NATIONAL HIV/AIDS STIGMA REDUCTION STRATEGY

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NINERELA+
ASSOCIATION OF RELIGIOUS LEADERS LIVING WITH OR PERSONALLY AFFECTED BY HIV/AIDS

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National HIV/AIDS Stigma Reduction Strategy

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FOREWORD

In Nigeria, a lot progress has been made over the years in terms of the stigma associated with HIV/AIDS - from 1986 when the first case was recorded to date. This has been as a cumulative result of various activities ranging from awareness campaigns and other behavior change interventions to the benefits of treatment which have witnessed significant scale up within the last decade. Nevertheless, the HIV/AIDS response in Nigeria is still encumbered by stigma which may constitute a major threat to the gains and outstanding opportunities to end the epidemic. This underscores the importance of efforts geared at putting a robust *Stigma Reduction Strategy* in place which is critical to further expanding willingness to access various HIV/AIDS services and ultimately ending the epidemic by 2030.

It is a known fact that unless something is done urgently to end stigma or at least reduce it to the barest minimum, ending the epidemic might remain a mirage. With time, accessing HIV Counselling & Testing (HCT) as an entry point to detecting may decline if the issue of stigma reduction is not put in the front burner. Furthermore, even those who have known their status may not take their drugs freely and openly and this in turn poses danger to adherence which could increase the risk of drug resistance and switching of drug lines which, in the long run, could result to death.

The multi-sectoral efforts at ending the epidemic has built both institutional and human capacities for prevention, treatment, care and support over time, but it is still true that attitude toward persons living or affected by the disease leaves much to be desired. Evidence shows that progress has been made to increase awareness and knowledge about HIV/AIDS but stigma still persists. NARHS+ 2012 reported that stigma still existing at 5.2% -25.8%.

This document is seen as 'the midas touch' in dealing with the issue of stigma which may threaten our efforts at ending AIDS.

Dr Kayode Ogungbemi
Ag. Director General
National Agency for the Control of AIDS (NACA) *2016*

PREFACE

Most people living with or affected by HIV/AIDS in Nigeria have suffered one form of stigma or discrimination at either the community level, workplace, place of worship etc. There is no gainsaying that stigma and discrimination is the biggest battle people living or affected by HIV/AIDS must fight. It is the long term challenge of Orphans and vulnerable children and its accounts for over 50% of death among person living with HIV/AIDS.

The Anti-Discrimination Act 2014 as passed into law was intended to address stigma and discrimination related offences. This provision seeks to support a society free from HIV/AIDS Stigma and Discrimination. It is common knowledge that there are different levels of stigma among which are the issues of self- stigmatization, inaction and denial that are largely attributed to individualistic perception of the burden.

The design of this document strategically exposes stakeholders to different level of planning in an attempt to address issues relating to Stigma and Discrimination with particular emphasis on community level planning where the interplay of forces of attitudes and behaviors are major drivers of the syndrome.

The various chapters of the document are designed towards providing guidance to basic planning in the prevention and management of stigma and discrimination. A lot of work involving various stakeholders including Ministries, Departments & Agencies, Private Sector, Civil Society and International Partners has gone into providing key inputs into this strategy. It is recommended to all stakeholders involved in policy formulation and implementation alike

Dr Emmanuel Alhassan
Director, Partnerships Coordination & Support
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ACKNOWLEDGEMENTS

The Stigma Reduction Strategy development process, while it lasted, was an experience driven by immeasurable efforts by key stakeholders who undauntedly, defied all odds in giving their time and talents towards its actualization. Worthy of note was the enthusiasm and support from partners and donors who all have seen the urgent need for this very important document and key into it.

The unflinching support given by Christian Aid/UK-aid is not only worthy of mention but expected to be emulated by other donors. This work would not have been completed without the support of UNAIDS who in their wealth of expert and experience provided constructive input in the finalization process. The tenacity of the Network of Religious Leaders Living with or Personally Affected by HIV/AIDS (NINERELA+)' passion and zeal in seeing to the completion of this process is highly appreciated.

We appreciate the passion and contributions of the Consultant, Mr Solomon Adebayo, whose creative contributions and hard work had made this document a reality. The support and technical direction provided by Dr Chidi Nwaneka, along with Mrs Kemi Ladeinde, Dr Emmanuel Agogo, Mr Cyril Ojeonu, Miss Fatima Zanna, Mr. Roland Abah is worthy of mention.

We also recognize the efforts of our key stakeholders in this process - including: United Nation Development Program (UNDP), Christian Association of Nigeria (CAN), Nigeria Supreme Council for Islamic Affaires (NSCIA), International Labor Organization (ILO), Catholic Action Committee on AIDS (CACA), Nigeria Security and Civil Defence Corps (NSCDC), Health Initiatives for Safety and Stability in Africa (HIFASS), Nigeria Inter-Faith Action Committee on AIDS (NIFAA), Foundation for Community Health, Right and Development (FOCHRID), Journalist Against AIDS (JAAIDS), Access Bank, Ecobank, Institute of Human Virology Nigeria (IHVN), Association of Reproductive and Family Health (ARFH), the National Human Right Commission (NHRC), The Legal AID Council, The Nigerian Bar Association (NBA), Nigeria Police Force (NPF), Federal Road Safety Commission (FRSC), AIDS Prevention Initiative in Nigeria (APIN), Pathfinder International, Network of People Living with HIV/AID (NEPWHAN), Association of Women Living with HIV/AIDS (ASWHAN), Nigeria Youth Network on AIDS (NYNETHA), Education as a Vaccine against AIDS (EVA), Nigeria Labor Congress (NLC), Federal Ministry of Justice, Federal Ministry of Health, Federal Ministry of Education, Federal Ministry of Women Affairs, Nigeria Immigration service and Action-AID just to mention a few.

Mr Tobias John

Assistant Chief Program Officer, Partnerships Coordination & Support

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List of Abbreviations and Acronyms

ANC	Antenatal Care
ART	Anti-retroviral Therapy
BCC	Behavior Change Communication
CBOs	Community-based organizations
FBOs	Faith-based organizations
HCT	HIV Counselling and Testing
LGAs	Local Government Areas
LGBTI	Lesbian Gay Bisexual Transgender Intersex
MIPA	Meaningful Involvement of People Living with and Affected by HIV/AIDS:
NARHS	National HIV/AIDS and Reproductive Health Survey (NARHS)
NDHS	Nigerian Demographic Health Survey
NGOs	Non-Governmental Organization
NOA	National Orientation Agency
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
S&D	Stigma and Discrimination
SOPs,	Standard Operating Procedure
TBD	To be determined
WHO	World Health Organization

Executive Summary

The Nigerian HIV prevalence rate is declining however, stigma indices does not show corresponding decline. Drivers of the HIV epidemic include the structural, contextual and social factors, such as poverty, gender inequality, inequity and poor access to health care, as well as stigma and discrimination and other human rights violations. However, several positive actions have been taken to address stigma and discrimination issues in the country. These action include the passage of the HIV and AIDS (Anti-Discrimination) Act, 2014 with the main objective is to protect the rights and dignity of PLHIV by eliminating all forms of discrimination based on HIV status. Other actions include the domestication of religious principle and the law in several states in the country. Worrying however, is the occurrence of stigma and discrimination against people living with HIV especially at community level and in faith institutions.

The purpose of the HIV/AIDS Stigma Reduction Strategy is to align the efforts of various stakeholders especially in the area of prevention intervention in addressing HIV-related stigma and discrimination in their various health and non-health settings to bring about synergy. The strategy aims at guiding all HIV/AIDS stakeholders (non-governmental organizations, (NGOs), faith-based organizations (FBOs), civil society network, community-based organizations (CBOs), and the formal and informal private sectors) in addressing stigma and discrimination within their ranks, based on inbuilt comparative advantages in their core functions.

The goal of the strategy is to eliminate all forms of stigma and discrimination towards people living with and directly affected by HIV and AIDS in Nigeria by 2020.

The strategy has nine strategic objectives with each objective having several strategic actions.
The following are the Strategic Objectives:

1. To **s**trengthen the identification process of the behavioral, biomedical and structural drivers of HIV-related stigma and discrimination.
2. To promote stigma-related conflict resolution and access to justice.
3. To integrate S&D prevention activities into existing community-based programs for HIV/AIDS.
4. To strengthen the capacity of the media, art and entertainment industry to deliver HIV/AIDS-related stigma interventions.

5. To strengthen and support the implementation of faith-based strategies to reduce HIV/AIDS related stigma and discrimination.
6. To strengthen behavior change interventions for stigma reduction in institutions of learning across all levels of formal and informal educational institutions.
7. To eliminate Stigma and Discrimination in healthcare settings.
8. To increase meaningful involvement of PLHIV and PABA to address HIV and AIDS related stigma & discrimination.
9. To promote workplace policies on HIV and AIDS towards elimination stigma and discrimination.

Each of the strategic objectives has several expected outcome with define key intervention and corresponding indicators.

Chapter four describes the monitoring framework for the strategy.

CHAPTER ONE

1.0 Introduction and Background 1.1 Overview of the AIDS Epidemic in Nigeria

The first case of AIDS in Nigeria was reported in 1986 thus establishing the presence of the epidemic in the country. Consequently, and in line with WHO guidelines, the government adopted ANC sentinel surveillance as the system for assessing the epidemic. Between 1991 and 2001, Nigeria witnessed an increase in the prevalence of HIV in the country. The first HIV Sentinel Survey in 1991 showed a prevalence of 1.8%. Subsequent sentinel surveys produced prevalence rates of 3.8% (1993), 4.5% (1996), 5.4% (1999), 5.8% (2001), 5.0% (2003), 4.4% (2005), 4.6% (2008), 4.1 % (2010), and 3.7% (2014). The National HIV/AIDS and Reproductive Health Survey (NARHS) was adopted in 2003 to provide information on key HIV/AIDS and Reproductive Health knowledge and behavior-related issues. In 2007, the scope was expanded to include estimation of HIV prevalence in the country. A more comprehensive survey was conducted in 2012 (NARHS Plus II 2012) which showed a decline to 3.4% in HIV prevalence, indicating a reversal of the epidemic in the country, compared to the 2007 figure of 3.6%.

Nigeria's epidemic is generalized, with wide variation in prevalence within the country. An analysis of the 2012 NARHS prevalence data in the country's six geopolitical zones shows that the prevalence is highest in the South-South Zone (5.5%) while the lowest prevalence is in the South East Zone at 1.8%. There are also differences between urban and rural areas with prevalence figures in urban 3% and 4% in rural area. The pattern of distribution of HIV prevalence by sex showed that irrespective of sex disaggregation, the HIV prevalence pattern is the same across all selected background characteristics.

Socio-demographic differences in the HIV p r e v a l e n c e are also o b s e r v a b l e with women, youths, and people with low level of formal education being worst affected by the epidemic. NARHS plus 2012 showed an increase from 1.7% in 2007 to 2.9% in 2012 in the 1519 years age group while the prevalence for the age category (20-24years) for both years remain the same with a value of 3.2%.

The National Strategic Plan (NSP) 2010-2015 highlighted that 'stubborn persistence of HIV/AIDS-related stigma and discrimination also significantly contribute to the continuing spread of the infection'

The consequences of stigma and discrimination are wide-ranging, and these limit access to HIV testing, treatment uptakes and other access to other HIV services. HIV related stigma and discrimination do not only hinder the chances to prevention options- for early detection and treatment; it increases vulnerability to exposure and possibly death in most cases of concealments of HIV positive status.

CHAPTER TWO

2.0 Stigma situation in Nigeria

The world has struggled against the HIV and AIDS epidemic for the past three decades with persistent challenges requiring new approaches and strong Global commitment. Nonetheless, there has been a lot of progress: the global infection rate is beginning to decline, a growing number of people living with HIV now access antiretroviral therapy (ART), and fewer babies are being born with HIV thanks to the innovation of prevention of mother-to child transmission (PMTCT) and technologies. However, much more remains to be done as the number of newly infected people is still high especially among women and youth, key affected population (Men having Sex with Men, Female Sex Workers, People with Injectable Drugs) and many adults and children who require ART lack access to it. Moreover, PLHIV continue to face various forms of stigma, discrimination, denial and violations of their rights and dignity, which are barriers to the efforts to scale up access to comprehensive care, treatment, and support. Stigma and discrimination have become major stumbling blocks to HIV and AIDS mitigation programs as they discourage people from using HIV Testing Services (HTS) and keep those living with HIV from accessing ART.

Stigma and discrimination are manifested in many forms. The need for addressing HIV- and AIDS-related stigma and discrimination cannot be underestimated due to the above factors and their impact on individuals, families, workplace and the community at large.

Over the years, the Nigerian government, through its relevant agencies, has set up a multisectoral response approach to address the rising incidence of HIV and provide treatment options for the PLHIVs who require care and support services and most importantly to aggressively implement treatment as a prevention option. However, there is evidence from community surveys that stigma and discrimination is increasingly hindering uptake of HIV services in the country. One of these communities is the faith-based community. Their views, which are based on religious beliefs, constantly tint HIV/AIDS in negative light, projects poor knowledge and information about HIV/sexual and reproductive issues, includes poor male involvement and contribute to reducing the efforts and expected results set by the national response for the attainment of Universal Access by 2015.

In the last National Strategic Plan for HIV/AIDS (2010–2015) the development of antidiscrimination laws was considered a major strategy; measurement of success and indicator for the thematic area was the passing of appropriate legislation. Several development partners had worked considerably to address the issues of stigma and discrimination in the country. Most of these partners considered stigma as a major barrier to accessing services and collaborated with government and civil societies to get HIV anti-stigma laws passed at the federal and some states. Currently only 7 states have HIV anti-discrimination laws passed in the country (Kaduna, Nasarawa, Benue, Cross River, Enugu, Ogun and Lagos). In addition, there is limited concerted effort to incorporate HIV/AIDS campaign in the religious activities, which can serve as fulcrum to stop stigma and discrimination in our larger society.

2.1 Measurement of Stigma in Surveys

Many countries have used Composite Indexes from the general population surveys to measure stigma (NARHS, NDHS, etc.), other surveys have attempted to measure stigma within sectors (health, education, community, religion, etc.). These actually measure perceptions rather than actual acts, there is no clear picture of the actual magnitude of HIV stigma and discrimination, as persons with wrong attitudes may not result in actual acts of stigma, and persons with 'perceived' good attitudes may actually stigmatize and discriminate

2.2 Drivers of Stigma and Discrimination

A recent PLHIV Stigma Index survey was conducted to collect and examine HIV-related stigma experienced among PLHIV, explore its direct and indirect effects on individuals, they measure what percentage of PLHIV actually experienced Stigma and NOT the potential of people to discriminate. The study documents the following current stigma issues.

Current Stigma issues	Current position
Stigma still exists (5.2% –25.8%)	Although progress has been made to increase HIV/AIDS awareness and knowledge (as reported in the NARHS+
Persons who know their HIV status	

are mainly supportive but stigma still displayed by some (spouse 11%; employers 15%)	2012), findings indicate that stigma and discrimination against people living with HIV is still rampant at the community level and in faith institutions. Furthermore, the drivers of stigma and discrimination vary from one community to another and fueled by social norms, gender and power issues. Religious leaders and their disposition to HIV and AIDS exacerbated stigma, shame denial, and discrimination.
Most stigmatizing attitudes experienced in the home for females and at work for males	Pupils and education professionals often commit stigmatizing acts in the course of their routine activities or responsibilities. One case of the continued existence of HIV- and AIDS-related stigma and discrimination among professionals is the nature of the training that shaped their thinking from the primary school level upwards. There exist stigmatizing attitudes and practices within the health care settings and health care providers lack skills and tools necessary to ensure patients' rights to informed consent, confidentiality, treatment and nondiscrimination are upheld.
PLHIV not really seeking redress Still no confidence in the legal system and most do not want further exposure	The National policy on HIV has specific directives that address stigma and discrimination, but have not been fully implemented and utilized. Efforts are needed to reach out to policymakers at all levels to enforce utilization of the existing policy documents. States need to collaborate with other actors to implement anti-stigma interventions within their respective communities and cascade the implementation to the Local Government Areas (LGAs).

Disclosure of status is done to mainly health workers and spouses	Health care providers know about their own human rights to health (HIV prevention and treatment, universal precautions, compensation for work-related infection,
	etc.) however, fall short in non-discrimination practices in the context of HIV. There exist stigmatizing attitudes and practices within the health care settings and health care providers lack skills and tools necessary to ensure patients' rights to informed consent, confidentiality, treatment and non-discrimination are upheld.

2.3 Rationale for Stigma and Discrimination Strategy

If stigma and discrimination are not addressed appropriately, it will result in more people acquiring HIV as the recent findings have shown high incidence among women, youths, etc.

Widespread stigma and discrimination towards people living with HIV adversely affect people's willingness to take an HIV test and even access treatment in a close proximity and therefore increase financial burden resulted. If people do not know their sero-status, the chances of those who are HIV positive being re-infected and infecting others increases. Therefore, addressing the epidemic through this Stigma and Discrimination Reduction Strategy is an appropriate approach to 'getting to zero stigma' and attainment of END HIV/AIDS EPIDEMIC by 2030.

The **purpose** of the *HIV/AIDS Stigma Reduction Strategy* is to align the efforts of various stakeholders in addressing HIV-related stigma and discrimination in their various health and non-health settings to bring about synergy. The strategy aims at guiding all HIV/AIDS stakeholders (nongovernmental organizations, (NGOs), faith-based organizations (FBOs), civil society network, community-based organizations (CBOs), and the formal and informal private sectors) in addressing stigma and discrimination within their ranks, based on inbuilt comparative advantages in their core functions and ensure all contributes by actions which will impact positively on larger society to drop stigma and discrimination acts. This document is also the basis for the advocacy to strengthen the provisions of HIV rights, stigma, and discrimination in the National Strategic Framework.

2.4 Development of the Strategy

The strategy builds on nearly three decades of Nigeria's efforts to address and cope with the HIV/AIDS epidemic. It borrows from the experiences gained in establishing an enabling environment for HIV prevention, testing services, care, treatment, and support, and impact mitigation. The strategy is based on review of available literature, situational assessments, and consultative interactions towards broadening the stakeholders' involvement.

CHAPTER THREE

STRATEGIC PLAN FOR HIV STIGMA REDUCTION

3.1 Goal

The goal is to eliminate all forms of stigma and discrimination towards people living with and directly affected by HIV and AIDS in Nigeria by 2020.

3.2 Strategic Objectives

3.2.1 Strategic Objectives1: *To **s**trengthen the identification process of the behavioral, biomedical and structural drivers of HIV-related stigma and discrimination*

Justification

In addressing any issue, identification of the root causes is usually the pathway to addressing the issue. Therefore identifying the behavioral biomedical and structural drivers of stigma and discrimination is the first step in addressing the problem. One of the objectives of the HIV and AIDS (Anti-Discrimination) Act, 2014 (Act No.7) is to protect the rights and dignity of PLHIV by eliminating all forms of discrimination based on HIV status (Objective 1)**.** Although progress has been made to increase HIV/AIDS awareness and knowledge (as reported in the NARHS+ 2012), findings indicate that stigma and discrimination against people living with HIV is still rampant at various levels including those at health and education settings. Furthermore, the drivers of stigma and discrimination vary from one community to another. Therefore, significant reductions in stigma and discrimination can be realized only if a process is put in place to identify community-specific behavioral, biomedical and structural drivers.

Strategic Actions

- Promote the identification of behavioral, biomedical and structural drivers of HIV-related stigma and discrimination.
- Scale up interventions to address drivers of HIV-related stigma and discrimination.
- Scale up intervention to reduce self- and institutional-based stigma and discrimination.
- Scale up educational platform on which the larger society knowledge can be broaden on HIV/AIDS associated activities.

Expected Outcome

- Well-targeted programs and interventions to address identified community-specific stigma drivers and increased knowledge and social behavioral communication changes of general population.

Table 1: Strategic key Intervention and indicators

Key Intervention	***Outcome Indicators***
Conduct survey on behavioral, biomedical and structural drivers of HIV/AIDS-related stigma and discrimination at all levels, including how compounded stigma affect uptake of HIV services.	Well-targeted programs and intervention to address identified communityspecific stigma drivers
Measure HIV-related stigma through the People Living with HIV Stigma Index, including in health care settings and in communities.	
Establish and institutionalize stigma and discrimination tracking systems at all levels	Documented evidence to show performance and result of stigma/discrimination related issues.

3.2.2 Strategic Objective 2: To promote stigma-related conflict resolution and access to justice.

Justification

Lack of reporting and conflict resolution mechanisms contribute to the perpetuation of stigma and discrimination. It would be useful to leverage on existing conflict resolution mechanisms within communities (village, religious community, workplace, hospitals, etc.) to confront stigma and promote dialogue between those who are stigmatized and those who stigmatize, and the community at large. If these conflict resolution mechanisms fail to solve the issues, recourse to

court systems should be made easily accessible. The HIV and AIDS (Anti-discrimination) Act, 2014 prohibits discrimination on the basis of real or perceived HIV status. However, for this piece of legislation to contribute to ending discrimination related to HIV, people need to be aware of its provisions and have the means for enforcing its provisions.

Strategic Actions

1. Improve awareness of HIV/AIDS-related laws and human rights, both among those who are likely to be discriminated against, those who are likely to discriminate, as well as among those who are likely to implement and enforce its provisions;
2. Promote access to justice, including through community-based conflict resolution to end HIV-related stigma and discrimination, speedy justice and legal aid; and
3. Support passage of legislation prohibiting HIV-related discrimination in states.

Expected outcomes

- Increased involvement and participation of communities and other actors to develop and implement their own plans to reduce stigma and discrimination based on the harmonized policies, laws, guidelines etc.
- Increased utilization of National HIV/AIDS documents, policies and laws on Stigma and Discrimination among stakeholders.

Table 2: Strategic Intervention and indicators

Key Interventions	***Outcome indicators***
Monitor and review laws, regulations and policies relating to HIV.	• PLWHA and PABA are able to seek redress based on the policies and laws from stigma and discrimination issues. • Improve legal awareness of HIV/AIDS stigma and discrimination.
Promote legal literacy (‘Know your laws, know your rights’ campaigns).	
Advocate for the passage of Anti-Stigma and Discrimination Act in all states	
Promote access to justice.	

3.2.3 Strategic Objective 3: *To integrate Stigma and Discrimination prevention activities into existing community-based programs for HIV/AIDS*

Justification

A community-based anti-stigma and discrimination intervention strategy is needed to reduce stigma and discrimination at various community levels.

This strategy will include establishment of a mechanism for early identification of both direct and indirect tendencies and causes of stigma and discrimination. The strategy will focus on empowering households and the communities with information to understand the underlying factors that promote stigma and discrimination, and instill in them a positive attitude towards people living with HIV and affected by HIV. The focus will include addressing social norms, gender and power issues with associated impact on other vulnerability issues like orphaned children and people with disabilities

Strategic Actions

- Build on and scale up existing community-based HIV/AIDS programs.
- Promote S&D prevention activities for community actors/influencers.

Expected outcomes

- Reduced social norms, gender and power issues that propagate stigma and discrimination.
- Increased participation by community based actors/influencers actively in addressing a wide range of Stigma and Discrimination issues

Table 3: Strategic Intervention and indicators

Key Interventions	***Outcome indicator***
Promote community-based HIV/AIDS anti-stigma and discrimination interventions.	Reduced stigma and discrimination at community level.

3.2.4 Strategic Objectives 4: *To strengthen the capacity of the media, art and entertainment industry to deliver HIV/AIDS-related stigma interventions*

Justification

Media stakeholders provide the quickest channels for communicating with a larger number of people at a reasonable cost. Several reports and information regarding HIV/AIDS-related stigma and discrimination have been disseminated through the various media channels. However, some of this information, due to ignorance or misperceptions among reporters, has resulted in increasing rather than reducing stigma and discrimination. Media stakeholders have a role in informing communities on various development issues—hence, the need to create trust between communities and the media houses. Media stakeholders must understand that the masses trust them to provide correct information in a rational and stigma-free manner. To prevent derogatory and dehumanizing coverage, it is important to impart accurate knowledge to artists and reporters in collaboration with relevant institutions.

Strategic Actions

- Promote the Anti-stigma and discrimination Act.
- Build partnership with Federal and State ministries of Information, NOA and other relevant government agencies to address cases of S&D and inform citizens of their rights on S&D.
- Build partnership with the media on whistle blowing in cases of S&D and inform citizens of their rights on S&D.
- Promote and scale up core education on HIV/AIDS, S&D to the media, art and entertainment industry.
- Build partnership with rights groups and the Human Rights Commission to ensure S&D Act is enforced.
- Promote S&D reduction through BCC, awareness and sensitization.

Expected outcomes

- Greater involvement and participation of media groups and organization to inform and provide accurate information on HIV/AIDS-related stigma and discrimination cases
- Better informed and positively influenced general population through participation for improved care for and support people living with and directly affected by HIV

Table 4: Strategic Intervention 4 and indicators

Key Interventions	***Outcome indicator***
Develop entertainment designed to educate as well as to be used by performing artists and musicians visual/ literary artists.	Increased awareness by the general population on measures to reduce S&D.
Collaborate and promote partnership with relevant Media, Art and entertainment groups, and relevant government agencies to create awareness on stigma reduction.	

3.2.5 Strategic Objective 5: To *strengthen and support the implementation of faith-based strategies to reduce HIV/AIDS related stigma and discrimination*

Justification

Religious leaders are key targets in the fight for reduction of Stigma and Discrimination, because of the roles they play in the communities they serve. Their roles are unique and touch on all spheres of life. Religious leaders have moral authority in the community. They play a major role in determining the direction taken by the community, they are considered to be role models and their actions and deeds are regarded highly. Religious leaders have a unique catalytic role to play in addressing stigma, shame, denial and discrimination within communities. They can influence a community's response. Religion is full of hope for humanity, especially for the ones who are suffering in the community. This can be translated into action to support those infected and affected by HIV and AIDS. In carrying out all these roles; not only are religious leaders well placed to address HIV and AIDS related stigma, shame, denial, and discrimination but they also have the mandate and the responsibility to overcome these issues especially with their ability to access government, policy makers, partner-donors and other philanthropist in the society.

Strategic Actions

- Reconstitute the National Faith Based Action Coalition on AIDS (NFACA).
- Recognize NIREC and Nigeria Inter-Faith Action Association (NIFAA).
- Strengthen linkages with different religion.

- Build partnerships with cultural/religious leaders to address socio-cultural and religious drivers of S&D.
- Strengthen capacity of faith based leaders and institutions to respond to HIV/AIDS related S & D.
- Promote behavior change communication through faith-based interventions for elimination of S & D.
- Establish/initiate mobilization of internal funding for HIV and AIDS stigma and discrimination elimination in faith based settings.
- Involve the Faith Based organization in national dialogue, implementation and provision of services ranging from prevention to support using different platform (both formal and informal sectors).

Expected Outcomes

- Increased self-initiated HIV/AIDS-related stigma and discrimination interventions by Faith Groups.
- Improved capacity of religious leaders and institutions to address HIV stigma and discrimination.
- Improved engagement of Faith Leaders at planning, implementation and evaluation of HIV/AIDS services.

Table 5: Strategic Intervention and indicator

Key Intervention	***Outcome Indicator***
Develop linkages with faith based coordination structures.	Better informed and positively influenced general population through participation of Religious Leaders to care for and support people living with and directly affected by HIV

• Build partnerships with cultural/religious leaders to address socio-cultural and religious drivers of S&D. • Build capacity of FaithBased Organisations for proper engagement of faith leaders on HIV/AIDS-related stigma and discrimination interventions.	on how to deal with HIV and AIDS related stigma and discrimination.

***3.2.6 Strategic Objective 6: To** strengthen behavior change interventions for stigma reduction in institutions of learning across all levels of formal and informal educational institutions*

Justification

Many members of the society commit acts of stigma and discrimination against people living with, suspected to be living with, or affected by HIV and AIDS. Pupils and education professionals often commit these acts in the course of their routine activities or responsibilities. One cause of the continued existence of HIV- and AIDS-related stigma and discrimination among professionals is the nature of the training that shaped their thinking from the primary school level upwards. Many of the curricula used to train professionals are not conscious of the negative consequences of stigma and discrimination. This knowledge needs to be inculcated in students beginning early in their training. The need to include HIV related knowledge and awareness in the schools at all levels is therefore key and very important.

Strategic Actions

- Promote BCC intervention such as Peer education, community dialogue, mentoring programs and anti-stigma champions to eliminate S&D.
- Strengthen Behavior change communication programs on awareness creation activities of

the Act in formal and informal educational institutions.

- Promote edutainment and sport programs including to eliminate S&D.
- Mainstream and strengthen S&D elimination in curriculum and modules in institutions of learning at all levels.
- Promote community conversation and dialogues for elimination of S&D in formal and informal educational institutions**.**

Expected outcome

 Reduced HIV/AIDS-related stigma and discrimination in formal and informal institutions.

Table 6: Strategic Intervention 6 and indicators

Key Interventions	***Outcome Indicator***
Support the inclusions of HIV/AIDS stigma reduction information in the curricula of all institutions.	Revised institutional curricula that reflect anti stigma components.
Sensitize and create awareness among informal institutions on S&D interventions.	Increased awareness within the informal education setting.

3.2.7 Strategic Objective 7: *To eliminate Stigma and Discrimination in healthcare settings*

Justification

Integrating stigma reduction interventions into current programs may not necessarily require a new set of activities or necessitate using additional funds to create stand-alone programs for stigma reduction. Introducing stigma reduction strategy will include using existing resources to support its scale-up, integrating stigma reduction into existing HIV programs to ensure sustainability, and engaging key stakeholders to broaden its impact. In a few exceptional circumstances, stand-alone stigma reduction activities may be necessary, such as in campaigns targeting the most vulnerable children and young people in healthcare.

There is need for human rights and ethics training for health care providers focusing on two objectives. The first being to ensure that health care providers know about their own human rights to health (HIV prevention and treatment, universal precautions, compensation for workrelated infection etc.) and to non-discrimination in the context of HIV. The second is to reduce stigmatizing attitudes and practices in health care settings and to provide health care providers with the skills and tools necessary to ensure patients' rights to informed consent, confidentiality, treatment and non-discrimination are upheld.

Strategic Actions

- Raise awareness of stigma and discrimination, including awareness of rights in the context of HIV, as well as the negative impact of stigma and discrimination on clients, PLHIV, PABA, etc.
- Strengthen mechanisms for enforcement of health workers codes of conduct
- Ensure that health care institutions provide the information and support necessary to make sure health care workers have access to HIV prevention (including the universal precautions needed for prevention of occupational transmission of HIV and PeP), as well as access to treatment and that they are protected from discrimination in their workplaces.
- Support the definition of patients' rights and obligations charters to be displayed in health care settings.

Expected outcome

- Eliminate Negative and biased attitudes among the healthcare providers towards people living with HIV and key populations are changed positively

Table 7: Strategic Objectives and indicators.

Key Intervention	***Outcome Indictor***
Review and support the implementation of code of conduct for health workers in addressing S&D.	Reduced stigmatizing attitudes and practices among health care providers.
Create awareness on the rights of PLHIV, PABA, clients, etc. on stigma and discrimination in the context of HIV within the healthcare setting.	
Strengthen mechanisms for enforcement of health workers codes of conduct.	
Support health care institutions provision of information and support necessary to make sure health care workers have access to HIV prevention (including the universal precautions needed for prevention of occupational transmission of HIV and PeP).	
Promote patients' rights and obligations charters in health care settings.	

3.2.8 Strategic Objectives 8: To increase meaningful involvement of PLHIV and PABA to address HIV and AIDS related Stigma & Discrimination

Justification

There is a need for the entire population to be reached with high-quality and sustainable services for HIV and AIDS prevention, care, and treatment, and impact mitigation. It is also important to adopt general strategic objectives aimed at reducing the risk of infection among the general

populations. There is need to ensure the active involvement of PLHIV and affected by HIV/AIDS in addressing and programming for the reduction of S&D

Strategic Actions

- Strengthen participation of PLHIV and gender representatives in all aspects of HIV policy, program design and implementation of HIV service delivery (meaningful involvement of people living with and affected by HIV/AIDS: MIPA).
- Advocate for affirmative action to support vulnerable PLHIV to benefit from programs including social protection.

Expected outcome

- Improved environment in engagement of PLHIV and key populations in overcoming Stigma and Discrimination.

Table 8: Strategic Intervention and indicators.

Key Intervention	***Outcome Indicator***
Develop affirmative action protocol on meaningful involvement of people living with and affected by HIV/AIDS (MIPA) in the delivery of HIV-related services.	Empowered PLHIV and PABA able to engage and handle effectively S&D issues.
Promote Peer mobilization and enhance support groups.	

3.2.2 Strategic Objective 9: To promote workplace policies on HIV and AIDS towards elimination stigma and discrimination

Justification

The National workplace policy on HIV has specific directives that address stigma and discrimination, but have not been fully implemented and utilized. Efforts are needed to reach out

to organizations and policymakers at all levels to enforce utilization of the existing workplace policy document. As part of these efforts, interventions can include advocacy and capacity building for all the relevant stakeholders such as employee, employers, policymakers, community gate keepers/leaders, faith leaders, traditional rulers, PLHIV groups, etc. and implementing partners to enhance their understanding of the issues outlined in the policy documents and the role they can play in putting such documents into action through their various leadership positions. An effective, comprehensive anti-stigma plan will link-up with other programs to accomplish the following:

1. Improve legal awareness of HIV/AIDS stigma and discrimination at workplaces;
2. Support the implementation of all components of S&D in national/state HIV workplace policy; and
3. Strengthen the capacity of state actors to deal with the issues of HIV discrimination.

Strategic Actions

- Support domestication of National HIV/AIDS workplace Policy in all sectors and at all levels.
- Promote the implementation of workplace policies at the public and private sectors at all levels.
- Build partnership with employers, employees, unions, associations etc. at all levels in the implementation of workplace policy.
- Support the implementation of all components of S&D in all sectors and at all levels.

Expected outcomes

- Increased involvement and participation of employees, employers and other actors to develop and implement their own plans to reduce stigma and discrimination based on the workplace policies.
- Increased utilization of HIV/AIDS workplace policies on S&D among stakeholders.

Table 9: Strategic Intervention and indicators

Key Interventions	***Outcome indicators***
Develop and support the implementation of HIV workplace policies and programs with a strong focus on employment related stigma.	• Reduced S&D in the workplaces • Workplace free from HIV and AIDS related Stigma and discriminated cases.
Support litigation against HIV related discrimination in employment.	
Promote stigma and discrimination reduction intervention in workplace including awareness creation on HIV/AIDS Workplace policies and anti-stigma law.	
Build capacity of labor inspectors and labor judges on HIV and AIDS S&D issues.	

CHAPTER FOUR

4.0 Monitoring Framework

Strategic Objective	Indicator	Baseline (2015)	Target (2020)	Date Source	Frequency of Collection
To strengthen the identification process of the behavioral, biomedical and structural drivers of HIV-related stigma and discrimination.	• Number of Surveys conducted • Number of community-specific (behavioral, biomedical and structural) drivers identified. • Developed tracking tools and level of utilization. • No of stigma index surveys done.	**0** **TBD** **TBD** **1**	**2** **TBD** **TBD** **5**	**NDHS/NARHS** **Report document** **Report document** **Stigma index survey**	**Every five years** **TBD** **TBD** **Annually**
To promote stigma-related conflict resolution and access to justice.	• Number of documents identified to be addressing S&D related to HIV/AIDS. • Number of stakeholders' integrating/mainstreaming S&D prevention into the implementation of their activities. • No of campaign materials produced. • No of actual campaigns	**10** **TBD** **TBD**	**37** at least 80% from baseline at least 80% from	**Report document**	**TBD** **TBD** **TBD**

	conducted. • No of people reached by the campaign. • No of telephone hotlines created. • No of states with S&D laws • No of state parliamentarians sensitized on HIV. • No of cases/disputes resolved both through community-conflict resolution mechanism and through legal systems. • No of cases receiving legal advice and representation. • No of materials produced for legal information and referrals. • No of lawyers, judges and law enforcement agents trained.	**TBD** **TBD** **TBD** **TBD** **TBD** **TBD** **TBD** **TBD**	baseline at least 80% from baseline at least 80% from baseline		**TBD** **TBD** **TBD**

To integrate S&D prevention activities into existing community-based programs for HIV/AIDS.	Number of community level programs with active S&D prevention components.	**TBD**	at least 80% from baseline	**Report document**	**TBD**

To strengthen the capacity of the media, art and entertainment industry to deliver HIV/AIDS-related stigma interventions.	• Number of packages developed. • Number of MOU signed. • No of programs/shows integrating nonstigmatizing messages.	**TBD** **TBD** **TBD**	at least 80% from baseline	**Report document**	**TBD** **TBD** **TBD**
To *strengthen and support the implementation of faith-based strategies to reduce HIV/AIDS related stigma and discrimination.*	• Number of linkages established • Number of plans developed. • Number of people trained and engaged to support provision of services.	**TBD**	at least 80% from baseline	**Report document**	**TBD** **Annually** **TBD**
To strengthen behavior change interventions for stigma reduction in institutions of learning across all levels of formal and informal educational institutions.	• Number of institutions implementing curriculum that reflect inclusion of HIV anti-stigma components. • Number of informal institutions sensitized.	**TBD** **TBD**	at least 80% from baseline	**Report document**	**TBD** **TBD**

To eliminate	• Number of health	**TBD**	at least		**TBD**

Stigma and Discrimination in healthcare settings.	• institutions implementing code of conduct. No of health care providers who went through stigma and discrimination • awareness session per year. • No of cases reported and received redress. No of health care institutions with universal • precautions. No of health care institutions with protocol for occupational exposure • to HIV. No of health care institutions with workplace policies that include non-discrimination on the basis • of HIV status. No of health care institutions that display 'Patients' rights and obligations Charter' on their premises.	**TBD** **TBD** **TBD** **TBD** **TBD** **TBD**	80% from baseline	**Report document**	

To increase meaningful	• Number of protocols developed.	**TBD**	at least 80%	**Report document**	**TBD**

involvement of PLHIV and PABA to address HIV and AIDS related Stigma & Discrimination.	• No of active support groups in states/LGAs. • No of general outreach programs conducted by these support groups on annual basis.	**TBD** **TBD**	from baseline		
To promote workplace policies on HIV and AIDS towards elimination stigma and discrimination.	• Number of documents identified to be addressing S&D related to HIV/AIDS. • Number of organizations integrating/mainstreaming S&D prevention into the workplace implementation plan. • No of ligation held • No of campaigns organized to create awareness on workplace policies. • Number of labor inspectors and judges trained.	**TBD** **TBD** **TBD** **TBD**	at least 80% from baseline	**Report document**	**TBD**

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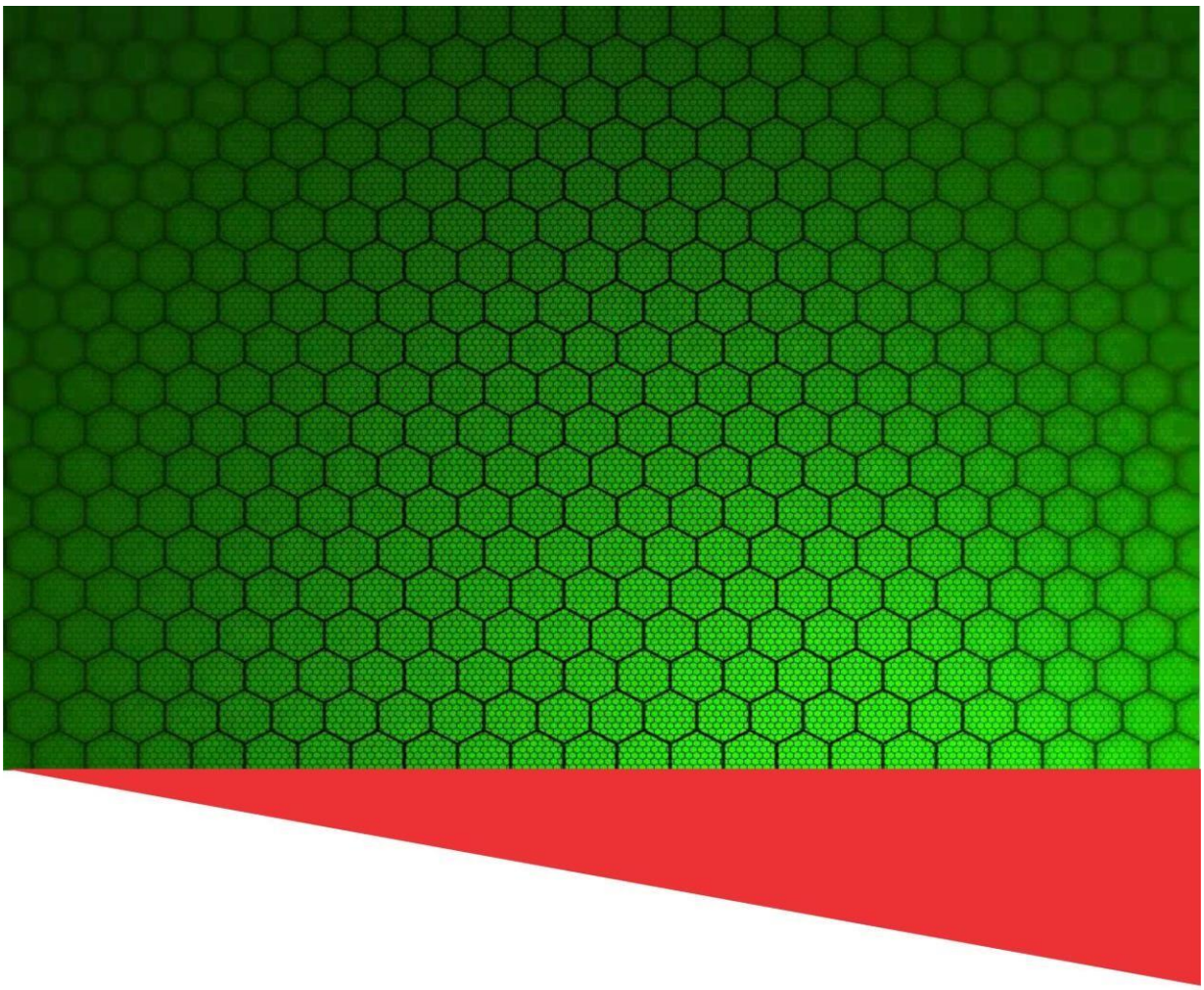

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