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HEALTH CARE FINANCING FOR VICTIMS OF CHILD TRAFFICKING IN NIGERIA: TRENDS AND ANALYSIS OF THE COST OF MEDICAL TREATMENT PER VICTIM PER YEAR

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Abstract
Human trafficking is the fastest growing criminal enterprise in the world, is the second largest criminal enterprise in the world. A relatively large percentage of young women and children that are trafficked for sexual exploitation will become HIV positive. Most victims of human trafficking suffer from malnutrition and therefore are subject to severe dental decay and pain. The study used both qualitative and quantitative methodologies. The quantitative method used a questionnaire developed by the research team. The qualitative method used in-depth interview, focus group discussion and direct observation. In the last 3 years (2006 – 2008), the numbers identified were 493, 787 and 1269 respectively. The figure for 2009 was 1, 500 persons. Victims in the age group 0 – 17 years accounted for 49% of total identified persons followed by 18 – 27 years 41% and 10% for 28 years above. More than 74% of identified victims are females while males are 26%. Total Cost for Medical Services (Drugs & Treatment) range from $634.00 to $33,333.00 only between years 2006 to 2008. The number of victims of Human Trafficking is on increase with serious health consequences. The health care available to victims could be more efficient and effective, that the current average cost of health care to victims is $20 per victim. It is recommended that health insurance scheme should be established for the victims with a sum of $13.3 be paid per person for 12 weeks. The Board of the National Agency for Prohibition of Traffic in Persons and other Related Matters (NAPTIP) should be paying the sum of $1.5 per quarter amounting to $27.0 in a year to the

National Health Insurance Scheme (NHIS).

Key Words: Human Trafficking; Victims; Health Care; Cost of Medical Services

Introduction

Trafficking in person is an act, and attempted act, involved in the recruitment, transportation within or across borders, purchase, sale, transfer, receipt or harbouring of persons involving the use of deception, coercion or debt bondage for the purpose of placing or holding the person; whether for or not in involuntary servitude (domestic, sexual or reproductive) in forced or bonded labour, or in slave like conditions (**National Agency for Prohibition of Trafficking in Persons – NAPTIP**, 2016). Despite the government's anti-trafficking law enforcement efforts, there are increased reports of government complicity in human trafficking. The Trafficking in Persons Law Enforcement and Administration Act, as amended in 2015, criminalizes all forms of trafficking and prescribes a minimum penalty of five years imprisonment and a minimum fine of one million naira ($3, 290) for sex and labor trafficking offenses; the minimum penalty for sex trafficking increases to seven years imprisonment if the case involves a child.

Human Trafficking is a violation of human rights. According to Article 25, paragraph 1, of the UN Convention which obliges States to take appropriate measures to provide assistance and protection to victims, particularly in cases of threat of retaliation or intimidation, which in the case of victims of trafficking, will often be the case. Article 6, paragraph 3, of the Protocol obliges States to consider implementing measures to provide for the physical, psychological and social recovery of victims of trafficking, in cooperation with non-governmental organizations and other elements of the civil society; in particular, the provision of appropriate housing, counseling and information, medical, psychological and material assistance and employment, education and training opportunities. (United Nations Office on Drugs and Crime – UNODC, 2009).

The International Labour Organization reported that trafficking is a serious violation of human rights. In the past decades, trafficking has grown to become a widespread, very profitable, international crime (ILO, 2015). Although the United Nation Children Fund (UNICEF) reliable statistics on trafficking are difficult to obtain because of its underground nature, it is estimated that at least 2, 450, 000 persons globally are in situations of forced labor as a result of trafficking, and that women make up 56% of the victims of economic exploitation and 98% of those exploited in commercial sex (UNICEF, 2016). Trafficked women suffer some of the most unspeakable acts of abuse, exploitation and degradation. Few victims emerged unscathed, either physically or psychologically from a trafficking experience. Yet, despite the profound and enduring damage to victims' health and wellbeing, relatively little action has been taken to identify and meet the health needs of victims. (Stolen, 2006).

Literature Review

While there is a significant amount of information regarding the magnitude, causes and practices of trafficking, little information exists on the health needs of trafficking victims and the way and means of providing the health services to meet those needs. There is a paucity of literature on health needs of victims of trafficking in developing countries. Specifically, insignificant studies have been conducted on a national scale to systematically assess the health needs of victims and the way and means of providing it to them have been conducted in

Nigeria. With the passage of the Trafficking in Persons (Prohibition) Law Enforcement and Administration Act of (2003) and the approval of the National Policy on Protection and Assistance to Trafficked Persons in Nigeria (2008), it is increasingly important to better understand the health needs of trafficking victims and the health services that should be provided to them. This study was carried out to conduct needs assessment for Social Health Insurance coverage for victims of trafficking in persons in Nigeria. It also examined cost estimates of financing health needs and costs of insurance services for victims of trafficking in Nigeria. Finally, it recommends financing strategies for health Insurance for victims of human trafficking in Nigeria.

Types of Health Insurance for Victims

The study obtained two opinions on the possibility and types of insurance for the victims. A group of respondents felt the characteristics of the victims as a group makes them not amenable to classical health insurance or, in the alternative, the premium payable would be very high. The characteristics identified are:

- that the group's size is small; about 1, 500 persons in a year;
- that the number is not static but widely varying over the period;
- that the period of stay in NAPTIP custody is short (2 - 4 weeks) and not specific; and
- that there would be adverse selection as majority of the victims would require medical care.

These respondents therefore suggested a "Third Party Administration" of health care services to the victims. Under this arrangement, **health maintenance organization (HMO)** would be appointed to accredit health care providers to the victims. The bills for treatment raised by such health care providers would be vetted by the HMOs before its settlement by NAPTIP. The HMOs would be paid a percentage of the bill (15 – 20%) as administrative charges. The main advantage of this option is quality of health care at an optimum cost. Its drawback is that, as a form of fee for services with payment of administrative charge, total cost may be high for the payer.

The second group of respondents suggested that a social health insurance scheme should be instituted for the victims. In their views, the information on the number of victims over the last 3 years; the type of illness and the cost of treatment, should guide in the determination of payable premium per victim while the National Health Insurance Scheme (NHIS) is to subsidize the funding of the health insurance for the trafficking group.

Methodology

The study used both qualitative and quantitative methodologies. The quantitative method used a questionnaire developed by the researcher. The questionnaire was pretested, reviewed and approved by NAPTIP. The qualitative method used in-depth interview, focus group discussion and direct observation. The semi-structured questionnaires were administered by trained interviewers. The questionnaire included a number of open-ended questions to enable respondents elaborate on the different issues explained in the questionnaire and portray as best as possible the complexity of the issues mentioned. All the filled semi-structured questionnaires were collected, collated and edited by the field interviewers and the supervisor. When the instruments arrived from the field, a data entry guide was prepared for the coding of the questionnaires. The information was then transferred to the computer softwares for analysis. The study also used evidence and information of

conclusions on reports, publications, interview, materials as secondary sources and participatory, thereby maximizing opportunities for different stakeholders to present their experience and views. This in addition to secondary data obtained from NAPTIP.

Results

Analysis of the results shows that a total of 2423 trafficked persons were identified between 2004 and 2008. Table 1: Victims of trafficking identified by State authorities in Nigeria, by type of exploitation given a total of 6, 923. This is in addition to 1, 500 recorded in 2009, total of 1, 900 recorded in 2010 and decreases to 910 victims in 2011 respectively. Table 2: Majority of those identified (49%) were children 0 – 17 years, followed by young adults 18 – 27 years (41%), while adults, 28 years and above, accounted for only 10%. There are more children victims than adult victims. (Fig 1)

In the period 2005 – 2008, 74% of victims identified by NAPTIP were females while the males identified were 26%. There was female preponderance across the zones visited. Sokoto has no male victim (Fig 2). On the zonal distribution of victims in the five zones visited, in the five of the seven NAPTIP shelters visited, Lagos shelter accounted for majority of victims 32%, followed by Abuja 24%, Benin 18%, Enugu 15% and Sokoto 11% (Fig 3). The Table 4 shows the number of victims present in the 5 shelters visited on the day of visit. Enugu has the highest number of victims – 72 (including 46 social mothers in the clinic). The victims in the other zones were 30 in Lagos, 15 in Abuja, 1 each in Benin and Sokoto. Meanwhile, the period of stay by victims in the health facilities ranges between 2 to 14 days, with majority staying for 7 days or less. Table 5: Current cost of providing medical services to the identified victims as seen in (Table 6), Abuja has the highest cost of health care in the 3 years (N2, 681,206) and the highest average cost per victim of N5, 088.00 over the period. Enugu is next with a total expenditure of N1, 690,500 and average cost per victim of N4, 929.00. Sokoto's cost for medical services was the lowest at N121, 930.00 total cost and N512.00 as average cost per victim. However, Lagos seems to be the most cost effective considering the economic environment. The explanation obtained for Abuja and Enugu are that medical services are expensive in Abuja, while in Enugu the hospital retained in 2006 charged very high and it was changed subsequently. Also in Enugu, the cost of hospital care for social mothers increased the total cost. On the qualitative findings, it was revealed that the International Organization for Migration (IOM) has provided financial support for the provision of health services to victims. UNICEF does provide drugs and other medical supply for children victims intermittently. The Nigerian Bar Association (Lagos Chapter) provides drugs for Lagos, and French Embassy has provided drugs and medical supply to Lagos and Abuja shelters once.

Analysis of average mean cost of medical services per victim over 3 years period, the average cost of medical services of N2, 681, 206.00 was used for the 527 victims that were housed in Abuja. This was on the high side when compared with the highest number of victims (705) in Lagos which cost N946, 208.00 with the cost of N1, 342.14 used in treating each victim. However, the average cost of treatment was very low in Benin where 412 were treated with N345, 100.000 with a cost of N837.62 per person. Table 7: Cost implication in the treatment of trafficked victim per year was very high in 2006 in Enugu State Nigeria, while victims in Sokoto State recorded the lowest cost implication. On the whole, caring for victims in Abuja was high through the three years period. (Fig 4)

Discussion of Findings

Trafficking in human beings, especially women and girls, is not new. Historically it has taken many forms, but in the context of globalization, has acquired shocking new dimensions. It is a complex, multi-faceted phenomenon involving multiple stakeholders at the institutional and commercial level. It is a demand-driven global business with a huge market for cheap labour and commercial sex confronting often insufficient or unexercised policy frameworks or trained personnel to prevent it. The magnitudes of the trafficked is not surprising, Nigeria has acquired a reputation for being one of the leading African countries in human trafficking with cross-border and internal trafficking as reported by the office of the US department to monitor and combat trafficking in persons (US, 2017 trafficking in person report). Trafficking of persons is the third largest crime after economic fraud and the drug trade. Decades of military regimes in Nigeria have led to the institutionalized violation of human rights and severe political, social and economic crises. This negatively impacts the development of community participation, especially of women and children, despite international institutions designed to advance their causes. (NAPTIP, 2016)

The age distribution across the zones is similar to the national picture with the age group 0 – 17 years accounting for the majority of identified victims except in Sokoto where 18 – 27 years dominate the identified victims. As seen in Figure 1, the high prevalence 32% of the trafficked victims for Lagos is not surprising as destinations for trafficked Nigerians include the neighboring West African countries (Côte d'Ivoire, Mali, Benin, Equatorial Guinea, Cameroon, Gabon and Guinea. Primarily, women and girls, but also boys, are trafficked for the purposes of sexual exploitation, forced labour and organ harvesting. Poverty is the principle driving force behind this trade, propelling vulnerable people into the hands of traffickers, who belong to both small scales, local enterprises with extensive criminal networks and to large scale multi-commodity businesses. (*Lydia*, 2014)

There is also an ignorance of the health dangers lying at the core of human trafficking. This is in line with a study on the plight of domestic workers in Lagos conducted by Banke in 2002. The study found that over half of the respondents were ignorant of HIV and AIDS and other sexually transmitted diseases, including prevention. Despite the recent increase in awareness-raising programmes about HIV and AIDS by the government, NGOs and international agencies, the curbing of the spread of the disease has been marginal due to the economic and socio-cultural factors already mentioned. (UNICEF Trafficking Information, 2010)

In terms of responsiveness of health services to the victims' health needs; though this study found out that all 28, 465 (100%) of the victims interviewed felt satisfied with the medical services being provided to them, however, it should be noted that the trafficked victims are just recovering from psychological trauma, and having been brutalized by the traffickers, any assistant provided to them was well appreciated and acceptable. According to Susie (2011), the average cost of treatment per trafficked victim was $25.00. In Nepal, the average cost of medicine for a victim with HIV was $3.00/day, yet most of trafficked victims were not able to afford to buy their medicine. One survivor reported that she received free care at a public facility, but most survivors explained that their traffickers charged them for the cost of their medical care and added the incurred debt to their overall debt burden.

According to a trafficker "My trafficker gave her money to pay the doctor and then added it to her balance."

The findings on the funding for health needs of trafficked victims was not surprising as different sources of funding for the care and insurance for the trafficked victims was not only from the government; other sources of fund for the victims include specific budgetary allocation by the Federal Government to NAPTIP 2016, Subsidy fund from National Health Insurance Scheme (NHIS), from surplus funds from the employed enrollee. Fund from NHIS to vulnerable groups including trafficked victims was established. Donations and contributions by development partners, e.g. IOM, UNICEF, projects in UNODC, ILO and donations and contributions by National Corporate bodies as part of their social responsibility, e.g. Communication companies, Oil & Gas companies, Financial Institutions and Donations/Contributions by National NGOs, e.g. First Lady's Foundation, Dangote Foundation, etc. This is similar to what is obtainable in other country where the costs associated with the care of human trafficking victims were not shouldered by the taxpayers alone but other cooperate bodies involvement. This approach resulted in large restitution awards for many Texas trafficking victims. (US Attorney's Office, 2010)

Conclusion

The victims of human trafficking need adequate comprehensive qualitative and accessible health care. The attainment of such services is a fundamental human right of the victim in accordance with section 17(3) of the 1999 Nigerian Constitution and Article 16 of Africa Charter on Human and Peoples Rights. That NAPTIP is currently providing health care services to victims but the quality of services is inadequate, not cost effective and not comprehensive. The health care available to victims could be more efficient and effective; giving that the current average cost of health care to victims is N2, 678 per victim. The current health care services are funded mainly from general budget allocation to NAPTIP as well as from the victims' trust fund. There is no specific fund allocation (or budget) for victims' health care.

Recommendations

In order to have a sustainable financing for the provision of comprehensive, qualitative and accessible health care to victims of human trafficking in Nigeria, it is necessary to recommend that

1. Separate fund be set aside for the health care of the victims. On the basis of data generated in this study, an estimated total of 2000 lives may be projected as beneficiaries of health insurance in the next two years. It is being proposed that a sum of N2, 000 be paid per person for 12 weeks of benefit.
2. The Board or NAPTIP should pay to NHIS the sum of N1, 000, 000 per quarter amounting to N4, 000, 000 in a year. This premium will make each victim to enjoy heath care package described above for a period of 12 weeks (from the date of registration).
3. The NHIS should subsidize any short fall in the amount required to ensure the provision of health care services needs of trafficked victims.

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Appendix

Table 1: Description of Sex Distribution of Victims

Year	Women 18 years +	Girls 0-17 years	Boys 0-17 years	Men 18 years +	Total
2004	44	12	17	-	73
2005	172	106	27	35	340
2006	202	128	18	15	363

2007	368	135	154	129	786
2008	327	400	73	61	861
Total	1,113	781	289	240	2,423

Table2: Victims of Trafficking Identified by State Authorities in Nigeria by Type of Exploitation

Year	Sexual Exploitation	Forced Labor	Total
2004	21	52	73
2005	116	225	341
2006	208	130	338
2007	366	628	994
2008	600	267	867
2009	520	980	1500
2010	789	1,111	1900
2011	347	563	910
Total	1,311	1,302	6,923

Table3: Victims of Trafficking Identified by Country of Citizenship (2005 – September 2008)

Country	No. of Victims
Nigeria	2,238
Benin Republic	229
Togo	62
Ghana	28
Guinea	6
Senegal	5
Cameroon	9
Mali	13
Burkina Faso	33
Another West and Central Africa	7
Total	**2,630**

NB: *The total number of persons by countries of origin is more than the total by sex. Reason for this is not provided in the report.*

Fig 1: Age Distribution of Identified Victims (2006-2008) in the 5 zones visited

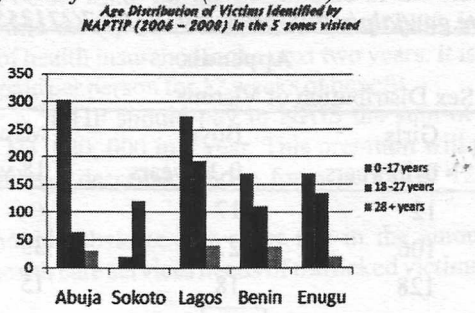


Fig 2: Gender Distribution of Identified Victims (2006 - 2008) in the 5 Zones Visited

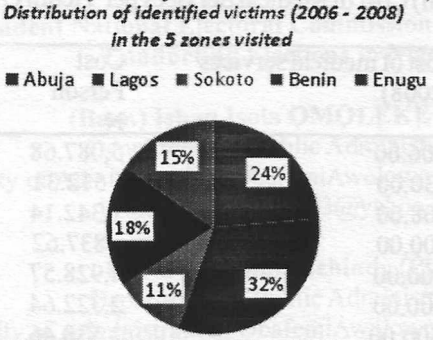


Fig 3: *Distribution of Identified Victims (2006 -2008) in the 5 Zones Visited*

Table 4: Number of Victims Present in the Shelters at the Time of Visit

Age/Zone	Abuja	Benin	Enugu**	Lagos	Sokoto	Total
Gender	M F	M F	M F	M F	M F	
0-17 yrs	2 9	- -	- 16	4 18	- 1	50
18-27 yrs	- 4	- 1	- 10	- 8	- -	23
18+yrs	- -	- -	- -	- -	- -	-
Total	2 13	- -	- 26	4 26	- 1	73

** *46 Social Mothers Were In The Clinic In Enugu Zone*

Table 5: Length of Stay of Victim in the Health Facilities

Zones	Length of Stay
Abuja	8 - 10 days
Sokoto	2 - 7 days
Lagos	7 - 8 days
Benin	10 - 14 days
Enugu	4 - 7 days

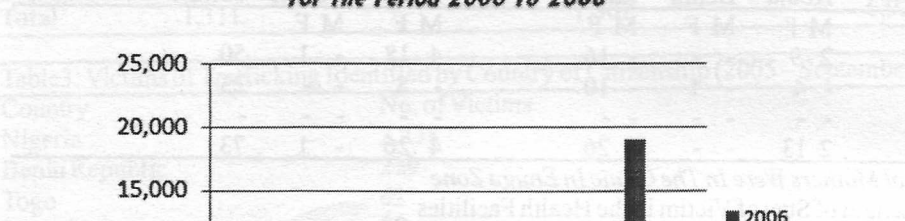
*In Enugu the period presented does not include that for social mothers who are pregnant women. They spend longer period of up to 12 weeks sometimes.

Table 6: Current Cost of Providing Medical Services to Identified Victims

Year/ Zones	Abuja	Sokoto	Lagos	Benin	Enugu	Total
	N	N	N	N	N	N
2006	234,350.00	6,220.00	258,650.00	92,020.00	400,000.00	991,240.00
2007	1,148,425.00	50,530.00	521,533.00	128,130.00	575,000.00	2,423,618.00
2008	1,298,431.00	65,180.00	166,025.00	124,950.00	715,500.00	2,370,086.00
Total	2,681,206.00	121,930.00	946,208.00	345,100.00	1,690,500.00	5,784,944.00

Table 7: Analysis of Average (Mean) Cost of Medical Services per Victim Over 3 Year

Zones	No. of Victims	Total Cost of medical services (2006-2008) ₦	Cost Person ₦	Pe
Abuja	527	2,681,206.00	5,087.68	
Sokoto	238	121,930.00	512.31	
Lagos	705	946,208.00	1,342.14	
Benin	412	345,100.00	837.62	
Enugu	343	1,690,500.00	4,928.57	
Kano	325	1,150,000.00	2,322.64	
Uyo	296	687,500.00	3,538.46	
Total	2,8465	7,622,444.00	2,678.30	



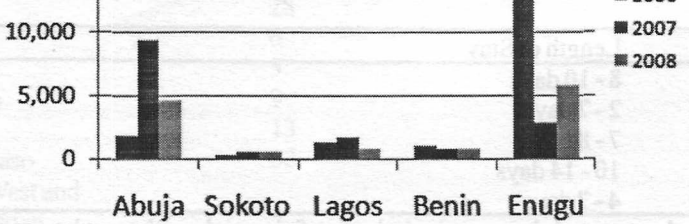


Fig 4: Trends in the Cost of Medical Treatment per Victim per Year for the Period 2006-2008