

Project Briefing

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Key points

- Social protection responses in Nigeria are still at pilot stage, poorly coordinated, and do not cover all HIV-related risks and vulnerabilities
- Social protection responses should consist of broad-based anti-poverty strategies, but have the flexibility to address HIV-related risks and vulnerabilities when needed
- Better coordination, political buy-in and ownership are critical for policy traction on social protection processes and to embed HIV-sensitive aspects within them

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HIV-sensitive social protection: the case of Nigeria

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Social protection has become an increasingly popular policy and programme option to address the vulnerabilities experienced by the poorest people in developing countries, including those affected and infected by HIV and AIDS. Social protection aims to reduce risks, mitigate their impacts and increase the capacity of households to cope and respond to the risks.

Although the ways in which social protection and HIV and AIDS link together remain complex and debated, a recent review of the evidence confirmed that social protection can improve the response and coping strategies of people infected and affected by HIV and AIDS (Temin, 2010). Social protection can also reduce the risk of HIV infection among vulnerable groups through anti-poverty strategies (see also UNAIDS, 2010). An equity approach is often integrated into social protection schemes, to address gender and social inequalities, as well as discrimination (Devereux and Sabates-Wheeler, 2004; Holmes and Jones, 2010).

This Project Briefing presents key findings from a larger study exploring social protection and related programming in a context of high HIV prevalence in Nigeria (Samuels et al., 2011). Drawing on secondary literature and primary qualitative data collection in four states (Adamawa, Benue, Edo and Lagos), four key issues were explored: the drivers of HIV-related vulnerabilities; the impacts of HIV and AIDS on different groups of people and related coping strategies/mechanisms; institutional responses to HIV and AIDS; and current social protection responses that link with HIV and the potential for replicating and/or scaling these up.

HIV-related vulnerabilities and drivers

The HIV epidemic in Nigeria remains a major public health challenge. While a number of often inter-related drivers were identified as part of this research, causal linkages are not always clear and sometimes go against expectations. For instance, socio-economic and gender inequalities are often considered to drive

the AIDS epidemic, with increased HIV-related vulnerabilities in poor socio-economic settings and where gender norms may be particularly inequitable. However, this may not always be the case, and there are instances where even states with low inequality may have high HIV prevalence. Religion and culture can also have an influence. In Nigeria, the primarily Christian southern regions have a higher prevalence than the mainly Muslim northern region: this can be explained by a range of cultural reasons, for example differing circumcision practices.

Low 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 still prevent individuals from disclosing their status and accessing services, although there is some evidence that these are reducing, largely because of increases in awareness.

Multiple sexual partners, low condom use and polygamy increase the risks of HIV transmission, as do transactional and intergenerational sex, particularly for women. Poor and inequitable distribution of health infrastructure and personnel has also been identified as a key driver of the epidemic in Nigeria (see Box 1 overleaf).

Vulnerabilities among different population categories

While Nigeria can be characterised as having a generalised epidemic, there are concentrated epidemics among most-at-risk-groups (MARPS), including female sex workers, men who have sex with men, and injecting drug users. MARPS are at a higher risk of HIV and other sexually transmitted diseases (STIs) because of behaviours or occupations.

Other vulnerable groups include youth (mainly young women), pregnant women, and orphans and vulnerable children (OVC) (of whom there

are 17.5 million), and the elderly. Such groups are particularly vulnerable because of socio-economic, age and gender characteristics, as well as the location in which they live. Case study respondents added widows, migrant workers, rich people ('since they can purchase sex at all costs'), drivers, transport workers and communities living along transport routes to this list. Characteristics of these groups which also make them vulnerable to HIV and AIDS include low HIV awareness among youths – only one quarter having comprehensive and correct knowledge about HIV; HIV testing among youths is also lower than the general population (7% versus 12%). Levels of knowledge on HIV were found to be higher among OVC than non-OVC, at the same time these children were living in more food-insecure households and were also at higher risk of rape, sexual abuse/exploitation and child labour. With variations by state, only 13% of pregnant women tested for HIV during an antenatal care visit in 2009 and only 22% of HIV-positive women accessed services to prevent mother-to-child transmission.

Impacts of HIV and coping strategies

Households affected by HIV and AIDS have experienced declining levels of income, agricultural production and family assets. Other impacts include increasing numbers of widows, orphans, and 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 have 20 or more individuals. Meanwhile, disinheritance and the loss of property affect women and OVC disproportionately.

With an estimated 3.3 million people living with HIV (PLHIV) in Nigeria, a growing demand for health services has greatly increased the workload of health providers – also implying a significant rise in patient-to-health-centre/professional ratios. At the same time, HIV and AIDS-related mortality and morbidity are also affecting health professionals and their families.

This study and the parallel study on the food, fuel and financial crisis in Nigeria (ODI, 2011) identified a number of informal coping mechanisms for dealing with poverty in general. These 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 early marriage of girls. Individuals and households affected by HIV and AIDS are likely to resort to similar strategies, although the impacts on them may be different or more severe. Similarly, many of the above coping strategies are likely to create HIV-related vulnerabilities, for example child labour, where children may work as domestic servants, sex workers or beggars, brings with it heightened vulnerability to numerous risks, including sexual violence and HIV and AIDS.

To cope with stigma and discrimination associated with being HIV-positive, people are reported to have relocated, resigned from their employment, withdrawn from social networks, stopped participating in organisations and taken on a disproportionate amount of additional tasks, as well as having taken up alcohol and smoking.

Formal coping strategies include turning to programmes of assistance run by non-governmental organisations (NGOs), joining support groups and turning to faith-based organisations (see Box 1).

Institutional response to HIV and AIDS

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

The first national HIV policy was adopted in 1997, and then revised in 2003 and 2009 through multi-stakeholder consultations, including with line ministries and PLHIV. The need for a more holistic response and a focus on treatment and universal access led to the development of the 2005-2009

Box 1: Drivers, impacts and coping strategies

Drivers of HIV

'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' (Lagos, key informant interview).

'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' (Edo, key informant interview).

'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' (Lagos, key informant interview).

Impacts of HIV and coping strategies

'Their coping strategies involve begging, trading, doing hard work to survive, cleaning of the compound and clothes for people, to survive. 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' (adolescents' focus group discussion, Lagos).

'The support group has been my life. I would have died of loneliness and lack of care until someone linked me up to the support group in Makurdi' (PLHIV, Benue).

'I go to my support group or pastor for counselling when I am in trouble or sad' (PLHIV, Adamawa).

Source: Samuels et al. (2011).

and 2010-2015 National Strategic Frameworks. All states have five-year HIV strategic plans (2010-2015) which articulate their needs and priorities and to a large extent mirror national policy.

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 face challenges in terms of generating policy traction.

Nigeria is highly dependent on donor funding for its HIV and AIDS response, with only 8% of programme financing coming from domestic sources in 2008. The President's Emergency Fund for AIDS Relief (PEPFAR) 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 (an increase of 32%), public funds decreased from 15% to 8%.

Civil society has played an important role since the early days of the epidemic. Currently, over 70% of HIV interventions are managed by international NGOs in collaboration with civil society organisations. However, there is no fully-fledged, mobilised and engaged grassroots community response, in part due to poor coordination and lack of government oversight.

The coverage and quality of HIV-related services varies across states, mostly depending on which external donor is providing support, the nature of existing health-related infrastructure, the capacity of health staff and the effectiveness of the SACA in attracting and coordinating funding.

In addition, states see limited and unsustainable funding as a factor restricting their ability to provide consistent services and increase coverage, and highlight ownership and responsibility as missing ingredients on the side of government.

Overall, there has been no systematic institutional response to HIV and AIDS. Although a relatively broad and multi-sectoral approach is often adopted, as the case studies show, whereby NGOs provide a range of HIV and non-HIV/health-related services (e.g. nutritional support, livelihood and skills development), a systems response is urgently needed. Such a response, if coordinated and joined-up, could provide a wide spectrum of services to OVC and their families, including educational assistance, psychosocial support, economic strengthening and health care.

Towards a social protection-type response in the context of HIV and AIDS

While HIV and AIDS-related programming in Nigeria is not currently framed in terms of social protection, there are a number of HIV-sensitive social protection components, which either directly or indirectly

target people affected or infected by HIV and AIDS. Such schemes improve access to education, health care and food security for vulnerable people – including those infected or affected by HIV/AIDS –, but remain scattered, poorly coordinated, limited in scale and do not cover the full range of HIV-related risks and vulnerabilities.

Similarly, approaches are often vertical in nature, with limited multi-sectoral engagement. Limited evidence is gathered on such programmes with monitoring and evaluation usually focusing on outputs and numbers of people reached, rather than outcomes, and there is limited capacity and resources among implementers to scale up or link to complementary initiatives.

The analyses above have 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 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 a need to ensure that social protection legislation, policies and strategies include HIV-related components, or are HIV-sensitive. One way to ensure this is to recognise particular national- or state-level HIV-related risks and vulnerabilities and ensure that people affected or infected are targeted appropriately.

Targeting and design of programmes:

- While targeting should be on the basis of vulnerability in general in order to limit stigma and discrimination, the specific needs of PLHIV may need to be taken into account. This includes needs during different stages of illness, whether they are receiving antiretroviral therapy (ART) or other support, and/or the nature of households in which they live.
- Programmes should 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) and those with limited



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labour capacity receive a different package (e.g. a cash transfer).

- Gender equality is critical in both HIV and social protection programming and should be integrated into programme design, through incorporating institutional linkages with other support programmes.
- 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

- There is a need to build on, replicate and scale up programmes that successfully promote cross-sectoral and multi-activity coordination and implementation, such as the National Poverty Eradication Programme, which coordinates and monitors all government poverty reduction programmes in the country.
- A coordinating committee should be established at national level and replicated at state level to improve coordination and facilitate linkages between HIV and social protection. It is critical to build on existing structures with cross-cutting or cross-sectoral mandates in order to avoid creating parallel structures.

Capacity-building

- There is a need to build the capacity of existing structures, which are both under-resourced and under-funded, to improve programming.
- Capacity-building should also occur for person-

nel working on HIV and on social protection, to increase their awareness and understanding of both topics and help to address implementation challenges and bottlenecks.

Funding

- Ways need to be explored to utilise the considerable funds available for HIV and AIDS programming more effectively, efficiently and equitably.
- An increase in government commitment to pro-poor expenditure is required to better link HIV and social protection.

Further evidence is needed on both the impacts of nascent social protection approaches in Nigeria and how best to provide social protection in a highly diverse HIV and AIDS context. Responses need to be tailored to specific states and, in order to tackle the root causes of vulnerability and poverty, they need to address the key drivers of this vulnerability at community level.

There is a need for a more coordinated and equity-based response to social protection, particularly in the context of HIV and AIDS, from national to local level and among all relevant national and international stakeholders. This would require an increase in political commitment at all levels of government, sustainable and efficient use of donor funding, and improvements in the effectiveness and efficiency of public expenditure on HIV and AIDS and social protection.

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Project Information:

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