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A Case for Investing in HIV-Sensitive Social Services for Vulnerable Children in Nigeria

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Abstract
HIV and AIDS are reported to be one of the leading causes of death in Nigeria, behind other child-related death illnesses – influenza and pneumonia (CDC, 2013). The presence of HIV and AIDS in a family, including related orhpanhood because of the disease has a significant impact on the health and wellbeing of children. It also dramatically impacts the long-term implications and costs to society. However, there remains a notable disparity between the contributions made by different actors – including all levels of the Nigerian government, international donors, private organizations and civil society. A desk review was conducted to examine the current gaps in investment related to care and treatment for children living with or affected by HIV. Findings reveal that foreign funding declined from 82 – 71% for financing of HIV related programming and interventions. While there seems to be some progress compared to increased contributions to orphans and vulnerable children (OVC) programming from domestic sources (e.g., government and private sector), this comes at the same time when there is a decline in foreign donor support towards the issue. Conversely, private sector contributions to OVC issues remain an untapped resource in Nigeria. Therefore, there is a need for an investment case to clear articulate and advocate for increased financial support for an HIV sensitive social service system that can adequately address and respond to the needs of vulnerable children.
Keywords: Investment case, OVC financing, cost of inaction, OVC programing, Nigeria

1. Why Invest in HIV Sensitive Social Services for Vulnerable Children

Nigeria is the most populated country in Africa with an estimated at 182 million (NPopC, 2015). More than half of Nigeria's population are youth who live in the rural areas with a median age of 18 years (NPopC, 2015). NPopC (2015) also posited that children, aged 0-17 years account for 43% or 97.6 million of the overall population.

The 2008 Situation Analysis on Orphans and Vulnerable Children conducted by the Federal Ministry of Women Affairs and Social Development identified 17.5 million or one-quarter of all children as orphaned and vulnerable (GoN, 2008). However, in the time period after 2008, there was an increase in child vulnerability due to a combination of reasons. These factors included an insurgency in the northern part of the country, a significant drop in oil price and gross domestic capital, increased inflation rate and cumulative health and related issues linked to HIV, malaria, malnutrition and polio.

Specifically, HIV and AIDS is reported to be one of the leading causes of death in Nigeria, behind the child-related death illnesses – influenza and pneumonia (CDC, 2013). The number of children living with HIV and AIDS is estimated to be 238,504 or 0.25% of children population. Children orphaned as as a result of AIDS (aged 0 to 17 years) is estimated to be 1,800,000 or 1.9% of child population (NACA, 2016; UNAIDS, 2015). The presence of HIV in a family, including orhpanhood as a result of the disease has a considerable impact on the health and other areas related to wellbeing and dramatically impacts the longer-term implications and costs to society.

2. Methods

A desk review was conducted to examine the gaps in investment (health financing) related to orphaned and vulnerable children (OVC). Literatures and materials used for this study were obtained through a thorough, systematic and in-depth evaluations of relevant and existing evidence that support the study ideology and concepts. The literature search was conducted through review of relevant and related scholarly published, and accredited articles in journals, books, conferences and dissertation as well as government policy documents including budgets, audited reports and program data. Approximately, five OVC partners reports, 12 state budgets, six audited reports and 19 published articles/database were collated for review.

The search for published articles was done using search engines, library catalogs, bibliographic databases and consulting scholars with related expertise. Materials obtained were further assessed to establish relatedness, provenance, value, objectivity and demonstration of strong argument to support research ideas. The next stage was to evaluate, analyze and interpret content for use and establishing its appropriateness depending on the sections of this work. The final stage was to critic literature evidence for gaps and correlate it with the focus and rationale for conducting this research.

From available data, the team also evaluated the ratio of financing of community services and ranked the percentage of OVC interventions funded by international and domestic partners. Data collated was used to develop an investment case. The data were analyzed and cross-examined with published evidences in peer-review journals to support the development of conclusions related to social investment dynamics for orphaned and vulnerable children in Nigeria.

3. Results showing the Investment Trend in Funding for HIV and AIDS programming in Nigeria

International and domestic support for HIV and AIDS has been significant over the two decades. The gains resulting from the continuous contribution have been tremendous. If the Nigerian government, at all levels, international donors, private organizations and civil society work in partnership and continue to ensure coordinated investment in the many dimensions of HIV and AIDS broadly (health, social services and behavior change) the control of the epidemic could be within reach. However, there remains a notable disparity between contributions by different actors. Figure 1 illustrates a decline in foreign funding from 82 – 71% for financing of HIV and AIDS related programming and interventions (NASA, 2012; 2014). The analysis also covers funding of orphan and vulnerable children programming.

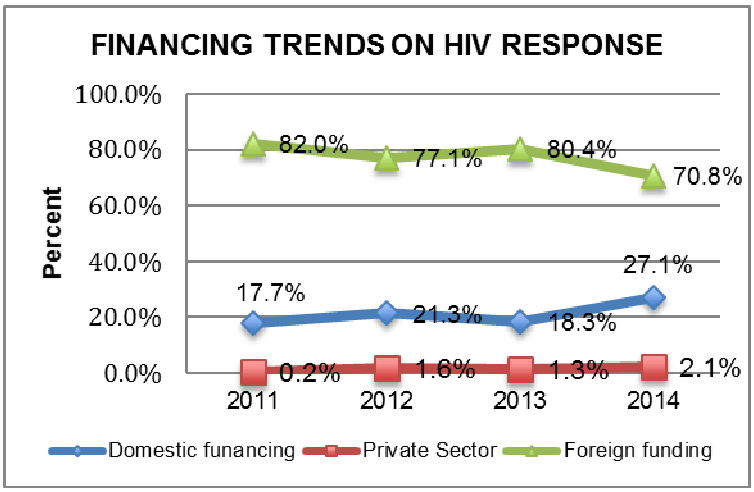


Figure 1: Financing share on OVCs in Nigeria

While there seems to be some progress related to increased contributions to OVC programming from domestic sources (e.g., government and private sector), this comes at the same time as a decline in foreign donor support towards the care for person living with HIV as shown in Fig 2 (PEPFAR, 2016).

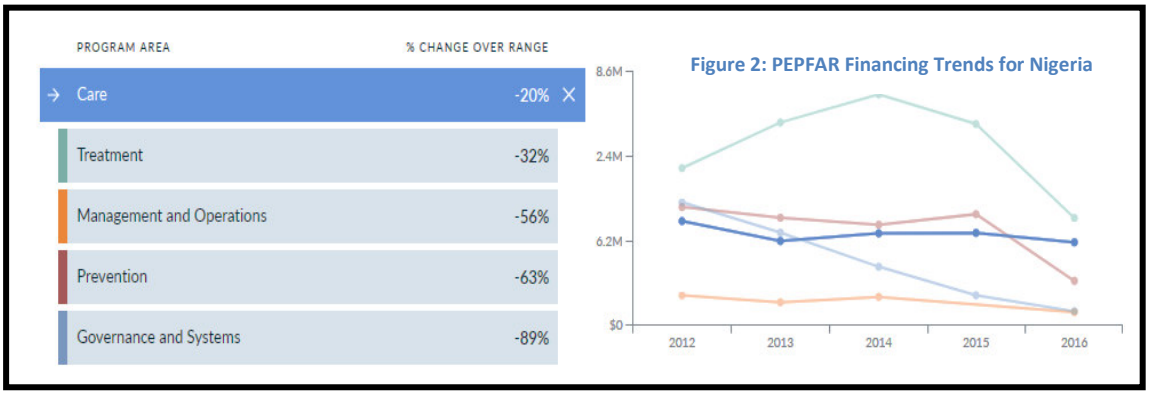


Figure 2: PEPFAR Financing Trends for Nigeria

Conversely, private sector contributions to OVC remains an untapped resource in Nigeria. There are enormous opportunities for both the Nigerian government and the private sector to further explore opportunities

at hand and contribute to the investment gaps identified in this document.

Figure 3 illustrates that whilst there is continued investment in HIV issues more broadly, funding towards OVC programming is explicitly the area with the least amount of targeted funding (NASA, 2012; 2014). Three and a half percent of all HIV funding targets children orphaned or made vulnerable by the HIV and AIDS. United States law overseeing PEPFAR funding requires that 10% of the funding for care and treatment is earmarked for orphans and vulnerable children programming, meanwhile the funding record in Nigeria shows dramatically less than the ideal 10% (Civic Impulse, 2016). A growing evidence base is illustrating that providing targeted services and support to this population of children now has a significant impact on both controlling the spread of the disease and minimizing the longer-term implications of the disease and costs to society (i.e., health costs, unemployment, etc.). The benefits of investing in this population of children will be felt now and in the future. Nigeria is at a critical crossroad where they can decide to spend in programming and interventions that help to ensure that a generation of children affected by HIV does not succumb to the long-term adverse effects of the disease. By investing in vulnerable children, specifically those affected by and living with HIV and AIDS, Nigeria had the opportunity to keep these children healthy, safe, stable and schooled which in turn will help lead to an adult population that contributes to the economic development of the country. Investing now in children made vulnerable by HIV is investing in the human potential of Nigeria.

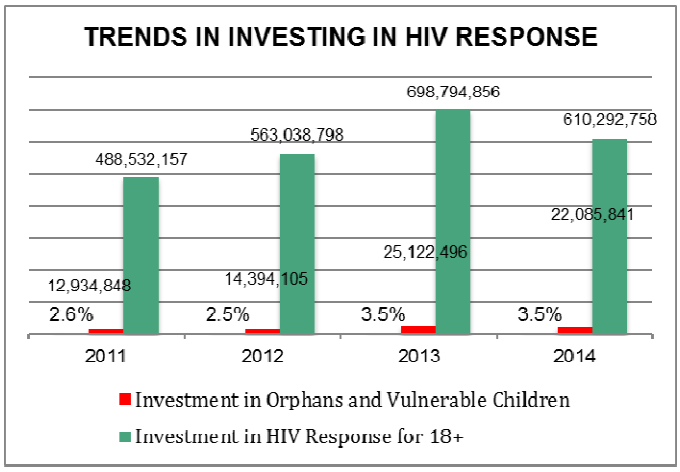
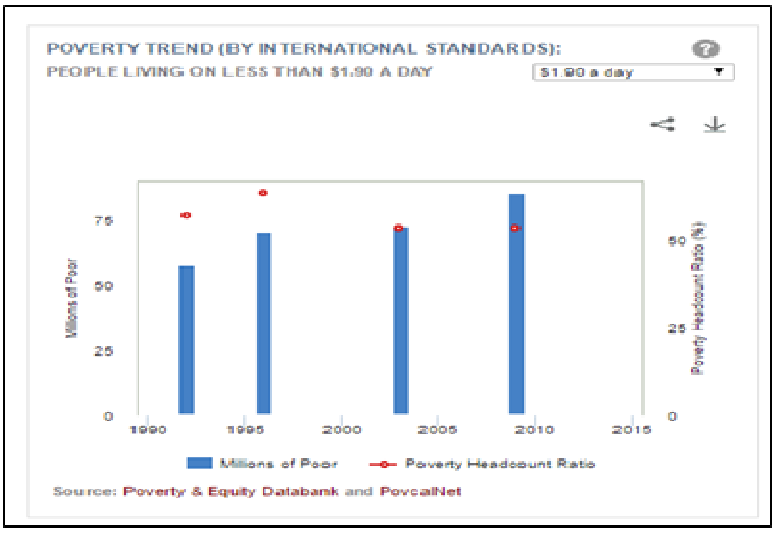


Figure 3: Comparison of Investment in HIV by age group

4. Investment Areas for Vulnerable Children

Global and Nigerian evidence demonstrates that HIV impacts children's wellbeing not just within health but also within the domains of nutrition, education, protection and economic stability thus illustrating why there should be a comprehensive approach to financing OVC programming.

Figure 4: People Living on Less than $1.90/day



4.1 Nutrition

Malnutrition in Nigeria has been an issue for many years and continues to be a challenge faced by many vulnerable families and children, especially in some geographic regions of Nigeria. Malnutrition and related diseases are causes of most deaths in infants and young children -71.54 infant deaths per 1,000 live births in 2015 (World Date Atlas, 2016).

The underlying causes of malnutrition in Nigeria are poverty, inadequate food production, insufficient food intake, lack of knowledge on proper nutrition and unequal distribution of food, and poor sanitation (FMOH, No Date). Poverty also remains a huge factor contributing to malnourishment in children. An average poor household consisting of eight persons spends a minimum of NGN110,000 per annum on food or NGN12,941 per child, which is equivalent to 0.12 USD per household expense per a day on food only (Magaji, 2011). With more than 53.5% of Nigeria's population living on less than 1.90 USD (Fig. 4,) ensuring proper nutrition for a child in such a vulnerable household is close to impossible. With areas of Nigeria facing food shortages and concerning rates malnutrition, it is critical that government invest in ensuring that children have access to clean and

nutritious food.

Malnutrition in children is worse when households are faced with HIV. HIV can increase the risk of economic vulnerability and access to sufficient food and water as low-income families battles to bare cost of treatment and care for loved ones. For example, if a caregiver is sick with AIDS and not able to work the loss of income impacts the ability to provide adequate food. Research across Africa has illustrated a link between maternal HIV status and malnutrition and stunting in children under five (Pascoe et al, 2015). Similarly, malnutrition in children living with HIV or TB has sown to have a negative impact on nutritional status and growth. (Magaji, 2011). Miller et al (2011) further affirms that food shortages, lack of access to food and hunger are factors that increases vulnerability and mortality among children living with HIV. Udoh et al (2009) and Underwood et al (2011) further agrees that food shortage and lack of food or hunger in the case of adolescent girls, increases their susceptibility to sexual abuse and exploitation which in turn increases risk to HIV infection.

TABLE 1: PERCENTAGE OF UNDERWEIGHT CHILDREN UNDER FIVE UNDERWEIGHT – 2003 – 2014 (WHO, 2017a)

YEAR	Children aged <5 years underweight (%)	Children aged <5 years underweight (%)	Children aged <5 years underweight (%)
	Both sexes	Female	Male
2014	19.8	18.3	21.3
2008	26.7	24.8	28.6
2003	27.2	25.4	29.1

4.2 Health Care

Access and utilization of quality health care services by children remains problematic due to various reasons including institutional weakness and inequity in access to quality health services. Advancements in medical treatment for people living with HIV have had dramatic positive impact on lifespan and quality of life. Antiretroviral Therapy (ARTs) when adhered to correctly can improve the health and lifespan of those living with HIV. However, there remain significant barriers to access to ARTs especially within the child population of Nigeria (WHO, 2017b). Data show that although improvement in ART coverage has improved over the past decade, Nigeria still lags far behind, especially as it relates to children and ART coverage. Currently, of the 380,000 Nigerian children living with HIV (CLHIV) and in need of and with the right to ART only 44,024 are receiving the lifesaving medication (NACA, 2015a). NACA (2015a) reported ART coverage in 2015 was 18% for children, compared with 41% ART coverage for adults (Fig. 5). Children represent 10% of the population of persons living with HIV (PLHIV) but only 5.5% of the HIV positive population receiving ART illustrating an urgent need to expand ART coverage in children (NACA, 2015).

Other factors affecting access to health care and treatment is the proximity of services and out-of-pocket expenses. The number of ART treatment sites in Nigeria has increased to 820 as of 2013 (NACA, 2016) but this number does not meet the growing population in need of reliable and easy to access HIV care. A recent study by 4Children Nigeria has also revealed that HIV treatment facilities are not always within the proximity of the people that require them. Perhaps even more concerning is that PLHIV choose to go to health facilities outside of their catchment area due to fear and HIV related stigma (CRS/4Children, 2016). However, HIV stigma is a significant concern and poses a barrier to accessing and adhering to treatment regimens thus putting the lives of thousands of children and their parents at risk (NACA, 2015b).

The minimum out of pocket cost for rural population/household to access health care treatment for their children coming is NGN 8,000. This number is then multiplied by eight as a minimum of eight visits per annum (Udoh et al, 2009). The cost does not include the calculation of unit cost for health care per child in need of ART within this document. Furthermore, time spent to travel and waiting creates an additional cost that might include the cost of a meal or lost work time. Furthermore, World Bank (2017) data illustrations shows that there are out-of-pocket expenses taken up by families to receive health care treatment, spending about 72% of total health care cost in 2014. This has significant influence on families who are still living below poverty line.

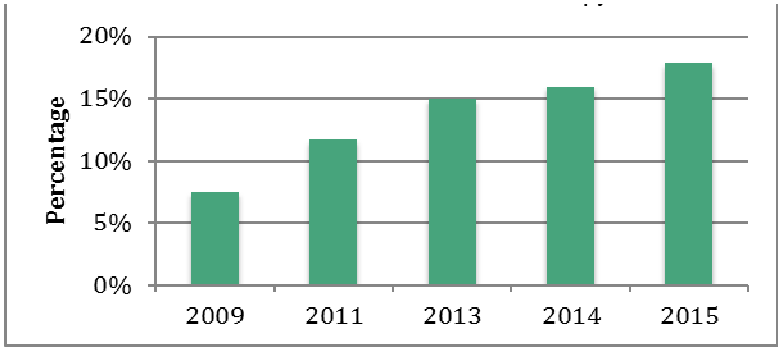


Figure 5: ART Coverage among Children - % of children (aged 0-14 years living with HIV who have access to antiretroviral therapy

In the case that ART treatment is not provided for free, the cost for the household will be a burden and will

create a significant barrier in the country and inhibiting its ability to reach the global goal of 90-90-90(90 percent of those living with HIV know their status, 90 percent of those who know their status are on ARTs and 90 percent of those on ARTs are adhering to their treatment regimen. The authors calculation reveals that an average cost of treatment is at 40,000NGN (inclusive of the consultation). Given that many households affected by HIV are poor, this begs the question of how many can afford lifelong treatment and the related costs. It must be acknowledged that resources, or lack thereof, plays a significant role in how many persons, including children living with HIV, are able to regularly access lifesaving treatment. Without this access, there is clearly a risk of increased mortality rates and barriers to reaching global goals to contain the disease.

3.3 Education

Participation in education for economically vulnerable households remains a challenge (Fig. 6). UNESCO (2017a) asserted that the gross number of children out of school in Nigeria was at 8.7 million. Approximately forty percent of Nigerian children aged 6-11 do not attend primary school with the Northern region recording the lowest school attendance rate in the country particularly for girls (UNESCO, 2017b). Despite a significant increase in net enrollment rates in recent years, estimates that close to 4.7 million children of primary school age are still not in school in Nigeria (UNESCO, 2017b).

Barriers to education include poverty (i.e., inability to pay related fees), access and distance to school and access or prioritization, especially as it relates to the girl child. Data collated from interviews as well as author's calculations' reveal that aside from free tuition cost per child in primary school, a school kit is estimated at 8,000 NGN whereas in secondary education cost of additional materials (lab materials) is17,000 NGN. While poor households are at a disadvantage, low-income families who are also affected by HIV are even more vulnerable. Households affected by HIV and AIDS suffer due to parents that are not able to work due to the illness or related stigma and therefore cannot afford the related costs (transport, uniforms and books and even providing help with homework). HIV related stigma continues to keep children away from school or leave school due to fear, bullying or discrimination.

The advent of HIV and AIDS has also created an additional burden on families to cope with caring for ill parents and children and affording the cost of education. Studies looking at the link between education and HIV have highlighted that when children, especially girls, stay-in-school they are more likely to remain HIV negative.

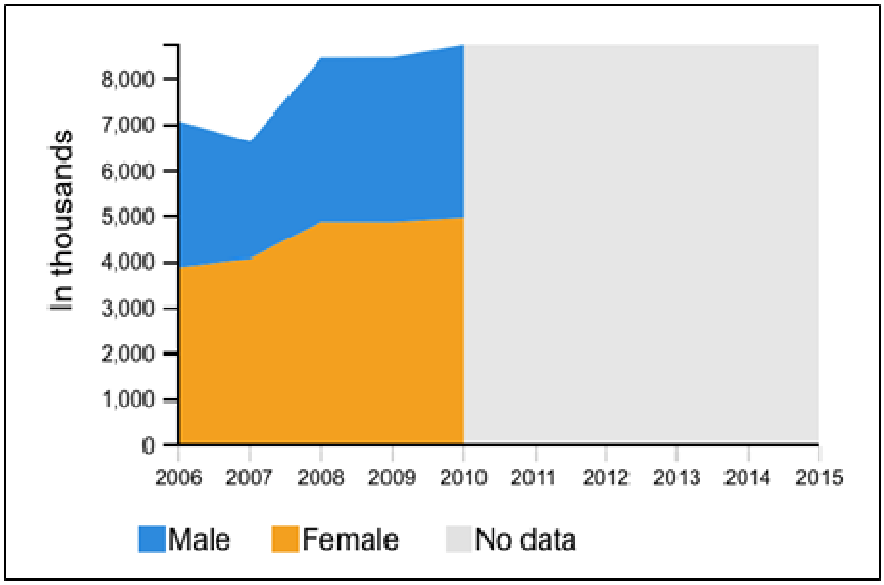


Figure 6: Out of school children between 2006 and 2010, UNESCO statistics

Conversely, when children are not in school, especially when it is due to parental HIV status, they are more prone to child abuse, increasing their risk of being affected by HIV and AIDS. The Nigerian Government is committed to free and Compulsory Universal Basic Education (UBE) whereby have demonstrated some success in closing the gap for illiteracy. Nevertheless, this does not address the challenge of additional cost for educational materials, feeding and transportation to attend school.

5. Cost of Inaction

Given the gaps in funding in the critical areas of child health, protection and education including those children and families affected by or living with HIV, there is an urgent need for increased funding and attention aimed at addressing these gaps. Efforts to support PEPFAR, WHO, UNAIDS and others engaged in the 90-90-90 efforts are critical if Nigeria hopes to contain the virus. Furthermore, protecting children from HIV and other adversities requires a holistic approach that addresses the vulnerabilities and protective factors in the domains of health, education and protection. Inaction will have drastic consequences not only for this generation but future

generations of Nigerian children. If accelerated action is not taken to invest in HIV-sensitive social services for vulnerable children in Nigeria, there is great risk of significant loss in the areas of social development and productivity. Continuing at the current low pace of social investment and losses in productivity due to children dying without reaching productive age, losses for Nigeria can account to 8.8 million life-years of lost productivity. Lifetime future losses as a result of morbidity and mortality due to increased labor productivity, averted orphan care, and deferred medical treatment are estimated at 497 billion USD or 158 trillion Naira for year 2017. If this trend is maintained by 2021, Nigeria will account for a cumulative loss on life-years productivity that are estimated at 5.8 trillion US Dollars or equivalent of 556 trillion Nigerian Naira.

6. Recommendations

Investment in HIV-sensitive social services for children is critical based on the evidence and facts presented in this paper. Government of Nigeria, international partners and the private sector need to make concerted effort and demonstrate their commitment to ensuring that the future of Nigeria's children is well cared for, protected and enabled to become productive citizens of tomorrow.

Local, State and Federal governments should increase allocations in National and State budgets for OVC related responses covering areas such as health, education and social services while ensuring regular and timely release of these funds. All relevant levels of government should work with Ministries of Health, Education and Social Development and in a multi-sectoral manner to ensure the integration of nutrition and psychosocial support interventions into health programming especially for children affected by or living with HIV. Government should also prioritize strengthening of primary health care services to provide ART for persons within local health facilities to enable easy access especially for families with minimal resources for transportation. Improved access to ARTs will contribute to greater adherence rates thus positively contributing to efforts to control and contain the HIV virus.

National and State Government should actively engage with the private sector to increase the sustainable delivery of health, nutrition and education services to vulnerable children, especially those affected by or living with HIV. This can be facilitated by creating an enabling environment that encourages the private sector to invest in social services through a tax reduction policy. All levels of government should aim to increase the allocation of funds towards education including primary, secondary and vocational. There should be active engagement and intentional inclusion of bilateral and multilateral organizations to expand distribution of finances in support of primary and secondary education including improving access to education, especially for those most at risk of HIV such as adolescent girls. Implementation of the recommendations will contribute to a more sustainable response and further address the investment gaps in social services for vulnerable children and households in Nigeria.

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