital registration" was the most common type of fee charged, reported by more than half of the study's sample. Hospital registration fees are sometimes paid by patients to enter the HIV ward or to have a nurse place a patient's files in the respective queue. The reported registration fees are unlikely to be related to first-visit one-time expenditures, given that the average length of time patients had been on ART in the sample was four years.

Although these are allowable charges, they pose a financial burden to the patient, which could be significant enough to serve as a barrier to seeking regular and timely care. Such fees can be reduced or eliminated through a number of policy instruments. For instance, scale-up of differentiated care service models can decrease the costs incurred by patients as they are assigned less frequent visits, depending on stability. Differentiated care service models represent significant potential cost savings, given that the patients in the study sample were picking up ARV medication an average of eight times per year, despite the average length of time on ARVs being four years. A policy tool that could start creating momentum toward the elimination of user fees for HIV services would be a blanket pronouncement from state-level authorities on the removal of user fees for people living with HIV, recognizing that such patients are vulnerable and require financial protection to ensure continuous care. Such a move has already taken place in Akwa Ibom and Rivers, two of the country's high HIV-burden states.

Informal fees were the second-most common type of charges incurred. Among patients who paid at least one user fee, 42 percent paid for ARV prescriptions or medications, CD4 count tests, or viral load tests. While there is a need to further explore the reasons for facilities charging for commodities or services that are supposed to be free, it is apparent that better enforcement is necessary to ensure that such charges do not proliferate. The government of Nigeria will have to lead in monitoring and responding to cases of informal fees, with potential support from civil society organizations and donor implementing partners to ensure accountability. It is necessary for the government of Nigeria and its partners to discuss and draft a policy, if necessary, on possible repercussions for facilities that have informal fees.

Recent Developments and Policy Recommendations

The dissemination of the results from this user fee study to NACA and other key stakeholders has added momentum to the current discussion and exploration of policies to reduce and/or eliminate user fees for HIV service delivery in Nigeria. The reduction or removal of user fees will serve as an effective strategy in increasing people's access to HIV services. The following activities can help reduce or eliminate user fees people living with HIV incur when seeking care.

Draft a state-level policy eliminating user fees for HIV services, recognizing people living with HIV as vulnerable and requiring continuous care. The presentation and dissemination of results from the user fee study by HP+ to key stakeholders in Nigeria generated renewed momentum for the reduction and elimination of such fees. This momentum, coupled with the recent approval of policies directed toward elimination of those fees in Akwa Ibom and Rivers states, should facilitate advocacy in other states and government at the federal level to consider the same. While it is not clear when such policies will be enacted and implemented, HP+ plans to work closely with the Network of People Living with HIV/AIDS to track user fee reduction or elimination in those states. HP+ will also explore options to create accountability mechanisms, possibly with the involvement of NACA and the Federal Ministry of Health.

Integrate HIV services into the national and state health insurance schemes to encourage reduced user fees for people living with HIV as facilities are reimbursed for service delivery through the schemes. Scale-up of these schemes will allow for prepayment of the costs of registration, clinical consultations, and basic laboratory tests for beneficiaries so that no user fees are required, substantially reducing the financial burden for people living with HIV. Health insurance coverage also will encourage timely care as it removes financial barriers to seeking care—a critical factor for people living with HIV to minimize their risk of developing opportunistic infections. HP+ is working with NACA, in collaboration with the National Health Insurance Scheme, state health insurance schemes, and other health financing actors to define a model for integration of HIV services into both national and state health insurance schemes. The model will include the development of a proposal for a national blueprint with a clearly defined HIV service package amenable for integration across diagnosis, treatment, and laboratory management to serve as a guide as states consider integration. Coverage of HIV services can also eliminate user fees in public facilities where no balance billing may be applied, given that reimbursement covers the full cost of services.

Scale up differentiated care service models to decrease costs incurred by patients who are assigned to fewer or less frequent visits, depending on medical stability. With the support of NACA, PEPFAR is scaling up differentiated models of patient-centered care to improve patient adherence and retention. HP+ found that patients have to travel to HIV facilities an average of eight times per year for check-ups and medication refills. Shifting more ART patients to models with multi-month scripting would reduce patients' exposure to direct fees and indirect costs by potentially cutting in half the number of visits per year. HP+ estimated that multi-month scripting may save up to US$52 annually for people living with HIV, a sum equal to one month's minimum wage in Nigeria. Scaled-up implementation and penetration of this multi-month scripting model will not only yield savings for patients, but also generate efficiency gains on the provider side and reduce wait times—the latter an issue patients identify as important. The financial benefit for people living with HIV from the multi-month scripting model is indirect; the model reduces the exposure to fees for people living with HIV but does not reduce their prevalence or magnitude.

Tap the network of private pharmacies in Nigeria to dispense ARV medication through a differentiated care model to reduce indirect costs incurred by people living with HIV. HP+ found that patients spend an average of four hours traveling to and from facilities and accessing care. Enabling patients to pick up ARV refills closer to home through Nigeria's extensive private pharmacy network would reduce patients' indirect costs. Contracting with private pharmacies to provide ARV refills under a decentralized drug pick-up system will relieve the burden of waiting at facilities. Using the private provider network would also allow patients to get refills outside HIV clinic days, when a higher volume of patients is expected. Use of private pharmacies and facilities for ARV prescriptions is already occurring in Nigeria. While this model currently charges fees, those who choose this service have both the willingness and ability to pay. This market segmentation relieves congestion at facilities where these services are provided free of charge though does establish an inequity in the delivery of service. Expansion of similar models through prepayment mechanisms (such as the state health insurance scheme or a state registry) that target the poor should be explored.

While some of these recommendations will indirectly address informal fees through prepayment schemes, as well as minimize opportunities for facilities to charge for such fees, additional measures are needed to directly address the issue.

Improve enforcement of the zero-fee policy for commodities and services that are already paid for by the government of Nigeria or donors. Accountability measures need to be put in place at donor-supported facilities as well as at public facilities that receive earmarked funding or government commodities. Monitoring and spot-checks to ensure that such charges do not proliferate can be carried out with support from civil society organizations and donor implementing partners. The government and its partners can consider a policy on repercussions for facilities that are found to charge informal or illegal fees.

Understand the extent to which allowable user fees and informal user fees are used to cover financial gaps at the facility level. Such understanding is critical in formulating appropriate policies for these facilities. Reasons for charging user fees may include the need to cover overhead costs and/or health workers' compensation, or to add to facility revenue. The study was not designed to identify these reasons, but a separate assessment at the facility level can identify facilities' financial and non-financial rationale for user fees. It is important to assess to what extent facilities rely on user fees and charges to cover their financial gaps. The National Primary Health Care Development Agency and the National Health Insurance Scheme gateways under the Basic Health Care Provision Fund could address the financial factors behind such user fees. It will be necessary to mobilize domestic resources and develop local strategies to compensate for the revenue gap associated with elimination of user fees.

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Health Policy Plus (HP+) is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-15-00051, beginning August 28, 2015. The project's HIV activities are supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). HP+ is implemented by Palladium, in collaboration with Avenir Health, Futures Group Global Outreach, Plan International USA, Population Reference Bureau, RTI International, ThinkWell, and the White Ribbon Alliance for Safe Motherhood.