# HIV vulnerabilities and the potential for strengthening social protection responses in the context of HIV in Nigeria

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February 2012

# Acknowledgements

This research project was commissioned by UNICEF Nigeria and the Nigeria National Planning Commission, funded by UNICEF Nigeria and UNFPA, and carried out by ODI and EPRI in partnership with GADA and CEWHIN. The project resulted in the following six reports:

- Hagen-Zanker, J. And Holmes, R. (2012) 'Social Protection in Nigeria: Synthesis Report'. ODI/UNICEF Nigeria
- Holmes, R. and Akinrimisi, B. with Morgan, J. and Buck, R. (2012) 'Social Protection in Nigeria: Mapping Programmes and Their Effectiveness'. ODI/UNICEF Nigeria
- Holmes, R., Samson, M., Magoronga, W. and Akinrimisi, B. with Morgan, J. (2012) 'The Potential for Cash Transfers in Nigeria'. ODI/UNICEF Nigeria
- Jones, N., Presler-Marshall, E., Cooke, N. and Akinrimisi, B. (2012) 'Promoting Synergies between Child Protection and Social Protection in Nigeria'. ODI/UNICEF Nigeria
- Samuels, F., Blake, C. and Akinrimisi, B. (2012) 'HIV Vulnerabilities and the Potential for Strengthening Social Protection Responses in the Context of HIV in Nigeria'. ODI/UNICEF Nigeria
- Hagen-Zanker, J. and Tavakoli, H. (2012) 'An Analysis of Fiscal Space for Social Protection in Nigeria'. ODI/UNICEF Nigeria

The authors gratefully acknowledge research support provided by Lesley Adams, Jessica Hagen-Zanker, Bose Ironsi, Yauri Nasiru, Nkiru Okoro and Joshua Samson, coordination by Ada Agina (GADA) and editorial assistance by Roo Griffiths. . Many thanks to the focus group and key informant interview participants in Adamawa, Benue, Edo and Lagos and key informants in Abuja.

We thank participants at the validation workshops in Lagos, 24 October 2011, Enugu, 26 October 2011 and Abuja, 28 October 2011 for their helpful comments.

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# Abbreviations

| | |
|---|---|
| ADSACA | Adamawa State Action Committee on AIDS |
| AIDS | Acquired Immune Deficiency Syndrome |
| ALGON | Association of Local Governments of Nigeria |
| ANC | Antenatal Care |
| ART | Anti-retroviral Therapy |
| BNSACA | Benue State Action Committee on AIDS |
| CBHIS | Community-based Health Insurance Scheme |
| CBO | Community-based Organisation |
| CCN | Community Care in Nigeria |
| CCT | Conditional Cash Transfer |
| CISHAN | Civil Society HIV and AIDS Network |
| CGS | Conditional Grants Scheme |
| CHAN | Christian Health Association of Nigeria |
| COPE | In Care of Nigeria's Poor |
| CUBS | Community-based Support |
| DFID | UK Department for International Development |
| DHS | Demographic Health Survey |
| FAO | Food and Agricultural Organization |
| FBO | Faith-based Organisation |
| FCT | Federal Capital Territory |
| FGD | Focus Group Discussion |
| FGM/C | Female Genital Mutilation/Cutting |
| FHI-GHAIN | Family Health International Global HIV/AIDS Initiative Nigeria |
| FMOH | Federal Ministry of Health |
| FMWA&SD | Federal Ministry of Women Affairs and Social Development |
| FNSP | Family Nutritional Support Program |
| FSW | Female Sex Worker |
| GDP | Gross Domestic Product |
| HIV | Human Immunodeficiency Virus |
| IBBSS | Integrated Biological and Behavioural Surveillance Survey |
| ICAP | International Center for AIDS Care and Treatment Programs |
| IDI | In-depth Interview |
| IDU | Injecting Drug User |
| IFAD | International Fund for Agricultural Development |
| IHVN | Institute of Human Virology Nigeria |
| KII | Key Informant Interview |
| LACA | Local Government Action Committee on AIDS |
| LGA | Local Government Area |
| LSACA | Lagos State Action Committee on AIDS |
| MARP | Most-at-risk Population |
| MDG | Millennium Development Goal |
| MDGs-DRG | Millennium Development Goals Debt Relief Gains |
| MSH | Management Sciences for Health |
| MSM | Men Who Have Sex with Men |
| MSS | Midwife Service Scheme |
| MTCT | Mother-to-child Transmission |
| NACA | National Agency for the Control of AIDS |
| NAPEP | National Poverty Eradication Programme |
| NAPTIP | National Agency for the Prohibition of Trafficking in Persons |
| NAWOCA | National Women Coalition on AIDS |
| NBS | National Bureau of Statistics |
| NDN | Nigerian Diversities Network |
| NEEDS | National Economic Empowerment and Development Strategy |
| NEPWHAN | Network of People Living with HIV and AIDS in Nigeria |

| | |
|---|---|
| NESSP | National Education Sector Strategic Plan |
| NFACA | National Faith-based Advisory Committee on AIDS |
| NGO | Non-governmental Organisation |
| NHIS | National Health Insurance Scheme |
| NIBUCAA | Nigerian Business Coalition against AIDS |
| NICaB | Nigerian Indigenous Capacity Building |
| NPC | National Planning Commission |
| NPHCDA | National Primary Health Care Development Agency |
| NSITF | Nigeria Social Insurance Trust Fund |
| NSF | National Strategic Framework |
| NYNETHA | National Youth Network on HIV and AIDS |
| ODI | Overseas Development Institute |
| OVC | Orphans and Vulnerable Children |
| PEPFAR | US President's Emergency Plan for AIDS Relief |
| PHC | Primary Health Carew |
| PLHIV | People Living with HIV |
| PLON | Positive Life Organisation of Nigeria |
| PMTCT | Prevention-of-Mother-to-child Transmission |
| PRO-ACT | Prevention and Organisational Systems Strengthening AIDS Care and Treatment |
| PRRINN-MNCH | Partnership for Reviving Routine Immunisation in Northern Nigeria<br>Maternal, Newborn and Child Health Initiative |
| RIDA | Rural Infrastructure and Development Association |
| SACA | State Action Committee on AIDS |
| SFH | Society for Family Health |
| SMOH | State Ministry of Health |
| SMWA&SD | State Ministry of Women Affairs and Social Development |
| STI | Sexually Transmitted Infection |
| Triple F | Food, Fuel, Financial |
| UK | United Kingdom |
| UN | United Nations |
| UNAIDS | Joint UN Programme on HIV and AIDS |
| UNDP | UN Development Programme |
| UNICEF | UN Children's Fund |
| US | United States |
| USAID | US Agency for International Development |
| VCT | Voluntary Counselling and Testing |
| WAPA | Ministry of Women Affairs and Poverty Alleviation |
| WEO | Women Enhancement Organization |
| WHO | World Health Organization |

# Executive summary

Although Nigeria's HIV prevalence appears to have stabilised in the past 10 years, the epidemic still remains a major public health challenge. While Nigeria's epidemic can be framed as a *generalised epidemic*, there are *concentrated epidemics* among high-risk groups or most-at-risk populations (MARPS), i.e. female sex workers (FSWs), men who have sex with men (MSM) and injecting drug users (IDUs). There are also considerable variations according to geographical area, rural/urban locality, age, gender, education and wealth quintile.

Drawing on secondary literature and primary data collection in four selected state-level sites (Adamawa, Benue, Edo and Lagos), including key informant interviews and focus group discussions at national and state levels, this report explores: the main drivers of HIV-related vulnerabilities; the impacts of HIV on different groups of people and related coping strategies/mechanisms; policy and programming responses to HIV; and social protection-type responses and approaches and their current and potential linkages with HIV.

## HIV-related vulnerabilities/drivers

A number of often interrelated drivers were identified through the review of secondary literature and were confirmed by the case studies; however, the causal linkages are not always clear and sometimes go against expectations. Thus, for instance, while socioeconomic and gender inequalities are often seen to drive the AIDS epidemic, with increased HIV-related vulnerabilities in poor settings and where gender norms are particularly inequitable, this may not always be the case: there are states with low inequality but high HIV prevalence.

Religion and culture can influence HIV-related vulnerabilities: the mainly Christian southern regions have a higher HIV prevalence than the mainly Muslim northern regions. This can be attributed partly to lower alcohol consumption and to circumcision practices in the north.

Low HIV and AIDS awareness is another driver. Although 90% of women and 94% of men in Nigeria have heard of HIV and AIDS, comprehensive knowledge about prevention is inadequate, particularly in the three northern zones, where women's knowledge is especially low. Stigma and discrimination remain key factors impeding individuals from disclosing their status and accessing HIV-related services, although there is some evidence that this is reducing, largely because of increases in awareness.

Multiple sexual partners and low condom use both contribute to the epidemic, as does polygamy. As a means of survival, women and, to a lesser extent, men engage in informal transactional and intergenerational sex, both of which can increase the risk of HIV transmission.

Finally, poor and inequitable distribution of health infrastructure and personnel has been identified as a driver of the epidemic.

## Vulnerabilities among different population categories

According to secondary sources, vulnerable groups in Nigeria include youth (mainly young women), pregnant women, orphans and vulnerable children (OVC) (of whom there are 17.5 million in Nigeria) and the elderly. Such groups are particularly vulnerable because of socioeconomic, age and gender characteristics as well as the location in which the live. MARPs are also at higher risk of HIV and other sexually transmitted infections because of behaviours or occupations that place them at risk of unsafe sex; the above mentioned demographic, locational and structural vulnerabilities are also likely to affect them. Case study respondents added to this list widows, migrant workers, rich people ('they can purchase sex at all costs'), drivers/transport workers and communities living along transport routes.

Other characteristics making particular groups vulnerable to HIV and AIDS include low HIV awareness among youth, with only a quarter having comprehensive and correct knowledge about HIV. HIV testing among youth is also lower than for the general population: 7% compared with 12%. While OVC have higher knowledge than non-OVC on HIV and AIDS, they

live in more food-insecure households and are at risk of rape, sexual abuse/exploitation and child labour. Although there are variations by state, overall only 22% of HIV-positive women accessed prevention of mother-to-child transmission (PMTCT) services and only 13% of pregnant women tested for HIV during an antenatal care (ANC) visit in 2009. The vulnerability of (young) women was emphasised in the case studies: women bear the brunt of the epidemic, may end up engaging in sex work and, with the loss of a husband, are also often disinherited.

### Impacts of HIV and coping strategies

The secondary literature on Nigeria shows that, as a result of HIV and AIDS, households have reduced levels of income and declining agricultural production and family assets. Other impacts include increased numbers of widows and orphans and increases in elderly- and child-headed households. High numbers of OVC have led to an increase in dependency ratios and large household sizes: 90% of poor households in Nigeria are composed of 20 or more individuals. Another impact of HIV and AIDS, affecting women and OVC disproportionately, is disinheritance and the loss of property. Moreover, with an estimated 3.3 million people living with HIV (PLHIV) in Nigeria, the number of individuals requiring health services is increasing, implying a significant rise in patient-to-health centre and patient-to-health professional ratios. Linked to this, heightened pressure for health services has greatly increased the workload of health providers. HIV and AIDS mortality and morbidity are also affecting health professionals and their families.

Informal coping mechanisms for dealing with poverty in general include diversifying household income, engaging in multiple occupations, migration, child labour, borrowing, reducing food and fuel consumption, withdrawing children from school, reducing health care-related costs, selling assets, engaging in illegal activities (e.g. selling black market fuel), commercial sex work and marrying girls off early. Individuals and households affected by HIV may have to resort to such coping strategies, although the implications of these may be different or more severe for such households. Similarly, many of the above coping strategies are also likely to create HIV-related vulnerabilities. For example, child labour brings with it heightened vulnerability to numerous risks, including sexual violence and HIV and AIDS. Specifically in relation to coping with stigma and discrimination associated with being HIV positive, people have relocated, resigned from their employment, increased alcohol intake and smoking, withdrawn from social networks, stopped participating in organisations and taken on a disproportionate amount of additional tasks. Formal coping strategies include turning to programmes of assistance run by non-governmental organisations (NGOs), joining support groups and turning to faith-based organisations (FBOs).

### Institutional response to HIV and AIDS

The institutional response to HIV and AIDS in Nigeria is led by the National Agency for the Control of AIDS (NACA), supported by State Action Committees on AIDS (SACAs) and Local Government Area (LGA) Action Committees on AIDS (LACAs). These bodies coordinate HIV and AIDS responses, bringing together different stakeholders at all levels of government, including NGOs, community-based organisations (CBOs), networks of people living with HIV and AIDS, donors, international agencies and the private sector.

The first national HIV policy was adopted in 1997 and revised in 2003 and 2009 through multi-stakeholder consultations, including with line ministries and PLHIV. The need for a more holistic response and the new emphasis on treatment and universal access led to the development of the 2005-2009 and 2010-2015 National Strategic Frameworks. All states have five-year HIV strategic plans (2010-2015) which articulate their needs and priorities. These mirror national policy to a large extent.

At a national level, HIV has been mainstreamed into the Nigerian poverty reduction strategy through the National Economic Empowerment and Development Strategy, the National Education Sector Strategic Plan, and Nigeria's economic development strategy Vision 20: 2020. However, no explicit link has been made between HIV and the proposed social security strategy (2009) or the draft social protection strategy (2004). Both of these are still incomplete, with limited ownership and challenges in terms of generating policy traction.

Nigeria is highly dependent on donor funding for its HIV and AIDS response, with only 8% in 2008 coming from domestic sources. The US President's Emergency Plan for AIDS Relief and the Global Fund accounted for 48% and 33% of the total budget, respectively. While total expenditure on HIV and AIDS rose from $300 million in 2007 to $395 million in 2008, increasing by 32%, public funds decreased from 15% in 2007 to 8% in 2008.

Since the early days of the epidemic, civil society has played an important role in Nigeria's response. Currently, over 70% of HIV programme interventions are managed by international NGOs in collaboration with local civil society organisations (CSOs), which are critical in terms of providing HIV-related services in the states. However, there is variability in terms of coverage and quality, depending mostly on which external donor is supporting the particular state, the coverage and quality of existing health-related infrastructure, the capacity of health staff and the effectiveness of the individual SACA in terms of coordinating and attracting donor funding.

Generally, lack of and unsustainable funding are issues of key concern at state level, limiting the ability to provide consistent services and increase coverage. More ownership and responsibility on the side of government is seen as a missing ingredient. Insufficient manpower and capacity within the health sector is another serious concern in most states, as is poor infrastructure. Another concern is the lack of coordination: while in theory NACA and SACAs should coordinate responses, the extent of this varies by state. Some SACAs are very active, and can attract and absorb relatively large amounts of donor funding. Others are less visible.

Generally, although a relatively broad and multi-sectoral approach has been adopted, with NGOs providing a range of HIV- and non-HIV/health-related services, a systems response is urgently needed. Through such a response, if it were coordinated and joined up, a wide spectrum of services could be provided to OVC and their families, including educational, psychosocial, economic and health care support. In addition, while much of the response to HIV and AIDS in Nigeria comes through civil society, a fully fledged, mobilised and engaged grassroots community response, to help with collaboration, coordination, outreach and targeting, remains missing.

## Building HIV-sensitive social protection responses

Evidence suggests that social protection can improve the response and coping strategies of people infected with and affected by HIV and AIDS, and can also reduce the risk of HIV infection among vulnerable groups through anti-poverty strategies.

While HIV and AIDS-related programming in Nigeria is not currently framed in terms of social protection, a number of interventions include HIV-sensitive social protection components and target, either directly or indirectly, people affected by or infected with HIV and AIDS. These schemes improve access to education, health care and food security for vulnerable people – including those affected by HIV and AIDS. However, these programmes remain scattered or in pilot stage, do not cover the full range of HIV-related risks and vulnerabilities and are poorly coordinated. Similarly, the approach is often vertical in nature, with limited multi-sectoral engagement. There is little evidence generated on impacts, monitoring and evaluation is limited and usually focuses on outputs and numbers of people reached and implementers lack capacity and resources to scale up or link to complementary initiatives.

The analyses above has shown that there are groups of people who are particularly vulnerable to HIV and AIDS and need to be prioritised in terms of HIV and AIDS-related support; however, careful consideration is needed in terms of how these groups should be integrated within a broader social protection-type response. While PLHIV could be targeted directly targeting could also be carried out on the basis of vulnerability markers, such as levels of income, household size or food insecurity, which would include HIV infected and affected people within a broader grouping. Although HIV can be one criterion related to poverty, social protection should not focus on targeting HIV specifically but rather on strengthening institutional linkages and coordination with agencies mandated to address HIV-related issues. To achieve this end, the following recommendations are made:

**Legislation, policies and strategies:**
There is need to ensure that social protection legislation, policies and strategies include HIV-related components, or are themselves HIV-sensitive.

**Targeting and design of programmes:**

- While programmes should target poor and vulnerable people in general, on some occasions the specific needs of PLHIV may need to be taken into account. Factors include the stage of the illness; whether PLHIV are on ART; and the support structure and/or household in which they find themselves.
- Programmes should therefore consider linking HIV-related service uptake to a social protection transfer. For example, to encourage HIV-testing and ART uptake, a cash or food transfer could be provided. International examples where this has worked include Uganda (Emenyonu et al., 2010).
- Several tracks of support should be considered within a single programme: households with labour capacity could receive one kind of support (e.g. income generating); those with limited labour capacity could receive a different package (e.g. a cash transfer).
- Gender equality is critical in both HIV and social protection programming; it can be integrated into programme design or by incorporating institutional linkages with other support programmes (see e.g. Holmes and Jones, 2010).
- Social protection programmes that focus on public works or agricultural input transfers should be further explored and include activities which could support PLHIV and make only limited physical demands. Findings from South Africa's public works programme can be considered further (see e.g. McCord, 2005).

**Institutional coordination and implementation:**

- While cross-sectoral and multi-activity coordination and implementation remain weak, there are some micro examples (e.g. the National Poverty Eradication Programme (NAPEP)) which have been successful. How to build on, replicate and scale up these successes needs to be explored.
- To improve coordination and facilitate linkages between HIV and social protection, a coordinating committee should be established at national level and replicated at state level; importantly, in order not to create parallel structures, this should build on existing structures which already have cross-cutting or cross-sectoral mandates.

**Capacity building:**

- Although appropriate structures may exist, they are often under-resourced and under-funded; one means to address this would be to build the capacity of such institutions.
- Capacity building should also occur for personnel working on HIV and on social protection; this would increase their awareness and understanding of both topics and would also help address implementation challenges and bottlenecks.

**Funding:**

- While there are considerable amount of funds available for HIV and AIDS, ways to harness these more effectively, efficiently and equitably need to be explored.
- An increase in government commitment to pro-poor expenditure in order to better link HIV and social protection would encourage and strengthen these linkages.

It is clear that further evidence is needed on both the impacts of nascent social protection approaches in Nigeria as well as how best to do social protection in Nigeria in a context of HIV and AIDS. Such a context is one of wide variations, differences and contradictions. Not only do responses need to be tailored to the specific states, but also, to tackle the root causes of vulnerability and poverty, responses need to go below the state level and into communities to understand the key drivers – something which this study and the Triple F study have sought to do. Nevertheless, much more is still needed.

What is certain is that there is a need for a more coordinated and equity-based response to social protection, particularly in the context of HIV and AIDS from the national to the local level, among all relevant national and international stakeholders. This will require an increase in political commitment at all levels of government, sustainable and efficient use of donor funding and an increase and improvement in the effectiveness and efficiency of Nigeria's public expenditure on HIV and AIDS and social protection strategies. UNICEF has a key role to play in this response as well as in providing guidance based on the above identified strategies and approaches.

# 1 Introduction and methodology

This report is part of a project to support the government of Nigeria in realising its overarching development strategy (Vision 20: 2020) and the recent National Social Security Policy for Inclusiveness, Solidarity and Sustainable Peace and Prosperity. Through five thematic reports on social protection,[1] the project aims to provide policy-oriented research-based evidence to inform a social protection implementation plan for these national strategies. This report explores the possibilities of implementing such an initiative in the context of HIV, by exploring four key issues: the main drivers of HIV-related vulnerabilities more broadly and for specific groups of people; the impacts of HIV on different groups of people and their coping strategies/mechanisms; responses to HIV; and finally social protection-type responses and approaches and their current and potential linkages with HIV.

These questions are explored through a review of secondary material and through case studies carried out in four states in Nigeria. These case studies were chosen based on prevalence of HIV and AIDS (at least two were to be in high prevalence states); specific child protection vulnerabilities; general state poverty profiles and susceptibility to shocks and stresses; and geographical spread (two were to be in the north and two in the south), so as to maximise synergies with the Overseas Development Institute/UN Children's Fund (ODI/UNICEF) Impacts of the Triple F[2] Crisis project (see Table 1).

Specifically, the objective of the HIV and AIDS case studies is to illustrate the types of vulnerabilities faced by people living with HIV (PLHIV), the drivers of HIV and the range of institutional responses at the state level. As such, we chose one HIV and AIDS intervention per state to highlight programmatic responses to HIV and AIDS. We primarily used key informant interviews (KIIs) and focus group discussions (FGDs), along with in-depth interviews (IDIs) with programme participants where possible. These latter were disaggregated by sex and age where feasible in order to capture specific gender and lifecycle experiences.[3] Throughout this report, findings from the case studies are interspersed with those from the literature review.

## Table 1: State selection

| State | General poverty profile | HIV prevalence |
|---|---|---|
| Adamawa | In the North East zone, selected for its high poverty rate | High (6.1-8%) |
| Benue | In the North Central zone, selected for its high levels of social vulnerability, its position as the nation's food basket and its declining trade opportunities | Very high (>8.0%) |
| Edo | In the South South zone, selected to represent the landlocked centre region; although income poverty is reportedly not as high as in other states, social vulnerability such as child trafficking and labour are significant | Medium high (4.1-6%) |
| Lagos | In the South West zone, selected because of its position as the economic centre of Nigeria and its urban density | Medium high (4.1-6%) |

In all states, a wide range of government, non-governmental organisation (NGO) and civil society organisation (CSO) stakeholders working on HIV, child protection and social protection were invited to an initial stakeholder meeting. This meeting was held to explore the range of programmes being implemented at the state level, to guide the choice of programmes for in-depth exploration and to choose the areas/communities for the case study. Programmes had to have a focus on HIV and AIDS but also components that went beyond purely a medical approach to include social protection-type responses, e.g. provision of nutritional or livelihood

[1] A mapping of social protection and its effectiveness and reports on cash transfers, HIV and AIDS, child protection and fiscal space.
[2] Food, fuel, financial.
[3] See the Appendix for KII, IDI and FGD guides.

support. Additionally, programmes had to have a medium-scale reach of beneficiaries (e.g. not be too small) and be run by government, NGOs or CSOs or a combination of these.

The research team encountered some limitations in terms of the methodological approach, including in relation to representation/participation of HIV and AIDS programmes in the state at the workshop. In addition, there was some variation in the overall number of FGDs conducted in the different states, and male and female FGDs were combined on some occasions as a result of constraints faced in travelling and organising discussions in the field.

In Adamawa, the study focused on Management Sciences for Health (MSH), an NGO working in a number of rural communities and focusing on Prevention and Organisational Systems Strengthening AIDS Care and Treatment (PRO-ACT). One KII was held with the MSH state team leader. Through MSH, three FGDs were carried out – two with adult men and one with adult women. Six IDIs were carried out – two with adult men and four with adult women. FGDs and IDIs were held with participants from HIV and AIDS interventions in poor communities.

In Benue, the study focused on urban and rural communities where the US President's Emergency Plan for AIDS Relief/US Agency for International Development (PEPFAR/USAID) Family Nutritional Support Program (FNSP) has been implemented for the past five years. BENPLUS, a network of PLHIV in Benue, is one organisation that has benefited from FNSP. BENPLUS facilitated the case study and two FGDs; four IDIs were conducted in the state. Most rural dwellers in Benue are farmers; in urban areas, most people are civil servants. Some men own their own business; some women are housewives.

In Edo, the team selected the Rural Infrastructure and Development Association (RIDA) and its Oriaifo Medical Centre, in Uromi local government area (LGA) – the peri-urban, mostly farming, community in which RIDA operates. Three KIIs were conducted – with the RIDA founder/Oriaifo Medical Centre managing director, the RIDA programme manager and the chief nursing officer in the HIV and AIDS clinic in Irrua General Hospital, in a neighbouring community. Four FGDs were carried out in Uromi, with women, men, girls and boys who had benefited from RIDA interventions in the community since 2003. The teenagers and young adults were attending various primary and secondary schools. Adult male and female respondents were mostly traders, drivers, retired civil servants and HIV and AIDS counsellors.

In Lagos, HOPE WorldWide was identified as the case study. Two KIIs were conducted with the director of Hope and the executive director of Positive Life Organisation of Nigeria (PLON), a community-based organisation (CBO) working with HOPE. Facilitated by PLON, four FGDs were carried out with girls, boys, women and men in Yaba, selected to reflect findings from the Lagos state sero-prevalence report, which shows an increase in new infections in peri-urban communities. Generally, adult respondents had education up to secondary school level and were traders, retired civil servants or HIV and AIDS counsellors. Children, aged between 10 and 19 years, were all in school (primary and secondary). Respondents were all beneficiaries of HOPE WorldWide's programmes.

Following this introduction, Section 2 presents an overview of the HIV context in Nigeria, followed by detailed descriptions of the states in which the case studies were conducted. Section 3 examines the drivers of HIV-related vulnerability, as seen in the literature and uncovered in the KIIs, IDIs and FGDs. Section 4 discusses the vulnerabilities facing specific groups of people, again using the two types of findings. It also assesses the impact of HIV on individuals', households' and communities' experiences of poverty and vulnerability, and looks to understand in more depth people's coping mechanisms. Section 5 outlines current institutional responses, going in more detail into the case study programmes. Finally, Section 6 concludes, exploring social protection-type approaches and responses focusing on HIV and drawing on existing literature on the role of social protection in HIV to provide recommendations to support the development of a social protection strategy in Nigeria in the context of HIV and AIDS.

# 2 Overview of HIV in Nigeria

Nigeria is the most populated country in Africa, with an estimated 150 million inhabitants (NACA, 2010a). With a three-tiered system of governance (federal, state and local), it is divided into six geopolitical zones – North West, North East, North Central, South West, South East and South South – which comprise 36 states and the Federal Capital Territory (FCT). These are further divided into 774 LGAs. Abuja, the capital city, is situated in the FCT. Nigeria has a highly diverse society, with more than 250 ethnic and linguistic groups (ibid.). Despite possessing many natural resources, such as oil and gas, Nigeria is ranked at 158 out of 177 countries on the Human Poverty Index (UNDP, 2009).

## 2.1 HIV in Nigeria as a whole

Nigeria's HIV prevalence appears to have stabilised in the past 10 years, going from 3.8% in 2001 to 3.6% in 2009 among the general population (UNAIDS, 2010b). However, the epidemic still remains a major public health challenge, with both prevention and impact mitigation strategies required in order to further curb the epidemic and increase the quality of life of PLHIV. Meanwhile, although it has a low HIV prevalence rate in comparison with other African countries (ibid.), the sheer size of the population implies that Nigeria is second only to South Africa in terms of numbers of PLHIV. Indeed, with an estimated 3.3 million PLHIV, Nigeria bears nearly 10% of the global burden of HIV (ibid.), with youth and in particular young women most vulnerable to infection (NACA, 2010a). Children aged 0-4 years are also at high risk of infection, with a mother-to-child transmission rate (MTCT) estimated at between 13.1% and 29.1% (ibid.). The Joint UN Programme on HIV and AIDS (UNAIDS) estimates that 330,000 Nigerian children aged 0-4 years were living with HIV and AIDS in 2009: a significant increase from the 2007 figure of 220,000 (UNAIDS, 2010b). Although access to anti-retroviral therapy (ART) has improved, coverage in Nigeria is still low: based on World Health Organization (WHO) guidelines, ART coverage is at 21%, with 302,973 people receiving it out of an estimated 1.4 million PLHIV needing access to these essential drugs (WHO et al., 2010).

The main mode of transmission is heterosexual sex, which accounts for 80-95% of all HIV infections in Nigeria (Adeyi et al., 2006). While Nigeria's HIV and AIDS epidemic can be framed as a *generalised epidemic*, there are *concentrated epidemics* among high-risk or most-at-risk populations (MARPs), i.e. female sex workers (FSWs), men who have sex with men (MSM) and injecting drug users (IDUs) (FMOH, 2007; 2010b). And the recent HIV/STI (sexually transmitted infection) Integrated Biological and Behavioural Surveillance Survey (IBBSS) shows that MARPs contribute to a significant number of new HIV infections (FMOH, 2010b). While representing only 1% of Nigeria's population, MARPs were estimated to contribute to 23% of new infections (NACA, 2009; 2010).

Since the first recorded Nigerian case in 1986, AIDS has claimed many lives in the country, accounting for more than 220,000 deaths in 2009 alone (UNAIDS, 2009). This high death toll is clearly perceptible through the country's significant number of AIDS orphans, which is estimated at 2.5 million children aged 0-17 years (ibid.).

Understanding Nigeria's HIV epidemic requires disaggregating national data according to a number of factors, including age; gender; education; wealth quintile; region and sub-region; and rural and urban locality. Even then, the context of HIV-related risks and vulnerabilities, or the factors which drive and therefore could help us understand the HIV epidemic in Nigeria, remain unclear. Instead, what emerges is a picture of complexity and variation, with differences according to a range of factors, including geographical location, wealth profile and education levels (see also Sections 3 and 4).

### Age distribution

According to Nigeria's 2008 antenatal care (ANC) survey, the highest prevalence rate is among the 25-29 age group (5.6%), which is the largest adult group, representing 7.9% of the total

Nigerian population. The lowest prevalence is among the 40-44 age group (2.9%) (FMOH, 2010a).[4] According to the draft 2010 ANC report, highest prevalence rates by age grouping vary by region. For example, in the South South zone, the highest prevalence is found among the 40-49 age group (8%); in the South West zone, it is among the 35-39 age group (4.3%); and in the North East zone it is among the 25-29 age group (4.9%).

### Gender distribution

Women are disproportionately affected by the epidemic, accounting for 56% of all adults aged 15 and above living with HIV and AIDS (UNAIDS, 2009). The 2008 ANC survey shows that HIV prevalence among pregnant women is at 4.6% (FMOH, 2010a).[5] Furthermore, in comparison with young men, the prevalence rate among young women aged 15-24 is particularly high, at 2.9% versus 1.2% (UNAIDS, 2010b), highlighting young women's specific vulnerability to HIV and AIDS. Although the prevalence rate has decreased in the past decade, it is still considerably higher than among men.

### Geographical differences

There is significant variation in HIV prevalence among regions, states and localities. At the regional level, HIV prevalence ranges from 2% in the South West zone up to 7% in the South South zone (FMOH, 2010b). Prevalence at state level ranges from 1% in Ekiti state in the South West zone to 10.6% in Benue state in the North Central zone (ibid.). However, the highest prevalence rate (22%) has been recorded in Bwari LGA in the FCT (Rhodes and Simic, 2005) (see Figure 1).

### Rural and urban differences

There are marked differences between urban and rural areas. For instance, the under-five mortality rate ranges from 121 deaths per 1,000 live births in urban areas to as high as 191 in rural areas (NPC and ICF Macro, 2009). In terms of HIV prevalence, the variation appears to be less: it is on average slightly higher in urban (3.8%) than in rural (3.5%) areas (FMOH, 2009), although on closer scrutiny (see FMOH, 2010a) there are many states, including Adamawa, Yobe, Jigawa and Kaduna, which have overall higher HIV prevalence in rural than in urban areas. Access to ART is significantly lower in rural areas, with 3% of rural health facilities providing such services in comparison with 20% in urban areas. This gap in service provision is further widened by the fact that there are already fewer health facilities in rural areas, even though this is where most Nigerians are to be found (Amanyeiwe et al., 2008).

### Education levels

Levels of education vary greatly across regions and states. Many Nigerians have no access to formal education – 36% of women and 19% of men aged 15-49 (FMOH, 2010b). The 2008 Demographic and Health Survey (DHS) shows a positive correlation between wealth and education, with people belonging to the higher wealth quintiles being the better educated (NPC and ICF Macro, 2009). Although there has been an increase in young women's education attainment since the 1990s (NACA, 2010a), there is still a significant gender gap in certain regions. For instance, in the North West and North East of Nigeria, as few as 20% of women have completed primary school and are literate (UNICEF, 2007). In terms of HIV and AIDS education, only 23% of public secondary schools have included life skills-based HIV and AIDS education in their curriculum, and only 25% of men and women (aged 15-24) are able to identify ways to prevent sexual transmission of HIV and discard major misunderstandings about HIV transmission (UNAIDS, 2010b). However, national surveys show that HIV prevalence is higher among people with education (primary 5.1%, secondary 5.8% and tertiary 4%) in comparison with those without (2.7%) (FMOH, 2009; 2010b).

[4] The draft ANC 2010 report shows that the highest prevalence is among the 30-34 age group (5.7%) and the lowest among the 40-49 age group (3.6%).

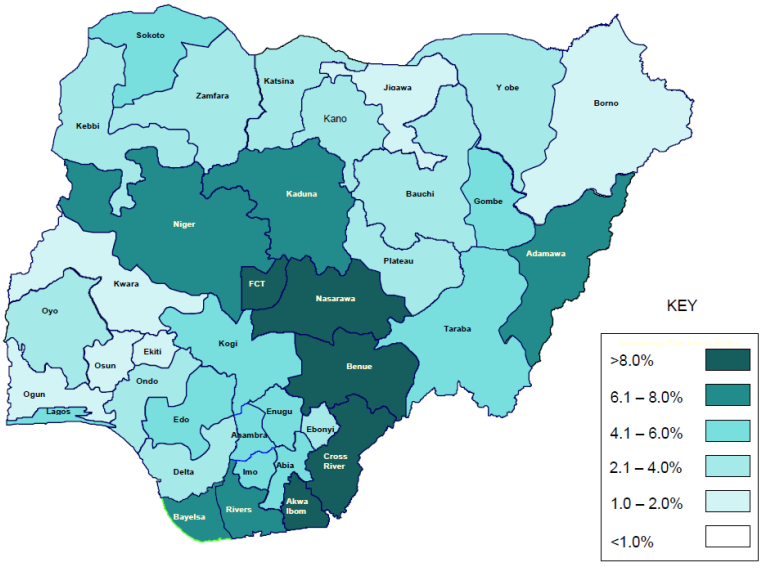
[5] The draft ANC 2010 report puts HIV prevalence at 4.1%, with variations by zone: the highest was found in the North Central zone (7.5%), followed by the South South zone (6.5%). The North West zone had the lowest prevalence (2.1%).

### Wealth quintile

According to the 2008 DHS, urban areas have higher proportions of people in the fourth and highest quintiles (30% and 47%, respectively) compared with rural areas (15% and 7%, respectively). Similarly, rural areas have higher proportions in the lowest and second quintiles (29% and 27%, respectively) than urban areas (3% and 5%, respectively). On some HIV-related indicators according to wealth quintile, it is apparent that the higher the wealth quintile, the more HIV-related knowledge and awareness, the fewer discriminatory attitudes towards PLHIV, the more pregnant women counselled and receiving an HIV test, the more use of condoms, the more knowledge of where to get an HIV test and the more people having had a test. This pattern is observed for both men and women, as well as for youth.

Similarly, by observing a few selected indicators, it is evident that people in the lower quintiles face heightened risks related to HIV: many more female youth (30% from the lowest quintile versus 4.5% from the highest) have had sexual intercourse before the age of 15; and many more female youth (15-19) have practised sex with a man 10 years or more older (23.7% versus 10.4%). Adult women from the lowest quintiles have the highest total fertility rate (7.1 versus 4.0) and the highest number of children (7.3 versus 4.8). Female youth from the lowest quintile are much more likely to have a teenage pregnancy/live birth (35% versus 3.1%). All these have been shown to be factors which can increase HIV-related risks and vulnerabilities. But people from richer quintiles can also be at risk: both female and male youths (15-24) from the highest quintile are more likely to practise higher risk sex (with a non-marital or non-cohabiting partner) than youth from the lowest quintile (NPC and ICF Macro, 2009).

## Figure 1: Geographic distribution of HIV prevalence, by state




Source: FMOH (2010a).

## Table 2: Zones and states

| Zone | States |
|---|---|
| North West | Sokoto, Kebbi, Zamfara, Katsina, Niger state, Kaduna, Kano, Jigawa |
| North East | Borno, Yobe, Gombe, Bauchi, Adamawa,* Taraba |
| North Central | Niger, Nassarawa, Plateau, Benue,* Kaduna, Kogi, Kuara, FCT |
| South West | Lagos,* Oyo, Ogun, Osha, Ekiti, Ondo |
| South East | Imo, Eboyi, Elubu, Abia, Anambra, Enugo |

| | |
|---|---|
| South South | Cross River, Bayelsa, Edo* |

Note: * Case study states.

## 2.2 Adamawa state and HIV context

Adamawa state is located in the North East zone and shares borders with a number of states as well as with Cameroon. With a total of 21 LGAs, the majority of people (65%) are involved in agricultural activities, mostly as farmers. The state is also known for livestock production and for breeding cattle, sheep and goats. Leatherwork is an important traditional industry.

In the 2006 Core Welfare Indicators Questionnaire (CWIQ), 7 out of 10 households sampled, or 71.8%, classified themselves as poor (74.0% of households in rural and 67.0% of households in urban areas) (NBS, 2006). Only 6.9% of the sampled population in the CWIQ had access to credit facilities (5.1% in rural areas and 11.0% in urban areas).

The social and human development profile of Adamawa state is similar to that of the rest of North East Nigeria. In the area of education, the adult literacy rate is 56.1%, with wide variation between the sexes – 67.1% of men and 44.8% of women – and between rural and urban areas – 49.9% of rural and 70.1% of urban adults (NBS, 2006; 2010b). The total fertility rate is 7.2, compared with a national rate of 5.7. Although the child mortality rate is gradually decreasing nationally, the under-five mortality rate is 222 deaths per 1,000 live births in the North East, compared with 89 in the South West (NPC and ICR Macro, 2009).

HIV and AIDS prevalence in Adamawa has been fluctuating over the years. It was at 5% in 1999, about 4.5% in 2001, about 7.5% in 2002, about 4.1% in 2005, about 7% in 2008 and 3.8% in 2010. It is at 4.6% and 3.4% in rural and urban areas, respectively (FMOH, 2010a). Discussions for the current study revealed that knowledge on HIV and AIDS is high as a result of, according to respondents, extensive work on awareness and contributions by NGOs such as Family Health International's Global HIV/AIDS Initiative Nigeria (FHI-GHAIN), Society for Family Health (SFH), MSH, UNICEF and other organisations.

## 2.3 Benue state and HIV context

Benue state is situated in the North Central zone of Nigeria and has an estimated population of 4.2 million (50.4% male and 49.6% female). Most of the inhabitants (75%) are farmers, producing at subsistence level. The major food crops are yams, maize, sorghum and soya beans; more than 70% of Nigeria's soya bean crop is produced in Benue, and the state has consequently been tagged the food basket of the nation.

The majority of the state's non-agricultural workers are in the formal sector, working as civil servants: the state government is the largest employer. The state currently has a low level of capital investment and very few entrepreneurs. There are very few industries, and previously state-owned manufacturing concerns, such as Taraku Mills Ltd., Benue Brewery Ltd., Benue Burnt Bricks and Benco Roof Tiles, are in various stages of privatisation.[6] However, Benue state is a vital link between the southern and northern parts of the country, and commercial activities in agricultural produce are now a focal point of the government's policy thrust. There is renewed enthusiasm in the state to develop agriculture and industry, with major areas of investment in commercial farming, agribusiness and mining.

Benue is the 11th-largest state in Nigeria and can be said to be prosperous relative to other states within the same geopolitical zone. This is despite the fact that more than half (54.6%) of the people consider themselves poor. General unemployment in the state is at 3.8%, and youth (15-24) unemployment stands at 9% (NBS, 2006). The level of mortality appears to be higher than the national average. Despite the state being drained by the Benue River and the Katsina Ala, 75.9% of the population does not have access to water (compared with a national

[6] www.nigeriagalleria.com/Nigeria/States_Nigeria/Benue_State.html

average of 50.9%). When compared with the national average, there are fewer underweight children under five (16.6% compared with 25.3%). Nevertheless, the Human Poverty Index for Benue state is 36.0, compared with a national average of 32.3 (UNDP, 2009).

The most recent education statistics, for 2006, show an adult literacy rate of 67% and youth literacy of 83.7% (NBS, 2006).[7] Literacy in urban areas was high, at 88.9%, compared with 61.1% in rural areas. More than 9 in 10 male youths were classified as literate, compared with 75.7% female youths. In the same year, access to primary schools was at 63.2% – higher in urban areas (89.2%) than in rural areas (59.6%). Benue had a 77.4% net enrolment rate for primary schools and a 14.6% primary school completion rate. Access to secondary school was at 33.5%; secondary net enrolment was 45%; and the secondary completion rate was 19.2%.

According to the same survey, 42% of households in Benue state had access to health services in 2006. Only 6.8% utilised medical services, and 47% of children aged 12-59 months were fully vaccinated at the time of the survey. A total of 11% of females in the state were circumcised. As of 2010, there were over 683,000 orphans in Benue state (NBS, 2010b).

Benue state has the highest HIV infection rate in the country: 16.8% in 1999, 13.5% in 2001 and 10% in 2010 (FMOH, 2010a).[8] HIV and AIDS in Benue state has also affected rural communities disproportionately, with women, children and the elderly bearing the burden of care and support for those infected and affected by the disease (Hilhorst et al., 2006). Also, the state continues to suffer from inadequate technical skills, inadequate access to ART (especially for the rural poor) and high levels of stigmatisation of and discrimination against PLHIV, among other problems.

## 2.4 Edo state and HIV context

Located in the South South zone of Nigeria, Edo state has a population of 3.2 million, of whom 50.6% are male and 49.5% are female (NBS, 2006). Benin City is the state capital and the commercial nerve centre; there are a total of 18 LGAs in the state. Sandwiched between many states and located on major transport routes from north to south, Edo faces many of the vulnerabilities associated with having a large body of mobile people. Edo is also a source state for many international migrants (see Box 1).

Agriculture is the predominant occupation of the people of Edo state. The major cash crops produced are rubber, cocoa and palm and its derivatives, with the main food crops being yams, cassava, rice, plantains and guinea-corn. Assorted fruits, like pineapples, coconuts, oranges and avocados, as well as green leafy vegetables, all grow abundantly. There is also a significant animal husbandry industry, mainly in cows, goats, pigs, rabbits and sheep. Mineral resources such as quartzite, marble, clay, limestone, chalk, gypsum, gold, petroleum, kaolin and lignite are also to be found in Edo state. Petroleum is also produced in the state and exploration for further reserves is underway.

Poverty in Edo is estimated at 54-64%, with gross domestic product (GDP) among the lowest in the country. The Human Poverty Index is 15.5, well below the 32.3 for Nigeria

### Box 1: Edo as a source of international migrants

According to a participant at the stakeholder workshop in Benin City:

'There is a general belief and perception that the surest means out of poverty and improved quality of life for the family is to ensure that at least one member is outside the shores of Nigeria even for the flimsiest reasons and excuses [...] Travelling abroad is the biggest economic industry in the state, as the average Edo indigene is willing to pay as much as N500,000 in fees to process travel documents [...] Society has been socialised into the belief that a successful livelihood is a consequence of travelling to Europe, Asia or the US or indeed anywhere outside the shores of Nigeria [...] Expectedly, this has come at a huge cost. The state is known for its very high prostitution rate, human trafficking and increasing numbers of orphaned and vulnerable children (OVC) as well as child-headed households. Incidence of HIV/AIDs is rising [...]'

[7] All education statistics in this document are from the same source.

[8] The 2008 ANC survey puts the prevalence rate for Benue at 12.7%, ranging from 5.3% in one rural area to 21.3% in another rural area (FMOH, 2010a).

as a whole, and the Gini index is 54. Residents lack access to quality water, sanitation, electricity, health and education services. The adult literacy rate is 77%, with men more literate than women (84.4% versus 69.3%). Rates are lower among rural dwellers.

Children in urban communities are markedly better-off than their rural peers: about 40% are delivered by a skilled attendant and more than half are fully vaccinated by the age of five. One in three young children is stunted, compared with one in five reported in Lagos state. Child mortality rates are at par with the national average – 180 per 1,000 live births.

Women in urban communities are also significantly better-off than their rural peers. Fewer than a quarter of the latter report using modern methods of contraception and over 10% have been pregnant before the age of 20, compared with a national average of 17%. Only 5 in 10 report receiving prenatal care from skilled attendants. Women are fairly involved in the decision-making process – 6 in 10 are able to make their own health care decisions and have significant control over how to spend their own earnings. However, female genital mutilation/cutting (FGM/C) is common in Edo state, especially in rural communities with strong cultural traditions, where over half of women report having been cut (NBS, 2010a).

The ANC survey of 2008 puts HIV prevalence in the state at 5.2% (FMOH, 2010a). Prevalence is generally higher in the semi-urban areas of Benin City, Uromi and Auchi as well as the industrial communities of Okpella and Fugar.[9] There are indications that HIV is currently spreading more quickly in rural communities owing to the tradition of taking multiple wives and sex partners. Overall, though, awareness of HIV as well as of modes of transmission is very high. Over 90% of the sampled population had heard of AIDS and knew it is transmitted through sex and the use of sharp objects. Slightly lower proportions (ranging from 85% to 95%) knew that AIDS was transmitted through blood transfusions and between 75% and 80% acknowledged that a healthy-looking person could be HIV positive.

## 2.5 Lagos state and HIV context

Lagos was the capital of Nigeria from 1967 to 1991 until this status was moved to Abuja. It has a population of 17.5 million and remains the commercial and industrial hub of Nigeria, attracting large numbers of both domestic and international migrants. It has a steadily increasing GDP and has benefited from being situated close to major sea ports and from natural resources of oil, natural gas, coal, fuel wood and water.

Lagos is a state of contradictions. Economic activities among the very poor range from agriculture to vocational trade, such as tire mending, carpentry, trading in used clothes and perishables and commercial bus and bike driving. Its poverty rate – 64% – is substantially higher than the national average of 55%, but its annual GDP per capita is among the country's highest, at over $2,500. Furthermore, one-third of the state's citizens consider themselves 'non-poor' – a higher number than the national average of 25%. The Human Poverty Index for the state is 14.5, compared with 32.3 for the country as a whole. Residents also have better services – over three-fifths of Lagos residents have access to an improved water source and nearly all have access to electricity. Access to good sanitation lags behind other indicators, though, with only one in four having improved facilities. Lagos' Gini index captures these contradictions: Nigeria's index is .49 while that of the state is 64.

Women and children in general do better in Lagos than in other states and when compared with their rural counterparts. Over 80% of children are delivered by a skilled attendant and more than half are fully vaccinated by the age of two. Only one in five young children is stunted and one in ten is wasted – rates half those seen in Adamawa, for example. Child mortality rates are also significantly lower than the national average – 150 versus 205 per 1,000 live births. Furthermore, nearly 80% of children attend primary school, and secondary

[9] The draft report estimates a prevalence of 5.3%, ranging from 3.3% in a rural area to 7.5% in Benin City (FMOH, 2010a).

school has a net enrolment rate of over 70%, with girls accounting for about 50% of total enrolment.[10]

Over a quarter of women report using modern methods of contraception and only 5% have been pregnant before the age of 20, compared with 13% in rural areas and a national average of 17%. Nearly 9 in 10 report receiving antenatal care from a skilled attendant. Women's educational attainment is also quite high – and closely matches that of men. The median education for both is over 11 years. Women in Lagos are also more involved in the decision-making process than many other Nigerian women: 7 in 10 make their own health care decisions and have sole control over how to spend their own cash earnings. Furthermore, 60% of the state judiciary is made up of women. However, FGM/C is quite common in Lagos, with over one-third of women reporting having been cut (NBS, 2010a).

The first HIV and AIDS case in Lagos State was recorded in 1986, and since then there has been a gradual but steady increase in the number of people testing positive for HIV and living with AIDS. The ANC survey of 2008 puts the HIV prevalence rate in the state at 5.1%[11] – a decline from a peak of 6.7% in 1999. HIV prevalence is higher among the urban 15-24 age group: in 2005, prevalence for urban youth was 4.0% whereas among rural youth it was 2.7%; in 2008, the urban sub-group had a prevalence of 6.1% whereas the rural sub-group had a prevalence of 1.2%.

Overall, awareness of HIV is very high in Lagos state, as is basic knowledge of modes of transmission. Over 90% of the sampled population had heard of AIDS and knew it was transmitted through sex and the use of sharp objects. Slightly lower proportions (ranging from 85% to 95%) knew that AIDS was transmitted through blood transfusions and between 75% and 80% acknowledged that a healthy-looking person could be HIV positive.

[10] www.esspin.org/index.php/resources/reports/non-esspin.

[11] The draft report gives the same HIV prevalence of 5.1%, ranging from 1.3% in two rural areas to 8.3% in the urban area of Badagry (FMOH, 2010a).

# 3 HIV vulnerabilities/drivers across Nigeria

Understanding the drivers of HIV transmission requires identifying the underlying social and structural determinants that increase risk and vulnerability. Structural drivers include social, political, economic, cultural, legal and policy characteristics particular to each setting. According to the National HIV and AIDS Strategic Framework 2010-2015, the main drivers of the epidemic in Nigeria are low risk perception, multiple concurrent partners, informal transactional and intergenerational sex, inconsistent condom use, lack of effective STI services, poor quality health services and stigma/discrimination. Poverty and gender inequality are at the root of most of the drivers sustaining the epidemic (NACA, 2009).

## 3.1 Socioeconomic inequalities

It is universally acknowledged that HIV and AIDS are especially prevalent in poor socioeconomic settings with high levels of inequality (Gillespie et al., 2007). This often implies poor living conditions, unequal gender relations, lack of employment prospects, food insecurity and poor access to education and health care. All these factors influence men's and women's vulnerability to infection, through poor knowledge on HIV and AIDS, early marriage, sexual exploitation and risky behaviours such as unprotected transactional sex (Gillespie, 2008). With over 50% of the Nigerian population living under the poverty line, socioeconomic inequalities have definitely become a challenge for HIV and AIDS prevention and impact mitigation (UNDP, 2009). Nevertheless, the picture may not be so clear cut: even where inequality is low, HIV prevalence may still be high.

## 3.2 Gender inequalities

Unequal gender norms have a great impact on men's and women's differentiated risks and vulnerabilities to HIV infection, as well as on their access to prevention, treatment, care and support. Not only are women biologically more susceptible to HIV infection, but also they can be more vulnerable because of their lower socioeconomic status. Gender inequalities increase women's exposure to infection, through their lower status and lower access to education, as well as their economic dependency on men. The 2008 DHS showed a positive correlation between women's participation in household decision making and their access to health services. However, with only 38% of women participating in household decision making in Nigeria, this means women's health is at risk (NPC and ICF Macro, 2009). In addition, gender inequalities increase women's risk of HIV infection as a result of abuse, sexual exploitation and trafficking (FMWA&SD, 2007; UNDP, 2009).

The role of gender inequality and cultural norms in perpetuating women's vulnerability to HIV was articulated strongly throughout the case study discussions, as Box 2 illustrates. However, as Section 3.1 pointed out, the picture is more complex than this: where gender inequality is low, HIV prevalence may still be high. There is no simple causal relationship for every location or situation.

### Box 2: Gender inequality as a key driver of vulnerability to HIV

In Lagos, one female key informant stated that the woman 'can't say no', even if she knows her partner is infected: 'women cannot ask their husbands to use condoms […] women are traditional care givers, this exposes them to infections through care giving […] men are also more likely to change partners than their female counterparts'.

During an FGD with women in Benue, they said that 'wife beating and battering is still a big issue in Benue state. […] When you hear a fight going on in the bedroom, it's certain that the wife is being beaten […] and it's usually related to a demand for sex by the man when the woman is not ready', said one woman. Male FGD respondents agreed: 'a woman cannot refuse her husband sex during sex times; if she does she is battered'. According to the women's FGD, in Tiv culture, when women get married, they have to swear to Aleku (a 'small god'); if she cheats, Aleku will catch up with here and deal with her mercilessly. This acts as an important deterrent while at the same time placing women at the mercy of their husbands. In some situations, the wife even prepares her marital bed for her husband and his 'visitor', as she often refers to the other woman. All of this puts women in an extremely vulnerable position.

Gender inequality also comes into play when women enter a new relationship: when a woman has lost her husband to AIDS complications, she often finds it difficult to enter into a new relationship; even when she attempts to do so, she may not get the full support of family members. Men, however, can easily establish new relationships after their wives die – and may not tell new wives of their HIV status. This again puts women at high risk of HIV infection.

In Edo, while women were said to make decisions on most domestic issues, when it comes to issues of reproduction and specifically, for instance, which hospital the women should go to for delivery, it is the men and their family who decide. Similarly, women do not have any control over the sexual behaviour of men – they cannot negotiate safe sex and they cannot control the number of wives, mistresses or girlfriends the men keep.

While women do not have a public voice and are usually not involved in community decisions, men often gather women's opinions privately and then feed them back to the community. However, men were said to be the final decision makers because they are the head of the family.

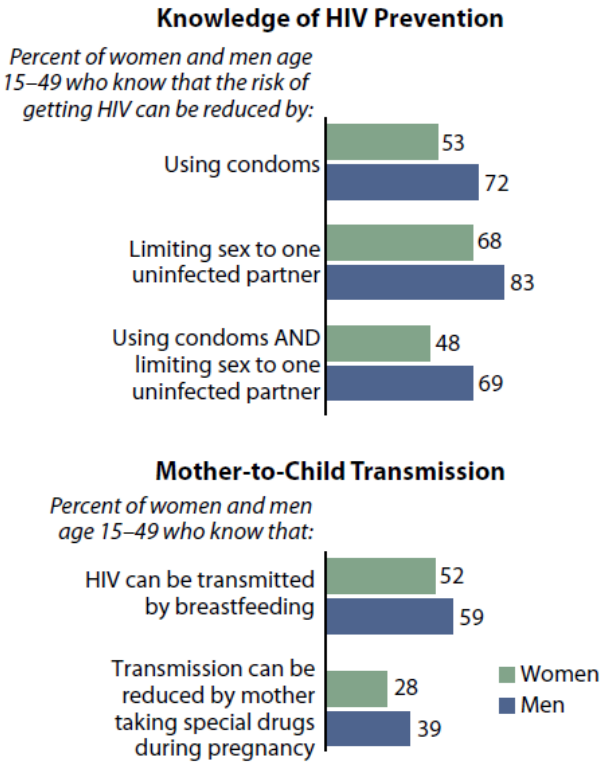
## 3.3 Religion and culture

The linkages between HIV and AIDS, religion and culture are clearly perceptible in Nigeria. The mainly Christian southern regions have a higher HIV prevalence than the mainly Muslim northern regions (NACA, 2010a). This discrepancy has been explained mainly by differences in alcohol consumption and circumcision prevalence among Muslims and Christians. Studies show that alcohol abuse increases a person's risk of high risk sexual behaviour (Chandra et al., 2003) and circumcision reduces HIV infection among men (Auvert et al., 2005; Gray, 2004). As alcohol consumption is forbidden under Islam, Muslims may be less exposed to high risk sexual behaviour than their Christian counterparts. Furthermore, unlike among Christians, circumcision is common practice for Muslims in Nigeria (WHO/UNAIDS, 2007). However, in the 2008 DHS – a survey carried out across Nigeria – 98% of respondents had been circumcised (NPC and ICF Macro, 2009). Thus, again, the picture is not so straightforward: circumcision, for instance, is perhaps only a partial explanation for differing HIV prevalence.

## 3.4 Low HIV and AIDS awareness

Although 90% of women and 94% of men in Nigeria have heard of HIV and AIDS, comprehensive knowledge about HIV prevention is inadequate (see Figure 2), particularly in the three northern zones, where women's knowledge is especially low. For instance, in the North East zone, only 39% of women versus 72% of men know that HIV can be prevented through the use of condoms (NPC and ICF Macro, 2009). Awareness that treatment can reduce HIV transmission ranges from 22% (North West) to 35% (South South) for women and from 34% (South West) to 52% (North East) for men (ibid.). Knowledge levels also vary by wealth quintile, with members of the highest quintile, both men and women and female and male youths, invariably having higher levels of knowledge (ibid.).

## Figure 2: Knowledge on HIV prevention




Source: NPC and ICF Macro (2009).

This clearly highlights that HIV and AIDS awareness in Nigeria is highly gendered and related to wealth and education (especially in the northern zones and rural locations): richer urban men in the south have better knowledge and access to information on HIV and AIDS. Even more disquieting is the very low understanding of MTCT among the general population. At a national level, only slightly more than half of men and women are aware that HIV can be transmitted through breastfeeding. This figure is as low as 34% among women living in the North West zone (NPC and ICF Macro, 2009).

The 2008 DHS further shows that, even though men have higher knowledge on HIV, this advantage does not necessarily translate into an increase in testing. Indeed, more than half of Nigerians know where to get tested for HIV, but only a mere 15% of women and 14% of men have tested and received their results (NPC and ICF Macro, 2009).

Lack of awareness and knowledge on HIV and ways of preventing it was also highlighted as a major driver of vulnerability in the case studies. Generally, it was pointed out that, while awareness has increased owing to the availability of more information and programmes, lack of knowledge still pervades and leads to, among other things, the persistence of stigma (see Section 3.5). Among case study respondents, many of whom were members of support groups, knowledge about HIV, mode of transmission and prevention strategies was relatively high. Increased knowledge and awareness has also had a positive impact on stigma, as all the case studies highlight.

## 3.5 Stigma and discrimination

Stigma and discrimination can prevent positive health-seeking behaviours and impede individuals from using HIV preventative methods (i.e. condom use) and accessing relevant health services and treatment (NACA, 2009). Stigma is fuelled at individual, community and institutional levels.

The 2008 DHS highlights the strength of HIV-related stigma: 24% of men and 40% of women would hesitate to take care of a family member with HIV, and about 40% overall would keep the HIV-positive status of a family member secret. Furthermore, fewer than half of respondents would buy vegetables from an HIV-positive shopkeeper (NPC and ICF Macro, 2009). A recent study in North West Nigeria showed that a quarter of the study's participants were experiencing stigma in their workplace and communities (Akpa et al., 2011); the Lagos case studies reflected the persistence of stigma when seeking employment – as one key informant reported, 'once they (the employers) know you are HIV positive, no one will employ you'. Indeed, this issue is so widespread that a bill with the aim of protecting the rights and dignity of people living with and affected by HIV and AIDS was passed by the lower house of the National Assembly, and is currently pending passage by the Senate. At state level, some states have been more active than others: the Lagos state government's Law for the Protection of Persons Living with HIV and Affected by AIDS in Lagos State and Other Connected Matters came into force on 18 May 2007, although the extent to which it is enforced is not known. Edo state passed a similar law in 2006, but to date no one has been arrested.

Furthermore, women's low status in Nigeria has been shown to increase their exposure to HIV-related discrimination, from families, communities and also health care providers. They are often blamed for their status and may thereafter be rejected by partners or relatives. Women's economic dependency can prevent them from accessing voluntary counselling and testing (VCT) and ART services, as health care providers may ask for the male partner's approval in order to secure payment of services (Mbonu et al., 2010).

Nevertheless, the case studies highlighted a trend towards a reduction in stigma within communities, albeit a very small one. According to informants from Lagos state, for instance, in the past, once people knew you were HIV positive, they did not want to get close, but now social acceptability has improved: 'culture used to be a barrier, but this is drastically reducing'. Similarly, disclosure is increasing. More people are confiding in close family members, and families are more accepting, with 'husbands now telling their wives of their status'. These changes owe largely to increased awareness generated by various programmes.

However, the situation varies by location and according to the amount of information available: 'in a community where there is a lot of enlightenment on the modes of transmission, you find that people don't mind, they don't want to look at you to find out if you are positive, but in areas where there is little enlightenment and you fall ill, people start to look at you and wonder'. In Edo state, stigma was said to be reducing but still present. According to respondents, 'stigmatisation is not really prevalent as most HIV-positive people hardly ever disclose their status'. Indeed, the majority of HIV-positive respondents had disclosed their status only to their spouse (also HIV positive).

In Benue also, current attitudes were said to be better than in the past, when an HIV-positive person was looked on as a 'walking corpse' and in most families was isolated from others. According to one respondent, 'the issue now is self-stigma; a lot of us, PLHIV, stigmatise ourselves, this makes us not disclose our status'. Meanwhile, stigma remains a significant challenge for PLHIV in Benue, as Box 3 illustrates. Another respondent highlighted the importance of institutional support to tackle discrimination: 'we want the anti-stigma bill to be passed into law, I believe when this is done stigma will definitely be a thing of the past'.

**Box 3: HIV-related stigma in Benue**

Stigma and discrimination are still present in Benue: because of fear of rejection or being disowned, respondents said men were afraid to disclose their status to their wives or girlfriends. Similarly, women who have lost their husbands to AIDS find it harder to engage in new and meaningful relationships because of the stigma attached to such conditions. As a member of a support group in Benue says, 'now that many people know I am HIV positive, who will kiss my lips again? My HIV status notwithstanding, I still feel like every woman and do have such needs for fulfilment as well'. A male key informant couldn't summon up the courage to tell his girlfriend of his status because he felt that, if she knew, she would abandon him, even though they used a condom each time they had sex. She found out from some acquaintance in his office and 'came in one day and rained abuse on me. I almost felt like the earth should swallow me up. She called me all manner of bad names; I couldn't stand it anymore; and finally she left me stranded. At that moment I felt like dying.'

## 3.6 Multiple sexual partners and low condom use

Both multiple sexual partners and low condom use are factors which contribute to the epidemic in Nigeria (UNAIDS, 2009). Women aged 15-49 have fewer sexual partners in their lifetime (1.6) than men (4.3) but, of those with multiple partners, only 23% of women and 33% of men used a condom in their last sexual intercourse (NPC and ICF Macro, 2009). Polygamy is also a risk for HIV transmission in Nigeria, although again there are differences according to gender, age, educational level, wealth quintile and location. Overall, 33% of married women are in polygynous unions, although this increases with age, from 26% among women 15-19 years to 44% among women 45-49 years. The proportion is higher in rural areas (38% versus 22%) and in the northern zones – 43% in North East, 42% in North West and 37% in North Central. Polygyny decreases with level of education, with 46% of women with no education in polygynous unions compared with 9% of women with more than secondary education. Women in the lower wealth quintiles are more likely to have polygynous marriages. Finally, only 16% of married men aged 15-49 years reported having two or more wives, with polygyny more common among men with the same characteristics as women (NPC and ICF Macro, 2009).

## 3.7 Informal transactional and intergenerational sex

In poor socioeconomic settings, women and to a lesser extent men struggle to get by on a day-to-day basis. This can increase the incidence of transactional sex – sex in exchange for money, shelter or basic necessities such as food and transport. A study conducted in Benue state showed that many young women used transactional sex to pay for basic necessities such as school fees and food, and that this practice was perceived as 'commonplace' (Gruber and Caffrey, 2005). These unequal relationships are also often intergenerational, mainly involving young women and older men, when the latter have the economic power to engage in such transactions. Another study reported that 35% of surveyed female sex workers joined the sex trade because of poverty and food insecurity (Oyefara, 2007).

## 3.8 Poor and inequitable distribution of health infrastructure and personnel

Provision of HIV and AIDS services (prevention, treatment, care and support) requires a significant number of health professionals, including physicians, nurses, counsellors, pharmacists and lab technicians. The number of health care professionals is considered adequate in Nigeria, with 39 doctors and 124 nurses per 100,000 population, versus a sub-Saharan average of 15 and 72, respectively (WHO, 2006). However, the inequality of their distribution among regions is severe: as Table 3 illustrates, the North East zone has the lowest share of all. For instance, it has only 245 pharmacists, compared with South West zone, which has almost half of the total number of pharmacists (6,532) (Amanyeiwe et al., 2008).

## Table 3: Distribution of health professionals among geopolitical zones

| Zone | Doctors | Nurses and midwives | Laboratory scientists | Pharmacists | Total |
|---|---|---|---|---|---|
| North East | 675 | 3,398 | 96 | 245 | 4,414 |
| North West | 1,388 | 3,941 | 201 | 502 | 6,032 |
| North Central | 1,841 | 5,778 | 434 | 1,342 | 9,395 |
| South East | 3,210 | 4,914 | 2,110 | 841 | 11,075 |
| South West | 7,300 | 4,487 | 1,603 | 2,859 | 16,249 |
| South South | 2,168 | 7,097 | 1,281 | 743 | 11,289 |
| Total | 16,582 | 22,518 | 5,725 | 6,532 | 5,854 |

Source: Amanyeiwe et al. (2008).

In terms of infrastructure and services, again certain regions and rural areas are more under-resourced than others, with rural primary health care (PHC) facilities 85% less likely to provide ART than those in urban areas (Amanyeiwe et al., 2008). Table 4 highlights the unequal provision of HIV-related services among regions and states. For instance, only 3% of facilities in the North West zone provide prevention of MTCT (PMTCT) services (any), in comparison with the 44% of facilities in the South South zone. Figure 3 illustrates the urban/rural divide in terms of HIV-related services.

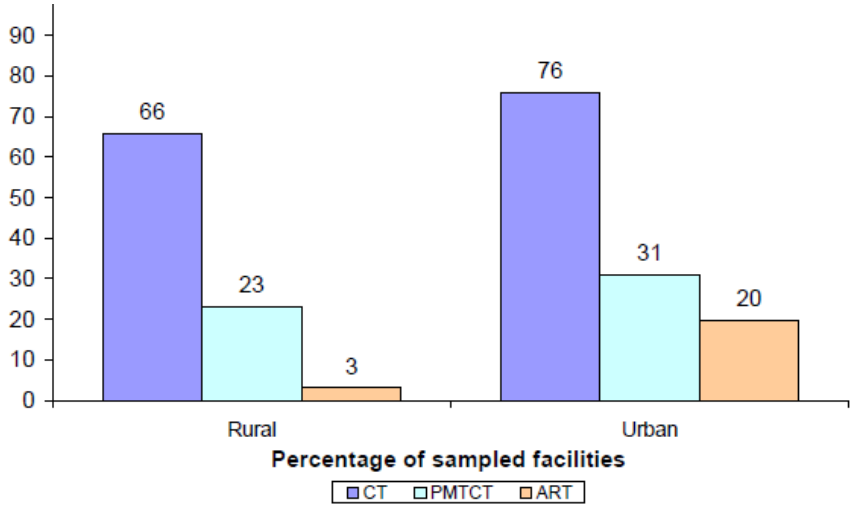
## Table 4: Facilities offering HIV services, by background characteristics

| Characteristic | VCT | PMTCT | ART | TB | Post-exposure prophylaxis | *No of facilities* |
|---|---|---|---|---|---|---|
| **Type of facility** | | | | | | |
| Primary | 64% | 22% | 4% | 31% | 9% | *103* |
| Secondary | 96% | 41% | 21% | 68% | 45% | *129* |
| Tertiary | 100% | 91% | 92% | 77% | 89% | *48* |
| **Managing authority** | | | | | | |
| Federal | 100% | 55% | 55% | 55% | 83% | *41* |
| State | 88% | 36% | 8% | 44% | 36% | *94* |
| Local | 61% | 21% | 5% | 33% | 6% | *55* |
| Military | 100% | 85% | 85% | 51% | 85% | *5* |
| Faith-based | 79% | 31% | 19% | 44% | 23% | *83* |
| **Region** | | | | | | |
| North Central | 67% | 38% | 9% | 38% | 3% | *77* |
| North East | 25% | 22% | 2% | 42% | 2% | *30* |
| North West | 69% | 3% | 2% | 26% | 16% | *44* |
| South East | 65% | 24% | 6% | 26% | 16% | *39* |
| South South | 84% | 42% | 5% | 19% | 44% | *47* |

| | | | | | | |
|---|---|---|---|---|---|---|
| South West | 99% | 28% | 21% | 77% | 7% | *43* |
| **Urban/rural** | | | | | | |
| Rural | 66% | 23% | 3% | 35% | 9% | *156* |
| Urban | 76% | 31% | 20% | 41% | 29% | *124* |
| **Total** | **68%** | **25%** | **7%** | **36%** | **14%** | ***280*** |

Source: Amanyeiwe et al. (2008).

## Figure 3: Facilities offering key HIV and AIDS services, by urban/rural location




Source: Amanyeiwe et al. (2008).

Despite Table 3 showing relatively high numbers of nurses and midwives, a recent survey found that 30-70% of the 652 PHC facilities in Nigeria had no midwives in service. Given their central role in PMTCT, these health workers are critically needed throughout the country and are likely to be even less prevalent in poor and remote areas. A Midwife Service Scheme (MSS) (see Holmes and Akinrimisi, 2012) has been set up to address this shortage, funded by the Millennium Development Goals Debt Relief Gains fund (MDGs-DRG). Through this, 2,608 midwives have been deployed to the 652 PHC facilities in 332 LGAs in all 36 states and the FCT. It is implemented by the National Primary Health Care Development Agency (NPHCDA) and provides antenatal, delivery, postnatal and family planning services, as well as community-based outreach, to contribute towards attaining MDGs 4 and 5 (NPHCDA, 2010).

In all case studies, unequal distribution of health- and HIV-related services and resources was stressed as a vulnerability factor. One respondent in Lagos said that ART was more available than three to five years ago, but that affordability and availability remain a problem: free ART is in theory available through government services but services are often diverted or delayed by bureaucratic bottlenecks, thus resulting in difficulties in access for the average person. Additionally, access to free ART is problematic because of the associated indirect costs, including travel and laboratory tests. In Benue, for instance, it was pointed out that, while ART, PMTCT and home-based care services are now more available at the Federal Medical Centre, people 'still suffer accessing drugs owing to the rigorous process involved, which includes having to travel from considerable distances for the testing and counselling services'.

# 4 Vulnerabilities/drivers among different population categories

As in all countries, in Nigeria the HIV epidemic affects some population groups more than others (FMOH, 2007). These groups can be divided into vulnerable groups and MARPs. Population groups vulnerable to HIV and AIDS are at heightened risk because of their socioeconomic, age and gender characteristics; as seen in Section 3 and again in relation to particular groups of people, those living in certain locations are also more likely than others to be more vulnerable. In Nigeria, the main vulnerable groups are youth (mainly young women), pregnant women, OVC and the elderly. MARPs, who include FSWs and MSM, are at a higher risk of HIV and other STIs because of behaviours or occupations that place them at risk of unsafe sex; the above more demographic, locational and structural vulnerabilities are also likely to affect them. Thus, for instance, as is shown below, FSW in certain states have much higher HIV prevalence than in other states.

When case study respondents were asked which groups were most at risk, the answer varied according to the state. In Lagos, migrant workers, sex workers and children infected by their mothers were said to be most at risk. In Edo, said to be a 'transient state', not only are the drivers and transport workers vulnerable to HIV and AIDS, but also the communities along the routes. This is particularly the case for widows, young women and orphans, who are said to be 'willing to exchange their body for money in order to survive'. Respondents in Edo also said it was not only the poor who were at risk, but also rich men, given their ability to purchase sex at any price: 'most rich men in Edo state have been found to be highly promiscuous'.

While working-age and young children were easily identifiable as groups at particular risk of HIV, people's analysis of the vulnerability of the elderly was more complex. According to a respondent in Lagos, for instance, the elderly were not necessarily at risk, especially if they were faithful to their partner. However, uneducated grandmothers were seen to be more vulnerable: they 'do not know the modes of transmissions [and] are very much at risk' – presumably because they are often enlisted to care for those infected by HIV.

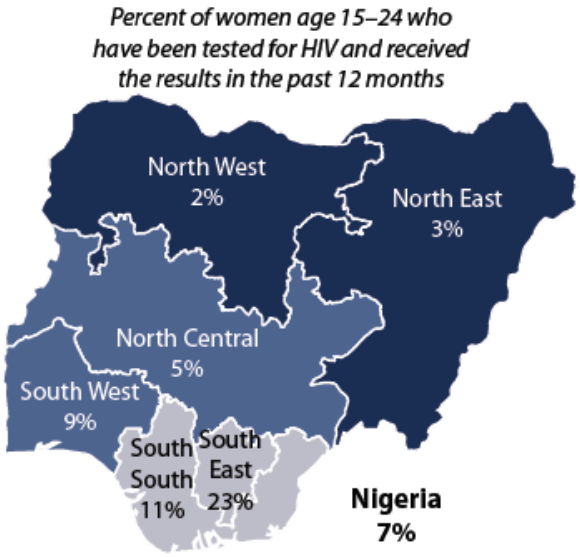
## 4.1 Vulnerable groups

### Youth

Like in many regions of the world, young women and men (15-24) in Nigeria are at particularly high risk of HIV infection, mainly because of unprotected sex and vulnerability to exploitation (UNAIDS, 2010b). Although HIV prevalence among youth is lower than the national rate of (2.4% versus 3.6%), because youth represent a large percentage of Nigeria's population, they actually account for 67% of national HIV prevalence (FMOH, 2009). Thus, youth are an important HIV risk group in Nigeria. Young women (14-24) are disproportionately affected by the epidemic, with prevalence almost three times higher than among young men (2.9% versus 1.2%) (UNAIDS, 2010b). Furthermore, 17.2% of young women (15-24) have had sexual intercourse before the age of 15, in comparison with 6.7% of young men (FMOH, 2009). All these indicators worsen for those in the lowest wealth quintile, as we have seen – for example 30% of young women in the lowest quintile have had intercourse before the age of 15.

HIV awareness among youth is quite low: only a quarter have comprehensive and correct knowledge about HIV (FMOH, 2009). HIV testing is also lower than among the general population, at 7% in comparison with 11.7% (ibid.). As Figure 4 shows, HIV testing among young women varies greatly by region, ranging from 2% in the North East and North West to 23% in the South East (NPC and ICF Macro, 2009). These wide disparities can be attributed to differences in the availability of VCT services, but also to cultural and religious differences. In the north, Islam is the dominant religion: Muslims have been shown to be less likely to attend HIV services because of the stigma and discrimination associated with HIV and AIDS and its relation to extra-marital sex (Akpa et al., 2011; Mack, 2006).

## Figure 4: HIV testing among young women




Source: NPC and ICF Macro (2009).

### Orphans and vulnerable children

There are an estimated 17.5 million OVC (aged 6-17 years) in Nigeria (FMWA&SD, 2008). A total of 5.5 million children are considered vulnerable and 12 million children are orphans, of whom 2 million are double orphans and 2.5 million are orphans as a result of HIV and AIDS (UNICEF, 2009). A total of 220,000 children are living with HIV and AIDS in Nigeria (UNAIDS, 2008).

Nigeria defines an orphan as 'a child (0-17 years) who has lost one parent (maternal/paternal orphan) or both parents (double orphan)' and a vulnerable child as 'a child who, because of circumstances of birth or immediate environment, is prone to abuse or deprivation of basic needs, care and protection, and thus disadvantaged relative to his or her peers' (FMWA&SD, 2007). Box 4 presents the list of vulnerable children. However, it is important to note that the term 'orphan' does not exist in most Nigerian languages.

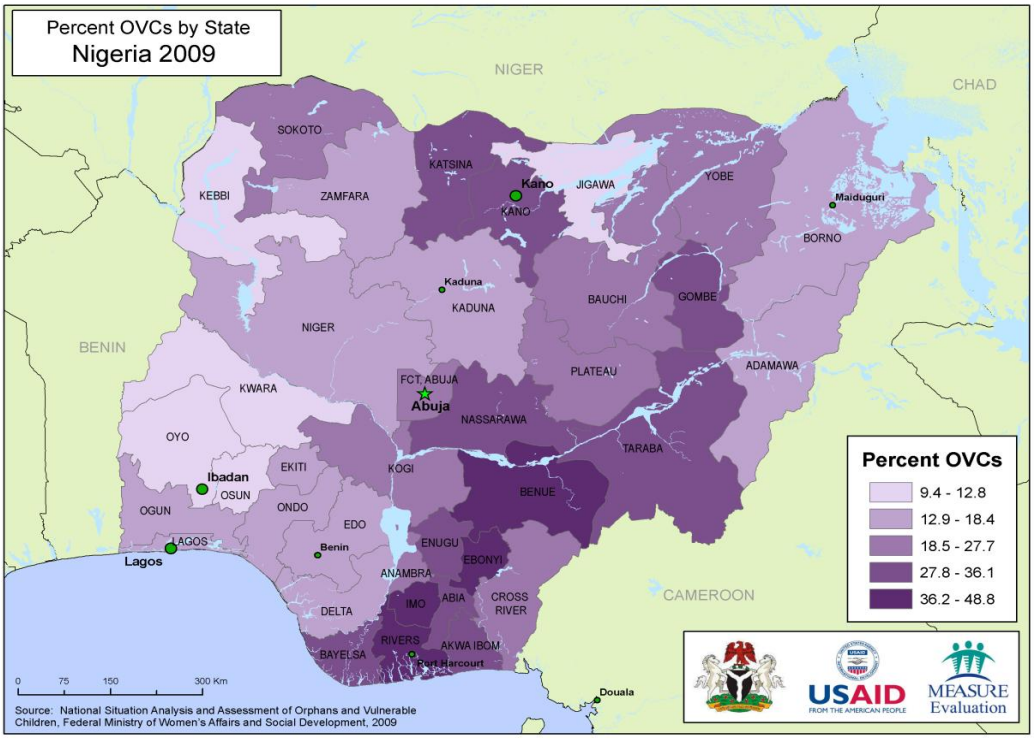
### Box 4: Categories of vulnerable children

- Children who have lost one or both parents
- Children living with terminally or chronically ill parent(s) or caregiver(s)
- Children on or of the street/ Child hawkers
- Children living with aged or frail grandparent(s)
- Children who get married before 18 years
- Neglected children
- Abandoned children
- Children in child-headed homes
- Children infected with HIV
- Child beggars/destitute children (including exploited almajiris)
- Internally displaced or separated children
- Child domestic servants
- Child sex workers
- Children with special challenges or disability, or whose parents have disability
- Trafficked children
- Children in conflict with the law
- Children of migrant workers e.g. fishermen or women, nomads
- Children living with teenage unmarried parent(s)

Source: FMWA&SD (2007).

Prevalence of OVC is similar in rural and urban settings, although there are significant regional and state-level differences. The North Central, South East and South South zones are particularly affected, with states such as Benue and Imo reaching close to 50% of OVC in comparison with lower prevalence states such as Kwara and Jigawa States (see Figure 5) (FMWA&SD, 2008). The highest prevalence of orphans is also found in Benue state (30.6%) where HIV prevalence is also the highest; this is followed by Akwa Ibom, Rivers and Enugu states, where more than 20% of children are orphans (ibid.).

## Figure 5: Percentage of OVC, by state




Source: FMWA&SD (2008).

Children's level of vulnerability to poverty, malnutrition, exploitation and HIV and AIDS differs according to socioeconomic factors such as age, gender and geographical location and also to the availability of family and community support networks as well as the accessibility of health and social services. A 2008 Situation Assessment and Analysis on OVC in Nigeria showed that they are more likely to live in food-insecure households than non-OVC (17.8% versus 7.4%), seemingly with no significant differences by gender or age (FMWA&SD, 2008). However, food insecurity among OVC varies greatly at the state level. In Abia, Bayelsa and Imo states, more than 30% of OVC are living in food-insecure households, in comparison with fewer than 2% in Borno, Kaduna and Kwara states (ibid.).

On the other hand, OVC have more knowledge of HIV and AIDS than non-OVC, with 50.3% of OVC (aged 13-17) versus 42.8% of non-OVC having heard of HIV and AIDS. However, there are significant regional differences, with OVC in all three southern zones having better knowledge than children in the northern zones (FMWA&SD, 2008). In terms of health care, 80% had accessed treatment for their last ailment – slightly higher for girls. However, major differences were found at the regional level, with only 56.9% of children in the North West having received treatment in comparison with 91.8% in the South West (ibid.).

Nearly a quarter of OVC, both girls and boys, have experienced disinheritance, meaning they have lost property that was rightfully theirs. There are marked differences at the regional level: North East (26.5%), South South (25.7%), South East (25.1%), North Central (20.3%), South West (15.7%) and North West (12.3%) (FMWA&SD, 2008). Disinheritance can lead to great vulnerability through loss of shelter (safety) and land (food security), which can increase risk for HIV through transactional sex, sexual violence and trafficking.

Indeed, according to young women in Benue, children face a number of risks, including rape, sexual abuse/exploitation and child labour. The latter, as is shown below, is also a coping strategy. In Edo, children and orphans from extremely poor households remain particularly vulnerable: many are given away to work as domestic assistants in rich homes, where their rights are not adequately protected. Similarly, many are unable to access HIV care services.

### Women

As mentioned above, young women aged 15-29 are especially vulnerable to HIV infection, with the epidemic peaking at 5.6% among the 25-29 age group (NPC and ICF Macro, 2009). With an estimated 23% of women aged 15-19 being pregnant or mothers (ibid.), HIV-positive women and their children are especially vulnerable in Nigeria. In 2009, out of the estimated 210,000 HIV-positive women, only 22% accessed PMTCT services (UNAIDS, 2010b). In fact, coverage of ANC and PMTCT services are so low (only 13% of pregnant women tested for HIV during an ANC visit) that Nigeria alone contributes to 32% of the global gap on the MDG target to attain 80% coverage of antiretroviral prophylaxis for PMTCT (WHO et al., 2010).

Although northern states have the highest percentage of pregnant women aged 15-24 (45% in the North West and 39% in the North East), access to VCT and PMTCT services is at the lowest in these regions (NPC and ICF Macro, 2009). Therefore, women of child-bearing age and HIV-positive pregnant women and their children are highly vulnerable because of high prevalence rates among young women's sub-population group and low access to prevention and treatment services. On the supply side, barriers to access to HIV services are linked to poor infrastructure and availability of drugs and lack of qualified health personnel to carry out HIV prevention and treatment, especially in rural areas (Amanyeiwe et al., 2008). On the demand side, barriers are mainly socio-cultural and economic factors, such as distance to a health centre and HIV-related stigma, which prevent HIV-positive pregnant women from accessing relevant services.

The specific vulnerability of women and their children was emphasised in all the case studies. According to informants in Lagos, women and children are more affected, as infection rates are higher among their sub-group and they are expected to bear the effects of their status alone, whereas men expect and receive care from women and children. Women's ascribed role as care givers also contributes to this vulnerability: 'those most affected are […] mainly women and children, although the men also get their own part of the scourge, yet we know our social system which is geared towards the women serving the men, and when the women are not there the children take over'.

Similarly, in Benue, HIV and AIDS have affected rural communities disproportionately, but women, children and the elderly bear the burden of care and support for those infected and affected by the disease. According to respondents, widows also face a double burden: loss of a husband – often being blamed for his death – and disinheritance and thus a loss of household assets. Respondents continued by pointing out that, while in the past widows used to be inherited by brothers or relations of the deceased, this practice is on the decline now, owing to increased awareness about HIV. This means that a downside of this positive trend in relation to HIV is that support for widows and their children is dwindling.

In Edo, respondents pointed out that not only are women particularly vulnerable, but also the gendered dimensions of poverty play out strongly in the context of HIV. For instance, as one key informant noted, 'women find themselves encouraging their female wards and children to go into sex work or trafficking so as to make money to meet family needs'. A female respondent (who was also HIV positive) told how her eldest sister encouraged her to go into sex work in Togo before she was rescued in 2010 by the National Agency for the Prohibition of Trafficking in Persons (NAPTIP). The same respondents said that vulnerabilities for women are higher between the ages of 15 and 25 and reduce soon after, when young girls settle down into a more permanent marriage relationship; however, they qualified this by saying that it depends on the type of spouse they marry.

## 4.2 Most-at-risk populations

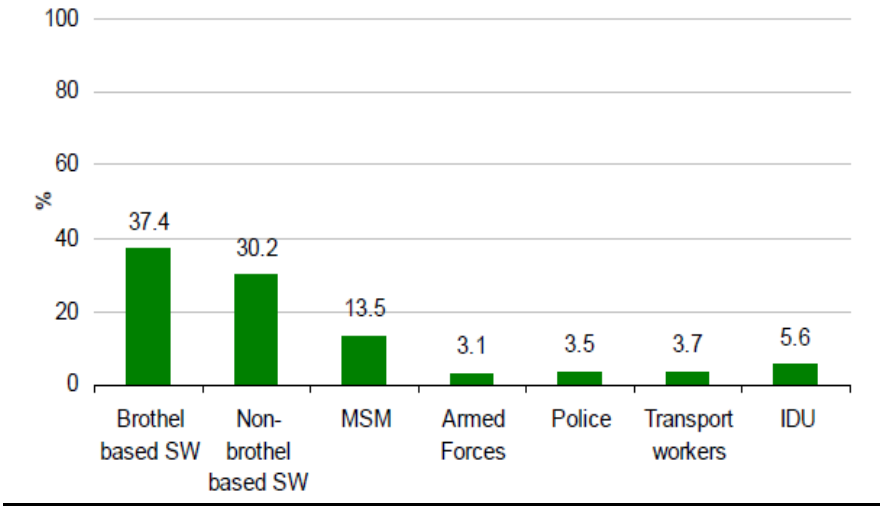
### Female sex workers and their clients

FSWs are the most affected by HIV and AIDS in Nigeria, with the highest rates of HIV infection found among brothel-based sex workers (37.4%) as opposed to non-brothel-based FSWs (see Figure 6). However, there are state-level differences, with extremely high prevalence rates recorded in the FCT (49.2%) and Kano state (49.1%), especially among brothel-based FSWs. Lower prevalence in the urban state of Lagos (23.5%, 12.9%) has been attributed to very high

condom use among FSWs (over 95%) and a lower number of weekly clients (FMOH, 2007). Condom use was lower in sexual relationships with boyfriends (38.1% for brothel-based and 46.1% for non-brothel-based FSWs) than with clients (reported at nearly 100%) (ibid.).

Knowledge about HIV prevention among FSWs is low in Nigeria, ranging from as low as 15.7% (Lagos state) to 33.3% (Cross River state) among brothel-based FSWs. Non-brothel-based FSWs have higher scores than brothel-based FSWs (FMOH, 2007). These statistics show that brothel-based FSWs not only access less information on HIV, but also are more vulnerable to HIV infection. This could be explained by the likelihood of a greater number of clients, weaker decision-making power and a possibly longer time span working as a sex worker.

## Figure 6: HIV prevalence by risk group




Source: FMOH (2007).

### Men who have sex with men

The overall HIV prevalence rate among MSM is estimated at 13.5%. Significant inter-state differences emerged from the 2007 IBBSS, with the highest rate in the southern state of Lagos (25.4%), followed by Kano (11.7%) and Cross River (2.8%) (FMOH, 2007). Although MSM showed adequate levels of HIV prevention knowledge, consistent use of condoms was lower than for FSWs. Risk of HIV infection and transmission is high among MSM, as condom use is generally low and the majority of MSM surveyed in the 2007 IBBSS reported having also had sex with female partners in the 12 months prior to the survey.

### Injecting drug users

In the three states (Kano, Lagos and Cross River) surveyed in the 2007IBBSS, Kano state in the North West zone had the highest prevalence rate among IDUs (10%) (Lagos had 3% and Cross River 3%) (FMOH, 2007). IDUs in Kano state are at particular risk as they are reported to inject drugs more than once a day, with only 40% using sterilised injecting needles in a consistent way. A total of 20% of IDUs surveyed had sex with FSWs, and they also reported low condom use. IDUs had a mean age of 34.1 years, except in Cross River state, where almost half were under the age of 25. Women represented only 5% of surveyed IDU (ibid.).

### Transport workers, the armed forces and the police

HIV prevalence among transport workers, the armed forces and the police ranges from 3.1% to 3.7%, but varies greatly among states (FMOH, 2007). HIV prevalence among transport workers was highest in the FCT (7.2%) and lowest in the northern state of Kano (1.4%). Prevalence among the police was also highest in the FCT (7.3%) and was lowest in Edo (2%). A gender sub-analysis enabled the identification of even higher HIV prevalence among policewomen, especially in the FCT. This may be attributed to lower decision-making power and thus lower condom use in comparison with their male counterparts. The armed forces had the broadest range, from as high as 7.6% in Anambra state to as low as 1.1% in the FCT.

### Summary

The most recent (draft) IBBSS estimates different prevalence rates for MARPs: 27.4% for brothel-based FSWs; 21.1% for non-brothel-based FSWs; 17.2% for MSM; 4.2% for IDUs; 2.6% for police; 2.5% for armed forces; and 2.4% for transport workers. It also shows wide variation across states (e.g. prevalence as high as 46.7% among brothel-based FSWs in Benue and as low as 12.1% in Lagos) and by age and education level (e.g. non-educated and older brothel-based FSWs (25-49) had higher HIV prevalence rates) (FMOH, 2010b).

Overall, though, in both cases, what emerges in terms of the main drivers of the epidemic is a complex picture, with differences according to region, state, rural/urban locality, gender, education and wealth. While this report goes some way towards explaining the drivers and, as we see below and in following sections, the coping strategies and current and potential responses, understanding and explaining the HIV epidemic remains challenging: further exploration and analysis are needed, particularly at local level.

## 4.3 Impacts of HIV and coping strategies

There is a large and growing body of literature which explores how HIV and AIDS affects individuals, households, communities and livelihoods more broadly.[12] Impacts include declining household income; selling off household assets to cope with increased health-related expenditure; loss of household labour and therefore increased dependency ratios; and loss of (transmission of) skills and knowledge and investment in local communities. Studies also explore how individuals and households respond, adapt, cope or just 'struggle'. There are local and contextual variations in terms of both the impacts and how people are adjusting, with some individuals, households and communities showing more resilience than others.

Responses and coping will be different according to a range of factors, such as location (urban/rural), education level, demographic composition of household, pre-existing wealth level and existing infrastructure and other services. Coping will also vary between formal and informal strategies, with the former including turning to official assistance programmes run by government, NGOs or faith-based organisations (FBOs) for instance, including credit and microfinance institutions. The latter, or informal strategies, are those adopted by individuals and families and are usually critical in contexts where formal programmes of assistance and social safety net programmes more broadly may be limited.

Turning to Nigeria, the impacts of HIV and AIDS and resultant coping strategies are also likely to vary by individual, household and community as well as by the other socioeconomic, demographic and locational variables. A recent study in Enugu state, for instance, showed that HIV and AIDS was heavily affecting female farmers (who represent the majority of small-scale farmers in Nigeria) and their households through reduced household income and declining agricultural production and family assets (Ugwu, 2009).

As in other countries in Africa and beyond, high AIDS mortality rates are increasing the number of widows and orphans. Elderly- and child-headed households are also on the increase – an estimated 16.82% of all households in Nigeria are headed by older people (Kakwani and Subbarao, 2007). Grandparents (and more often grandmothers) act as the family safety net, by taking care of their sick children and later their orphaned grandchildren. Elderly-headed households can live in very precarious situations, as grandparents take on heavy productive and reproductive roles which they may not have the capacity to cope with anymore.

The high number of AIDS orphans in Nigeria also implies an increase in dependency ratios, with an estimated 20% of households fostering orphans (de Waal, 2003; NPC and ICF Macro, 2009). Households with large numbers of dependants are often in difficult economic situations and are more at risk of poverty, food insecurity and malnutrition. In fact, 90% of poor households in Nigeria are composed of 20 or more individuals (UNDP, 2009). These impoverished households, infected and/or affected by HIV and AIDS, are then at increased risk

[12] E.g. Baylies (2002), among many others.

of further HIV infection (i.e. through transactional sex in return for food) while facing increased difficulties paying for services such as health care and schooling (Gillespie and Kadiyala, 2005).

Another impact of HIV and AIDS, affecting women and OVC disproportionately, is disinheritance and the loss of property. As discussed in earlier sections, on the death of a spouse, often as a result of AIDS, not only is the wife blamed but also she is dispossessed of the inheritance which would otherwise have gone to her. Similarly, OVC have lost property which was rightfully theirs.

With an estimated 3.3 million PLHIV in Nigeria (UNAIDS, 2010b), the impacts of HIV and AIDS on the health system and service delivery cannot be underestimated. First of all, the epidemic is increasing the number of individuals requiring health services, implying a significant increase in the patient-to-health centre and patient-to-health professional ratios. Although the recent rollout of ART in Nigeria has been beneficial to those fortunate enough to access it, it is mostly accessible in urban areas (Amanyeiwe et al., 2008).

Moreover, increased pressure on health services has greatly increased the workload of health providers (Amanyeiwe et al., 2008); at the same time, HIV and AIDS are reducing the health workforce, as the high toll of mortality and morbidity is also affecting health professionals and their families. HIV-related deaths among health professionals negatively impact health service delivery, even more so in already under-staffed services. In addition, health professionals taking care of sick family members may be prevented from attending work.

Studies have shown that informal coping mechanisms for dealing with poverty more generally and HIV in particular in Nigeria include child labour, early marriage for girls, sale of household assets and remittances from extended family networks (Hilhorst et al., 2006). Findings from the Triple F crisis study (2011) also identify a number of informal coping strategies at individual, household and community level. These include diversifying household income, migration, child labour, borrowing, reducing food and fuel consumption, withdrawing children from school, reducing health care-related costs, selling assets, engaging in illegal activities (e.g. selling black market fuel), commercial sex work and marrying girls off early.

The above coping strategies are likely to vary by, among other things, geographical area, rural or urban location and wealth profile of individuals and households. Thus, for instance, for poorer households with already limited access to fuel, reducing fuel consumption may be irrelevant. The Triple F study also finds, for instance, that a response more common in rural areas is to increase working hours during the 'hungry' season. Another coping strategy in rural areas is to engage in non-farm labour. In urban areas, or among people with more formal jobs (e.g. teachers), a coping strategy is to engage in other activities to supplement their income.

While the above are coping strategies to deal with poverty in general, they are also relevant for dealing with HIV. Thus, individuals and households affected by HIV may also have to resort to such strategies, although the implications of these may be different or more severe for such households. Many of the strategies are also likely to create HIV-related vulnerabilities.

We now pick a few of the informal coping strategies and explore their HIV-related linkages and implications. As discussed above, child labour among OVC in Nigeria is relatively common, with 22.6% reporting having worked for money or other compensation. Orphans and double orphans are more likely to have worked for compensation than non-orphans. There are marked state-level variations, with the highest percentages of children working for money or other compensation found in the states of Osun (39.9%), Bayelsa (38.7%) and Bauchi (38.2%) (FMWA&SD, 2008). Children working as domestic servants, sex workers or beggars have heightened vulnerability to numerous risks, including sexual violence and HIV and AIDS. Furthermore, children who work are less likely to access education.

As the Triple F study shows, withdrawing children from school is another informal coping strategy, and this also has linkages to HIV, directly or indirectly. School attendance and dropout rates vary by gender and state. Girls are more likely to drop out of school than boys, with early marriage and teenage pregnancy being the primary reasons. This is especially prevalent in the North West and North East zones. Furthermore, the loss of one teacher to HIV

and AIDS can have a tremendous impact on children's access to education, as classes may be interrupted temporarily or permanently. This is especially the case in rural areas, where student-to-teacher ratios are usually very high. Meanwhile, a total of 40 percent of OVC do not access primary education (FMWA&SD, 2008). Financial constraints, sick mothers and high numbers of children per household are causes of poor access and high dropout rates of OVC (ibid.). Improving OVC's access to education has the potential to promote socioeconomic development, gender equality and life skills, to prevent sexual exploitation, early marriage and pregnancy and also to curb maternal and child mortality in the long run (UNICEF, 2007). All these factors contribute to preventing HIV and AIDS and mitigating its negative effects.

HIV and AIDS is putting additional pressure on other informal strategies which are already being weakened by multiple other risks – resulting in more negative coping strategies being adopted, which reduces the resilience of families to deal with future risks. This came out particularly strongly in the case studies. For instance, the Benue case study highlighted that the HIV and AIDS crisis is just one crisis that urban and rural people and communities have to deal with in a context of long-term chronic poverty.

Turning to more specific informal coping strategies, respondents in Benue reported that savings are diverted into care and funerals for family members affected by AIDS; production and consumption decrease as does demand for labour; and girls are often withdrawn from school and forced into early marriage, particularly in rural communities. These are reminiscent of the more general responses or coping strategies adopted to deal with poverty or crises as found in the Triple F study but here they were spoken about in the context of HIV and AIDS.

In the Edo case study, a range of negative informal coping strategies were identified, which related very directly to HIV and AIDS: driven by both self- and wider stigma, respondents spoke about relocating to areas where they were not known and leaving current employment to seek work elsewhere where their HIV status was a secret. The respondents here were wealthier, more educated and in formal sector employment – able (well enough) to move as well as to find other employment. This may well not be the case for less educated and poorer people, who may be unable or too sick to move to another location.

Adolescent respondents from the FGD in Lagos state pointed out that some go into sex work and infect others, others end up drinking and smoking and others still 'engage in self-pity, will give up on life and even commit suicide'. In Benue, it was noted that individuals and members of households affected by HIV withdraw from social networks out of fear of rejection and stigmatisation by others; others stop participating in organisations because they can no longer afford the contributions. They thus suffer more from social isolation than households experiencing chronic illness or death from other causes. Edo respondents also pointed out that many HIV-positive people did not join support groups for fear of stigmatisation.

Informal coping strategies also differ by gender and age. Women – and to lesser extent children – tend to take on a disproportionate amount of additional tasks, both domestically and outside the home. According to the FGD with adolescents in Lagos, for women, 'coping strategies involve begging, trading, doing hard work to survive, cleaning the compound and clothes for people. The children are also made to go out to hawk […] they give children out to work […] they give children as slaves for money [… they engage in] sex for money'. In Edo, it was pointed out that, when men and heads of households are infected, their wives and children rally around to provide care and comfort. However, when children and women are HIV positive, men do not give the same level of support.

While women/mothers are usually the carers, this strategy was said to be changing, with children taking over responsibilities as a result of the death or incapacity of their parents. These include income earning, caring for the sick and covering educational costs for younger siblings. This often results in increasing impoverishment, as children's capacity to carry out these tasks, particularly to earn an income, is much less than that of their parents.

An important means of coping is to turn to formal programmes of assistance run by NGOs and others in the community. One such programme in Benue fosters OVC; under this programme,

children are placed either with their relatives or with other HIV-infected families. Such families are then enrolled in income-generating, nutritional and educational support programmes. However, challenges were observed in this programme, with cases of neglect and abuse reported: 'sometimes the adopting parents do not feel the same kind of love and responsibility towards their adopted wards as they do towards their other children. As a result, the adopted children may be deprived of food, may not go to school as frequently as their other children and may have a larger and heavier share of household chores.' This finding is symptomatic of similar challenges found within the fostering system across Nigeria (Jones et al., 2011).

However, other types of institutional support – networks and programmes – offer opportunities for PLHIV to adopt more positive coping strategies. For instance, according to respondents from Adamawa, Lagos and Benue, opportunities include joining a support group, which is common among those who have accepted their positive status and are actively seeking care and support. For a respondent in Benue, 'the support group has been my life': she thought she would die of loneliness and lack of care before someone linked her up to a support group in Makurdi. Since joining this, she has found 'new family members' and discovered new hope to live her life. Another member of the support group in Benue said of the network: 'the fact that there are people to talk to, share one's feelings with and feel accepted when one is down is a medicine for life in itself'.

The support groups have also been an avenue for some of the members to gain new skills. For example, through the National Poverty Eradication Programme (NAPEP), 20 PLHIV in Benue were trained on income-generating activities. Support groups also on occasion provide food and loans and donations of, for example, mosquito nets.

Others seek support from family and community sources, including community groups and associations such as trade groups. FBOs also play an important role in coping strategies. Often, the support is limited to counselling, as this respondent from Adamawa says: 'I go to my support group or pastor for counselling when I am in trouble or sad'. However, respondents in Adamawa also pointed out that, sometimes, religious organisations provide financial and medical assistance. Thus, many health services are provided through church organisations (e.g. the Christian Health Association of Nigeria (CHAN)). Also, churches offer temporary shelter to people in transit and, according to respondents in Adamawa, sometimes sponsor the education of orphans as well as looking after their health. In addition, mosques often tax members to assist those in need and also sometimes provide assistance for the aged and food for people in need. Thus a form of redistribution is occurring, although the extent to which it reaches the poorest and those affected by HIV and AIDS is unclear.

# 5 Institutional response to HIV and AIDS

This section starts by providing a brief overview of the national-level policies and programmes in place to tackle HIV and AIDS, and then moves on to discuss specific responses by the case study states. It is important to note that, to date, there has been no systematic institutional response to HIV and AIDS programming. Responses are almost totally reliant on donor funding, with numerous HIV-related projects and programmes being implemented across the country through a variety of state and non-state actors.

Indeed, as our examination of state-level responses will show, although a relatively broad and multi-sectoral approach to HIV and AIDS is often adopted (i.e. programmes focus on issues beyond just health, e.g. livelihood opportunities, skills development, etc.), a systems approach is urgently needed, particularly to respond to the needs of vulnerable children, including those affected by AIDS. Such a response, working in a coordinated and joined-up way, could provide a wide spectrum of services to OVC and their families, including educational, psychosocial, economic and health care support. Meanwhile, much of the response to HIV and AIDS in Nigeria comes through civil society: missing is a fully fledged, mobilised and engaged grassroots community response, which could, among other things, help with issues of collaboration, coordination, outreach and targeting.

## 5.1 National-level policy and programmes

A government-led response to the rising HIV epidemic was introduced in Nigeria in 1999, after the advent of democracy. This response moved beyond a health-centred approach to include multiple sectors (NACA, 2010a). This national response was strengthened through the establishment of the National Agency for the Control of AIDS (NACA) in 1999, supported at state level by State and Local Government Action Committees on AIDS (SACAs and LACAs). These bodies coordinate HIV and AIDS responses, bringing together a range of different and multi-sectoral stakeholders at all levels of government (national, state and local), as well as NGOs, CBOs, networks of people living with HIV and AIDS, donors, international agencies, the private sector and academia.

The first national HIV policy was adopted in 1997. It was revised in both 2003 and 2009 through multi-stakeholder consultations, including with line ministries and PLHIV. The 2009 policy revision was aimed at addressing a number of critical issues, including,

- Rising HIV prevalence among women;
- Expansion in the number of OVC;
- Stigmatisation of people living with HIV and AIDS and violation of their rights as well as their roles and responsibilities;
- Differences in communication messages on abstinence and condom use in secondary schools and higher institutions of learning;
- Issues associated with increased access to treatment and care.

The need for a more holistic response and the new emphasis on treatment and universal access led to the development of the 2005-2009 and 2010-2015 National Strategic Frameworks (NSFs). The main features of the current NSF are the focus on improving behaviour change communication towards a reduction in new HIV infections as well as on care and support for OVC (NACA, 2010a).

In terms of HIV mainstreaming into other national policies and laws, the situation varies according to the sector and the sub-national level. At a national level, HIV was mainstreamed into the Nigerian poverty reduction strategy through the National Economic Empowerment and Development Strategy (NEEDS) (NACA, 2010). HIV is also present in Nigeria's economic development strategy, Vision 20: 2020, which aims to bring the country into the top 20 global economies by 2020. While it is not a priority, the HIV focus in the Vision 20: 2020 document is

on i) reducing MTCT of HIV and AIDS by 10% annually; ii) strengthening prevention among youths and provision of care and support for young people living with and affected by the disease; and iii) reducing prevalence of HIV and AIDS, substance abuse, cultism and violence among young people by 30% by 2013. HIV has also been mainstreamed into the education sector through the National Education Sector Strategic Plan (NESSP).

However, there is no explicit link made with HIV in the recent (2009) draft Social Security/Social Protection Strategy proposed by the Nigeria Social Insurance Trust Fund (NSITF). Meanwhile, the previous (also still draft) Social Protection Strategy (2004) simply acknowledges that there is a gap between HIV and AIDS and social protection and a consequent urgent need for intervention and risk coping measures.

For both policies, particularly the latter, which does not come under an institution with a clear mandate and therefore has difficulty gaining recognition, there does not appear to be ownership across the board. This means generating policy traction remains a challenge (see also Holmes and Akinrimisi, 2012). What is necessary is for the federal government first to agree on the importance of social protection in reducing Nigerian's vulnerabilities, then to recognise its role in helping achieve Vision 20: 2020 targets and then to identify the relevant institutional arrangements and cross-sectoral coordination mechanisms. The link to HIV response should be firmly located within all of this.

Gaps still remain at the national policy level in terms of more direct HIV and AIDS-related policy. For instance, Nigeria is a low performer on human rights and HIV, lagging behind in terms of laws and policies that protect vulnerable sub-populations and also PLHIV against discrimination (UNAIDS, 2010b). While a number of states have passed laws on discrimination against PLHIV (e.g. Edo and Lagos), for instance, the extent to which these have been operationalised is questionable.

Challenges in terms of obtaining traction on social protection and within it HIV and AIDS are likely to be even more visible when going from national- to state-level policy and implementation. The three-tiered governance system implies that policies are not necessarily translated into policy and programmes at state and local levels (this relates to policies in general and to HIV-related policies in particular). This may owe to lack of resources, funding or capacity or simply poor political will to address the HIV epidemic and its impacts (Amanyeiwe et al., 2008). Similarly, the many local- and state-level governments have different political agendas, different relationships with donors and different priorities, all of which means there is no uniform and coordinated response to HIV and AIDS (UNDP, 2009).

Nigeria is highly dependent on donor funding to implement the majority of its HIV and AIDS services, with only 8% in 2008 coming from domestic sources. PEPFAR and the Global Fund accounted for 48% and 33% of the total budget, respectively (NACA, 2010b; Resch et al., 2009; UNAIDS, 2010b). While total expenditure on HIV and AIDS rose from $300 million in 2007 to $395 million in 2008 (32%), public funds decreased from 15% in 2007 to 8% in 2008. Hence, Nigeria is becoming more reliant on donor funding for its HIV and AID response (NACA, 2010b) (see also Figure 7).

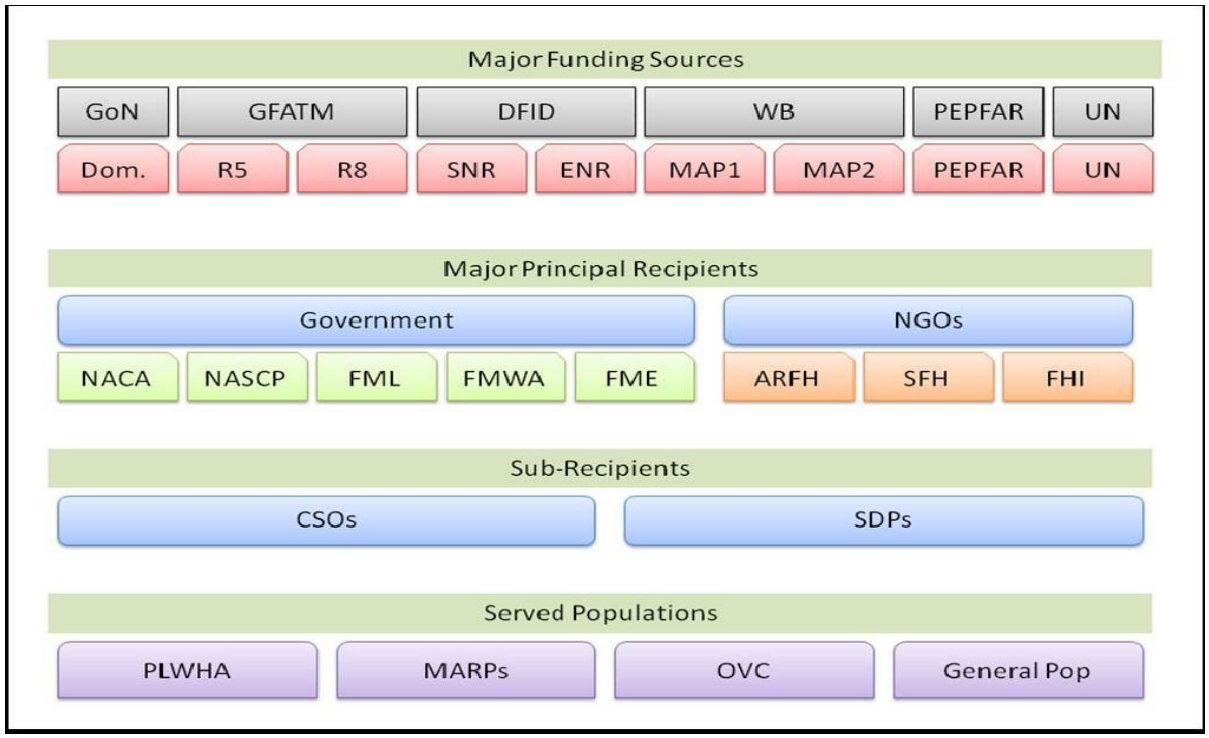
A sustainability analysis conducted in 2009 found that the total cost of the volume of HIV and AIDS services, if maintained at 2009 levels through 2014, would be approximately $650 million per year (Resch et al., 2009). To continue scaling up services over the next five years, the study suggested that a dramatic increase in resources to $1.6 billion per year by 2014 would be needed. Reaching universal access by 2014 would require even greater resources – over $1 billion in 2011, rising steadily to over $2 billion in 2014.

Civil society's important role in Nigeria's response to HIV and AIDS since the early days of the epidemic is clearly demonstrated by the fact that more than 70% of HIV programme interventions are managed by international NGOs in collaboration with local CSOs (NACA, 2010a). CSOs are often coordinated under large HIV and AIDS organisations such as the Network of People Living with HIV and AIDS in Nigeria (NEPWHAN), the Civil Society HIV and AIDS Network (CISHAN), the National Faith-based Advisory Committee on AIDS (NFACA), the

National Women Coalition on AIDS (NAWOCA), the Nigerian Business Coalition against AIDS (NIBUCAA), the National Youth Network on HIV and AIDS (NYNETHA) and the Nigerian Diversities Network (NDN), which works with MARPs such as FSWs and MSM.

However, despite the existence of a number of umbrella organisations, there appears to be relatively little coordination between different stakeholders involved in HIV and AIDS-related interventions. While it is the role of NACA and SACAs, among other responsibilities, to coordinate responses, particularly at state level and below, the extent that this occurs varies considerably by state. Some SACAs are very active and can attract and absorb relatively large amounts of donor funding; others are less visible in this regard.

### Figure 7: Flow of funds to Nigeria's response to HIVAIDS




Source: Resch et al. (2009).

## 5.2 State-level responses

All states have developed five-year HIV strategic plans (2010-2015), which articulate their needs and priorities. While to a great extent these mirror national policy, in particular the national policy of HIV prevention, the analyses upon which these State plans are based could have been more rigorous and could have, therefore, outlined or detailed more state-level specificities.

### Adamawa state

**Structures and services**

Adamawa's SACA (ADSACA) is a major player in the state, although some respondents questioned its effectiveness. Since 2005, ADSACA and the state government, with support from the World Bank/UNICEF, have been giving free testing and free ART and PMTCT services. A number of NGOs and donor-supported programmes are also key in the state in terms of providing HIV-related services, including FHI-GHAIN, MSH and SFH.

ART, PMTCT and other services, such as HIV counselling and testing, are available at the Federal Medical Centre in Yola, the General Hospital in Garkida and other sites operated by various NGOs such as MSH. However, the study revealed that a number of PLHIV still go as far

as Maiduguri in the neighbouring state of Borno to access drugs and treatment; apparently, doctors are more attentive there and the medical facilities are more advanced.

Nevertheless, most respondents felt that HIV-related services, provided mostly through NGOs, had had huge benefits. HIV-related awareness and knowledge in the state have increased, which has led to reduced stigma and discrimination – according to one key informant, 'positive persons now find it easier to declare their status'. Additionally, PLHIV have access to treatment at the various sites operated by the NGOs and HIV prevalence has reduced.

Many people have accessed leadership training through the various NGO programmes and are now peer educators themselves. Additionally, through NGOs, but also ADSACA, PLHIV have access to vocational training and income generation schemes, and have thus become economically empowered. Many support groups for PLHIV have been set up, providing a safe environment to share and discuss issues. Through these groups, some PLHIV have been provided with material support and sometimes cash.

**MSH: PRO-ACT**

MSH, known as PRO-ACT in Adamawa, is one of the most visible NGOs working in the state. Since 2009, funded mostly by USAID, it has focused on the following areas: care and support, OVC, HIV prevention and testing, provision of clinical services and laboratory services. It has a surgical supply chain management unit anchored by a pharmacist and does monitoring and evaluation. It supports five sites/communities in terms of HIV care and treatment (Hong, Song, Michika, Garkida and Fufore) and does prevention work in these same areas as well as three others (Yola North, Yola South and Mubi).

The programme has thus far tested an estimated 60,000 people. It provides not only medical and clinical services, but also income-generating activities, skills development and nutritional support. According to the state team leader,

> *'Every one of our treatment sites has income-generating activities which we provide by linking infected persons with NGOs, programmes of the wife of the governor, where they can be trained in vocational skills like barbing, hairdressing, tailoring, carpentry, etc. We go to the extent of registering their organisations so they can make demands and proposals to necessary institutions.'*

As well as psychosocial, medical and educational support to OVC, nutritional support is provided to those between the ages of 0 and 17. A review of Phase 1 is currently underway.

Through an implementer's forum, PRO-ACT coordinates and partners with a number of organisations, including ADSACA, the Tuberculosis and Leprosy Control Programme, Adamawa Health State Medical Board, UNICEF, WHO, traditional and religious organisations and state ministries such as the State Ministry of Health (SMOH), the State Ministry of Women Affairs and Social Development (SMWA&SD) and the State Ministry of Education.

Respondents raised a number of challenges, related to both Adamawa and Nigeria as a whole. Although state-level HIV-related services are available, these are partial and inconsistent – which is why people travel to Borno. First, although service implementers, particularly NGOs and donor-supported programmes, are doing a great deal in the provision of services, there is still a need to cover more ground. Linked to this, there are question marks as to sustainability, with the government yet to take ownership and responsibility for programmes and projects. Currently, according to respondents, the government provides only administrative services and is not involved in treatment, leaving this in the hands of NGOs – all of which contributes to limited coverage. This is compounded by the fact that the state's infrastructure is poor. Hospitals are few, and those that exist have limited capacity and poor services. Staffing is inadequate and the attitudes of those who are there are often discriminatory. The poor power supply aggravates this already challenging situation, making storage of essential drugs problematic. From a demand side, respondents pointed out that people do not access services, although this is slowly changing, with increasing awareness and a reduction in stigma and discrimination. Also, from a user's perspective, receiving ART is a long process, with patients

having to wait many hours, often without meals, all of which discourages them both from coming to seek treatment and from coming to collect drugs.

## Benue state

### Structures and services

Benue state has mounted several responses to the HIV and AIDS epidemic, ranging from a demonstration of political will by the state executive council and the state government to the development of policies and guidelines and the implementation of various interventions and programmes. CBOs and development partners have been very active in the area of HIV and AIDS in the state, and a support group network exists.

Benue's SACA (BNSACA), along with partners, including NACA, developed its five-year strategic plan in 2010. The development of this document took into consideration achievements by different donors and partners in the past 10 years in the state. Several awareness and sensitisation programmes have been mounted, with funds from the UK Department for International Development (DFID), USAID, the World Bank and other donors. Benue was one of the first states in Nigeria to establish a support group for people living with HIV and AIDS, and currently every LGA has such a group. Home-based care services (provided by volunteer health, education and social workers within communities) and counselling programmes have been in place since around 1994.

Currently, there are 18 sites providing ART in Benue, up from just one in 2006. The number of PLHIV on ART has increased from less than 5000 to 14,253 by March 2008. Partners supporting these services include AIDS Relief, the International Center for AIDS Care and Treatment Programs (ICAP), FHI/GHAIN, PEPFAR, the Institute of Human Virology Nigeria (IHVN), Nigerian Indigenous Capacity Building (NICaB)/CHAN and Hygeia with Clinton Foundation (focusing on paediatric services alone. Post-exposure prophylaxis is being provided in 15 sites.

Catholic hospitals in Benue state have established care teams (comprising volunteers from communities) to help provide home-based care to PLHIV. Palliative care and support, including bed bathing, are some of the services provided. Sometimes, teams assist in house cleaning or farm work, especially in rural communities, and provide help to abandoned children, linking them to orphanages or some form of community support.

Other responses in the state include training to PLHIV on income generation (supported by NAPEP) and basic business management (USAID MARKETS/FSNP). However, securing start-up capital remains a challenge as, in the voice of one beneficiary, 'no one wants to give a loan to an AIDS patient, they think we will die and won't be able to pay back the loan'.

### FNSP

FNSP, funded by PEPFAR/USAID, targets the immediate nutritional needs of the most vulnerable children and addresses the long-term livelihood support needs of OVC and their care givers. The first component, which addresses immediate nutritional needs, aims to formulate, produce and distribute fortified, nutritious, locally available dietary supplements as ready-to-prepare packaged products[13] to OVC and their care givers through their implementing partners. The second component, on household nutrition and income, addresses the longer-term household nutrition and income generation needs of 7,500 OVC households through a programme to promote home gardening. A total of approximately 22,500 OVC in Benue state have been reached over four years working through 11 NGO implementing partners.

Since most respondents were members of BENPLUS, the benefits and challenges of programme participation were discussed. As we have seen, the benefits of belonging to a support group are many, including social and emotional support and new skills. Respondents pointed out, however, that more support is needed from government. Currently, government

[13] Some examples of products are cowpea flour with a good shelf life and robust packaging; ready-to-cook, balanced porridge for morning meals; and nutritious, ready-to-eat energy bars, packaged to distribute or sell.

support is more about creating policy and an enabling environment; while they acknowledge that this is important, 'if it does not translate into tangible benefits for PLHIV, the support is not yet complete'. The same respondent went on to say that the government should create job opportunities for members, many of whom are graduates with degrees and diplomas, and help them integrate meaningfully into the larger society. This would help reduce stigma, leading in turn to status declarations and a reduction in the rate of HIV transmission. Meanwhile, the respondent said, finding funding for the state's strategic plan and activities had been a hard task, and 'consequently, the plan is on the shelf for now'.

## Edo state

### Structures and services

The HIV response in Edo state is overseen by SMOH in partnership with Edo's SACA, which coordinate development partner responses. However, according to case study respondents, SACA is somewhat inactive owing to a lack of funding, and its future remains uncertain. Its greatest achievement was said to be the passage of a law against the stigmatisation of PLHIV in 2006. Enforcement agencies and any other authorised government agencies have the power to makes arrests for the following offences: parents, family or guardians segregating and neglecting a person living with HIV and AIDS; refusal of admission of a prospective student with HIV and AIDS into school or dismissal of such a student from school because he or she is living with HIV or AIDS; refusal to employ a person living with HIV or AIDS or dismissal of a person who has tested positive; refusing people living with HIV or AIDS health services or treatment or not allowing them to associate with others on the grounds of their status; and refusal of accommodation to any person living with HIV or AIDS by landlords/landladies. However, few people know of this law, and nobody as yet has been convicted.

Partners engaged in the HIV response in Edo state include FHI/GHAIN, IHVN-Pathfinder, SFH and Community Care in Nigeria (CCN). These in turn fund a number of CBOs, such as RIDA. Among other things, various CSOs working on HIV/AIDS have conducted trainings on income-generating activities for PLHIV. Over $456,000 has been channelled to various microcredit initiatives to further empower PLHIV economically and to create alternative sources of income. Beneficiaries have included OVC, widows and single mothers, PLHIV, FSWs, out-of-school youths and in-school youth.

### RIDA

With funding from a range of donors, including Mercy Foundation, FHI/GHAIN and Christian Aid, RIDA has been providing broad-based poverty-related support, particularly in relation to HIV, since 2006. Focusing on Uromi community (a peri-urban area in Edo state), it provides care and support for OVC (2,058 OVCs have been reached, over 1,530 have been provided with free access to basic education and a number have been provided with nutritional support); supports home-based care and the establishment of support groups (over 1,868 PLHIV have been supported); and carries out HIV and AIDS awareness raising. PMTCT and HIV and AIDS counselling and testing (1,160 people) are also supported, and a total of 39 people in Uromi community are on ART supported by RIDA. Other areas of work include support to income-generating activities through the provision of microcredit facilities (nine savings and loans associations have been established) and running training to improve the skills of care givers in business management.

The image of poverty portrayed by the founder of RIDA highlights HIV-related vulnerabilities in Uromi community (see Box 5). In particular, it shows the multidimensional nature of HIV-related vulnerabilities, touching on education, food security/nutrition and health. This implies also that a multi-sectoral and integrated approach is necessary for community members to lift themselves out of poverty, while at the same time lessening their risks of contracting HIV.

### Box 5: Views on Uromi community by the founder of RIDA

'Uromi people have in the last three decades built a culture of nonchalant attitude to their health and educational issues and this is worrisome especially for the young generation.. They don't seem to care either about malaria or HIV and AIDS. They also do not want to know. They are ignorant and are not looking for solution. The level of poverty is so high that the people do not have time for anything except looking for means of sustenance and survival Uromi community has large numbers of Ignorant youths and the most vulnerable are the ages from 18 to 25 years, young married women whose husbands would refuse to do HIV/AIDS tests despite the risks.

'Children suffer from poverty, malnutrition, anaemia, malaria, typhoid and tuberculosis. Children of school age are hardly in school. Many prefer to sell or hawk articles on the streets than go to school to acquire life skills. As a result, Edo state has large numbers of people, especially youths, who are not prepared for life. They are saddled with ignorance, lack of education, poverty and lack of finance.'

The above narrative shows that, in a sense, day-to-day survival is uppermost in people's minds: people do not have the luxury or time to be educated, with all their effort spent on survival. This results in limited knowledge and information about HIV, which in turn perpetuates stigma, risks and vulnerabilities. This highlights the importance of awareness raising and education in general, and also the need for a coordinated and comprehensive approach in which different sectors work together in order to stem both poverty and HV and AIDS-related risks and vulnerabilities.

According to respondents, given the relative inaction of Edo's SACA since 2008 and the winding down of several international donor-driven HIV and AIDS programmes in early 2011, continued support to HIV and AIDS programming in the state remains a challenge. Respondents also spoke about a serious lack of manpower in the state and, again, inadequate finance to support health needs more broadly. Another challenge was said to be reliance on external support: 'people here still believe in handouts and getting things done for them'.

## Lagos state

#### Structures and services

The Lagos SACA (LSACA) was established in January 2001. Located within the Governor's Office, it has its own secretariat and staff and is headed by the special assistant to the governor on HIV and AIDS, who serves as the chief executive officer. Stakeholders come from within government, from the NGO/CSO/CBO/FBO and donor community and from NEPWHAN.[14]

Most programmes in Lagos state for those affected and infected by HIV and AIDS are provided by NGOs in collaboration with government agencies and departments. The state has established 56 counselling and testing sites and several mobile initiatives providing such services. Approximately 350,000 persons have accessed these to date.

There are 16 ART sites providing free ART (both adult and paediatric) services. Most are located in general hospitals, with three located within tertiary facilities or research centres (the Nigerian Institute for Medical Research, Lagos University Teaching Hospital and Lagos State University Teaching Hospital). Six sites have the capacity to conduct early infant diagnosis and two conduct viral load estimations. Most treatment sites are located in urban LGAs but some (e.g. Ikorodu, Badagry and Epe) also serve rural populations within such areas. All the ART sites offer comprehensive services, including management of opportunistic infections. To date, over 10,000 persons have been reached with ART, which include first and second line medications, with children accounting for approximately 10% of these clients.

[14] Development partners in Lagos state include Africare, the AIDS Prevention Initiative in Nigeria, the Centre for Development and Population Activities, Community Participation for Action in the Social Sectors, FHI/GHAIN, IHVN, John Snow Making Medical Injections Safer and the World Bank.

PMTCT services are available in 28 sites, most of which are located in urban LGAs, although a few can be accessed by rural populations. Approximately 65,000 pregnant women have been counselled and tested and had received their results as of June 2009.

There are reported to be about 20 positive support groups in the state, three of which receive transportation and refreshment stipends from LSACA for monthly meetings. In the last half year, 500 people (PLHIV and PAHIV) have accessed income generation training provided by LSACA in collaboration with the Lagos State Ministry of Women Affairs and Poverty Alleviation (WAPA), three of whom have accessed microcredit facilities through LSACA.

Respondents also identified USAID's MARKET programme, which provides nutritional services to children, and NAPEP, which provides economic empowerment for the very poor. WAPA was reported to be building shelters for the abused, through its poverty alleviation programmes.

**HOPE WorldWide Nigeria**

Starting in 1991 with three small local programmes, HOPE provides services in five core areas: OVC; income generation; HIV and AIDS education; AIDS treatment; and media relations management. Activities are implemented through CBOs – over 40 of them in the case of Lagos state. The main objectives are to build local capacity to respond to OVC issues; provide services to OVC; and build capacity of families to care for OVC. Activities include economic strengthening projects for OVC and their carers and providing carers with vocational skills and start-up funds for their businesses. HOPE also provides psychosocial support and treatment for opportunistic infections by linking up with PHC centres, and links with government programmes by providing technical support to WAPA and the OVC Child Protection Unit. For example, HOPE builds capacity in relation to identification, registration, provision of psychosocial support and implementation of income generation activities.

Activities are funded by USAID, MTN Foundation and others, such as Coca Cola, Citigroup and Rotary. Thus, for instance, the USAID-supported Assistance and Care for Orphans at Risk currently supports over 38,000 children, providing nutritional, education and income generation support for OVC and their carers. MTN Foundation and Coco Cola Africa currently support 250 and 11,000 children, respectively, also through educational and income generation support for OVC and their carers.

Respondents raised a number of programme-related challenges. According to HOPE's director, although many people need assistance, funding constraints limit coverage. As few NGOs have the capacity to implement innovative HIV and AIDS prevention and OVC programmes, the needs of the state cannot be met. HOPE's own capacity was felt to be adequate, but the issue of community care providers remains a challenge: although there are people in the community who can serve as volunteers, they do not come forward (they want to be compensated and/or the lack of an organised structure discourages them). According to HOPE's director, 'We are looking at getting the community to take responsibility/ownership, and then the problem of volunteers will be solved […] They could be given stipends for transport, recharge cards or support for emergency needs/technical assistance.'

Challenges include the facts that HIV-related services are not readily available, accessible and affordable, and that stigma and non-disclosure remain a barrier to accessing services. Attitudes of health staff represent another barrier: according to the director of HOPE, NGO staff, including HOPE staff, do not show discriminatory behaviour towards HIV-positive people (and indeed other marginal populations), but attitudes among staff from public hospitals may not be so neutral. This may also be because they face the stress of large numbers of clients.

The director suggested a child welfare system at federal, state and LGA levels should be institutionalised:

> *'an efficiently implemented social development programme will ensure that structures are developed at every level and are functional, that staff have the capacity to provide services and an efficient monitoring and evaluation system is integrated into the plan. If this is done effectively all other challenges can be overcome. Funding is not enough but can be sought more widely.'*

This response echoes our calls for a broader, more integrated and better-coordinated systems approach for dealing with vulnerable children, including those affected by HIV and AIDS. Additionally, there were requests for a welfare approach in which vulnerable children affected by HIV and AIDS are incorporated.

# 6 Building HIV-sensitive social protection responses

The preceding sections demonstrated the highly unequal distribution of HIV prevalence and access to services according to factors such as geographical location, socioeconomic strata, gender, age and education. Women, and particularly young women, are disproportionately affected by the epidemic and have poor access to HIV-related services, including family planning and PMTCT services. Coverage of HIV-related services vary greatly across geopolitical zones, states and LGAs and among rural and urban areas, with rural areas in particular facing limited capacity and resources. According to some observers, these regional differentials are explained mainly by a lack of political commitment to HIV and AIDS at the state and local levels of government, in combination with a lack of national coordination and a largely donor-driven response to HIV and AIDS in Nigeria (NACA, 2010a).

As we have seen, a large number of interventions focusing on various aspects of HIV programming, mostly run by international NGOs in partnership with CSOs, have proliferated. Currently, most of these take a health-centred and medicalised approach to HIV and AIDS, i.e. most are providing, or promoting easier access to, prevention, treatment and care services. Additionally, a rights-focused approach is in evidence, as seen in the efforts of the positive networks, for instance. Clearly, all of this is critical to curb the HIV epidemic, and continued efforts are needed to provide these services as well as to distribute them more equitably and to target gaps in knowledge and services.

In addition to the above HIV and AIDS specialist services, a social protection-type response or framework could be a useful way in which to conceptualise a more holistic approach to dealing with poverty and vulnerability in the Nigerian context of high HIV and AIDS prevalence. Linked to this, a systems approach to tackling HIV and AIDS needs to be developed, so that social protection can more effectively link up the various strands required, which cross sectors and include health, education and protection. Using the lens of social protection through which to tackle the multidimensional nature of HIV and AIDS can also ensure a stigma-free approach, since it focuses on markers beyond HIV and AIDS for identification, targeting and provision of services. This would allow people affected by and infected with HIV and AIDS to remain anonymous unless they choose to disclose their status or that of other members of their family. In more operational terms, a programme could provide a more holistic response to HIV and AIDS by providing services or support activities which do not focus solely on medical benefits, but which include a longer-term vision of dealing with vulnerability. For instance, they could address issues of nutrition, food security and livelihoods; skills acquisition and job creation; and insurance and other protective measures. Clearly, providing all these services is likely to be beyond the scope of a single organisation or programme, but ways in which people could be referred or linked to other programmes or projects providing such benefits could be explored.

## 6.1 The literature on social protection in the context of HIV and AIDS

In recent years, social protection has become an increasingly popular policy and programme option to address the vulnerabilities experienced by the poorest quintiles living in developing countries, including those affected by and infected with HIV and AIDS. Social protection aims to reduce risks, mitigate their impacts and increase the capacity of households to cope with and respond to the various risks they encounter. An equity approach is often integrated to address gender and social inequalities as well as discrimination. Social protection strategies are often based on lifecycle approaches, which acknowledge the different risks associated with each age group. They are therefore transformational by essence, as they aim to break the cycle of poverty and vulnerability (Devereux and Sabates-Wheeler, 2004; Holmes and Jones, 2010; Temin, 2010, Holmes et al., 2012).

One recent review explores the evidence on how social protection can be applied in the context of HIV and AIDS (Temin, 2010). Overall, it suggests that social protection can improve the response and coping strategies of people infected with and affected by the disease, and can also reduce the risk of HIV infection among vulnerable groups through anti-poverty strategies. Temin goes on to categorise HIV-sensitive social protection strategies into three broad groups: i) financial protection, which includes cash and food transfers for PLHIV and people affected by AIDS; ii) access to affordable quality services, both health care and education; and iii) policies, legislation and regulation developed to protect the rights of excluded and vulnerable people living with and affected by HIV and AIDS.

Evidence shows that financial protection through cash and food transfers decreases HIV infection (Frega et al., 2010); improves adherence to treatment protocols (Emenyonu et al., 2010); improves nutritional status and reduces risks of infection from diseases; and improves the resilience of vulnerable households to the impacts of AIDS (Temin, 2010). Cash and food transfers may also contribute to HIV prevention, by reducing vulnerability. For instance, cash and food transfers can maintain children in school, with the potential of decreasing early marriage and pregnancy as well as HIV infection.[15]

Social protection schemes can also increase access to HIV health services. For instance, a voucher enabling a pregnant HIV-positive woman to pay for medical fees to deliver in a health facility was found to decrease maternal mortality and MTCT of HIV (Emenyonu et al., 2010; Lagarde et al., 2007). An initial evaluation of the Maternal and Child Health Programme of the National Health Insurance Scheme (NHIS), for instance, estimated that up to 470 women's lives and 1,070 children's lives may have been saved under the first 15 months of Phase 1 (USAID, 2010, in ODI, 2010). Cash and food transfers can also improve adherence to treatment, by improving access to health services and the nutritional status of PLHIV (Gillespie and Kadiyala, 2005). In Uganda, cash transfers to cover the costs of transportation to a HIV clinic were shown to increase treatment adherence among patients (Emenyonu et al., 2010).

In terms of care and support, cash and food transfers can support vulnerable households with high dependency ratios. For instance, pension plans can assist elderly-headed households (often owing to high levels of AIDS-related mortality) to provide dependants with basic necessities, such as food, clothing and access to education and health care (Temin, 2010). Indeed, the majority of In Care of Nigeria's Poor (COPE) respondents interviewed for this study reported that increasing the number of meals the family eats has been one of the main benefits of the programme (Holmes et al., 2012).

Livelihood promotion can also be seen as a form of social protection, as income-generating activities may improve the economic situation of people affected by HIV and AIDS, as long as they are paired with access to ART and relevant health services to enable beneficiaries to stay healthy and maintain the capacity to work. Although evidence on the impact of livelihood promotion on HIV and AIDS is quite limited, microfinance has been shown to deliver tangible results (Temin, 2010) (although other studies show that microfinance does not necessarily reach the poorest). For instance, it can improve the economic status of a household, as well as its health-seeking behaviour, access to health care and women's autonomy (Goss and Mitten, 2007). This approach can also protect OVC from vulnerability to HIV, by reducing child labour and exploitation and increasing food security and access to education (Pronyk et al., 2007).

Finally, HIV-sensitive social protection requires transformative approaches that address the inequalities sustained by laws, policies and regulations at all levels of government. Although Nigeria has a free ART policy, universal access to drugs is still far from a reality, as this would require a large increase in the supply of ART and in the availability of skilled human resources (NACA, 2010a). In addition, the criminalisation of sex work and men having sex with men can prevent MARPs from accessing relevant preventative and curative services, because of fear of discrimination and prosecution (UNAIDS, 2010b). It is therefore important to understand how the policy and legal environment is both promoting and hindering access to HIV services.

[15] See www.oxfamblogs.org/fp2p/?p=1696.

## 6.2 Examples of HIV-sensitive social protection programmes in Nigeria

As discussed in Holmes and Akinrimisi (2012), social protection components have been integrated in different national strategies, such as Vision 20: 2020, but also in programmes at state and LGA levels. However, the 2004 draft Social Protection Strategy and the 2009 proposed social security policy have not resulted in policy traction or been operationalised.

While HIV and AIDS programming in Nigeria is currently not framed in terms of social protection, a number of interventions come under the heading of social protection, as including HIV-sensitive social protection components, with targeting people affected by HIV and AIDS as either a direct or an indirect aim. These schemes improve vulnerable people's – including those affected by HIV and AIDS - access to education, health care and food security.

Before exploring some of these schemes in a bit more detail, it is important to define briefly what is meant by HIV-sensitive social protection. Building on the literature, such policies or programmes should address PLHIV and households affected by HIV, for example by ensuring that they have access to services, that policies are inclusive and non-stigmatising and that the form of social protection helps reduce an individual's chance of becoming infected with HIV (susceptibility) and the likelihood that HIV will have damaging effects on individuals, households and communities (vulnerability) (see Temin, 2010).[16]

More practically, and in the context of Nigeria, HIV-sensitive social protection programmes can be said to be either those which have a specific named focus on people and families infected with and affected by HIV or those which deal indirectly with the most marginalised and vulnerable who, in Nigeria, are often those most vulnerable to and at risk of acquiring HIV.

Below are some brief descriptions of programmes that could be classified as HIV-sensitive social protection programmes. These are presented using the overall approach used for thinking about social protection, which includes a transformative aspect.[17] This is by no means a comprehensive list, and there are likely to be many more programmes/interventions at the state level that could be categorised as such. Similarly, there are likely to be many HIV-related programmes which also incorporate social protection-type components such as those identified in the case studies, including consumption support to households and support to access services. However, these programmes are not conceived as social protection programmes, as they address social protection goals only implicitly as a secondary objective at the most.

### Protective social assistance

**COPE** is a social assistance scheme developed by NAPEP in 2007.After being piloted in 12 states, the second phase was implemented in all 36 states and the FCT, but its third phase has seen a decline in the number of states committed to operationalising it through the Conditional Grants Scheme (CGS). COPE is a conditional cash transfer (CCT) scheme targeting the poorest of the poor, who are especially vulnerable to HIV and AIDS because of the gender and age composition of their households. The target beneficiaries are:

- Poor female-headed households with children of primary school age;
- Poor elderly-headed households with children of primary school age;
- Households headed by physically challenged persons;
- Households headed by PLHIV and other vulnerable groups.

The transfer scheme is conditional, as participants are required to adhere to certain programme components, such as enrolment and retention of children in primary education, ensuring immunisation and primary health care of under-five children and participation in life skills training courses.

[16] See also www.unaids.org/en/strategygoalsby2015/socialprotectionandsupport/.

[17] Much of this section draws on the social protection mapping paper prepared as part of this overall study (Holmes and Akinrimisi, 2011).

Cash transfers have the potential both to increase access to treatment for PLHIV and enhance care and support for households affected by HIV and AIDS. Initial findings from COPE beneficiaries, however, showed that COPE transfers were spent largely on food and, to some extent, education. Health expenditure was much less reported. In order for cash transfers to be effective for scale-up, a more conducive environment would be necessary, one where quality health services and schools in proximity to COPE participants were available.

A **CCT to promote girls' education** is being funded by DFID and the World Bank. This is a three-year pilot being implemented in 12 LGAs in Bauchi, Kano and Katsina states. It targets single girls between the ages of 9 and 16, who are in Classes 4, 5 or 6 or junior secondary school. By keeping girls in school, it not only potentially increases their awareness and knowledge of HIV and AIDS, but also reduces their vulnerabilities and risks of being exposed to it once they leave school and may have to engage in risky livelihood-related activities. In Kano, the programme is managed by a Programme Management Unit answerable to the Ministry of Education and solely comprising government personnel rather than external individuals or consultants. Four payments per year are provided – the first on the condition that girls have enrolled in either grades 5, 6 or Junior Secondary 1 in September 2010, and the subsequent ones on the condition that they achieve at least 80% attendance. Senior females in households are encouraged to act as principal recipients.[18]

**Health subsidies** are also part of protective social assistance, and by their nature link to HIV and AIDS-related issues, albeit indirectly. Part of the NHIS, the Maternal and Child Health Care Programme, started in 2008 and provides free PHC for children under five, and primary and secondary care (including for birth complications and caesarean sections) for pregnant women and for up to six weeks after childbirth. While not specifically targeted at the poor, they are certainly a focus, given that rates of child and maternal mortality disproportionately affect the poor. The programme is being implemented in phases, and only public health facilities can be accredited. It is funded by the MDG-DRGs (NHIS, 2010), and there is a requirement that each state must provide matching funds of 50% of the amount disbursed. Funding has now finished, and states have not provided counterpart funding for the scheme so far.

**Health fee waiver systems** also exist in some states. In Jigawa, for instance, the State Drug Revolving Fund Programme has a Deferral and Exemption Component, whereby certain groups of particularly poor people are provided with free drugs and medical treatment. In Adamawa, there is a medical fee waiver for children 0-5 years, and pregnant women have access to free medical services from public health centres and hospitals. Children benefit from free immunisation and ADSACA gives free medical services to PLHIV. In Edo, the Women Enhancement Organisation (WEO), an NGO, caters to children who are orphaned as a result of HIV and AIDS and helps eradicate poverty in poor and secluded communities in Etsako West. One of the components of the programme pays hospital bills for OVC.

**Nutrition programmes** can also be critical for people infected with and affected by HIV and AIDS. Despite the severe malnutrition in the country, affecting young children in particular, there is no nationally led targeted nutrition programme. HIV and AIDS-related programmes run by NGOs tend to include nutritional supplements in their broader programming. For instance, Save the Children has led an emergency nutrition programme to treat moderate and severe acute malnutrition on an outpatient basis, with inpatient care for those with complications. Many of those malnourished are also likely to be affected by HIV and AIDS. However, key informants recognised that the programme was not addressing the chronic, cyclical root causes of food insecurity.

Similarly, in Benue, where HIV prevalence is very high, there are a number of programmes providing therapeutic food for malnourished children, e.g. through the USAID MARKETS project. Recently, SMOH facilitated the urgent distribution of ready-to-use therapeutic foods to moderately/severely malnourished under-five children and lactating mothers. Vitamin A

[18] An impact evaluation is being carried in Kano led by the World Bank, with the baseline survey covering 11,000+ households. Findings were not available at the time of this study.

supplements are given to children 6-59 months every six months. Iron folate for pregnant women and de-worming of children 12-59 months are also available in the state.

The Family Nutritional Support Programme (FNSP), used in the Benue state case study for this report, provides nutritional transfers to people affected by or infected with HIV and AIDS. Funded by PEPFAR/USAID, the programme aims to improve the nutritional status of OVC infected with and affected by HIV and AIDS. At present, it has been implemented in five states (Bauchi, Kano, Lagos, Cross River and Benue), and it is intended that it will be scaled up to nine more in the near future.

Finally, in Edo, Girls' Power Initiative, a youth development organisation, provides support to over 1,868 people living with HIV and AIDS, offering nutritional services to OVC as well as carrying out de-worming for them every three months. Community volunteers are trained to help mobilise participants to access the services. WEO provides nutritional support to OVC households, distributing food items such as rice, groundnut oil and beans.

### Preventative social insurance

The pilot **Community-based Health Insurance Scheme** (CBHIS) will be implemented in 12 states. It aims to enable risk pooling within communities to cover the costs (or partial costs) of health services run by the NHIS. A voluntary scheme managed at the community level, it intends to secure people's equitable access to health care and reduce high out-of-pocket health payments that can drive households into deeper poverty (PATHS2, 2010). According to key informants for Holmes and Akinrimisi (2012), however, community-based health insurance has failed in the past in Nigeria, mostly as a result of the mismanagement of funds by community members and poor and rushed design (PATHS2, 2010). The CBHIS has the potential to provide a safety net for over 60,000 people in the informal sector; when fully rolled out it is expected to cover 112 million Nigerians in the informal sector (ibid.).

Another form of health insurance scheme is the **Partnership for Reviving Routine Immunisation in Northern Nigeria – Maternal, Newborn and Child Health Initiative** (PRRINN-MNCH). The MNCH initiative of the DFID-funded PRRINN was implemented in 2006 to increase access to MNCH services in four northern states (Jigawa, Katsina, Yobe and Zamfara) with high maternal and child mortality rates. It is based on a community engagement approach supported by three components:

- A community forum to identify challenges and solutions with regard to MNCH;
- Community volunteers to carry out activities and build capacity within communities;
- Development of community systems that enable a response to MNCH emergencies.

The main activities are the development of community savings and transport schemes for maternal health emergencies and the establishment of facility health committees to improve communication between health providers and communities (DFID, 2009). PRRINN-MNCH has the potential to decrease maternal and child mortality and morbidity, and also to increase HIV-positive pregnant women's timely access to skilled birth attendance, a prerequisite to reducing MTCT of HIV. Furthermore, this scheme not only increases access to health care but also improves financial security. By lowering expenditure and decreasing maternal and child mortality, households will be less vulnerable to other shocks, such as debt and food insecurity.

The **Community-based Support** (CUBS) for OVC project aims to support OVC and care givers by increasing their access to basic necessities, such as nutritious food, decent living conditions and health care. The project also has the specific mandate of reducing girls' and young women's vulnerability to risks, such as HIV and sexual exploitation. Funded by PEPFAR, CUBS has been implemented in 11 states; by 2014, it hopes to reach 50,000 OVC with comprehensive OVC services consistent with national OVC guidelines (MSH, 2010).

### Productive transfers, works and subsidies

Nigeria lacks an overarching strategy for the role of **public works** in its social protection strategy, and there is little in the way of public works programmes in the country. While there are a number of **targeted subsidised input programmes** in the agriculture sector, these

appear to be relatively uncoordinated, and currently benefit only the better-off farmers. Poverty and vulnerability, also experienced by those infected with and affected by HIV and AIDS, are by no means a focus in these programmes.

**Productive transfers**, in the form of grants or loans linked to training skills, and saving schemes are popular at the state level, and often have an HIV focus or are targeting people affected by or infected with HIV and AIDS. In Benue, BENPLUS, with funding from ActionAid and NAPEP, trained 20 PLHIV in knitting and carpentry and were provided with equipment. A number of other HIV programmes provide income-generating activities, including revolving grants to support small businesses. RIDA in Edo includes a household economic strengthening programme, through which it has established nine savings and loans associations. Using these, care givers save money and can then borrow and establish business ventures.

## 6.3 Strengthening social protection responses in the context of HIV and AIDS

The above shows that, while programmes and projects that can be seen as social protection-type responses with a focus on HIV and AIDS do exist, they remain scattered, fragmented, in pilot stage and small scale; do not cover the full range of HIV-related risks and vulnerabilities; and are poorly coordinated. Similarly, their approach is often vertical in nature, with limited multi-sectoral engagement. There is also little evidence generated from these schemes - what evidence does exist is mostly anecdotal – monitoring and evaluation is limited and usually focuses on outputs and numbers of people reached rather than impacts. Meanwhile, NGOs and others implementing such projects lack the capacity and resources to scale up or link to other related and complementary initiatives.

The analyses above have shown that there are a number of groups of people particularly vulnerable to HIV and AIDS. These include OVC, of whom there are an estimated 17.5 million aged 6-17 years (11% of the total population) (FMWA&SD 2008). Youth are also particularly vulnerable, as the age group bearing the highest burden of HIV and AIDS in the country (NACA, 2010a). Women, and especially young women of child-bearing age, are also particularly vulnerable: they are disproportionately infected with HIV in comparison with men, while having very poor access to both maternal and HIV health services (NACA, 2010a; UNAIDS, 2010b). According to the 2008 ANC, HIV prevalence among pregnant women is at 4.8%, although the most recent draft shows overall prevalence dropping to 4.1% (FMOH, 2010). Finally, MARPS, despite representing only 1% of the population, are said to contribute to an estimated 23% of new HIV infections (NACA, 2009; 2010a).

Such groups need to be given particular priority in terms of HIV and AIDS responses. However, how they are integrated and targeted, particularly within a broader social protection-type response, needs careful consideration. In some cases, such groups could be targeted directly; in others, vulnerability markers (e.g. levels of income, household size, food insecurity) could be generated which would also cover HIV infected and affected people. This approach is supported by other studies, which indicate that, except in very specific circumstances, social protection mechanisms should target vulnerable people to reduce risks, some of which are the result of HIV and AIDS, rather than targeting only people affected by HIV and AIDS ( e.g. Temin, 2010; UNAIDS, 2010a).

Thus, although HIV can be one criterion related to poverty, social protection should not focus on HIV specifically, but rather on strengthening institutional linkages and coordination in the long run. For instance, if poor households are also affected by HIV and AIDS, then referrals and other systems to support them to access HIV services should be in place.

Returning to the framework put forward by Temin (2010) regarding HIV-sensitive social protection strategies, the findings from this Nigeria case study show the following:

- Cash transfer programmes such as COPE can provide **financial protection**, mostly in the form of food security. FNSP provides financial protection through food and cash transfers and livelihood support. These programmesare likely to assist PLHIV adhere to their medications (both ART and others) and to help them and others to

engage in non-risky livelihood strategies and income-earning opportunities. It must be noted, however, that the value of the transfers are very low. Other cash transfer programmes, such as girls' education, can provide financial security in the form of schooling; maintaining children in school has been shown to decrease the likelihood of early marriage, pregnancy and HIV infection. However, more evidence is needed on the effects of cash and food transfers, and financial protection in general in the context of HIV and AIDS in Nigeria.

- In terms of **access to services**, there is some evidence that social protection-type approaches, through community-based schemes (e.g. CBHIS, PRRINN-MNCH), can support linkages with maternal and child health programmes. Currently, however, there do not appear to be direct linkages for PLHIV to health services or for programme beneficiaries to HIV testing, for instance.
- Finally, under **policies and legislation**, while there are some laws which aim to protect the rights of vulnerable people living with and affected by HIV, awareness of these rights is limited and the extent to which they are enforced is negligible. More efforts are needed to raise awareness of these laws and to develop and promote others that tackle the vulnerabilities of different people, including those living with and affected by HIV and AIDS.

Perhaps more importantly in the Nigerian context, and when considering the link to social protection, there is a need to ensure that social protection legislation, policies and strategies include HIV-related components, or are themselves HIV sensitive, given the high prevalence of HIV in Nigeria as a whole and in certain states in particular. The Social Protection Strategy needs to refer to minimum social protection guarantees and a package of support for all poor and vulnerable people, irrespective of their HIV status. Once this aspect is included in legislation, steps need to be made to implement and operationalise it. This is often difficult – as acknowledged by Vision 20: 2020 and the draft Social Protection Strategy itself.

Aside from any issues that need to be addressed in the social protection and HIV sectors themselves, there are a number of other areas for focus in terms of strengthening the response to HIV through social protection. These include the following.

### Targeting and design of programmes

As shown above (and discussed in Holmes and Akinrimisi, 2012), some programmes (most notably COPE) include OVC and people and households affected by HIV among their target beneficiaries. However, one key question relates to whether programme design is the most appropriate when considering HIV-related criteria. For instance, COPE is based on a household receiving a basic income grant for 12 months, then an accelerator lump sum to invest in income-generating activities. While best practice suggests targeting vulnerable people in general, of whom some are made vulnerable as a result of HIV and AIDS, on some occasions the specific needs of PLHIV may need to be taken into account. Thus, for instance, PLHIV whose labour capacity is low may need further support than just an income grant; similarly, they may be unable to use an accelerator lump sum since they may not be well enough to engage in income-generating activities. Factors to take into account include the stage of the illness of PLHIV; whether they are on ART and therefore are able (again) to earn an income/engage in livelihood activities; and the support structure and/or household in which they find themselves. Such factors are likely to affect the ways in which a grant could be used.

Other programme design aspects, related to the above, include the potential to link HIV-related service uptake to social protection transfers. For instance, in order to encourage HIV testing, people could be provided with a cash or food transfer; similarly, to encourage efficient uptake and use of ART, a food transfer could be provided, at least in the initial stages of therapy when, presumably, they are least able to engage in income-generating activities. Such aspects of design are already included in some HIV and AIDS-related programmes/projects but are not present in social protection planning and programming.

Thus, several tracks of support may be necessary within a single programme (as in Ethiopia and Rwanda, for example). For example, households with labour capacity could receive one

kind of support (e.g. income generation or public works-related social protection), while those with limited labour capacity could receive a different package of assistance, including direct cash transfers. Such interventions need to be planned carefully, drawing on disaggregated evidence and analysis of the differential effects of HIV and AIDS on specific individuals and households – evidence which is often missing.

The case studies highlight that young women are a particularly at-risk group. While identification and targeting of young women is critical, more needs to be done to tackle the issues underlying this increased risk – the gender inequalities and power imbalances that place some people in a more vulnerable position than others. Hence, a more holistic and integrated approach is needed. Gender equality needs to be a vital component of HIV and social protection programming, either in the core design (e.g. supporting women's access to productive resources directly and/or ensuring that programmes do not place a double burden on women) or by setting up strategic institutional linkages with other support programmes (e.g. women's empowerment to address inequalities in the home and decision making and inequalities in inheritance, among other things).

The case studies also highlight the importance of networks and support groups, as well as income support for those able to work. Both of these areas are gaps in current social protection discussions. There is little discussion on the role of informal/community safety nets and how these can be strengthened through formal social protection interventions, and relatively little on productivity-enhancing social protection, beyond the COPE accelerator transfer. Hence, there needs to be more consideration of the potential for including a focus on, for example, public works or agricultural input transfers in social protection approaches and programmes. It may also be possible to build into the design activities which may be less labour intensive, to support PLHIV. For instance, in South Africa, home-based care is considered a public works activity; this approach could be explored in the Nigerian context.

### Institutional coordination and implementation

As is apparent in the HIV-related case studies, along with the other case studies in this overall study, there are challenges in terms of coordination and implementation, both horizontal and vertical. Horizontally and within states, there are a range of actors involved in HIV-related activities and interventions, including government ministries, donor-funded programmes, NGOs and FBOs. Although SACAs are supposed to lead and coordinate at state level, their capacity varies across states, with some much more active and engaged than others. Lack of coordination can lead to, among other things, duplication of activities, lack of consistency, limited building on success and learning from challenges and, in general, absence of a joint state-level coordinated HIV response. These characteristics also make states less able to attract external funding and support.

Vertical linkages, i.e. coordination from federal through to states and LGAs, are also a challenge. Although states may have different priorities to the federal level, some programmes may be national and top-down. Similarly, the state Ministries of Local Government are in charge of activities in LGAs, which may also have different priorities and needs. In the HIV sector specifically, NACA should coordinate national-level responses, building from SACAs at state level; however, the capacity and reach of NACA need to be strengthened.

Given this lack of coordination and the multitude of players working on HIV, integrating social protection responses may be challenging. However, there are some micro-level examples of this happening. For example, NAPEP has training programmes for PLHIV, and many NGOs and donor-supported programmes successfully link multiple activities and objectives within one programme (e.g. health, nutrition, social support, income-generating activities, etc.). Thus, it is important to explore how such an approach could be replicated and implemented at scale, both vertically and horizontally. Social protection approaches can also take some lessons from this in terms of thinking more broadly about the economic and social risks the poor face.

As recommended by best practice (e.g. Temin, 2010; UNAIDS, 2010a), it is important to keep programmes simple and part of the larger social protection system, as opposed to creating parallel systems and machineries. Thus, one possibility could be to establish a coordinating

committee at national level, to be replicated at state level (as in Cameroon), to facilitate linkages between HIV and social protection players. Ideally, such a committee would build on existing structures – to make things simpler, ones which already have a cross-cutting or cross-sectoral mandate. These might include, for instance, FMWA&SD and SMWA&SDs or the Ministries of Local Government through their Associations of Local Governments of Nigeria (ALGONs). Members could include representatives from key ministries/agencies (NAPEP, FMOH/SMOHs, FMWA&SD/SMWA&SDs, etc.), NACA/SACAs and NGOs/donor-supported programmes and FBOs working on both HIV and social protection activities.

### Capacity building

Linking to the previous point, although appropriate structures may be in existence, they may be under-resourced and under-funded, and fraught with internal problems and corruption. One means to address this would be to build the capacity of such institutions. In addition, and in order to encourage further linkages between HIV and social protection in terms of both awareness and understanding, but also to address implementation challenges and bottlenecks, capacity building should also occur for personnel working on HIV and on social protection and poverty more generally. Hence, social protection staff should have training in HIV-related issues, and specifically in gender issues and in identifying issues around OVC. Similarly, staff working on HIV programmes should be trained in the concepts and approaches related to social protection and how these are being operationalised in the Nigerian context.

### Funding

Currently, there seem to be considerable amounts of funding available for HIV and AIDS-related programming. However, recent evidence shows not only that public contributions are declining, with Nigeria becoming ever-more reliant on donors (NACA, 2010b), but also that, continued scale-up (let alone reaching universal access by 2015) would require a dramatic increase in funding (Resch et al., 2009). Meanwhile, the way funding is allocated varies by state, with preferences for certain states based on their capacity and donor confidence in them. This preference leads to, and potentially reinforces, existing inequalities. Hence, ways in which the currently significant amount of HIV funding could be harnessed to address HIV more strategically need to be explored. One way might be to strengthen NACA and SACAs, supported by other national- and their partner state-level organisations, to identify state-level HIV-related priorities and needs, building on existing state-level plans and priorities but with further analysis and data, then assigning specific funds to these priorities and needs. Thus a pooling of funds, or a 'basket approach' to HIV funding, could be adopted.

An increase in government commitment to pro-poor expenditure, in order to better link HIV and social protection, would also encourage and strengthen such linkages. Currently, expenditure on social protection in Nigeria is very low, in relation to other national sectoral expenditure as well as to other African countries, and especially compared with other lower-middle income countries. As government budgets and expenditure are linked not only to resources but also to political priorities, more information, data and vulnerability assessments, disaggregated by sex and age, are needed to strengthen government commitment.

### Summary

It is clear that further evidence is needed on both the impacts of nascent social protection approaches in Nigeria as well as how best to do social protection in Nigeria in a context of HIV and AIDS. Such a context is one of wide variations, differences and contradictions. Not only do responses need to be tailored to the specific states, but also, to tackle the root causes of vulnerability and poverty, responses need to go below the state level and into communities to understand the key drivers – something which this study and the Triple F study have sought to do. Nevertheless, much more is still needed.

What is certain is that there is a need for a more coordinated and equity-based response to social protection, particularly in the context of HIV and AIDS from the national to the local level, among all relevant national and international stakeholders. This will require an increase in political commitment at all levels of government, sustainable and efficient use of donor funding and an increase and improvement in the effectiveness and efficiency of Nigeria's public

expenditure on HIV and AIDS and social protection strategies. UNICEF has a key role to play in this response as well as in providing guidance based on the above identified strategies and approaches.

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# Appendix: Fieldwork guides

**KII guide on role of social protection in the context of HIV and AIDS: state and intervention level**

| | Questions |
|---|---|
| *HIV related vulnerabilities and risks* | • Who is particularly vulnerable to HIV and why? Probe different categories of people<br>• (women, children, migrants, adolescents, elderly)<br>• What kinds of HIV-related vulnerabilities and risks do different people face? (cultural, access/barriers to services, employment related, migration, geographical, stigma and discrimination). Does this vary by age, gender, location? In what way?<br>• Are these risks and vulnerabilities related to a particular phase / stage in the life-cycle and or to different stages of HIV and AIDS?<br>• Have these vulnerabilities and risks changed over the last couple of years? How, why?<br>• How do people cope with vulnerabilities and risks? Have coping strategies changed over last couple of years? How, why? Are they different for men, women, boys, girls? Are they different according to household – e.g. two parents, single parent, foster parent/guardian? |
| *HIV-related services* | • What services are available (testing, ART, PMTCT), by whom, where, how are delivered, Coverage/numbers of people, costs?<br>• What are the challenges to providing services? Resources, training, overlap with other programmes?<br>• What are the barriers to accessing services? Infrastructure, staff attitudes, stigma and discrimination, cultural? |
| *For programme implementers* | Details of the programme: what do they provide, where, who/how are they targeting, what is the coverage (area and numbers of people), costs. Challenges to providing services? Challenges for people accessing services / being part of the programme? |
| *Additional interventions/ services* | • Have any social protection interventions explicitly addressed HIV/AIDS related vulnerabilities? In what way? If not, why not?<br>• What are the opportunities for linking social protection and HIV/AIDS related services? What are the challenges?<br>• What additional services or linkages for HIV-positive people (and their families) to other programmes exist – nutrition, cash transfers, livelihood, skills-building? Are there other social protection kinds of services which HIV-positive people cannot access? Which, why?<br>• What are the challenges to providing services? Resources, training, overlap with other programmes<br>• What are the barriers to accessing services? Infrastructure, staff attitudes, stigma and discrimination, cultural, costs? Does this vary by gender, age, location (state, urban/rural)? |

**IDI guide on role of social protection in the context of HIV and AIDS**

| | Questions |
|---|---|
| *Family status and living arrangements* | Are you married, since when, who do you live with, the number of children you have, educational level |

| | Questions |
|---|---|
| *Household and individual livelihood* | • (What do you do to survive/get by?) What are your main livelihood activities? Where do you work, what work do you do? Since when, how much do you get/earn?<br>• Probe also remittances.<br>• How do you make money? When do you make money (seasonal activities)<br>• What is division of labour in the household? Who does what activity? (cooking, cleaning, farming, trading, working for money?)<br>• Who earns an income in the household? |
| *HIV history and experience* | • Since when have you known your status?<br>• Have you disclosed your status? To whom, when<br>• What have been your experiences of being HIV-positive? Sickness, Stigma, expenses?<br>• How have you/your family coped? (Probe on different effects per household member including children)<br>• How has being HIV-positive affected other members of your household, your children, etc. In what ways? |
| *HIV-related services* | • What HIV-related services do you / have you used (probe testing, counselling, PMTCT)? Where have you accessed these services? How often do you access them? What are the costs? How long does it take you to get there?<br>• Are these services adequate? If not why not? If yes, in what way?<br>• Are you taking ARVs? Since when, where do you get them from, how often do you get them?<br>• What challenges do you face accessing and taking ARVs?<br>• How do you adhere, who helps you to adhere?<br>• What other related services do you receive? probe nutritional, cash, livelihood support, skills training? Who provides these?<br>• Since when, how often, what have been your experiences of them?<br>• What barriers / challenges do you face accessing HIV-related and other services? Infrastructure, staff attitudes, stigma and discrimination, cultural?<br>• Are there factors which determine who, when and How people are able to access HIV-related and other services?<br>• Do you think this is the same for other men/women/youth living in your area?<br>• Have you ever used traditional health practitioners? Why, for what, at what stage, costs, experiences of this...?<br>• Do you receive family/community/church/mosque/NGO support? What kind of support? Is this support more important to you than formal services? In what way? (e.g. more regular and reliable? Costs etc.) |
| *Programme membership* | • Since when have you been part of the programme / receiving benefits from the programme?<br>• How did you become part of the programme? Were you selected, did you come forward?<br>• What do you receive, how often, how do you receive it?<br>• Is it adequate for your needs?<br>• If you receive food or cash, how do you use it? Probe share with members of the family, sell, etc.<br>• What challenges / barriers do you face in being part of the programme?<br>• What has worked particularly well / what has worked least well in terms of being part of the programme? |
| *For people who are HIV-positive, who are not part of the programme but who live in the catchment area of the programme* | Do you know about the x programme? Why are you not part of it? How were people selected? Do you want to be part of it? If not, why, if yes, why are you not?<br>Do you know the benefits of the programme?<br>Do you know what challenges people face being part of the programme? |

| | Questions |
|---|---|
| *Social networks – membership of groups* | • Are you a member of a positive support group, if no why not? If yes, since when? What do you do? How many members are there? How do you become a member? How often do you meet? What benefits /support do you get from belonging to the group?<br>• Are you a member of any other a group? (formal and informal) Since when? What do you do?<br>• How many members are there? How do you become a member? How often do you meet? What benefits do you get from belonging to the group?<br>• What other informal / formal support mechanisms and networks exist/are you a member of, e.g. if you are in trouble, feeling sad, etc. where do you go? What do you do? What support do you receive (emotional, economic, in-kind).<br>• If they (formal and informal groups) exist and they are not a member probe why |
| *Awareness of rights* | Is there anything people who are making laws for you in Nigeria / the leaders can do to help you?<br>What do you think you are entitled to which you are not getting? (not talking about money, food..)<br>Do you know about your rights as a women/adolescent/man/HIV-positive person?<br>Are you aware of the rights which should/could have protected you from getting HIV? (e.g. testing before marriage, rights of getting partners/her/his own information/ results of HIV test result, etc. ) |

**FGD guide on role of social protection in the context of HIV and AIDS**

| Theme/sub-theme | Questions |
|---|---|
| *Contextual information* | • What are the main occupations/livelihoods of people here? Probe, migration, farming, business, etc.<br>• Who does what? E.g. men, women, children<br>• What are the major challenges people face here? Have these changed over the last few years? If yes, how, why?<br>• Has anything improved in the last few years? If so, what, and why? |
| *Gender issues* | • How much control do women have over decision-making in the community? What types of decisions? Probe education, health-seeking behaviour, older children's/young adults' choice of marriage partners? Are there major differences between different ethnic groups, regions, ages?<br>• Are there any women's organisations? What do they focus on (e.g. informal credit?). Are women involved in community decision making? If no, why not? If yes, in what capacity? |
| *HIV-related knowledge and attitudes* | • What do you / people here know about HIV? How is it transmitted, how is it prevented, how is it treated? Ask for examples.<br>• How do people here view HIV-positive people? Do they stigmatize, discriminate or are they accepted? How, who, when/during which situations? How is it manifested?<br>• Has stigma and discrimination changed over last couple of years? Has it got worse or better? Why, how? |
| *HIV-related risks and vulnerabilities* | • What are the HIV-related risks in this area? (selling sex, negotiating safe sex, alcohol abuse, exchange sex for food...)<br>• Who is at particular risk of getting HIV and why (probe men, women, girls, boys, children, migrants, female headed households, guardians?)?<br>• What HIV and other vulnerabilities do people face? Probe in relation to access to services, access to information, knowledge, gender norms, employment, stigma and discrimination<br>• What are the kinds of HIV-risks and vulnerabilities that children / orphans face?<br>• Have risks and vulnerabilities changed in the last few years? If yes, why, how? |

| Theme/sub-theme | Questions |
|---|---|
| *Coping strategies* | • How do people cope with these challenges/vulnerabilities?<br>• Through government programme support? NGO? Church/mosque? Family? Community?<br>• What kinds of support do people get from these? Spiritual, financial, emotional....<br>• Do these ways of coping differ by type of person? E.g. men, women, types of hh, female headed households, guardians?<br>• How important are the various coping strategies? E.g. is family support more important than formal service provision?<br>• How do orphans cope? Taken in by other household members? Can they access services? What are the challenges?<br>• Do any of you / within your community provide support for other people living with HIV/AIDS? In what way? Advice, care counselling support, resources, money, medicine etc. |
| *HIV-related services* | • What HIV-related services are available in the area?<br>• Can everyone who needs these services access them?<br>• If not, why not? Who? What challenges do people face in accessing these services? Probe distance, cost, staff attitudes, infrastructure, cultural practices...<br>• Do people use traditional /informal health providers? If yes, for what purposes, when, how? Who uses them? Men, women, children?<br>• What are the costs, what are the challenges? |
| *Programme membership / service provision* | • Which kinds of people are members of the programme? How are members selected? Who decides? Men, women, youth?<br>• What are the key benefits of the programme?<br>• What are the key challenges of the programmes?<br>• What solutions would you propose to improve the programme, replicate it and/or scale-it up if it was to be carried out somewhere else? |