NATIONAL AGENCY FOR THE CONTROL OF AIDS
NACA

Report of the Gender Assessment of the HIV Response in Nigeria

2022

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"I applaud Member States' commitment to reform laws and protect rights. The evidence shows that when laws are strengthened to support gender equality and the rights of key populations and confront stigmatisation, countries have much greater success in treatment and prevention programmes, benefiting everyone. They've rolled back HIV. We need to keep moving forward in our common journey, away from harmful, punitive, outdated often colonial laws and from all forms of discrimination. Epidemics magnify our worst traits—inequalities, injustices, and fear; but also, our best traits—ingenuity, resilience, and courage. I'm confident we will win, together."

-Opening remarks by UNAIDS Executive Director,
Winnie Byanyima
at the High-Level Meeting on AIDS, 8th June 2021

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FOREWORD

The HIV prevalence among adults 15-49 years is 1.4% (1.9% females to 0.9% males and 1.9% females to 1.1% males ages 15-64 years). Furthermore, the HIV prevalence gender disparity between females and males was greatest among younger adults, with females age 20-24years (1.3%) having almost 4 times the prevalence of males in the same age group (0.4%) NAIIS, 2018.

This, amongst other statistics contribute to persisting evidences which reveal that advancing gender equality, Sexual and Reproductive Health and Rights (SRHR) is key to ending the HIV epidemic as a public health threat by 2030. In Nigeria, it has been acknowledged that women, girls, HIV key and vulnerable populations face multiple, intersecting and shifting socio-cultural, economic, environmental and health challenges all through their life cycles. Thus, it is imperative that interventions geared towards bridging gender equality gaps in the national HIV and AIDS response be subjected to continuous assessment to the extent to which the national HIV/AIDS response consider gender disparity. The National Agency for the Control of AIDS (NACA) collaborated with the Federal Ministry of Women Affairs, UNAIDS and the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) to conduct this 2021 Assessment.

The 2021 Gender Assessment of the HIV and AIDS Response in the Federal Republic of Nigeria evaluated available information, providing a condensed report of the country's HIV epidemic, context, and response from a gender perspective. Furthermore, the assessment afforded several gender-responsive and gender-transformative recommendations and standard interventions to address key gendered- breaches pertaining to HIV & AIDS treatment and community care and support services; thereby encouraging allocation of resources towards a sustainable and revolutionary HIV response.

We recommend that the information in this 2021 Gender Assessment Report be deployed for national policy decision by government institutions, decision-makers and programme leaders from varied sectors: comprising of, but not limited to employment, child protection, adolescents and young people, health, education, justice and labour; local governments; professionals; Civil Society Organizations (CSOs), including girls, women and youth groups; as well as partners and donors working on HIV, gender equality, health, sexual and reproductive health and rights (SRHR), and human rights, as it provides robust evidence to guide gender responsive interventions towards the achievement of a gender transformative HIV and AIDS response in Nigeria.

Dame Paullen Tallen OFR KSG
Minister of Women Affairs

PREFACE

In Nigeria, girls and women are disproportionately burdened by HIV. The most recent data available from UNAIDS: - AIDS info, 2021- shows that HIV prevalence among adult women aged 15 to 49 years (1.6%) is considerably higher than of men at 1.0%. Furthermore, in 2020, women accounted for 62% of new HIV infections among adults in the country while more women than men are retained in HIV care and have higher viral suppression rates.

The National Agency for the Control of AIDS (NACA) with support from UNAIDS Country Office (UCO) in Nigeria and the Joint UN Team on AIDS conducted the first Gender Assessment of the HIV response in 2013. Its findings and recommendations facilitated the development of evidence-based priorities to achieve a gender transformative, equitable and rights-based approach in the response.

To ensure a sustained gender response in HIV/AIDS programming, a second gender assessment was conducted in 2021 with support from UNAIDS and the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women). This national assessment is aimed at providing a comprehensive and in-depth review of the gender equity and inclusion dimensions of the national HIV epidemic and the national policy and programmatic response, as well as making evidence-based recommendations that can and should be implemented.

The Gender Assessment of the HIV Response in the Federal Republic of Nigeria was guided by the UNAIDS Gender Assessment Tool which was adapted to fit the local context. A steering committee was constituted to secure high level commitment of all relevant stakeholders in the national HIV and AIDS response. The process involved rigorous qualitative data collection and collation in six (6) States plus the Federal Capital Territory. The qualitative data was analysed to better understand entrenched gender inequalities and to further provide clarity on the available quantitative data gathered from the comprehensive up-to-date secondary information on the national HIV epidemic and the HIV response. The findings were utilized to generate evidence-based recommendations and develop action plans for a more gender responsive national and multi sectoral HIV response.

I am therefore delighted to present the report of the 2021 Gender Assessment of the Nigerian HIV Response and hope that the information in it will facilitate advancing gender equality, sexual, reproductive health and rights (SRHR) towards ending the AIDS epidemic as a public health threat by 2030.

Gambo Aliyu, MBBS, PhD
Director General, (NACA

ACKNOWLEDGEMENTS

Gender responsiveness is critical and key to achieving desired outcomes in programming. Periodic assessment of gender management systems, programmes and outcomes will further enable gender equality and improve results geared towards the achievement of the global targets of ending AIDS by 2030. It is against this background that the National Agency for the Control of AIDS (NACA) collaborated with the Federal Ministry of Women Affairs and with support from UNAIDS and the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) to conduct the second Gender Assessment of the National HIV/AIDS response in Nigeria in 2021. Many institutions and individuals contributed to the timely success of the assessment.

I sincerely recognise the effort of the coordinating team for the second Gender Assessment of the national HIV/AIDs response in Nigeria ably led by Dr. Yinka Falola-Anoemuah, the Deputy Director, Gender Human Rights and Cares Services NACA and the GHRCSS team. I want to communicate our immense gratitude to the consultants- Dr Maria Nyikuri (International), Dr. Izeduwa Derex-Briggs (national lead consultant) and the three national co-consultants- Dr Ejiro Otive-Igbuzor, Dr Bisayo Odetoyinbo and Mr Jacob Awolaja. We appreciate your tenacity and professionalism that cumulated in the delivery of this report.

The technical guidance, contributions and the support by the core team, the Gender Assessment Team (GAT) and all the partner institutions at all the technical meetings which were physical, virtual and hybrid made the assessment the success it is. Worthy of special note is the effort of officers of UNAIDS & UN Women global, in-country offices and Technical Support Mechanism (TSM) who worked with us on the project, particularly Rupa Bhadra, Gabriel Undelikwo, Sam Anya, Doris Ogbang, Patience Ekeoba, Nazneen Damji and Elena Kudravtseva.

The insights provided by various organization leads during interviews are well appreciated. We also appreciate the efforts of the zonal representatives and staff of SACA of the six (6) States who participated in the assessment including Akwa-Ibom, Anambra, Benue, Lagos, Taraba, Kano States and FCT.

To the community members, especially women, men, youths, adolescents, key population members including transgender and people with disability who were bold enough to share their experiences during the qualitative sessions, we say a big thank you.

Finally, the efforts of the staff of the Gender, Human Rights and Care Support Services (GHRCSS) Division of the Community Prevention and Care Services (CPCS) Department of NACA is worthy of mention here.

I believe this effort by all is worthy of the great results which would be deployed appropriately for use towards a more gender transformative national HIV/AIDS response in Nigeria

Alex Ogundipe, B. Pharm, MPH
Director, Community Prevention and Care Services, NACA

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ABBREVIATIONS

ABYM	Adolescent Boys and Young Men
AGYW	Adolescent Girls and Young Women
AHD	Advanced HIV Disease
AIDS	Acquired Immunodeficiency Syndrome
APYN	Association of Positive Youths Living with HIV in Nigeria
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASWHAN	Association of Women Living with HIV and AIDS in Nigeria
cART	Combination Antiretroviral Therapy
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHW	Community Health Worker
CP	Concurrent Partnerships
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organizations
DBS	Dried Blood Spots
DFID	Department for International Development
EID	Early Infant Diagnosis
ELISA	Enzyme-Linked Immunosorbent Assay
ENR	Enhancing National Response
FBO	Faith Based Organizations
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FMoH	Federal Ministry of Health
FP	Family Planning
FWSS	Females Who Sell Sex
GA	Gender Assessment
GAM	UNAIDS Global AIDS Monitoring
GAT	UNAIDS Gender Assessment Tool
GBV	Gender-Based Violence
GBVI	Gender-Based Violence Initiative
GDI	Gender Development Index
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HCT	HIV Counselling and Testing
HCW	Health Care Worker
HDI	Human Development Index
HEAP	HIV/AIDS Emergency Action Plan
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSHSP	Health Sector HIV and AIDS Strategic Plan
HTC	HIV Testing and Counselling
HTS	HIV Testing Service
ICPD	International Conference on Population and Development
IEC	Information, Education, Communication
ILO	International Labor Organization
IP	Implementing Partner
IPV	Intimate Partner Violence
IRC	International Rescue Committee
KII	Key Informant Interviews
KVP	Key and Vulnerable Populations
KP	Key Populations
LACA	Local Agency for the Control of AIDS
LDTD	Long Distance Truck Drivers
LGA	Local Government Authorities

M&E	Monitoring and evaluation
MARPs	Most at Risk Populations
mCPR	modern Contraceptive Prevalence Rate
MDAs	Ministries, Departments and Agencies
MHM	Menstrual Hygiene Management
MOEST	Ministry of Education, Science and Technology
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
NACA	National Agency for Control of AIDS
NASA	National AIDS Spending Assessment
NBBFWSS	Non-Brothel Based Females Who Sell Sex
NEPWHAN	Network of People Living with HIV/AIDS in Nigeria
NARHS	National HIV/AIDS and Reproductive Health Survey
NSP	National Strategic Planning
NSP	Needle and Syringe Programs
OSS	One Stop Shop
OST	Opioid Substitution Therapy
OVC	Orphaned and Vulnerable Children
PABA	Persons Affected by AIDS
PCRP	Presidential Comprehensive Response Plan
PEP	Post- exposure Prophylaxis
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
PrEP	Pre-exposure Prophylaxis
PWID	People Who Inject Drugs
RCT	Randomized Control Trial
RH	Reproductive Health
SACA	State Agency for the Control of AIDS
SBCC	Social and Behaviour Change Communication
SES	Socioeconomic Status
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TBA	Traditional Birth Attendants
TW	Transport Workers
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNPF	United Nations Population Fund
USG	United States Government
VAW	Violence Against Women
VC	Vulnerable Children
VCT	Voluntary Counselling and Testing
VLS	Viral Load Suppression
VMMC	Voluntary Medical Male Circumcision
WLHIV	Women Living with HIV

"During COVID-19 restrictions, GBV cases escalated. It is exciting that stakeholders rub minds together and pave the way for the intervention of GBV."

Mrs Assumpta Reginald

The National Coordinator of ASWHAN

"Nothing for us without us" PLHIV want to be at the table in decision-making processes, "let's decide the way forward together" NEPWHAN

EXECUTIVE SUMMARY

Introduction: The HIV epidemic is driven by various structural factors acting at macro and community levels, to shape patterns of risky behaviours and vulnerability. Gender inequality, Sexual and Gender-Based Violence (SGBV), socio-economic factors including unequal access to and control over resources and cultural/religious beliefs and practices enable or impede the ability of individuals and various population groups to embrace HIV prevention practices, access services along the HIV Care continuum.[1] Data show that women, especially adolescent and young women, key population groups such as Female Sex Workers (FSW), Men having Sex with Men (MSM) and People Who Inject Drugs (PWID) are disproportionately affected by the HIV/ epidemic.[2] Women and girls and Key and Vulnerable Populations (KVPs) face multiple, intersecting and shifting socio-cultural, economic, political, environmental and health challenges throughout their life cycles. The current state of insecurity in Nigeria, coupled with the rampaging COVID-19 epidemic have exacerbated pre-existing vulnerabilities, deepening exclusion and poverty. People Living with HIV (PLHIV) are among the most affected. Advancing gender equality and Sexual and Reproductive Health and Rights (SRHR) is key to ending the HIV epidemic as a public health threat by 2030. Gender inequality and social exclusion are grounded in systems and require systemic approaches to tackle.

Rationale for the Assessment: The purpose for the gender assessment, which was a nationally owned and country-driven process, was for the provision of evidence based recommendations, to guide national policy and planning processes and programmes as well as resource allocation and investments, including the national strategic plan, the Global Fund to Fight AIDS, TB and Malaria (GFATM).

The comprehensive multi-stakeholder process was designed to give voice to the communities, PLHIV, KVPs and provide the country context and specific needs as it relates to the gender, human rights and SRHR dimensions of the HIV epidemic and response. The analyses bring out strategic evidence, recommendations and priorities that could inform gender responsive planning and Programmes in the country.

The objectives of the assessment were: to identify strategic investment areas that will improve gender responsiveness in the national HIV response; to identify the strategic planning and budget processes that have essential information surrounding the potential epidemic, context and response from a gender perspective; to generate evidence and facilitate learning on the extent to which the national response recognises and acts on gender inequality and gender based violence as a critical enabler of the HIV response; to enhance monitoring and evaluation of gender management systems in the national HIV response; to understand the challenges and opportunities that could be useful in ensuring improved gender mainstreaming at state and community levels in the HIV response; to document good practices that address gender and human rights related barriers in the national HIV response; to examine the extent to which gender equality women's empowerment principles are prioritized in the HIV & AIDS response to achieve a gender transformative, equitable and rights-based approach; to understand how COVID-19 and other emerging issues have impacted on gender and HIV and opportunities thereof for an improved gender mainstreaming at all levels in the HIV response.

Methodology: The gender assessment process was led by the National Agency for the Control of AIDS (NACA) representing the Federal Government of Nigeria (FGN) in conjunction with the Federal Ministry of Women Affairs (FMWA), with support from the UNAIDS Country Office (UCO) in Nigeria, UN Women and the Joint UN Team on AIDS. A Gender Assessment Team was put in place comprising partners from various sectors and the donor community, to facilitate the process. The team of thirteen included representatives from Government, the UN system, development partners and civil society networks with special inclusion of women living with HIV and five consultants (national and international). The assessment methodology applied the UNAIDS Gender Assessment Tool. A two step process was applied in data collection. The first step was an in-depth desk review of HIV and gender national documents and relevant literature by the consultants in order to populate the tool. The second step was the collection of primary data at state and national levels through Key Informant Interviews (KII) and Focus Group Discussions (FGD).

[1] (Lancet, 2019)

[2] (National Agency for the Control of AIDS, 2020 (A))

Some key Findings:

- A review of the progress made since the 2013 Gender Assessment shows increased efforts at mainstreaming gender. Such efforts among others include the development of Guidelines and Training Manual for Gender Mainstreaming and Access to Justice Manual among others. (Table 4)
- Through the coordination of NACA and concerted efforts of partners, Nigeria has successfully lowered the HIV epidemic with prevalence among adults 15-49 years dropping from 1.4% in 2010 to 1.3% in 2020.[3] Available HIV transmission metrics corroborate this fact. For instance, over the last decade between 2010 and 2020, new infections for the general population declined from 110,000 to 86,000 (22% reduction) while AIDS-related death also declined from 68,000 to 49,000 (28% reduction).[4] For new infections, among adults the trend shows a 22% reduction among females aged over 15 years from 50,000 in 2010 to 39,000 new infections in 2020, while males aged over 15 years recorded 39% reduction from 41,000 new infections in 2010 to 25,000 in 2020. However, with AIDS related deaths, the available data shows that more men are affected; the trend shows 20% reduction from 25,000 deaths recorded in 2010 to 20,000 deaths in 2020 while it was 38% reduction in females from 26,000 deaths in 2010 to 16,000 deaths in 2020[5].
- There is a steady increase in the coverage of PLHIV receiving ART and consequent increase in viral load suppression. Between 2015 and 2020, coverage of PLHIV receiving ART increased from 36% to 73% among men and 62% to 98% among women, viral load suppression increased from 35% to 61% among men and 58% to 85% among women between 2018 and 2020.[6]
- Coordination structures at national level are replicated at state levels including the multi sectoral response to the HIV epidemic. All State Agencies for the Control of AIDS (SACAs) have gender focal persons, in line with national guidelines though levels of effectiveness vary from state to state. The engagement of the Ministry of Women Affairs in some states was weak.
- Gender and human rights are recognised as cross cutting across all HIV thematic areas as alluded to in the NSP (2017-2021). The One Stop Shop (OSS) facilities also provide requisite services for members of the key and vulnerable populations free of stigma and discrimination. These centers enable members of key populations express their freedom and receive HIV messaging in a friendly manner which helps to reduce transmission.
- Gender inequalities in the sociocultural and economic landscapes are still major drivers that fuel risky behaviours such as transactional sex, multiple sexual partnerships, among others, making individuals and groups vulnerable. There is a gap in the national interventions to systematically and holistically address the gender inequalities that are perpetuated by cultural norms, beliefs and practices.
- Adolescent friendly services are in short supply. Adolescent girls have an earlier sexual debut than their male peers. On average, women initiate sexual intercourse 4.5 years earlier than men. Nineteen percent of women initiate sexual intercourse by age 15 and 57% by age 18. By age 20, 7 out of 10 women have had sexual intercourse. Three percent of men aged 20 49 have their first sexual intercourse by age 15, and 3 out of 10 men have had sexual intercourse by age 20.[7] The likely lack of information or strategies for safer sex increases their risk and vulnerability to HIV. This is espoused by the increased infection rate of HIV in adolescent girls compared to boys of the same age group with prevalence among adolescent girls and young women being about four times more than those of adolescent boys and young men (0.8 to 0.2).[8]
- Patriarchy and its attendant narratives of male superiority, power and dominance in regulating sexual behaviour plays a central role in promoting gender inequalities and fuel the risk of HIV transmission. This is reinforced by religious beliefs that promote girl's/women's subservience compared to boys/men. Unfortunately, patriarchal norms affect boys and men too which can be indicated in their poor health seeking behaviours and increase in intimate partner violence
- The non-release of appropriated funds for implementing gender specific strategies and activities especially at the State level is a challenge. There is however a clear improvement in resourcing and release of funds for gender and human rights activities at the national level since the last gender assessment in 2013.

[3] (UNAIDS , 2021 (A))
[4] (UNAIDS , 2021 (A))
[5] (UNAIDS , 2021 (A))
[6] (UNAIDS , 2021 (A))
[7] (National Population Commission (NPC) and ICF, 2019)
[8] (Federal Ministry of Health, 2019)

- The general lack of awareness of the Anti-Discrimination Law in most of the study locations, except in the FCT and Lagos, may have led to lack of follow up of cases of discrimination by healthcare providers reported during the study. Also noted was the lack of synergy between Law Enforcement Agencies (LEA) and other key factors such as the National Human Rights Commission (NHRC) and the Federation of Women Lawyers (FIDA), resulting in weak legal aid in some states. As Nigeria celebrates the passage of the Anti-Discrimination Act (2014) as well as progress made in the area of key population programming, the Same Sex Prohibition Act (2013) continues to retard gains made. The National Strategic Plan has as a strategic intervention -4.5.5.6. *Strengthen the implementation of the HIV and AIDS Anti Ðiscrimination Act. NACA and the* National Human Rights Commission (NHRC) in 2020 jointly led partners in the national HIV/AIDS response to develop a National HIV-AIDS Access to Justice Capacity Building Manual but its implementation and impact are yet to be seen.
- Mobile and Community HIV Testing which increases access to testing for women including pregnant women were reported to have reduced drastically. Majority of HIV testing was reportedly facility based. However, HIV Self- Test (HIVST), a national testing strategy being adopted using Total Market Approach (TMA) seems devoid of gender integration in its roll out.
- The study did not find evidence that the key players within the national HIV response have adequately engaged the strategic planning and budget processes that have the potential to significantly address the epidemic from a gender perspective, including the UN Development Assistance Framework (UNDAF) process and the National Development Plan process.
- Persons with disability (PWDs) are still largely excluded from the National and State HIV/AIDS responses, the existence of the 2018 Discrimination against Persons with Disability (Prohibition) Act, notwithstanding. This was corroborated by the level of ignorance of representatives of this group participating in FGDs during the study. There was no evidence of direct targeting of PWDs in the national response.

RECOMMENDATIONS

1. As the HIV response has made strides to mainstream gender in policies, plans and programmes, the gender machinery needs to be more-pro active in mainstreaming HIV in policies, plans and programmes with verifiable indicators. One key way of doing this is to institutionalize gender-responsive budgeting nationally.
2. Enforce legal provisions – policies and laws that promote and protect the rights of persons living with HIV across the populations:
   - Review and repeal discriminatory laws that have adverse effects on HIV transmission, including laws that criminalize key populations.
   - Domesticate, disseminate, and implement legislations that protect citizens, including capacity strengthening for PLHIV and key and against human rights abuse and sexual and gender-based violence.
3. Existence of the association of women living with HIV has improved engagement of women in the response. However, women are still absent at decision making levels. Going a step further in line with the SDG 5 and the National Gender Policy to give women a seat at the leadership tables of coordinating structures and mechanisms will increase and strengthen the voice and agency of women.
4. Government should explore modalities to replicate, scale up and sustain good practices such as the one stop shops (OSS) that improve access to HIV services for key and vulnerable populations and to include persons with disabilities with HIV.
5. Adopt a systemic approach to tackling gender and other forms of inequalities by the issuance of clear guidelines and timelines for setting up Gender Management Systems with monitoring indicators at all levels – States, LGAs and line MDAs.
6. Institutionalise a capacity building programme to build gender analysis and planning expertise in the various sectors and in all stages of policy and programme analysis, design, implementation, monitoring and evaluation.
7. Re-invest in anti-stigma awareness campaigns and campaigns that address patriarchy, cultural norms and practices that increase vulnerability and risk to HIV.
8. Position and monitor gender equality and social inclusion as component parts of implementing the National Development Plan.
9. Implement interventions addressing young people particularly the provision of youth and adolescent friendly health and other services.

CHAPTER

01.

INTRODUCTION

There are approximately 37.7 million people living with HIV (PLHIV) worldwide. Girls and women constitute more than half (20.1 million or 53%) of all people living with HIV.[9] Young women (aged 15-24), and adolescent girls (aged 10-19) in particular, account for a disproportionate number of new HIV infections, largely due to socio-economic inequalities and harmful gender norms.[10]

In sub-Saharan Africa, adolescent girls and young women (aged 15 to 24 years) accounted for 25% of HIV infections in 2020, despite representing just 10% of the population.[11] Six in seven new HIV infections among adolescents (aged 15 to 19 years) are among girls, and young women (aged 15 to 24 years) are twice as likely to be living with HIV than men.[12] Furthermore, AIDS-related illness remains one of the leading causes of death for women of reproductive age (15 to 49 years).[13]

As in sub-Saharan Africa, girls and women in Nigeria are also disproportionately burdened by HIV. The most recent data available from UNAIDS shows that HIV prevalence among adult women aged 15 to 49 years (1.6%) is considerably higher than of men at 1.0%.[14] Furthermore, in 2020, women accounted for 62% of new HIV infections among adults in the country. The disparity in burden of HIV between sexes is even more pronounced among young people with prevalence in young women aged 15 to 24 years (0.6%) double that of men, and also young women account for 70% of new HIV infections in their age group.

Across the testing and treatment cascade women report better results; more women than men know their status (>98% Women vs 79% Men), are on treatment (>98% Women vs 73% Men), and virally suppressed (85% Women vs 61% Men). These figures indicate that men are more likely to be accessing or are being retained on treatment at a lower rate than women.

Significant efforts have been made by the National HIV and AIDS response to bridge the gaps in gender equality priorities. Noteworthy was the first Gender Assessment of the HIV response in 2013 conducted by the National Agency for the Control of AIDS (NACA) with support from the Joint United Nations Programme on HIV/AIDS (UNAIDS) Country Office (UCO) in Nigeria and the Joint UN Team on AIDS. The assessment identified issues which were critically addressed to strengthen the national HIV/AIDS response (Table 4).

To ensure a sustained gender response in HIV/AIDS programming in the country, NACA with support from UNAIDS and the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) commenced processes to conduct another gender assessment in 2021. This assessment is geared towards determining the status of the HIV/AIDS response from a gender perspective. Additionally, the results from the 2021 Gender Assessment would be compared with that of the 2013 Assessment and recommendations made for a more gender responsive national HIV/AIDS response in Nigeria.

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[9] (UNAIDS , 2021 (A))
[10] (UNAIDS., 2019)
[11] (UNAIDS, 2021 (B))
[12] (UNAIDS, 2021 (B))
[13] (UNAIDS., 2019)
[14] (UNAIDS , 2021 (A))

1.1 CONTEXT OF HIV EPIDEMIC IN NIGERIA

Although Nigeria's HIV prevalence is low at 1.3%, because of the country's large population, this prevalence translates to approximately 1.7 million people living with HIV, making the HIV epidemic in Nigeria the fourth largest in the world.[15] [16] Nigeria has achieved a 26% reduction in new infections between 2010 and 2020, however, it accounted for roughly 45% of new HIV infections in West and Central Africa in 2020.[17]

According to the 2020 NACA study modelling modes of HIV transmission in Nigeria, the largest number of new infections among the adult population is estimated to occur among never married females (46.7%) and never married males including both circumcised and uncircumcised (34.6%) totalling (81%). These two groups along with Female Sex Workers (FSW) and Men who have Sex with Men (MSM) accounts for 91% of new infections among adults. It is also to be noted that Key populations (FSW, MSM and PWID) are estimated to account for about 11% of new infections although they represent less than 2% of the total population.[18] New child infections due to mother-to-child transmission represent the second source of new infections accounting for 22% of all new infections.

The state with the highest HIV prevalence is Akwa Ibom with 4.8% prevalence and an estimated 130,000 PLHIV (83,000 Women vs 51,000 Men), followed by Benue with a prevalence of 4.3% and an estimated 120,000 PLHIV (66,000 Women vs 54,000 Men), and third is Rivers state with a prevalence of 3.6% and an estimated 140,000 PLHIV (89,000 Women vs 54,000 Men).[19] Across all three states women are disproportionately burdened with HIV.

HIV prevalence is higher among all KP groups compared to the general population. Findings from IBBSS 2020 indicate the prevalence is highest among transgender (28.8%) followed by MSM at 25% and then FSW with 15.5% and lastly PWID at 10.9%. A quick comparison of HIV prevalence among KPs from the previous IBBSS 2014 reveals a considerable rise in prevalence for PWID from 3.4% in 2014 to 10.9% in 2020.[20] [21]

Among adolescents (15 to 19 years), young people (ages 15 to 24), and people of reproductive age (adults 15 to 49 years), HIV prevalence and incidence are consistently higher for women compared to men.[22] The disparity in prevalence and incidence, indicate women's higher vulnerability to HIV in Nigeria.

There are several reasons why women are more vulnerable to HIV. Women are more biologically susceptible to HIV infection. Furthermore, women in Nigeria face complex and intersecting cultural, social and economic factors such as – early sexual debut and cross-generational relationships[23]; discriminatory gender norms and cultural practices; power imbalances between sexes[24]; lack of economic power, limited education and skills; inability to inherit land or other resources; sexual exploitation, violence, and abuse[25] – which combine to increase women's risk of HIV and limit their ability to cope with infection. In Nigeria, gender inequalities and women and girls' low socio-economic status continue to fuel susceptibility to HIV for women and girls.

Since 2019/2020, the world including Nigeria has been dealing with the COVID-19 pandemic. Since the outbreak of COVID-19, emerging data and reports have shown that all types of violence against women and girls, particularly domestic violence, have intensified.[26] [27] [28] A study on GBV and COVID 19 by UN Women

[15] (Central Intelligence Agency (CIA), n.d.)
[16] (National Agency for the Control of AIDS, 2019 (A))
[17] (UNAIDS , 2021 (A))
[18] (National Agency for the Control of AIDS, 2020 (B))
[19] (Federal Ministry of Health, 2019)
[20] (Federal Ministry of Health, 2015)
[21] (Federal Ministry of Health, 2021)
[22] (Federal Ministry of Health, 2019)
[23] (UNAIDS, 2016)
[24] (World Economic Forum, 2017)
[25] (Birchall, 2019)
[26] (Cabello, Sanchez, Farre, & Montejo, 2020)
[27] (Fawole, Okedare, & Reed, 2021)
[28] (Sanchez, Vale, Rodrigues, & Surita, 2020)

reported that half (48%) of Nigerian women have experienced at least one form of violence since the COVID-19 pandemic and 4 out of 10 women (39%) reported that COVID-19 has made them feel even less safe at home.[29] Pre-existing toxic social norms and gender inequalities, economic and social stress caused by the COVID-19 pandemic, coupled with restricted movement and social isolation measures, have led to an increase in GBV cases across the country. Evidence shows that women who have experienced physical or sexual intimate partner violence are 1.5 times more likely to acquire HIV than women who have not experienced such violence.[30]

1.2 SOCIO-ECONOMIC AND DEMOGRAPHIC CONTEXT

Nigeria is a multi- ethnic and culturally diverse federation of 36 autonomous states and the Federal Capital Territory. The political landscape is partly dominated by the ruling All Progressives Congress party (APC) which controls the executive arm of government, holds majority seats at both the Senate and House of Representatives in parliament, and holds 23 out of 36 State Governorship positions.[31]

President Muhammadu Buhari secured a second term at the 2019 presidential elections. General elections are scheduled in February 2023. Since 2011, the security landscape has been shaped by the war against Boko Haram terrorist group in the northern states in addition to cases of banditry and kidnappings including school girls in the north west and continued unrest in the southeast resulting from separatist agitations. Such volatility can hinder access to HIV services and more often than not, women are more affected.

1.2.1 ECONOMIC OVERVIEW

In 2020, Nigeria experienced its deepest recession in two decades, but growth resumed in 2021 as pandemic restrictions were eased, oil prices recovered, and the authorities implemented policies to counter the economic shock. Nigeria was highly vulnerable to the global economic disruption caused by COVID-19, particularly due to the decline in oil prices. Oil accounts for over 80% of exports, a third of banking sector credit, and half of government revenues. In 2018, 40% of Nigerians (83 million people) lived below the poverty line, while another 25% (53 million) were vulnerable.[32] The number of Nigerians living below the international poverty line is expected to rise by 12 million in 2019–23.[33] Such low economic situation can cause people to focus on how to make ends meet and let down their guard against HIV.

As part of its COVID-19 response, the government carried out long-delayed policy reforms in 2020. Notably, it: (i) began to harmonise exchange rates; (ii) initiated reforms to eliminate gasoline subsidies; (iii) adjusted electricity tariffs to more cost-reflective levels; (iv) cut non-essential spending; (v) enhanced debt management; and (vi) increased transparency in the public sector, especially for oil and gas operations.[34]

The COVID-19 crisis continues to disrupt Nigeria's labour market and women seems to bear the brunt more. A World Bank study found that following the COVID-19 outbreak, the share of working women shrank in Ethiopia, Malawi, Nigeria and Uganda. In Uganda and Ethiopia, more women lost their job due to COVID-19 than men. This deepens the already wide gender gap in employment. In Nigeria, the gender gap did not widen among respondents.[35] While it now exceeds pre-pandemic levels, improvements have been primarily due to workers turning to small-scale, non-farm enterprise activities in retail and trade, the revenues of which remain precarious.[36]

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[29] https://data.unwomen.org/sites/default/files/documents/Publications/Measuring-shadow-pandemic.pdf
[30] https://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf
[31] (World Bank, 2021)
[32] (National Bureau of Statistics, 2019)
[33] (World Bank, 2020 (A))https://www.worldbank.org/en/programs/lsms/brief/nigeria-releases-new-report-on-poverty-and-inequality-in-country
[34] (Ozili, 2020)
[35] (World Bank, 2020 (B)) https://blogs.worldbank.org/opendata/labor-market-impacts-covid-19-four-african-countries
[36] (World Bank, 2021) https://www.worldbank.org/en/country/nigeria/overview#1

Nigeria's economic outlook remains highly uncertain. Uncertainty around the pace of vaccinations and the duration of COVID-19 persists. Moreover, the modest projected recovery can be threatened by volatility in the oil sector, including an unexpected shock to oil prices, and weaknesses in the financial sector. Even in the most favourable global context, the policy response of Nigeria's authorities will be crucial to lay the foundation for a robust recovery. Impoverished people can be pushed into unhealthy behaviours and practices that can put them at risk of HIV.

Evidence from literature reveals that women constitute over 60% of the poorest people in Nigeria.[37] While female headed households are more disadvantaged in terms of socioeconomic deprivation than the male headed households,[38] female sex worker in Nigeria live day to day in conditions of poverty, linked to migration, unemployment, unstable housing and mounting financial responsibilities related to being primary providers for dependents. For these women, sex work is a rational, economic strategy adopted to meet basic subsistent needs in the face of large-scale structural and gendered inequalities.[39]

1.2.2 DEVELOPMENT CHALLENGES

While Nigeria has made some progress in -socio economic terms in recent years, its human capital development ranked 150 of 157 countries in the World Bank's 2020 Human Capital Index. The country continues to face massive developmental challenges, including the need to reduce the dependency on oil and diversify the economy, address insufficient infrastructure, build strong and effective institutions, as well as address governance issues and public financial management systems. Insufficient infrastructure can impact on cost of access to health facilities and therefore access to HIV services.

Inequality, in terms of income and opportunities, remains high and has adversely affected poverty reduction. The lack of job opportunities is at the core of the high poverty levels, regional inequality, and social and political unrest. High inflation has also taken a toll on households' welfare and high prices in 2020 are likely to have pushed an additional 7 million Nigerians into poverty in 2020.[40] Poor households may not afford out of pocket costs that could be associated with access to HIV services.

Gender inequalities is also reflected in low literacy level (86% vs74% in urban area) in favour of men[41] and limited participation in workforce among women compared to men with Nigeria having a labour force participation rate of 47.9% among women aged 15 years or older, versus 57.9% among men;[42] all of these could further affect women's economic power, decision-making ability and vulnerability to HIV infection.

1.2.3 DEMOGRAPHIC CONTEXT

The current population of Nigeria is 213.3 million based on projections of the latest United Nations data. This put Nigeria as the most populated country in Africa and accounts for 50% of West Africa's population. According to the world population review, the major contributors to Nigeria's population growth are early marriages, high birth rates, and a lack of family planning access. The birth rate in Nigeria is about 37 births per 1,000 people.

Its population is made up of about 200 ethnic groups, 500 indigenous languages, and two major religions – Islam and Christianity. The fragmentation of Nigeria's geographical, ethnic and cultural identity lines is effectively balanced by the country's federal structure and the strong emphasis of the federal government on representing ethnic and cultural identities by grouping the country into six geopolitical zones.[43]

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[37] (Onwuka, Nwadiubu, & Isiwu, 2019)
[38] (Buba, Abdu, Adamu, & Jibir, 2018)
[39] (Nelson, 2020)
[40] (World Bank, 2021) https://www.worldbank.org/en/country/nigeria/overview#1
[41] (Sasu, 2022) https://www.statista.com/statistics/1124741/literacy-rate-in-nigeria-by-area-and-gender/

[42] (UNDP, 2022) http://hdr.undp.org/en/content/gender-inequality-index-gii

[43] (World Bank, 2020 (C))

1.3 RATIONALE FOR GENDER ASSESSMENT

Gender inequalities (socio-cultural, economic, and political) and GBV, are among the key drivers of the HIV epidemic. Advancing gender equality and sexual and reproductive health and rights (SRHR) is key to ending the AIDS epidemic as a public health threat by 2030. Recognising that women and girls and KVPs face multiple, intersecting and shifting socio-cultural, economic, environmental and health challenges throughout their life cycles, the evidence indicates that women and girls continue to bear the burden of HIV and these intersectional issues. In essence, gender inequality is one of the root causes of the HIV epidemic globally and in Nigeria.[44] The global health and development community is therefore putting its weight behind multi-sectoral and integrated strategies, programmes and services, which address the multiple and different needs of women, girls, men, boys and KVPs in all their diversity.

The gender assessment, which is a nationally owned and country-driven process, engaging multi-sectoral key country stakeholders from government, civil society, communities, the United Nations (UN) and other Development Partners, is essentially a research action project. This work aims to collate qualitative and quantitative information and data, to propose evidence-based recommendations, which will guide national policy and planning processes and programmes as well as resource allocation and investments, including by the Global Fund

This national gender assessment, conducted by the National Agency for the Control of AIDS (NACA) with support from UN Women and UNAIDS, is aimed at providing a comprehensive and in-depth review of the gender equity and inclusion dimensions of the national HIV epidemic and the national policy and programmatic response, as well as making evidence-based recommendations that can and should be implemented.

1.4 PURPOSE OF THE GENDER ASSESSMENT

The primary purpose of the gender assessment is to review and understand the gender dimensions of the HIV epidemic and response in Nigeria and to assess the achievements and gaps. The findings will help to empirically determine the progress made and existing gaps within the HIV response and develop evidence based priorities and recommendations to achieve a gender transformative, equitable and rights-based approach. Based on the analysis of data, the gender assessment process generates evidence to guide national policy, planning, programmes, and interventions, and provides recommendations to move towards gender transformative processes and address the HIV-related and SRHR needs of women, men, girls, boys and KVPs in Nigeria.

1.5 OBJECTIVES OF THE GENDER ASSESSMENT

The specific objectives of the GA are:

1. To identify strategic investment areas that will improve gender responsiveness in the national HIV response
2. To identify the strategic planning and budget processes that have essential information surrounding the potential epidemic, context and response from a gender perspective
3. To generate evidence and facilitate learning on the extent to which the national response recognises and acts on gender inequality and gender- based violence as a critical enabler of the HIV response
4. To enhance monitoring and evaluation of gender management systems in the national HIV response
5. To understand the challenges and opportunities that could be useful in ensuring improved gender mainstreaming at state and community levels in the HIV response
6. To document good practices that address gender and human rights related barriers in the national HIV response
7. To examine the extent to which gender equality and women's empowerment principles are prioritised in the HIV & AIDS response to achieve a gender transformative, equitable and rights-based approach

[44] (Lancet, 2019)

8. To understand how COVID-19 and other emerging issues has impacted on gender and HIV and opportunities thereof for an improved gender mainstreaming at all levels in the HIV response.

1.6 GUIDING PRINCIPLES

This gender assessment was guided by the following principles:

1. A human-rights-based approach.
2. Meaningful participation of women and girls.
3. Evidence-informed approach.
4. Ethical responses based on equity and fairness.
5. Partnership with civil society, including people living with HIV and other key affected populations.
6. Strong and courageous leadership.
7. Engagement of men and boys.
8. Impartiality.
9. Transparency.
10. Strategic and forward-looking approach.
11. Recognition of geographical and cultural diversity – the way gender is perceived varies between ethnic groups, cultures, and religion and this is pertinent with over 350 ethnic groups in Nigeria.
12. Multi-sectoral approach that is community - based and forges broad partnerships, dialogue, consultations, coordination, and synergies at all levels.

1.7 GENDER ASSESSMENT APPROACH

The assessment was guided by the UNAIDS Gender Assessment Tool (GAT) and adapted to fit the local context. The GAT was updated in 2018 and assists countries in providing a comprehensive, in depth assessment of the HIV epidemic, context and response through a gender lens, cognizant of the socio cultural context, inequalities and where possible disaggregating data by gender, sex and age.

In line with the GAT and explained in Figure 1 there are four key stages: (i) preparation – in this stage political and high-level commitment to the process is crucial and a landscape analysis of current policies and available data was carried out; (ii) defining the national HIV epidemic and context utilising and collating up-to-date data and information from the last 7 years (2013-2020), although where there was limited data, sources from earlier years were collected and collated; (iii) mapping the HIV response in detail; and (iv) using the evidence to provide recommendations for a gender transformative HIV response.

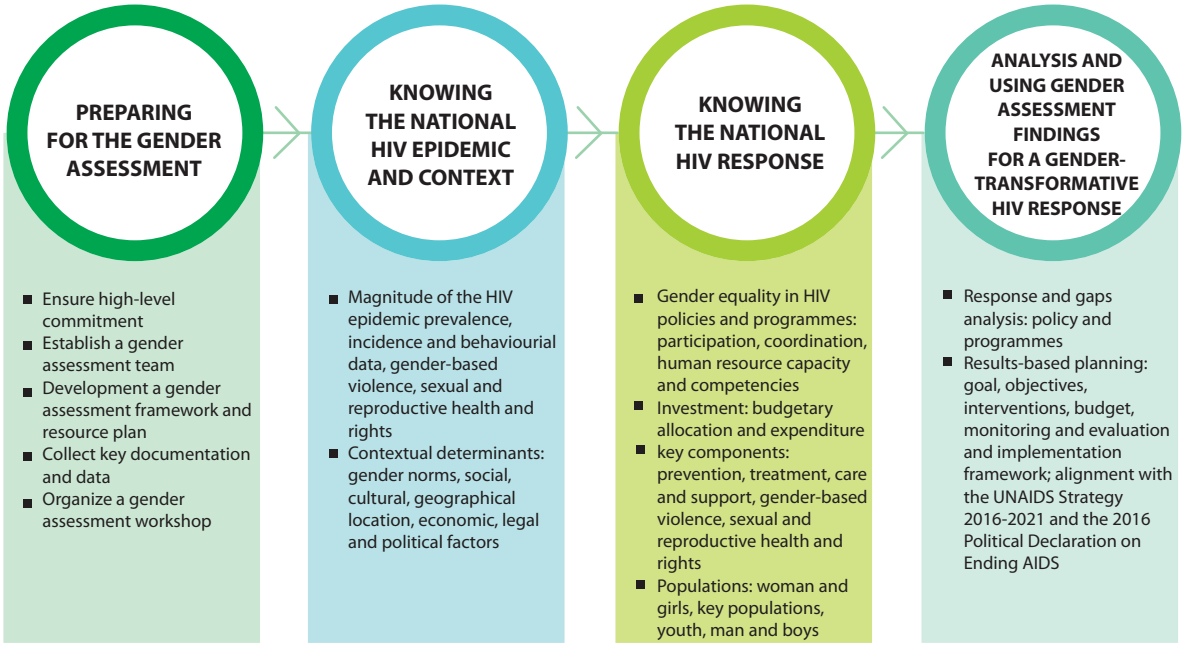


***Figure 1**: Stages for the National Gender Assessment of HIV Source UNAIDS*

The assessment was commissioned and implemented by NACA and FMWA from August 2021 to March 2022 and supported by UN Women and UNAIDS. The GA secured the high-level commitment of all stakeholders in the national HIV and AIDS response. It was overseen by a core team or steering committee. The inaugural meeting convened by NACA consisted of officials of various Ministries, Departments and Agencies, representatives from the United Nations, the United States Government and their implementing partners, other Civil Society Organizations including persons living with disabilities, network of people living with HIV and other HIV key and vulnerable populations, UN Women and UNAIDS. A five member consultant team (national and international) was recruited to support the assessment. During the first stage, an inception meeting of a wide range of stakeholders was held to map out the process for conducting the assessment.

This first stage also involved the Adaptation of the GAT to the Nigerian context. This tool was adapted to the Nigerian context following the activities below:

1. NACA formed and inaugurated the Gender Assessment Team which was made up of multi sectoral stakeholders. The consultants had various consultations with the stakeholders to draft the roadmap for the assessment. This provided an inception report endorsed by the Gender Assessment Team.
2. Adaptation of the GAT –The GAT was reviewed by the consultants and tailored to reflect the Nigerian context and was populated with information from relevant literature. The tools were shared with and endorsed by the Gender Assessment Team
3. Comprehensive desk review to include the status of gender in the HIV response, the response thus far and the gender gaps in the response.
4. A tool to collate information for the Gender Management System was also developed
5. Additional tools such as consent forms, FGD and in depth key informant interview guides were developed to gather data at the sub-national levels

The second and third stages of the Gender Assessment involved a rigorous data collection, collation and analysis. Data collection was centred on understanding entrenched gender inequalities as well as providing comprehensive up-to-date information on the national HIV epidemic and the HIV response.

Throughout the process, the GA entailed analysis of the findings to generate evidence based recommendations and actions for the national level, multi-sectoral HIV response – the pathway to a gender transformative response.

1.8 DATA COLLECTION METHODS

For each of the objectives above, we developed specific methodological approach as described in Table 1

Table 1: *Data Collection Methods*

Objectives	Data Source	Method
To identify strategic investment areas that will improve gender responsiveness in the national HIV response.	Primary data from key informants	Key Informant Interviews with relevant implementers/experts in government, development partners/donor agencies and selected CSOs.
To identify the strategic planning and budget processes that have essential information surrounding the potential epidemic, context, and response from a gender perspective.	Primary data from key informants	Key Informant Interviews with relevant implementers/experts in government, development partners/donor agencies and selected CSOs.
To facilitate learning about the extent to which the national response recognises and acts on gender inequality as a critical enabler of the HIV response.	i. Secondary data from desk review (populate the adapted GAT with data from desk review) ii. Primary data to complement findings from the desk review	Adapted GAT Focus Group Discussions and Key Informant Interviews with NACA/SACA staff, Key Populations, relevant development partners, People living with HIV, women's

		groups, selected local and international NGOs/ CSOs.
To enhance monitoring and evaluation of gender management systems in the national HIV response	i. Conduct a desk review of the existence, functionality and monitoring and evaluation of the core elements of Gender Management System in the National and State HIV/AIDS Responses. ii. Collect primary data on GMS at state and national levels.	A self-administered, digitised questionnaire, supported by virtual or face-to-face interviews. Respondents: Relevant staff at NACA, SACA, Ministry of Women Affairs and Social Development, People living with HIV, Legislators and/or women's groups, Legislative aid, Civil Society.
To understand the challenges and opportunities that could be useful in ensuring improved gender mainstreaming at the State and community levels in the HIV response.	Primary data from key informants/relevant stakeholders at national, state and community levels.	Focus Group Discussions and Key Informant Interviews with NACA/SACA staff, Key Populations, relevant development partners, people living with HIV, women's groups, selected local and international NGOs/ CSOs.
To document good practices that address gender- and human rights-related barriers in the national HIV response.	Primary data – Collection of stories of change- Case study tool	Case study tool administered on key informants in government, donors, NGOs/CSOs
To examine the extent to which gender equality and women's empowerment principles are prioritised in the HIV & AIDS response to achieve a gender transformative, equitable and rights-based approach	Primary data from key informants/relevant stakeholders at national, state and community levels	Focus Group Discussions and Key Informant Interviews with NACA/SACA staff, Key Populations, relevant development partners, People living with HIV, women's groups, selected local and international NGOs/ CSOs.

1.8.1 DESK REVIEW

Data used for the gender assessment was collected from existing databases, national-level policies, donor reports, existing literature, other UN agencies' data/programme documents and civil society organisations' (CSO) reports. The desk review provided the background and the context of the situation of the epidemic and the national response so far from the perspective of gender.

The main source of secondary data (quantitative) that was used to map the national HIV epidemic and the roll-out of the national HIV response in the country was the UNAIDS Global AIDS Monitoring (GAM), which is a collation of the most recent data at a national level: https://aidsinfo.unaids.org/. Published literature on drivers of HIV epidemic was also reviewed.

Other sources include:

1. The 2013 Gender Assessment Report
2. Stigma Index Report 2011, 2014 & 2020
3. IBBSS 2014 & 2020 reports
4. The NAIIS 2018 report
5. Nigeria demographic and health survey 2018 full report
6. Spectrum Report
7. Laws and regulations related to HIV, gender, and human rights issues.
8. Policies, strategies, and guidelines including international, country and state specific documents from State and non-State actors.
9. Other documents and reports, including situation analyses on gender topics; country and state-specific reports from international donors and NGOs on specific topics related to gender and HIV.
10. Websites providing relevant information.
11. World Bank Reports

1.8.2 PRIMARY DATA COLLECTION

Primary data collection was carried out to complement and explain the HIV epidemic in terms of gender inequalities and contextual socio-cultural factors. Purposive and snowballing sampling techniques were used to identify interviewees. Primary data collection included focus group discussions (FGDs), key informant interviews (KII) and consultative workshops. Only adults aged 18 and above were interviewed.

The national assessment was designed with field work that extended to seven distinct locations, including six different states across the six geo political zones namely Akwa Ibom (South South), Anambra (South East), Benue (North Central), Lagos (South West), Kano (North West), Taraba (North East), as well as the Federal Capital Territory (FCT). The states were purposively pre-selected by NACA.

Figure 2: *States where primary data collection took place*

Some of the criteria utilised in selection of the States include HIV prevalence; accessibility to the States; availability of functional on-ground support for the assessment; and high political commitment to the HIV response.

Ethical considerations of seeking consent and maintaining the privacy and confidentiality of participants were maintained throughout the process-Appendix III contains a full list of stakeholders interviewed).All KIIs and FGDs were conducted by two consultants, one is a note taker while the other acted as a moderator. Digital recording was also done as a backup. During the data collection, the team of consultants specifically collected stories of success and change. Whenever possible, these participants were asked and gave consents for photo taking as well as for detailed narratives.

1.9 DATA ANALYSIS

Quantitative data were analysed using excel while qualitative data was transcribed verbatim and analysed using the thematic content approach. Secondary data analysis involved mapping information according to indicators of the epidemic and response defined in the GAT. Where possible, all data was disaggregated by

sex, gender, and age with consideration of KVP groups. Data triangulation, including the political/legal landscape, policy analysis and qualitative data collected was used to unpack indicators through a gender lens, but also to explain trends in the epidemic and highlight gaps within the response. The analysis was complemented by reading existing literature. Data extraction using the UNAIDS GAT (know your epidemic and know your response) was analysed quantitatively using Excel packages to generate graphs and tables.

Primary data collected from the states was grouped accordingly and all the demographic and numerical data on HIV statistics were subjected to quantitative analysis. All data collected qualitatively through KIIs, FGDs, and consultation workshops involved a three stage analysis. The first stage involved verbatim transcription, the second stage was to counter check the transcript against the detailed notes and the last one was the thematic analysis where themes across and within population subgroups were analysed. Where possible, quotes to demonstrate the richness of the stories were extracted and used in the presentation of the findings. State level data collected during the field assignment were analysed and this culminated into state level reports. The analysis was later used to form part of the national report, where necessary. To provide an assessment of the HIV epidemic and response in Nigeria through a gender lens, it was imperative to unpack socio-cultural norms and gender differences to shed light on inequalities, barriers to access to HIV prevention, treatment, care and support and other SRH services including services for GBV survivors.

1.10 LIMITATIONS

The study basically used s econdary quantitative data available at the national and global HIV data depositories and platforms. The qualitative data collection is only limited to six (6)) States and FCT. For a country with large diversity as Nigeria, the use of qualitative explanation of some of the gender inequality issues may vary in some other settings not particularly covered in the assessment.

CHAPTER

02.

THE NATIONAL HIV EPIDEMIC

NAIIS 2019, NDHS 2018, IBBSS 2020 and AIDSinfo 2021 data were preferably used in this report considering the fact that they present the most up to date data.

2.1 KEY HIV INDICATORS

2.1.1 HIV PREVALENCE

With over 200 million people, Nigeria is the most populous nation in Africa and the largest black nation in the world. The country also has one of the highest number of people living with HIV globally. According to UNAIDS 2021 estimates, 1.7 million people in Nigeria were living with HIV –this translates to a national HIV prevalence among adults aged 15 – 49 years of 1.3% and makes Nigeria the second largest HIV epidemic in Africa. Over the last two decades Nigeria's HIV prevalence has reduced from 1.5% to 1.3%.[45]

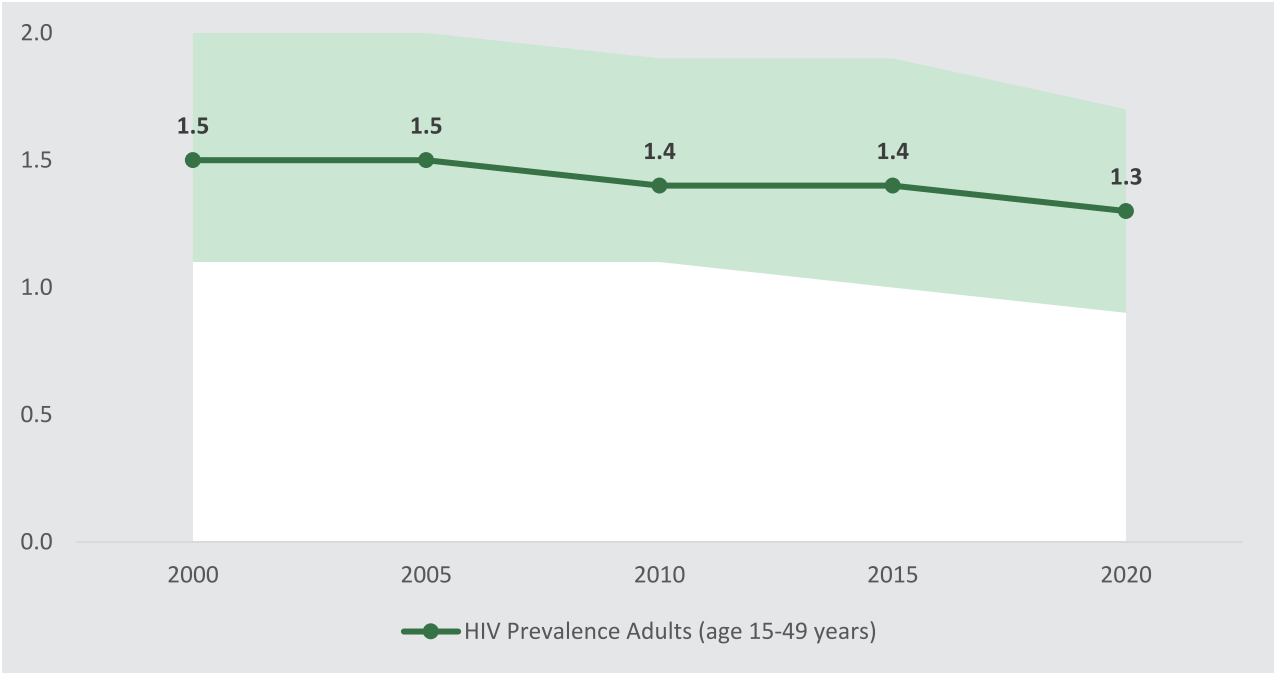


Figure 3: *Trend in HIV Prevalence*

Although key populations contribute to the spread of HIV, heterosexual sex remains the main mode of HIV transmission. However, mother-to-child transmission and transfusion of infected blood and blood products, are also notable modes of transmission.[46]

[45] (UNAIDS , 2021 (A))
[46] (National Agency for the Control of AIDS, 2013)

The epidemic in Nigeria is feminised – women are disproportionately affected by HIV. According to UNAIDS 2021 estimates, women account for 60% of adult (15 – 49 years) living with HIV (790,000 women vs 510,000 men).[47] Consequently, adult women have a higher HIV prevalence than adult men (1.6% Women vs 1.0% Men). Furthermore, the proportion of women living with HIV in Nigeria has increased over the last two decades (Figures 4 and 5).

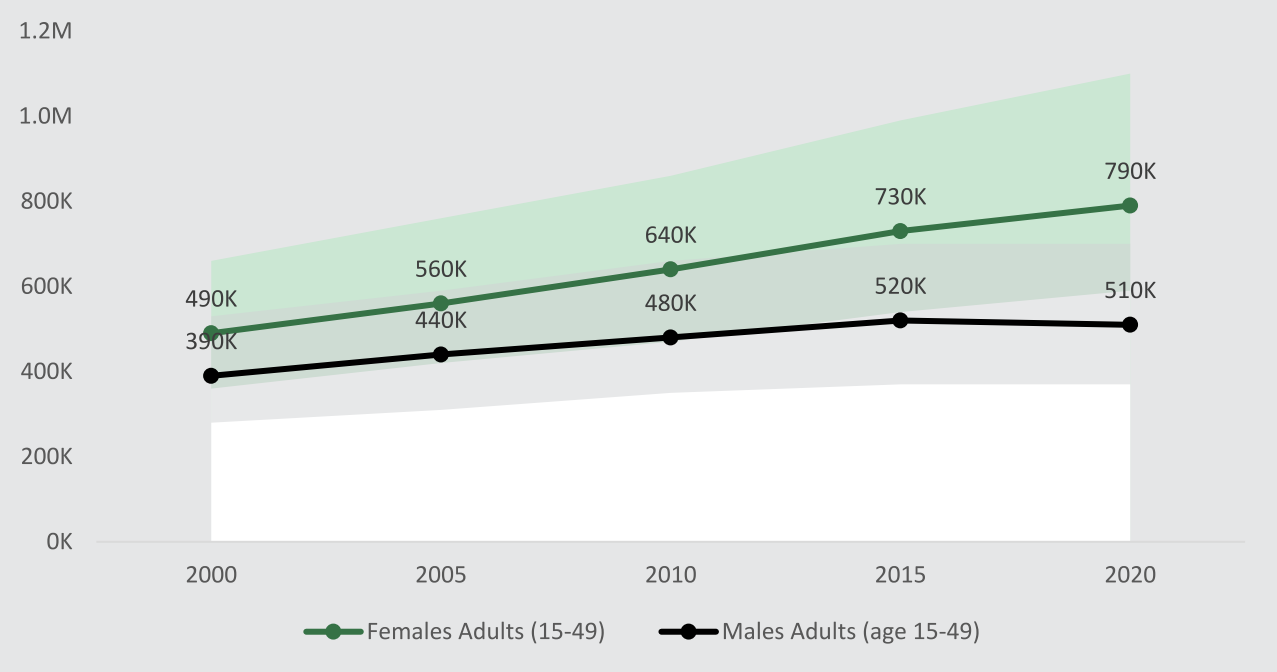


Figure 4: *Number of adults (aged 15-49years) living with HIV disaggregated by sex*

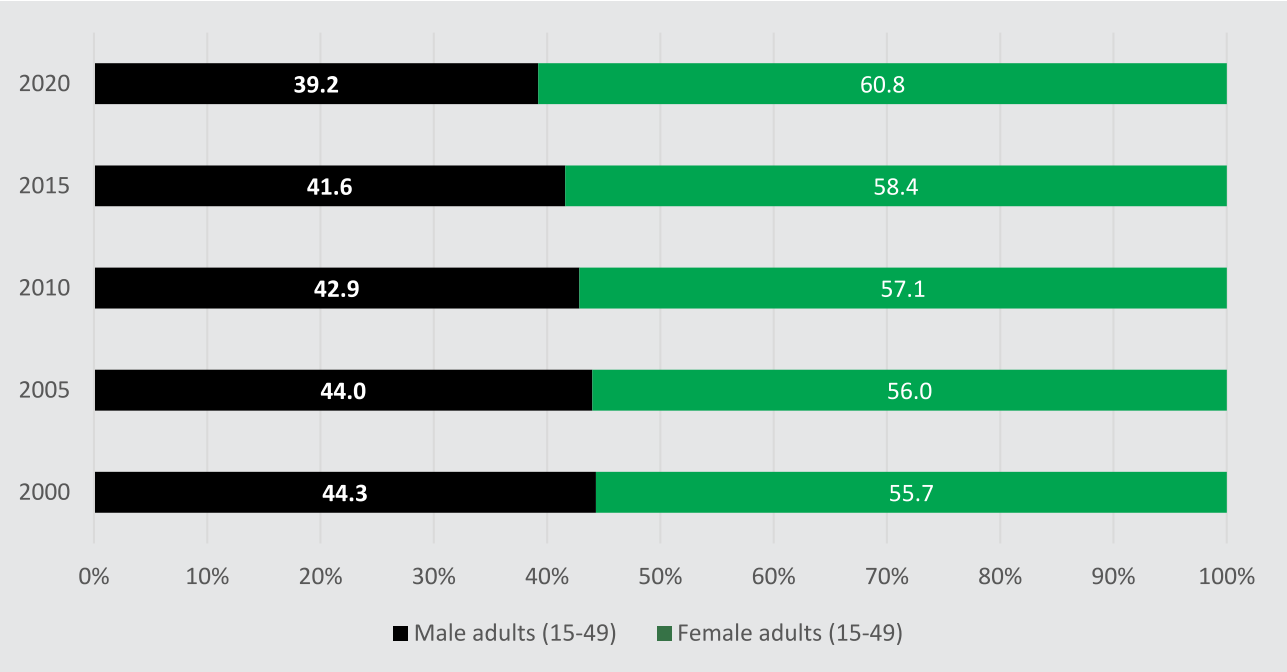


Figure 5: ***Proportion of Adults living with HIV disaggregated by Sex and Year (%)***

The disproportionate burden of HIV is even more pronounced among young people aged 15– 24 years with young women accounting for nearly two-thirds (63%) of young people living with HIV (110,000 vs 64,000).[48]

[47] (UNAIDS , 2021 (A))
[48] (UNAIDS , 2021 (A))

In addition, HIV prevalence among young women is double that of young men (0.6% women vs 0.3% men)- **Figures 6 and 7.**

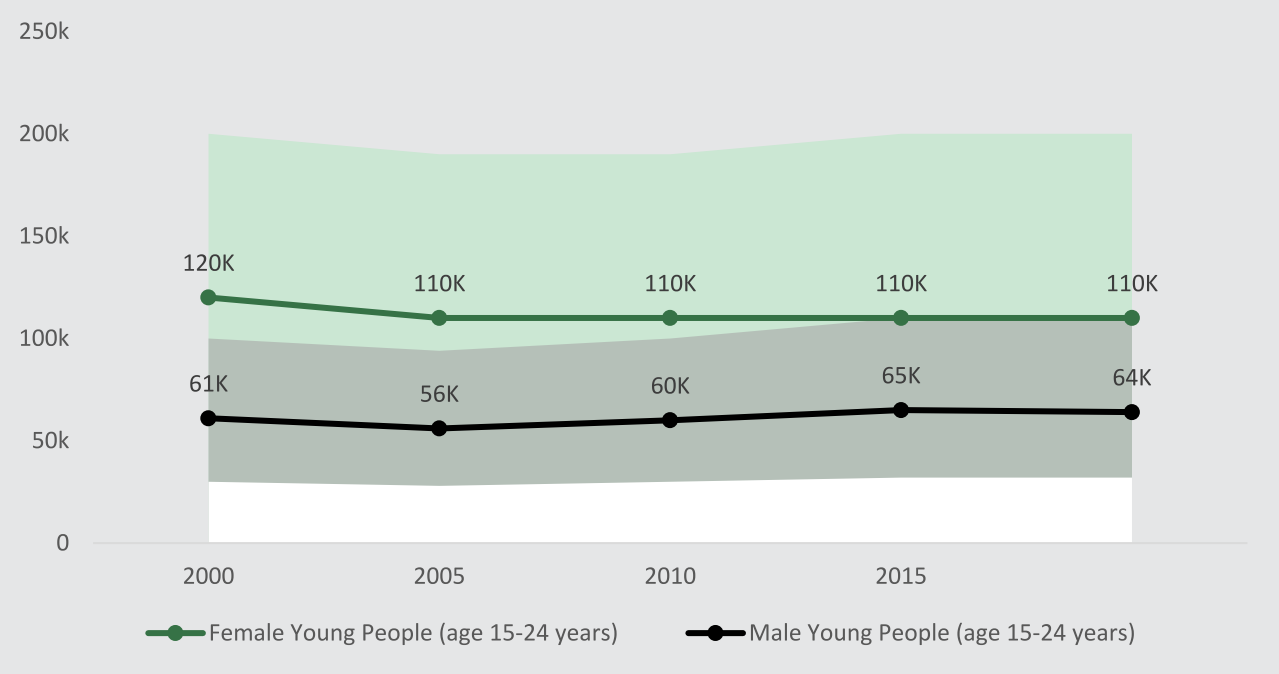


Figure 6: *Number of young people living with HIV (aged 15 24 years) disaggregated by Sex*

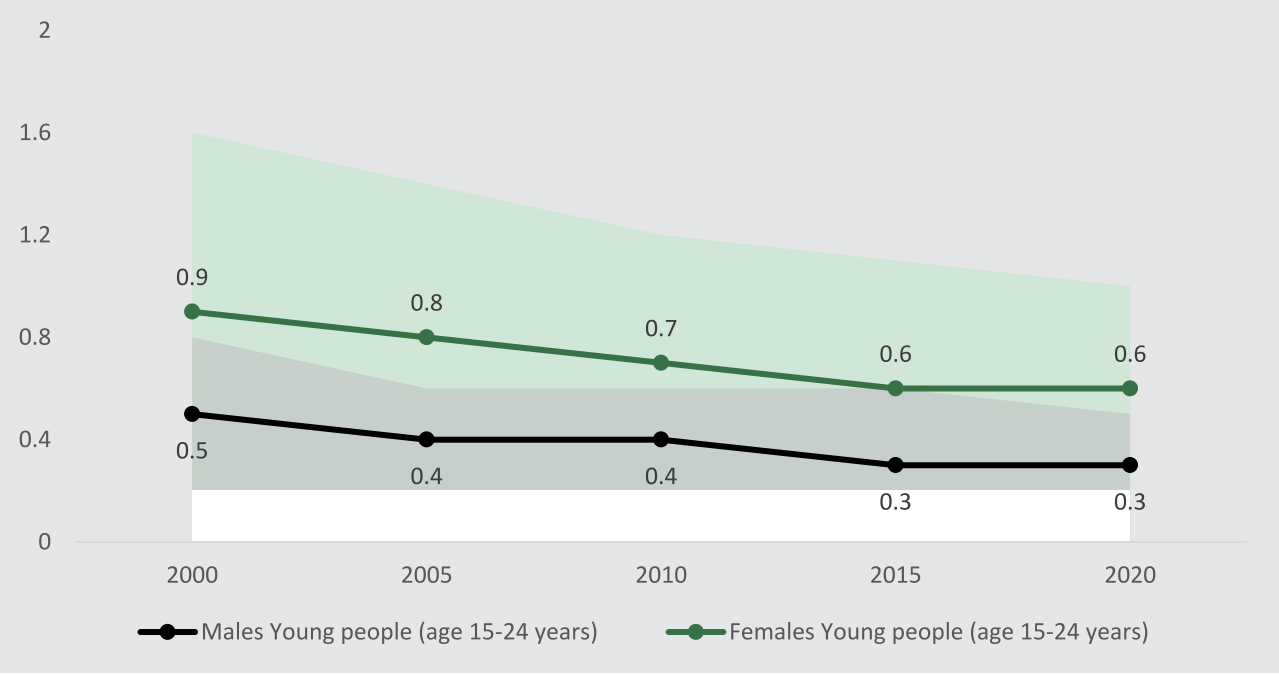


Figure 7: *HIV prevalence among young people aged (15 24 years) disaggregated by Sex*

HIV in Nigeria is geographically heterogeneous, with significant variations in the prevalence and trends of the epidemic at State levels. Figure 8 shows the variation in HIV prevalence for men and women across each of the 36 states.

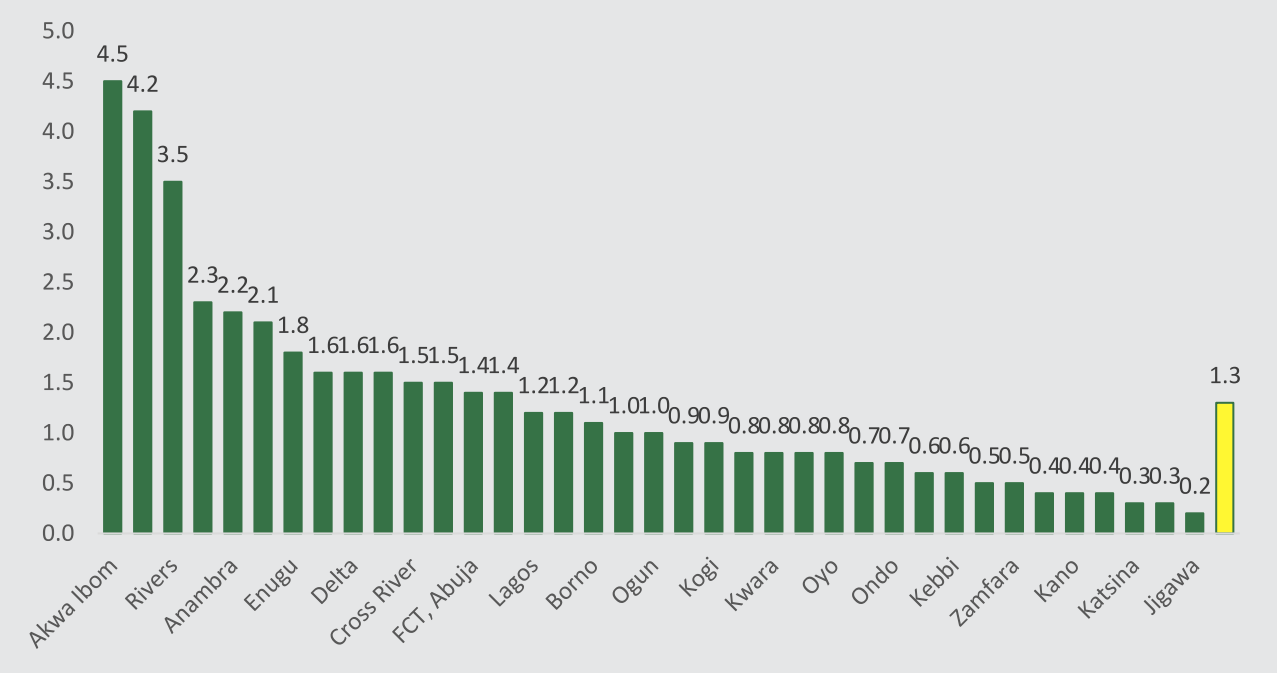
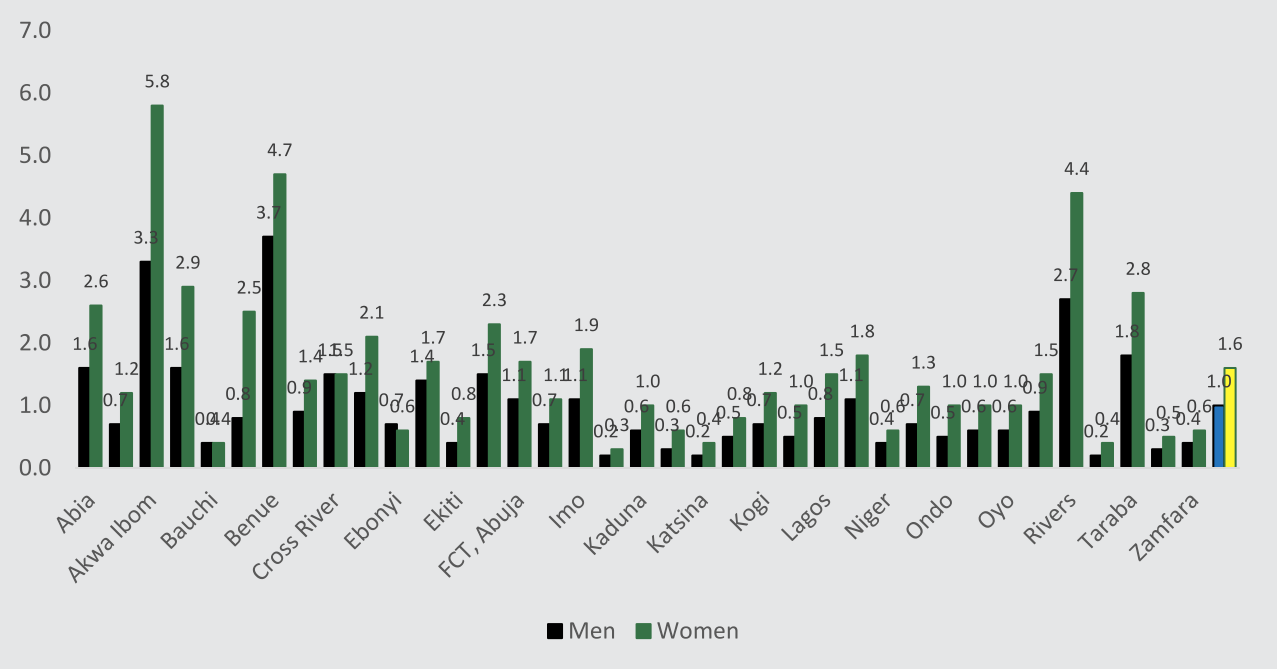


Figure 8: *HIV prevalence across the 36 states and FCT*



Akwa Ibom, Benue and Rivers state report the highest HIV prevalence at 4.5%, 4.2% and 3.5% respectively, while Jigawa, Katsina and Sokoto state report the lowest HIV prevalence at 0.2%, 0.3% and 0.3% respectively. Six states – Akwa Ibom, Benue, Rivers, Taraba, Anambra, and Abia – account for 41% of people living with HIV in Nigeria. A number of reasons have been given for the high HIV prevalence in these states, for instance Benue and Akwa Ibom are coastal states where economic activities of migrant fishermen and petroleum oil businesses have favoured high levels of transactional sex in the coastal cities.[49] Anambra and Kano are national trade centres with major junction towns and businesses; and a resultant high influx of people on a daily basis making its towns and villages hotbeds of transactional sex.[50]

Furthermore, examining the correlation between culture and high HIV prevalence in Benue and some other high burden states identified permissive casual unprotected sex, rare long-term monogamous unions,

[49] (National Agency for the Control of AIDS, 2014)
[50] (National Agency for the Control of AIDS, 2014)

polygamy, unsafe blood transfusion and quack medical practice as major associated factors. In terms of risk settings, commercial sex workers, truck drivers, youths and migrant traders combine to sustain the epidemic in the high burden states.[51]

NAIIS also indicates that HIV prevalence is highest in rural areas than urban (1.5% vs 1.3%) and also highest among respondents with primary education while it is lowest among respondents with no education (2.0% vs 1.1%) while along the wealth continuum, HIV prevalence is highest among the middle quintile and lowest among those at the lowest rung of the ladder(1.7% vs 0.8%).[52]

Table 2: *HIV prevalence across socio demographic characteristics*

Sociodemographic characteristics	**Place of residence**		
	Men	**Women**	**Total**
Urban	0.9	1.6	1.3
Rural	1.0	1.9	1.5
Sociodemographic characteristics	**Education**		
	Men	**Women**	**Total**
No education	0.8	1.3	1.1
Primary	1.3	2.5	2.0
Secondary	1.0	1.9	1.4
Tertiary	0.9	1.9	1.3
Others	0.4	0.6	0.5
Sociodemographic characteristics	**Wealth quintile**		
	Men	**Women**	**Total**
Lowest	0.6	1.0	0.8
Second	0.8	1.5	1.1
Middle	1.1	2.3	1.7
Fourth	1.1	2.2	1.6
Highest	1.1	1.8	1.4

Interestingly, across all socio-demographic indicators and strata, women are worse off (Table 2). In both rural and urban areas and across all levels of education and wealth, women report higher HIV prevalence than men.[53]

2.1.2 HIV PREVALENCE AMONG KEY POPULATIONS

Nigeria's HIV and AIDS epidemic has been described as generalised but there are concentrated epidemics among key populations, i.e., TG, FSW, MSM and PWID.

Among key populations, prevalence is highest among Transgender (28.8%), followed by MSM (25%), FSW (15.5%) and PWID (10.9%)[54] (Figure 9). Data from the IBBSS shows an increase in HIV prevalence among MSM

[51] (National Agency for the Control of AIDS, 2014)
[52] (Federal Ministry of Health, 2019)
[53] (Federal Ministry of Health, 2019)
[54] (Federal Ministry of Health, 2021)

and PWID between 2007 and 2020. Between 2014 and 2020, HIV prevalence among PWID more than tripled from 3.4% to 10.9%. [55][56]

Among FSW, HIV prevalence has been consistently higher among the brothel-based sex workers, although there were some declines between 2007 and 2020 (37.4% to 17.1%) and non brothel-based (30.2% to 15.0%).[57] [58] This decline may be attributed to the prioritisation of prevention interventions for these groups of key populations by implementing partners and donors.[59] On the contrary however, in another journal article, findings indicated that a higher proportion of NBB FSWs reported being forced to have sex without condoms compared to the BB FSWs. The communal structure of the brothels may discourage and reduce incidents of sexual violence within the brothel by partners and/or clients.[60] With the gender inequalities and gender power plays that abound within the society especially among vulnerable groups of women, FSWs are often exposed to sexual violence and rape from intimate partners and clients. Whichever way, HIV prevalence increased from 14.4% in 2014 to 16.7% in 2020 among FSW generally and it is still unacceptably higher when compared to the general population.

The story is different among MSM where the prevalence almost doubled from 13.5% to 25% during the same period (2007 to 2020). The considerable increase in HIV prevalence among MSM is concerning.[61] This increase may be partly attributed to the Same Sex Marriage (Prohibition) Act 2013 passed into law by the federal government. The prohibitive and restrictive environment has driven MSM underground and made it more challenging to reach these communities with HIV information and services. This, in addition to the criminalisation of sex work by a number of states including the FCT is a major impediment that continue to fuel the epidemic among this and other key populations.

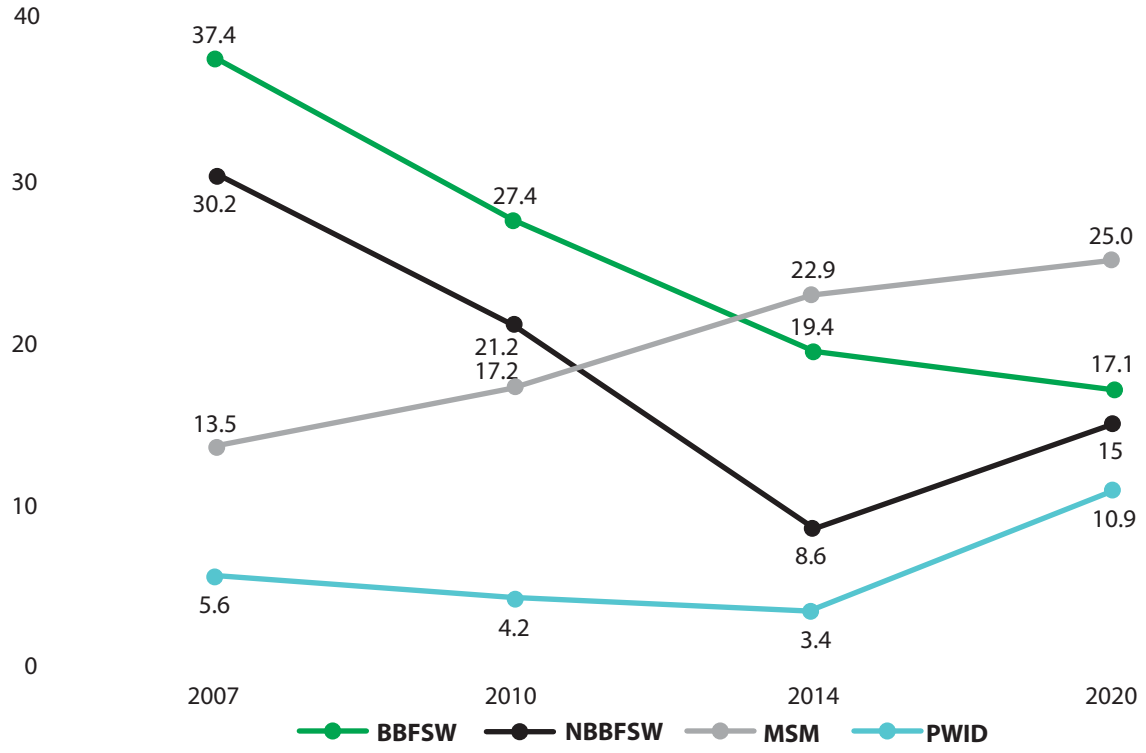


Figure 9: *HIV prevalence among key populations*

[55] (Federal Ministry of Health, 2015)
[56] (Federal Ministry of Health, 2021)
[57] (Federal Ministry of Health, 2007)
[58] (Federal Ministry of Health, 2021)
[59] (National Agency for the Control of AIDS, 2014)
[60] (Okafor, Crutzen, Ifeanyi, Adebajo, & Van den Borne, 2017)
[61] (Federal Ministry of Health, 2021)

Among the KP on ART, FSW reported the highest rate of viral suppression at 83.3% followed by MSM at 72.4% and lastly Transgender at 65.5%.

2.1.3 HIV INCIDENCE

According to UNAIDS 2020 estimates, Nigeria had an incidence rate of 0.61 per 1000 persons. This translates to approximately 61,000 new infections among adults aged 15 to 49, with women making up majority (60%) of these new HIV infections.[62] As with prevalence, among young people, the disparity between both genders is more pronounced, with young women reporting more than double (70%) the number of new HIV infections in comparison to young men (16,000 young women vs 7,100 young men).[63]

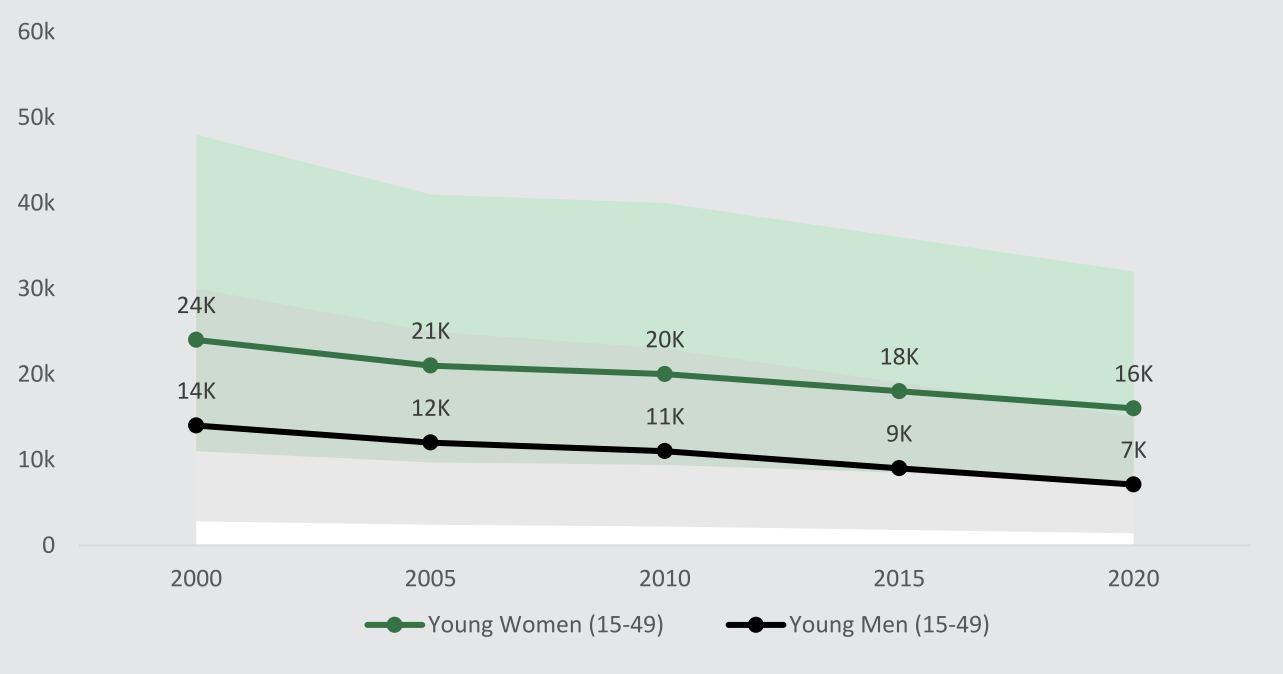


Figure 10: *New Infections*

2.1. 4 AIDS RELATED DEATHS

Despite significant progress in the epidemic response, AIDS remains the 5th leading cause of deaths in Nigeria for both men and women. Although more women are being infected and living with HIV, UNAIDS estimate that more men are dying from HIV/AIDS.[64] 2020 data show that 15,000 adult men (aged 15 – 49) died from HIV compared to 13,000 women in the same age group.[65] The fact that more men are dying from HIV suggests that men are accessing HIV services less than women.

[62] (UNAIDS , 2021 (A))
[63] (UNAIDS , 2021 (A))
[64] (UNAIDS , 2021 (A))
[65] (UNAIDS , 2021 (A))

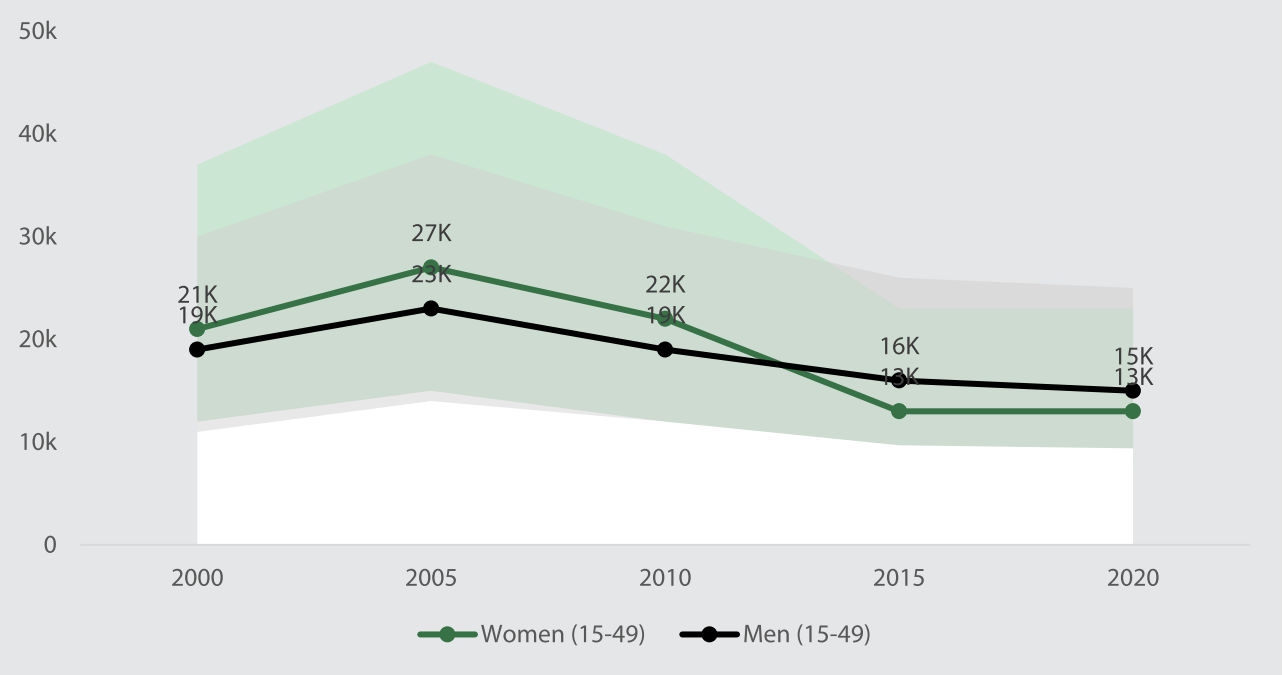


Figure 11: *AIDS related death disaggregated by sex*

2.1.5 Testing and Treatment Cascade

Across the HIV treatment cascade, women reported markedly better results compared to men. More women know their HIV status (>98% women vs 79% men), more women who know their status are on treatment (>98 women vs 73 men) and more women are virally suppressed (85% vs 61%). This is partly due to better health seeking behaviour among women; and the existence of HIV-related services designed specifically to reach women (such as services to prevent mother-to-child HIV transmission that are provided during antenatal care). Over the years, there have also been HIV programming and services targeted at women which are also yielding results.

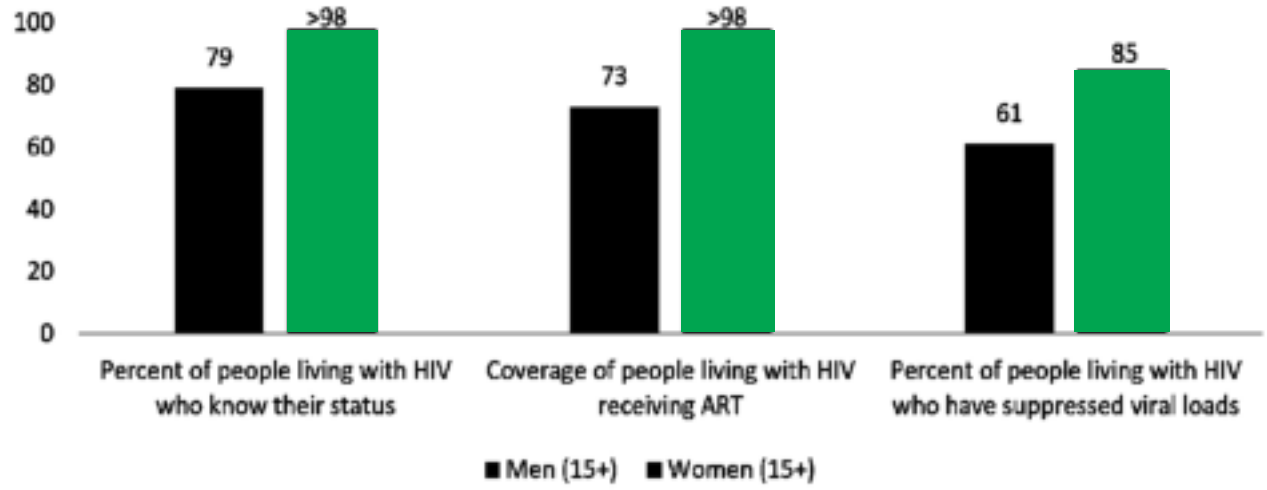


Figure 12: *HIV treatment cascade disaggregated by sex*

Over the last 5 years, the number of men and women on ART has steadily increased, however, each year more women are on ART and virally suppressed compared to men.

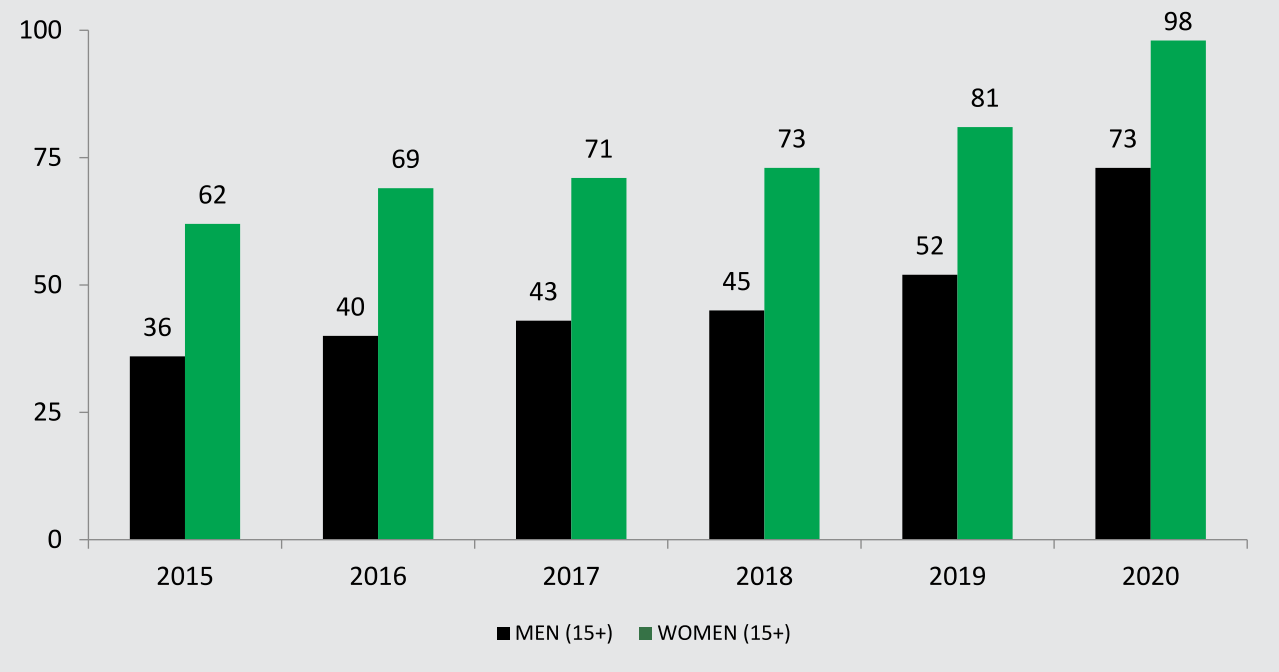


Figure 13: *Percent of people living with HIV receiving ART disaggregated by Sex*

2.2 STRUCTURAL DRIVERS, RISK AND VULNERABILITY FACTORS FOR HIV EPIDEMIC

Evidence from research shows a complex relationship connecting HIV with different 'upstream' drivers of vulnerability.[66] Structural drivers including poverty, cultural/social norms and practices, sexual and gender based violence, among others, shape patterns of risky behaviours and vulnerability to HIV. There is also evidence that addressing these drivers over time results in changing patterns of vulnerability, increasing access to and demand for biomedical interventions, and improving ART adherence.[67] This section discusses selected drivers and drills down on how they result in risky behaviours that predispose women and men to HIV infection and increase the impact of the epidemic.

2.2.1 SOCIO CULTURAL AND ECONOMIC FACTORS

2.2.1.1 POVERTY

Poverty entails more than the lack of income and productive resources to ensure sustainable livelihoods.[68] Poverty includes deprivation, constrained choices, and unfulfilled capabilities, and refers to interrelated features of well-being that impact upon the standard of living and the quality of life.[69] Empirical evidence suggests that HIV/AIDS is a disease of poverty.[70] [71] [72] [73] [74] Similarly, several studies on HIV/AIDS in Nigeria have long since established the inter-relation between HIV and poverty.[75] [76] [77] [78]

[66] (STRIVE, 2022) http://strive.lshtm.ac.uk/resources/addressing-structural-drivers-hiv
[67] (STRIVE, 2022) http://strive.lshtm.ac.uk/resources/addressing-structural-drivers-hiv
[68] https://www.un.org/en/global-issues/ending-poverty
[69] (Mbirimtengerenji, 2007)
[70] (Hawkers & Ruel , 2005)
[71] (Chacham , Mala , Greco , Silva , & Greco , 2007)
[72] (Cluver & Gardner, 2007)
[73] (Foster , 2007)
[74] (Ezeokana, Nnedum, & Madu, 2009)
[75] (Udoh, Mantell, Sandfort, & Eighmy, 2009)
[76] (Oyefara, 2007)
[77] (Udoh, Mantell, Sandfort, & Eighmy, 2009)
[78] (Maijama'a & Kachalla , 2013)

For example, the 2004 Human Development Report of Nigeria stated that "poverty increases vulnerability to HIV and other STIs". Fast forward to 2022, and poverty still strongly influences the burden of disease in the country. The 2019 Poverty and Inequality study in Nigeria, reported that 40% of the total populace, i.e., about 83 million people live below the country's poverty line.[79] With the economic effects of the COVID-19 crisis coupled with natural population growth, it is estimated that the number of poor people will increase to 100 million, or 45% of the population, in 2022.[80]

Under conditions of grinding poverty, the risk of HIV assumes a lower priority among people's daily concerns. People in such circumstances are more concerned about the immediate consequences of survival than the chances of contracting a virus whose effects do not manifest immediately. The poor lack recreational facilities and often sex becomes the means for passing time. Poverty may also drive women into trading sex for money, food and other goods. Poor people migrate from rural areas to urban settings in search of jobs, leaving their closely-knit family settings for an environment where sexual risk takings are higher than in their rural home areas. Indeed, it has been argued that poverty is the greatest single facilitator of HIV transmission in Nigeria.[81] The 2019 Poverty and Inequality report produced by National Bureau of Statistics indicates that female heads of household in Nigeria are less likely to be poor than male heads of household. However, further analysis of the report by BFA Global shows that among heads of household, women in Nigeria are in fact poorer than men.[82] That is, female heads of household have higher rates of poverty, taking account of other determinants of poverty.[82]

When all the households in the country are considered, those with female heads of household appear to have a lower overall rate of poverty, as reflected in the report. The intuitive explanation is that women must be better off than men in the aggregate, but it does not hold up to scrutiny. If the rates of poverty conditional on the main determinants of poverty is considered, it turns out that female heads of household have higher rates of poverty than their male counterparts. In the aggregate, women appear to be doing better but at a comparable household size, men are less likely to be poor.[82]

The findings of this analysis are consistent with other studies that also suggest that poverty in Nigeria is feminised.[83] [84] These studies suggest that women in Nigeria –especially in rural settings –tend to have a lower economic status, i.e. poorer than men, which increases their vulnerability to engaging in high-risk or transactional sex. Poverty can also lead to dependence on men, which creates a power imbalance in relationships, making it challenging and sometimes even dangerous to negotiate safe sex. Furthermore, the immediate worries of poor women such as paying rent or having enough food their children, may reasonably take precedence over protecting themselves from HIV. Therefore, poverty greatly limits the decision-making power of women and increases their vulnerability to HIV.

Poverty functions as a proxy for variables that increase the risk of disability, including unsafe living and working conditions, poor health and nutrition, and low educational attainment.[85] Every FGD and KII conducted with PLHIV and KP groups as part of this study highlighted how HIV infection can be an outcome of poverty as well as a contributor to poverty. Poverty was also cited as a major economic driver of the epidemic especially among women, adolescent girls, and boys.

The findings of this study suggest HIV is a disease of inequality in which poorer individuals experience disproportionate morbidity and mortality from infection. This association was assumed to be consistent across social and geographic contexts in Nigeria, with poorer individuals in poorer areas at greatest risk of HIV infection. However, these findings are in contrast with NAIIS figures which show HIV prevalence increasing with wealth (Table2).

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[79] https://www.worldbank.org/en/programs/lsms/brief/nigeria-releases-new-report-on-poverty-and-inequality-in-country

[80] https://blogs.worldbank.org/opendata/using-data-combat-ongoing-crisis-and-next-nigeria#_ftn2

[81] https://www.undp.org/sites/g/files/zskgke326/files/publications/37.pdf

[82] https://bfaglobal.com/insights/the-enduring-gender-gap-in-nigerian-household-headship/

[83] (Boyi, 2019)

[84] (Adepoju, 2004)

[85] (Aluko, 2020)

There are several potential explanations for these observations. One explanation suggests that the wealthy and educated may feel insulated from the risk of HIV infection and therefore do not take the same precautions others do.[86] Another example suggests that relatively rich and better educated men and women have higher rates of partner change because they have greater personal autonomy and spatial mobility – therefore they have greater risk of HIV.[87]

Another explanation suggests that the NAIIS being a household -based survey, covering household populations, misses people who are not in households, especially some of the poor who may not be living in households or in dwellings. The World Bank estimates that roughly 13% (over 24 million) of the nation's overall population is homeless,[88] and because majority of the homeless are poor, they may have not been covered in the NAIIS, 2019. This explanation agrees with findings from the FGDs and KIIs of this study, with members of PLHIV groups, especially KP groups interviewed during this study stating that they have no fixed abode or households and move around often, due to fear of violence and discrimination because of their orientation and HIV status; they also identified as "poor" and strongly affirmed how poverty increases their risk of HIV and vice versa.

The links between socioeconomic conditions, such as wealth and education, and HIV prevalence and risk are complex, perhaps too complex for a single explanation. What can be appreciated is the need for more studies that employ qualitative and quantitative research methods to not only answer questions of what but also of why.

> *"you don't expect that you are spending so much on a lady and I'm a yahoo boy I ask you for sex and you tell me you can't give me sex and the yahoo boy has this psychological effect on them because of too much money that they feel they can do anything and get away with it and when a lady acts that way and say I cannot give you that sex without protection, they tend to be violent or even rape her. Some are so brutal that they will call their fellow guys and have sex with the girl eventually"* - FGD with PLHIV, Lagos State

Boys and girls alike are influenced by their peers and social media and in a bid to belong, they do anything to have money including having sex with persons they don't know. Poverty drives many girls to accept relationships with 'sugar daddies' (older men who are prepared to give money, goods or favours in return for sex).[89] [90] The unequal power relations reflected in such relationships affect adolescent girls' ability to refuse unsafe sex, and expose them to sexually transmitted infections and diseases, including HIV.[91] [92]

The act of paying for sex introduces an uneven negotiating ground for safer sexual intercourse. Transactional sex is the exchange of money, favours, or gifts for sexual intercourse. This type of sexual intercourse is associated with a greater risk of contracting HIV and other sexually transmitted infections (STIs) because of compromised power relations and the likelihood of having multiple partners.[93] Participants mentioned that their need for money to meet their basic needs made it very difficult to negotiate condom use or practice safe sex.

> *"If somebody want to have sex with me without a condom and I keep saying no, they will drop big money and that will weaken my stance, because when I start thinking about how I can even support my family with that kind of money, I need money to put food on the table"*- FGD with PLHIV, Lagos State

2.2.2 CULTURAL/SOCIAL NORMS AND PRACTICES

[86] (Andrus, Mojola, Moran , & Eisenberg, 2021)
[87] (Gillespie, Kadiyala, & Greener, 2007)
[88] (World Bank, 2021)https://www.worldbank.org/en/country/nigeria/overview
[89]https://www.pulse.ng/news/local/hivaids-sugar-daddies-and-blessers-a-threat-to-fight-disease/jk5zfet
[90] https://bigthink.com/sex-relationships/the-troubling-persistent-phenomenon-of-sugar-daddies/
[91] (Bamidele, Abodunrin, & Adebimpe, 2009)
[92] (Smith, 2002)
[93] (National Population Commission (NPC) and ICF, 2019)

2.2.2.1 PATRIARCHY AND MALE CHILD PREFERENCE

Gender inequalities that are grounded in systems either in the family, community, health, and education systems are major drivers of the epidemic. Men are seen as the head over women, and they have rights, but women are subject to them.

The patriarchal nature of the society that inherently condones gender inequalities seems to be strongly engrained in culture. This begins early where boys are socialised and expected to be strong and to be the breadwinner. The male child is told to be in absolute control and thus takes decisions on everything including on his wife's health and well- being.

Many women who test positive for HIV face blame and backlash from their husbands. Subsequently, they cannot visit a health facility without the permission of their husband. In addition, due to stigma and fear of discrimination, the men may not go to collect their medication, and may refuse to allow their wives to do the same. In some circumstances, they may both resort to taking herbs.

> *"You have women usually playing second fiddle such that they cannot make informed decisions pertaining to their health without input or plain directive from the males"*-KII with implementing Partner, Lagos State.

> ***"Men by culture are expected to keep secrets. They therefore don't disclose their HIV status to their wives, even when on treatment. This has implications for further transmission and drug adherence" -*** FGD with CSO, Akwa Ibom

Nigeria, like many other nations, is patriarchal in nature with stereotypes on expectations of boys' and girls' behaviours. These negative masculinity and stereotypes mostly affect men in their health seeking behaviours. Men are seen and treated as superior, stronger and 'emotionless' by the society and they also try to maintain the status quo. Men and boys are influenced by many gender norms that affect their health and discourage them from accessing health services. The concept of masculinity and the stereotypes associated with it create conditions that make having safer sex, taking an HIV test, accessing and adhering to treatment—or even having conversations about sexuality—a challenge for men.[94] These views were corroborated by participants during FGD sand KIIs.

In Nigeria, the preference for sons is very prevalent and exists in several cultures as it dates back to pre-historic times and it is tied to inheritance. Some changes have occurred. A landmark judgment in 2004 upheld women's right to inherit property. This judgment was appealed and has been upheld by the Supreme Court, in two recent judgments (2020) which abolished the ancient culture in Igboland that denies women the right of inheriting property in their father's house. A-5 person panel of Justices of the apex court, held that the practice conflicted with section 42(1)(a) and (2) of the 1999 Constitution.[95] it has not succumbed to societal changes but has remained sacrosanct because of the desire for a son to carry on the family name and guarantee the family lineage. Not having a male child is seen as a challenge to the sustainability of the family name. Anecdotal evidence from the field study shows that in some cultures in the south east, a family with only female children may retain one of the girls at her parents' homes to try her luck with different men in the hope of siring a male child. This finding corroborates evidence from Urama's paper of 2019 titled *The Values and Usefulness of Same Sex Marriages Among the Females in Igbo Culture in the Continuity of Lineage or Posterity* which states the following,

> *A man who does not have a male child after marrying many wives performs some traditional rites and allows one of his daughters not to get married. She is to stay in his home and produce male children who will bear his name. Her parents arrange a man who would be*

[94] (Pascoe, Peacock, & Stemple, 2018)
[95] (Vanguard Newspapers, 2020) https://www.vanguardngr.com/2020/08/supreme-courts-decision-on-female-inheritance-divides-igbo/

impregnating her. In some part of Igboland, the girl may be allowed to choose her own lovers. The ritual, known as Nluikwa makes the daughter a "male daughter.".[96]

This practice exposes the so-called male daughter to HIV risk because she cannot negotiate for safer sex. Men are at liberty to have multiple sexual partners and also prefer to go 'raw' without the use of condom while the woman is not at liberty to have multiple sexual partners and has no right to demand for the use of condom because then she will even be viewed as being promiscuous. Again, all these put the woman at a disadvantage and increase her vulnerability.

The issues of male child preference and child marriage encourage multiple sexual partnerships. Women not having control also debars them from negotiating safer sex as well

"Men tend to now go and have several partners outside in a bid to look for a male child and end up having different partners that they have to sleep with without using any form of protection and you don't know what type of disease is in the other partner's body, you'll see a man having like 3-4 different partners, all in the bid of looking for a male child, and then comes back to the same woman and also have sex with her and he can also transmit if there is any disease"-FGD with CSO, Anambra State

Men engage in multiple sexual relationships either in their bid to get a male child or just for the fun of it. Again, men are said to be busy and cannot afford the waiting time in health facilities. These gender norms that encourage male dominance and emphasise myths of male invulnerability are also harmful to men and boys and can fuel new infections, transmission and access to HIV services.[97] It may also be responsible for lower viral suppression among males.

2.2.3 HARMFUL TRADITIONAL RITES

WIFE INHERITANCE

Other harmful practices include wife inheritance, also referred to as the levirate marriage. This occurs where a "family member inherits a married woman whose husband is dead", and it continues to be practised under various customary law systems in Nigeria.[98] Levirate marriage is considered a custom of the Yoruba, the Igbo, and the Hausa-Fulani and continues to be practiced in rural communities.[99] Described as "degrading and harmful", the practice of levirate marriage has been identified as one of the leading causes of the spread of HIV/AIDS in Nigeria.

This arrangement is akin to a forced marriage and exposes the woman to marital rape, and HIV infection for them both if either is HIV positive, as well as for the existing wife or wives of the brother, and their babies if they become pregnant. In essence, wife inheritance still persists, even when an AIDS-related death is the reason that the woman is widowed. in one study, about one in three of the Nigerian men interviewed said they would still inherit their brother's wife should he die of AIDS.[100] Furthermore, in certain states, for example, Lagos and Akwa Ibom, cultural festivals that involve unsafe sex are regularly held. An example is Salejeje, which is observed in some Yoruba communities as 'the day of the concubine'. Participants at such festivals are at risk of HIV infection through unsafe sex.

2.2.3.1 POLYGAMY

Although NAIIS data show that HIV prevalence is low among individuals in polygamous unions, in the FGDs, polygamous unions were perceived by the FGD participants to be one of the risk factors for HIV. According to participants, polygamy and wife inheritance are common practices in Nigeria and they opined that these practices have led to many cases of HIV transmission. Polygamy is culturally accepted and in addition, men

[96] (Urama, 2019) https://journals.sagepub.com/doi/full/10.1177/2158244019850037
[97] (Genyi & George-Genyi, 2013)
[98] (National Agency for the Control of AIDS, 2013)
[99] (National Agency for the Control of AIDS, 2013)
[100] (Atilola, Akpa, & Komolafe, 2010)

are encouraged to also keep concubines outside the home, so having multiple sexual relationships is seen as normal for men.

2.2.3.2 WOMEN'S DECISION MAKING

Women hardly have a voice in anything without the man's consent by societal design and this affects women and continues to fuel HIV infection, transmission and even access to services. Some of the factors identified as drivers of the epidemic among women include inability to negotiate safer sex, lack of power to unilaterally take decisions about health, empowerment and other vital issues. Reports of NDHS 2018 also corroborated the fact that 55.5% of health decisions for women are taken by their husbands.

Men are seen as the head, and they have rights but women are subject to them. A woman is sick, before she goes to the hospital, she goes to the husband to ask for permission. If the husband says no, she isn't going, elders will support the man because of the rights he has over the woman. A woman gets pregnant, and she is ordered to go to an old woman (TBA) to take care of her even if she's educated

FGD with PLHIV Anambra State

2.2.3.3 SEXUAL AND GENDER-BASED VIOLENCE (SGBV)

Sexual and gender-based violence against women has been acknowledged worldwide as a violation of basic human rights. Increasing research has highlighted the health burdens, intergenerational effects, and demographic consequences of such violence. Studies have demonstrated strong links between SGBV and HIV infection, with violence as a risk factor for HIV as well.[101] Violence against Women and Girls (VAW/G) pervades the entire landscape (at home, school, the workplace, and the wider society) in the forms of sexual harassment, rape (including spousal rape), wife and child battery, widowhood rites, excessive burden of housework, and so on.
Data from Domestic and Sexual Violence Response Team (DSVRT) in Lagos in 2020 indicates that of the 2,584 reported cases among adults, 2,349 representing about 91% of total reported cases are women with domestic violence accounting for 73%.

Data from the 2018 NDHS shows that among women aged 15-49, 31% have experienced physical violence and 9% have experienced sexual violence; 6% of women have experienced physical violence during pregnancy. 36% of ever-married women have experienced spousal physical, sexual, or emotional violence. The prevalence of one or more of these forms of spousal violence was higher in 2018 than in 2008 (31%) and 2013 (25%). Key informants and focus group participants said that violence perpetrated by the husband's seen as normal. Being a patriarchal society, a man is expected to discipline his wife.

"Even at home among the married women, there are some men that will want to have sex with the wives and the woman will say no they'll still force the woman, beat her and have sex when they want to have sex, they don't care about the woman they beat and rape" –FGD with PLHIV, Lagos State.

However, few of those who face violence seek help. NDHS 2018 data show more than half of women (55%) who have experienced physical or sexual violence have never sought help to stop the violence; only 32% have sought help, approximately the same percentage in 2013 (31%). Women's own families are the most common source of help.[102] Sexually diverse persons also experience sexual and gender-based violence. A speaker at FGD among KPs said:

> *"They (rapists) are raping men and boys, not just girls, sometimes when you enter the facility, you will see just men and boys. In one month we had about 800 cases of rape, and these are the one s that came to the facility"* FGD with KP, Kano State

[101] (Apondi, et al., 2021)
[102] (National Population Commission (NPC) and ICF, 2019)

Studies have shown that rape victims are at risk of acquiring HIV, STIs, and a range of adverse reproductive health consequences. Furthermore, the impact on mental health of victims could lead to risky and destructive behaviours, depression and feelings of vulnerability, shame, guilt, fear and low self-esteem.[103]

2.2.3.4 CHILD MARRIAGE AND FEMALE GENITAL MUTILATION

Child marriage is any formal marriage or informal union where one or both people are under 18 years old. Child marriage and FGM/C are reflections of gender inequality and expressions of norms and traditions in which families and communities seek to protect girls from social and economic risks. Although there have been efforts towards eradication of these harmful traditional practices, early marriage is still a challenge as girls are seen as a source of wealth.

> *"Girls drop out of school for marriage especially if the family runs into hard times, it is the girls whom family drops out of school while the boy continues"* –FGD with CSO, Benue State
> *"Sometimes you see parents say that you know I don't have money and you know what your friends are doing to help their family you too you can do to help your family you are a girl you should be able to also bring something to the table so they see the girl child as a means of making money so they force the girl child into marriage when the child is not even ripe for marriage"* –FGD with PLHIV, Lagos State

In addition, the inconsistencies in the tripartite legal system (comprising statutory, customary and sharia laws) regarding the legal age of marriage complicates what child marriage is. For example, early marriage is encouraged under the article 16 of the Muslim Code and the minimum marriageable age is 15 for both sexes.[104]

The consequences of early marriage are far-reaching: married girls are likely to drop out of school, some are withdrawn from school to get married. Uneducated girls lack voice to participate in decisions at the family, community and wider societal levels, including negotiating safe sex. The impact of keeping girls in school on HIV prevention cannot be overemphasised. Studies have shown that each additional year of secondary schooling for girls leads to an absolute reduction in the cumulative risk of HIV infection of 11.6 percentage points.[105]

Girls are also at risk because, culturally, they marry older men who have had other sexual partners. This can predispose them to an increased risk of bleeding during intercourse which may increase the risk for HIV transmission. Also, the increased prevalence of herpes in women subjected to female genital mutilation may also increase the risk for HIV infection, as genital herpes is a risk factor in the transmission of HIV.[106]

2.2.3.5 FEMALE GENITAL MUTILATION

Female Genital Mutilation (FGM), also known as female genital cutting or female circumcision, is defined by the World Health Organization (WHO) as any procedure that involves partial or total removal of the external genitalia and/or injury to the female genital organs whether for cultural or any other non-therapeutic reasons.[107]

Data from NDHS 2018 shows that 20% of women aged 15-49 are circumcised, a decrease from the figure of 25% reported in 2013. Eighty-six percent of circumcised women aged 15-49 were circumcised before age 5,

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[103] (Oluwaleye & Adefisoye, 2021)
[104] (Cherry & Dillion, 2014)
[105] (Jan-Walter , Günther , Subramanian, Sikhulile , & Jacob , 2015)
https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(15)00087-X/fulltext

[106] https://www.unaids.org/en/resources/presscentre/featurestories/2008/march/20080304jointstatementfgm

[107] https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation

while 5% were circumcised at age 15 or older.[108] FGM is recognised internationally as a violation of the human rights of girls and women.[109] It reflects deep-rooted gender inequality and constitutes an extreme form of discrimination against women. One of the FGD participants said

> *"Although there is no need to cut the female child, this practice still goes on"….."There is no assurance that these people sanitize their cutting equipment and that is how you will see HIV being transmitted from one person to another"….."I thought this practice no longer happens, but a colleague confirmed to me that their cousin was just cut very recently"* - FGD with NEPWHAN, FCT

2.2.3.6 STIGMA AND DISCRIMINATION

Despite decades of scientific advances in prevention and treatment, as well as widespread awareness-raising efforts, irrational fears of HIV infection and negative attitudes towards people living with HIV are persistent barriers to addressing the epidemic.[110] Data from the Demographic Health Survey 2018, indicate that 47% of women and 46% of men think that children living with HIV should not be able to attend school with children who are HIV negative; 53% of women and 50% of men would not buy fresh vegetables from a shopkeeper with HIV.[111]

Again, the only trend is with regards to the second indicator and there is not much difference between 2013 NDHS and 2018. In the 2013 Report, 51% of women and 46% would not buy fresh vegetables. The implication is that stigmatisation still persists.

During the 2014 Stigma Index Survey in Nigeria, a total of 4,241 PLHIV were interviewed. Forty five (1.1%) respondents claimed that they were denied access to healthcare services due to their HIV status. In addition, many respondents (89.8%; 3,808 PLHIV) were denied family planning services. 39.2% (n=1663) of respondents reported feeling ashamed because of their HIV status and 7.1% reported feeling suicidal. Likewise, 8.6% of respondents reported they were tested for HIV without their knowledge. Less than one quarter of the respondents were aware of the national law, policy and set guidelines on HIV/AIDS, while less than half had any knowledge of the declaration of commitment from the government.[112]

In 2021 however, the Stigma Index Survey revealed that 1,240 PLHIV were interviewed, whereas 1.1% reported being denied health services due to HIV care; 0.1% were denied family planning while 19.5% reported that their status was disclosed without their consent. On a general note, it would seem that stigma and discrimination is still an issue as various human rights abuses as a result of forced disclosure ranges from 16% to 26% and is higher among women.[113]

Some participants shared some of their battles

> *"It happens every day, on a daily basis, it happens because I am a gay man, I am effeminate, even when I am just walking alone on the street, without talking to anybody, I get discriminated. Some people go as far as throwing pure water on me. "Na them be that" "Useless people" "Kill them" for just walking alone. Now when they find out that I'm HIV positive, that becomes double stigma. They stigmatise me because I am HIV positive. The stigma gets worse because they believe that HIV virus is caused by gay people"* -FGD with KP, FCT

For the key populations who are made up of FSW, MSM, PWID and transgender, it is a cultural and religious taboo to self-identify because they 'do not fit or align culturally to what is societally acceptable'. Their sexual orientation and gender identities and practices do not align with societal norms and as such they are not

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[108] (National Population Commission (NPC) and ICF, 2019)
[109] (World Health Organization, 2020)
[110] (UNAIDS, 2014)
[111] (National Population Commission (NPC) and ICF, 2019)
[112] (Network of People living with HIV/AIDS in Nigeria, 2014)
[113] (Network of People living with HIV/AIDS in Nigeria, 2021)

accepted. This is evident in derogatory languages used and high level of discrimination against them. Laws correctly or incorrectly interpreted exacerbate the woes of this group and further drive them to the background.[114] To openly acknowledge their gender identities is not an encouraging option for fear of being mobbed and nabbed. Two quantitative studies with MSM in Nigeria have found that sexual orientation stigma served as a barrier to HIV testing and healthcare utilization.[115] [116]

> *"Inasmuch as we know that FSW is not accepted but they still patronise them, married men, singles still patronize them but when it comes to MSM, they don't even want to hear about them, they see it as a total taboo"*-FGD with PLHIV, Lagos State

> *"Anyone who is not heterosexual by orientation is seen as a taboo in Benue state. Culturally therefore, lesbians, gays, bisexuals, transgender, queer, and other key populations like female sex workers, people injecting drugs and men who have sex with other men are not accepted. The discrimination of these groups of Benue indigenes which is so high everywhere, at the health facility, in schools, in churches and other places of worship, in the community and at the workplace has driven them underground"*- KII with CSO, Benue State

> *"My gender expression has always been feminine. My parents were divided about me with my dad being really angry and abusive when I did 'girly' things or exhibited 'weaknesses' as expected of female children"* – KII with Transgender female, Akwa Ibom State

A STORY OF HATE AND TRIUMPH

I am a young bisexual male, born into a polygamous Christian family.
Growing up, everything about me was of the church. I was in the choir and I play many instruments. I was born into one of the old orthodox churches. Because of my sexuality, I was very conscious of what part of me I exposed. As a result of biblical teachings and what I hear preached I was extremely careful. I found the church a safe space but was not comfortable enough to disclose my sexuality.
I cannot say when or how my sexuality was noticed or queried in the Church. On one fateful day, the Overseer requested that all young people in the church bring in and submit their cell phones. I didn't think anything of it and I submitted mine, they must have seen my chats and the sites I visit frequently they planned to deal with me. At this time, I was an anti-GBV peer educator with an NGO, and a community role model. Recounting this story remains really traumatic for me. Knowing I had to speak to you I had sleepless nights yesterday as what I went through is still so fresh and painful that I met with this kind of treatment in a community that I put in my everything and that I called home.
The following day, after choir rehearsals I was called to follow the Pastor to the back of an uncompleted building for a meeting. The minute we got there I was beaten. Many other church workers came on the scene and once the story of rape was told to them, they joined the assault. I was thoroughly beaten up with planks and stones and was swollen and bleeding all over. My legs were broken, and the same people that I had called family for about 8 years now ostracised me. I was taken to the Overseer whom I took as my father and my hopes of rescue were dashed when he too flogged me with his belt and kicked me as I laid on the floor broken. One of them decided to take me to the Police Station and right in my presence they reported me of raping a boy. At the Police station, I shared my HIV status thinking that would help me. To my surprise the assault on me at the Police Station worsened. I had called in my guardians because I had lost my parents and they too spread the word about my sexuality, warning their children and other children in the extended family to stay away from me. It was my guardians who began to spread the falsehood that I had raped a younger boy in the Church including to my landlord who in turn told the other tenants, the community and area boys. I was very scared for my life. I got a grant from an NGO that supports survivors of GBV which was meant for my house rent.
I was ex- communicated from the church which was extremely painful for me. I have since gone back to my original church who have no clue about my sexuality. A shocking experience I had is that within the KP community, when I shared my story hoping it will bring me healing as previously counselled, I was discriminated against.

[114] (Alubo,, Zwandor, Jolayemi, & Omudu, 2002)
[115] (Schwartz , et al., 2015)
[116] (Crowell , et al., 2017)

2.2.4 MYTHS AND MISCONCEPTIONS SURROUNDING HIV

According to the findings from the NDHS 2018, 73.4% of men and 72.5% of women say HIV cannot be transmitted by supernatural means; however, in this study some participants still believe that HIV can be transmitted via spiritual means indicating that
the myths around HIV are still rife.

> *"… if you ask 70% of people with HIV, they will tell you that is a spiritual arrow, we are so much affected with our beliefs that arrow is flying from left and right"* -FGD with CSO, Lagos State
>
> Other myths include the belief that HIV can be gotten through witchcraft and by sharing utensils with those infected. The belief that witchcraft and juju are the reasons behind being infected with HIV is driving prevention and care efforts negatively. People on therapy stop therapy after 'deliverance' either in the church or by a native doctor. An HIV positive person believes that the infection is due to arrows from the enemies and so it is viewed as a spiritual attack and must be handled spiritually not through drugs.
>
> Masquerade carriers in Benue State are believed to have special spiritual powers, and women strive to have sex with them for protection. Many of these men have to be under the influence of drugs to perform the rituals.
>
> *"People believe that sexual intercourse with a virgin can cure HIV" Some people believe that taking herbs can cure HIV" "I heard one strange belief that sacrificing an albino person can cure HIV"* - FGD with NEPWHAN, FCT

When religious leaders and traditional medicine specialists emphasise prayer and herbal remedies over ARV treatment, it undermines the medical system. Religious practices and ideologies are causing clients to defer or default from treatment believing that they are cured from HIV. As a result, there are many clients presenting to facilities with unsuppressed viral loads, AIDS and opportunistic infections.

Participants confirmed the findings of the Demographic Health Survey 2018 that people would not patronise a woman living openly with HIV if she is a food seller or a hairdresser (for examples) because of misconceptions about modes of transmission. In the survey, 53% of women and 50% of men would not buy fresh vegetables from a shopkeeper with HIV.

There are misconceptions of how HIV can be treated. For example, an FGD participant working at a facility mentioned the prevailing myth that a local drink called zobo could reduce viral load and produce a negative result even when a person is positive. People ten d to use it in an attempt to disguise their positive status. Belief in virgin cure is still prevalent and results in rape of young girls.

2.2.5 LEGAL AND POLICY ENVIRONMENT

Although several national laws have been domesticated in the states, there is no law that protects people of various sexual orientations and the law against Same Sex Marriage (the Same Sex Marriage Prohibition Act) totally discriminates against some members of the key populations. They are criminalised, with stated penalties / jail terms and are often harassed by law enforcement agents, a situation that tends to drive their activities underground.[117] Furthermore, criminalization of key populations also impedes their access to services. Indeed, a 2021 study found that countries that criminalize same-sex relationships, sex work and drug use have significantly more people with undiagnosed HIV and lower rates of viral suppression than countries that do not criminalize or criminalize these areas to a lesser extent.[118]

Participants reported lack of legal redress for MSM to seek support or redress because they are not socially acceptable and there are no laws protecting them and their sexual orientation. A plural and incongruent legal system in which important human rights issues regarding marriage age, divorce, inheritance and domestic violence are regulated by statutory, customary and Islamic laws, each speaking a different tune, makes access

[117] (Allman, Adebajo, Myers, Odumuye, & Ogunsela, 2007)
[118] (Kavanagh, et al., 2021)

to justice difficult. New laws that ordinarily should address inequality such as the Child Rights Act (CRA) and the Violence Against Persons Prohibition Act are only enforceable in the Federal Capital Territory and in the States where these laws have been domesticated. The CRA has been domesticated in all, except 11 Northern States, out of 36 States of the Federation. These are Sokoto, Kano, Zamfara, Kaduna, Jigawa, Katsina, Bauchi, Yobe, Borno, Adawama and Gombe.

Nigeria's extant laws on sexual and gender- based violence have been grossly inadequate to protect women and men and other sub-populations. The enactment of the Violence Against Persons Prohibition Act of 2015 is considered a step in the right direction as its provisions create access to justice, not just for women, but for men and boys. This is important for the national HIV response as the gender assessment reveals that rape is commonplace and is experienced across genders.

The Penal Code, applicable in Northern Nigeria, describes sex with a girl under 14 years of age or who is of unsound mind as rape, irrespective of whether there is consent. The document contradicts the provision of the Nigerian Constitution, which stipulates 18 years as the age of adulthood. The VAPP Act however recognises rape as a criminal offence irrespective of whether it is perpetrated on a minor or an adult.

While Section 282 of the Penal Code states that a husband cannot be charged with marital rape, the VAPP Act defines the offence of rape in Section 1(1) without an exception for marital rape, which had not traditionally been recognised as an offence (note that the Penal Code Act of 1960 does include an exception for marital rape).

There are differing punishments for the offence of assault against men and women in the Criminal Code Act, applicable in Southern Nigeria. In Section 353 unlawfully and indecently assaulting a man is a felony with three-year jail time and the perpetrator can be arrested without a warrant while in Section 360 unlawfully and indecently assaulting a woman is a misdemeanour with two years jail time.

The VAPP Act deviates from the Criminal Code by making provisions for a minimum jail term of 12 years, once rape is proven, irrespective of whether the victim/survivor is female, male or other gender.

> The Evidence Act of 1990, Section 211 states that "*when a man is prosecuted for rape, or for an attempt to commit rape, or for indecent assault, it may be shown that the women against whom the offence is alleged to have been committed was of a generally moral character.*" In the Evidence Act 2011, section 234 says:
> *Where a person is prosecuted for rape or attempt to commit rape or for indecent assault, except with the leave of the court no evidence shall be adduced, and, except with the like leave, no question in cross-examination shall be asked by or on behalf of the defendant, about any sexual experience of the complainant with any person other than the defendant.*

This is in consonance with the VAPP Act of 2015 which does not put any qualifications of moral character of the victim for justice to be served.

A novel achievement of the VAPP Act is the fact that it posits clearly that women and men can be raped. In addition to penetration of the vagina with the penis, the law recognises rape to include unlawful anal or oral penetration. Also, it expands the instrument of rape beyond the penis to include objects such as dildo, pens or pencils and body parts such as a hand. The VAPP Act thus focuses on violation of a person's body and not just penetration by genitals.

The VAPP Act only has the force of law in the Federal Capital Territory (FCT) unless it is domesticated at state levels. Several civil society organisations, including the over 150 CSO members of the Legislative Advocacy Coalition on Violence Against Women (LACVAW) have been at the forefront, advocating for the passage of the VAPP Act at State levels. A total of 27 States have passed the VAPP Act or equivalent legislations. Of the States visited for field work, only Kano and Taraba are yet to pass the Act. Taraba is at an advance stage in the process of domesticating the Act. However, study participants in Kano had never heard of the Act, except for the representative of the Ministry of Women Affairs.

Other legal, institutional and policy frameworks to address SGBV include the National Policy on the Elimination of FGM/C, the National Strategy to End Child Marriage, a Road map and National Priority Actions to End

Violence Against Children, the National Health Act and the One PHC per Ward Initiative, the establishment and institutionalisation of Sexual Assault Referral Centres (SARC) and State Domestic and Sexual Violence Response Teams (SDVRT) across the country including in the FCT. The FCT SDVRT brings together a team of agencies and civil society organisations in the forefront of providing holistic support to survivors of SGBV in the Federal Capital Territory- Abuja. The Lagos State Domestic and Sexual Violence Response Team (DSVRT) comprises of lawyers from Ministry of Justice, medical personnel from the Ministry of Health, representatives from Ministry of Youth Ministry of Women Affairs and the Nigerian Police.

Lagos and Ekiti States have Protection Against Domestic Violence Law and Gender-Based Violence Prohibition Law respectively, and they have some of the provisions found in the VAPPA.

PROTECTION AGAINST DOMESTIC VIOLENCE LAW OF LAGOS STATE, 2007

The Protection Against Domestic Violence Law of Lagos State (2007) is **Lagos**-specific and was passed to provide protection against domestic violence and for connected purposes. The law offers protection to any person who is or has been subjected or allegedly subjected to an act of domestic violence.

EKITI STATE GENDER-BASED VIOLENCE (PROHIBITION) AMENDMENT LAW, 2019

The Ekiti State Government has harmonised existing GBV Laws for clarity and to ensure effective persecution of offenders. Specifically, a key provision of the Violence Against Persons (Prohibition) Law is included in the Ekiti State Gender-Based Violence (Prohibition) Law, 2019. It is the provision on the expanded definition of rape as provided for in section 1 of the VAPP Act. Section 2 of the Ekiti Law is identical to that provision.

Most gender violence cases have also suffered delays or termination due to cracks in enabling laws to guide and protect victims from sex offenders. The Administration of Criminal Justice Act (ACJA) signed into law in 2015 provides for speedy dispensation of justice. It repealed the Criminal Procedure Act (CPA), Criminal Procedure Law (CPL), and Criminal Procedure Code (CPC) of the FCT, Southern and Northern Nigeria respectively. The purpose of the ACJA is to ensure that the system of Administration of Criminal Justice in Nigeria promotes efficient management of criminal justice institutions, speedy dispensation of justice, protection of society from crime and protection of the rights and interests of the suspect, defendant, and victim. Section 110 ACJA provides for a timeline in which criminal trials must be commenced and concluded in Magistrates' Courts. The Act requires that trial must commence within thirty days of filing and concluded within a reasonable time.[119]

Discriminatory social institutions drive inequalities between the sexes. These consist of informal sanctions, taboos, customs, traditions, and codes of conduct and formal rules that regulate behaviour and determine girls'/women's and boys'/men's claims to entitlements.[120] Unless social norms and discriminatory codes are addressed, development projects, no matter how well designed, may not fully deliver intended results to the generality of the people, especially those whose rights are not respected. Below are some highlights of findings from research that informed the 2019 SIGI report:

The legal system often provides little protection for women against violence. While rape is punishable by life imprisonment in Nigeria, the laborious process of proving rape, the pain and shame of reliving the experience coupled with societal pressure to keep silent, victim-blaming, and stigma dissuade women from reporting it.[121] The Police usually dismiss cases of domestic violence as a 'family affair' and are reluctant to intervene unless the woman has sustained serious injury. This leads to impunity on the part of husbands. Customary law offers even less protection. Under Sharia law, the husband can withdraw maintenance if his wife refuses sexual intercourse. Also, a woman alleging rape must produce four witnesses. If the rape is not proved, she can be

[119] (HURILAWS, 2019)

[120] (Otive-Igbuzor, 2013) https://www.ejirootiveigbuzor.com/wp-content/uploads/2018/02/Study-3-Analysis-of-Structural-Systemic-Causes-of-Gender-inequality-in-Nig-.pdf

[121] (US Department of States, 2011)

punished for adultery with a prison sentence or flogging.[122] These clearly highlight the need for awareness creation, legal reforms and access to justice for women whose rights have been violated.

Highlights of the Protection of Persons Living with HIV and Affected by AIDS Law of Lagos State[123]

> *The Law offers special protection to PLWHA, guaranteeing their all-round protection in private and public settings. It protects people that are not living with HIV by penalising endangerment to their lives through wilful infection. It protects health workers in all government health institutions by imposing on the state government the duty of providing them with universal safety tools to ensure safety in the performance of their duties. It provides for free distribution of anti-retroviral drugs to PLWHA from the Lagos State Anti-Retroviral Drugs Trust Fund.*
>
> *It provides that anyone could be a contributor to the Lagos State Anti-Retroviral Drugs Trust Fund. It offers social safety nets to vulnerable and indigent people affected by AIDS. It compels the formulation of HIV/AIDS policy by all corporate organisations for the benefit of employees who are PLWHA. It establishes the Justice and Human Rights Watch Group under the control and management of LSACA to monitor the implementation of the Law. It prohibits and penalises various discriminatory acts meted out on PLWHA.*
> *It does not compel employers to employ a job-specific unqualified employee. It does not mandate employers to employ where no vacancy exists.*

Who is protected under the Law?

> *The Law is non-discriminatory in its protection of People Living with HIV and AIDS (PLWHA) and others. Section 1 provides for the protection of everyone living with HIV and affected by AIDS in Lagos State.*

2.2.6 OTHER RISK FACTORS

2.2.6.1 BIRTH DELIVERY OUTSIDE THE HEALTH FACILITIES

Health facility delivery has been described as one of the major contributors to improved maternal and child health outcomes. For rural families with limited resources, traditional birth attendants (TBAs) have played a vital role in helping women deliver their babies. Yet, TBAs traditionally receive no formal training or knowledge of safe labour and delivery practices and have little to no understanding of mother-to-child HIV transmission. Traditional birth attendants can play a fundamental role in providing maternal health services to pregnant women, particularly in rural communities. Discussants voiced delays and health worker attitude as reasons for preferring TBAs.

> *"Even for me when I went to the government hospital to access antenatal care they said they could not register me, that I am too early that I need to come back when I am 7 months pregnant that I am too early to register now. Can you imagine that? This is why women prefer to use TBAs and many women use them"-FGD with* WLHIV, FCT

[122] (Africa for Women's Rights, 2010)
[123] https://hivlawcommission.org/2015/01/06/nigeria-understanding-the-law-protecting-persons-living-with-hiv-aids/

CHAPTER

03.

3: NATIONAL HIV RESPONSE

3.1 A REVIEW OF THE COUNTRY'S COORDINATION MECHANISM

Nigeria's HIV response is guided by the National Strategic Plan (NSP) 2017-2021 that was developed through evidence driven process at subnational and national levels and whose vision is "An AIDS-free Nigeria, with zero new infection, zero AIDS related discrimination and stigma, with a broad goal to "Fast-track the national response towards ending AIDS in Nigeria by 2030".

In line with the design of the national response, implementation has been multi-sectoral in nature, with NACA serving as the national coordinating body. Other federal level sectoral agencies such as the Federal Ministry of Health, Federal Ministry of Education, Federal Ministry of Youth and Sports, and Federal Ministry of Women Affairs and Social Development had played leadership roles in their sectoral responses. The State Agency for the Control of AIDS (SACA) coordinates the response at each state level, while the Local Agency for the Control of AIDS (LACA) coordinates activities at the local government level. The civil society and PLHIV have played active roles in the response to different dimensions across the three levels of governance.

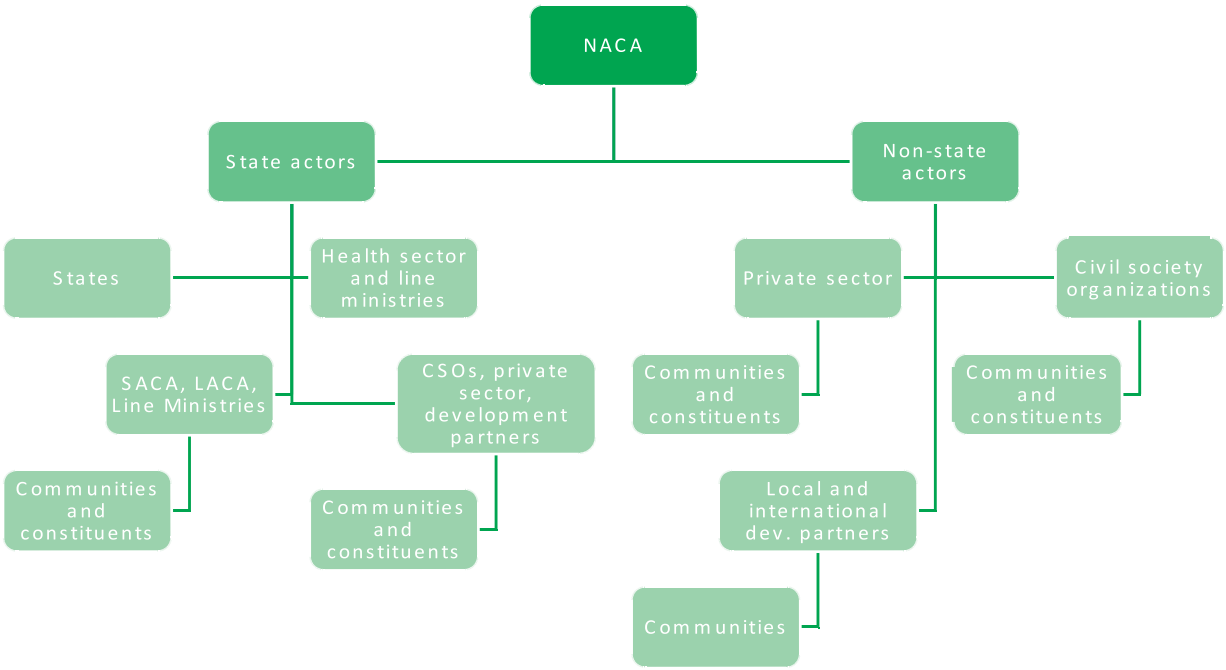


Figure 14: *National HIV Response Coordination Mechanism*

There is a Department in NACA – Community Prevention and Care Services with a Division for gender – Gender, Human Rights and Care Support Services. All SACAs have a gender desk. There is also a Gender and Human Rights Technical Committee (GHRTC) with GHR- State Response Team being rolled out in States among others.

The human and institutional capacity of the states and local governments to lead the national HIV response was strengthened by funding support from the World Bank, United States Government (USG), and the United Kingdom Department for International Development (DFID) through the "Enhancing Nigeria's Response to HIV/AIDS" (ENR) programme. However, the ability of LACAs to anchor the community HIV response remains weak. Multiple platforms and reporting structures through which all partners engaged in the HIV response are coordinated were set up by NACA.

3.2: A REVIEW OF THE POLICY AND LEGAL FRAMEWORK FOR A GENDER AND HIV RESPONSE

In Nigeria, policies and programmes for the national HIV response are coordinated by NACA. Other key partners include the Federal Ministry of Health (FMoH) as well as the State AIDS Control Agency (SACA) and Ministries of Health in the 36 states of the federation and the Federal Capital Territory (FCT). Policies are usually formulated at the national level and domesticated by the states. Though the administrative structure in Nigeria stipulates that states are federating units with autonomy to develop their own policies and programmes on issues such as health and education, there is a lot of synergy and cooperation among the federal and state government agencies. However, only policies and programmes enacted by the federal government are reviewed because they apply across the entire country.[124]

Laws and policies are in place to ensure the rights of PLHIV first as human beings and then as seropositive individuals. Such national laws include the 1999 Constitution of the Federal Republic of Nigeria (as amended), Child Rights Act (2003), Violence Against Persons Prohibition Act (2015), Sexual Offences Act, Administration of Criminal Justice Act, Criminal Code, Penal Code and Anti-Discrimination Act (2014)

Overall, nearly all NACA documents such as the National Policy on HIV 2009; National HIV/AIDS Strategic Plan (2017-2021); National HIV/AIDS Strategic Framework (2019 2021); National HIV/AIDS Community Care and Support Guidelines (2020-2023); NAIIS (2018), National HIV/AIDS Strategic Plan (2017-2021); and National HIV/AIDS Strategic Framework (2019-2021) have categorised the HIV national response according to the general and key population consisting of the general population with age categories of 0-9 years (Children); 10-19 years (Adolescents); 10-24 years (Adolescents and Young People); 15-49 years (Adults of Reproductive Age); and 15-64 years (Adults).

An improvement over the 2013 Gender Assessment is the inclusion of data on prevalence among others for children aged 0-14years as well as transgender and incarcerated persons (Table 4).

It is laudable that the country has a workplace non discrimination policy. First developed in 2005 to address the workplace response to the epidemic, it was reviewed, adopted and published in 2020.[125] Such a policy became necessary because the population most affected by HIV in Nigeria are youths and those who are in the reproductive age groups. They also constitute the workforce of the country. The latest review was necessitated by: changing epidemiology of HIV in the country; revision of the national HIV/AIDS policy which was its parent document; and the implementation of the International Labour Organization (ILO) recommendation on the HIV/AIDS in the workplace.[126]

Nigeria is a signatory to several ILO recommendations and conventions. Guided by the 2009 National Policy on HIV/AIDS, the workplace policy document showed linkages with several other documents and legislations in Nigeria. One of the eight specific objectives of the policy focused on "eliminating discrimination and stigmatization in the workplace based on real or perceived HIV status including dealing with HIV testing, confidentiality and disclosure". The scope of the policy includes both public and private sectors including the uniformed services. Its guiding principles also conspicuously included "non discrimination" alongside nine others. Responsibilities for the following stakeholders were also identified: Federal Ministry of Labour and Productivity, employers, workers and their organisations, National Agency for Control of AIDS, State Agency for Control of AIDS and National Steering Committee for HIV Workplace Issues.

[124] (Odimegwu, Akinyemi , & Alabi, 2017)
[125] (National Agency for the Control of AIDS, 2020 (C))
[126] (International Labor Organization , 2010)

However, the implementation and action plans which were to be developed by different stakeholders are still being awaited.

The country also has an HIV Anti-discrimination Act of 2014. First introduced to the National Legislature in 2005, the bill was passed and signed into law in April and November 2014, respectively. It serves a significant milestone in the national response to HIV/AIDS in Nigeria. Its passage was in response to recurrent comment in the PLHIV stigma index and gender assessment report. Information from the Gender and Human Rights Division of NACA is that the Act has been domesticated in 18 states while 3 States have bills in motion in the State Assemblies.

NACA with other stakeholders developed National HIV/AIDS Stigma Reduction Strategy in 2016 with the aim of "eliminating all forms of stigma and discrimination against people infected and affected by HIV in Nigeria by the year 2020". It integrates many of UNAIDS suggestions[127] on programmes and initiatives to promote stigma reduction at individual, community, structural and institutional levels.

However, stigma and discrimination was reported to still be rife. Health care settings was one of the main sources of stigma and discrimination. Many participants in the study complained of the stigma and discrimination they experienced from healthcare providers.

> ***"One of our clients is an orphan and he struggles to take his medication, every time he goes to the healthcare facilities. All the doctors, the nurses, everybody is shouting at him, and he really hates it when people shout at him, asking him do you want to die? So, he stopped going to the healthcare facilities for treatment. Now is on second line treatment"***
> -FGD with PLHIV, FCT

Some women who test positive for HIV are unable to disclose their status to their spouses for fear of stigma and rejection. Non-disclosure of HIV status perpetuates the cycle of infection and re-infection.

> ***"KPs contribute to new infections. If we keep excluding them, we are unlikely to achieve the 95-95-95 targets"*** - KII with government official, Kano State

The government of Nigeria, both at the state and federal level, has taken some steps to address the needs of persons with disabilities. One significant step came in January 2019 with the ratification of the Discrimination Against Persons with Disabilities (Prohibition) Act 2018, though implementation is yet to materialise because it is not in NSP, NSF, Treatment, Prevention and Care Guidelines with only a mere mention in the Community Care and Support Guidelines (2020-2023) which is not sufficient. There are no specific national programmes targeting the PWD and this needs to be looked into.

Therefore, although a lot of progress has been made over the years in the HIV response from 1986 when the first case was recorded to date, as a result of various activities ranging from awareness campaigns and other behaviour change interventions to the benefits of treatment which have witnessed significant scale up within the last decade, 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.

Women living with HIV have a higher risk of HPV infection, cervical dysplasia and cervical cancer than do HIV negative women.[128] Preventive measures such as cervical screening programmes are therefore an integral part of a comprehensive management of HIV positive women. It is therefore laudable that the revised NSF 2019-2021 recommends cervical screening while both NSF and NSP mention referral strengthening and promotion with regards to non-communicable diseases (NCD). The National HIV Treatment Guidelines give detailed guidance on cervical cancer. However, a study carried out to assess uptake of cervical cancer screening among HIV positive women at a tertiary healthcare centre in Nigeria found out that, the knowledge and uptake of cervical cancer screening was very poor due to lack of awareness by the patients and lack of counselling initiation by health care providers.[129] A similar study reported fear of the screening procedure as

[127] (National Agency for the Control of AIDS, 2016)
[128] (Chibuike, Chukwunyere, & Awonuga, 2019)
[129] (Chibuike, Chukwunyere, & Awonuga, 2019)

a potential barrier to get screened among HIV-positive women. This was related to the fear of painful pelvic examination, bleeding or contracting diseases through cervical cancer screening.[130] They also reported financial issues and screening costs and poor patient-HCP relationship and negative attitude of HCPs toward HIV-positive women as barriers toward cervical cancer screening uptake.[131]

3.3: REVIEW OF EXPENDITURE ALLOCATION IN RELATION TO GENDER IN THE HIV RESPONSE

The biennial National AIDS Spending Assessment (NASA) is a comprehensive and systematic resource tracking method that describes the level and flow of resources and expenditures of the HIV and AIDS response in Nigeria. The general picture of HIV funding is revealed in Table 3[132]:

	2017		2018	
Financing Source	**Amount (USD)**	**%**	**Amount (USD)**	**%**
Public funds	66,045,257.23	11.79	91,477,782.19	17.18
Private Funds	2,936,398.20	0.52	197,273.00	0.04
International Funds	491,314,743.38	87.69	440,696,444.00	82.78
Total	560,296,398.81	100.00	532,371,499.19	100.00

Table 3: *HIV funding in Nigeria 2017&2018.*

A further exploration of the funding process revealed that gender was treated as a cross cutting issue with no direct line budget to address gender equality interventions. There are some systemic issues that if addressed will take care of most of the issues. Specifics are part of the recommendations made on self-test, mobile test and community HIV testing but rather budgets are lumped in thematic areas where programme data is disaggregated by gender either for general or key populations. For example, for key populations, the total budget allocation for 2017 is 0.85% and 0.23% in 2018.[133] In NASA, gender issues related to the various thematic areas are addressed under the specific thematic activities as well as in the indicators.

While the National Strategic Plan identifies specific actions to address the needs and rights of women and girls, it does not include a specific budget to fund activities geared towards the needs of men, women, girls and boys. Figure 13 shows total HIV expenditure between 2006 and 2018, with high donor dependency.

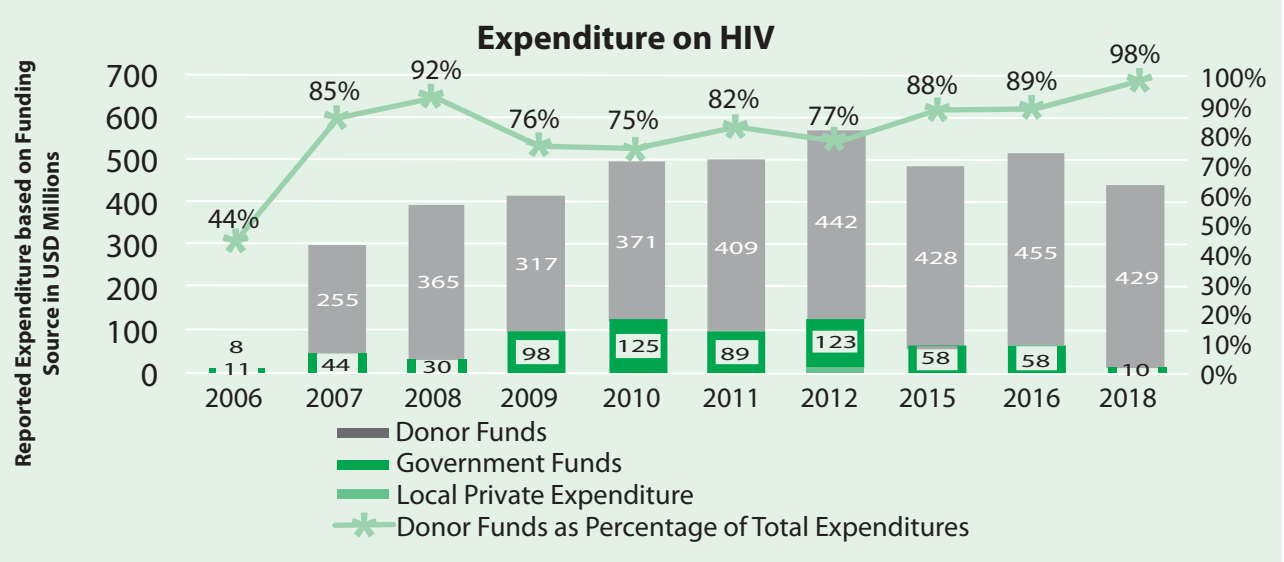


Figure 15: *Expenditures on HIV*

[130] (Adibe & Aluh, 2018)
[131] (Adibe & Aluh, 2018)
[132] (National Agency for the Control of AIDS, 2019 (B))
[133] (National Agency for the Control of AIDS, 2019 (B))

Figure 16: *shows Nigeria's total expenditure on HIV between 2007 and 2018.*

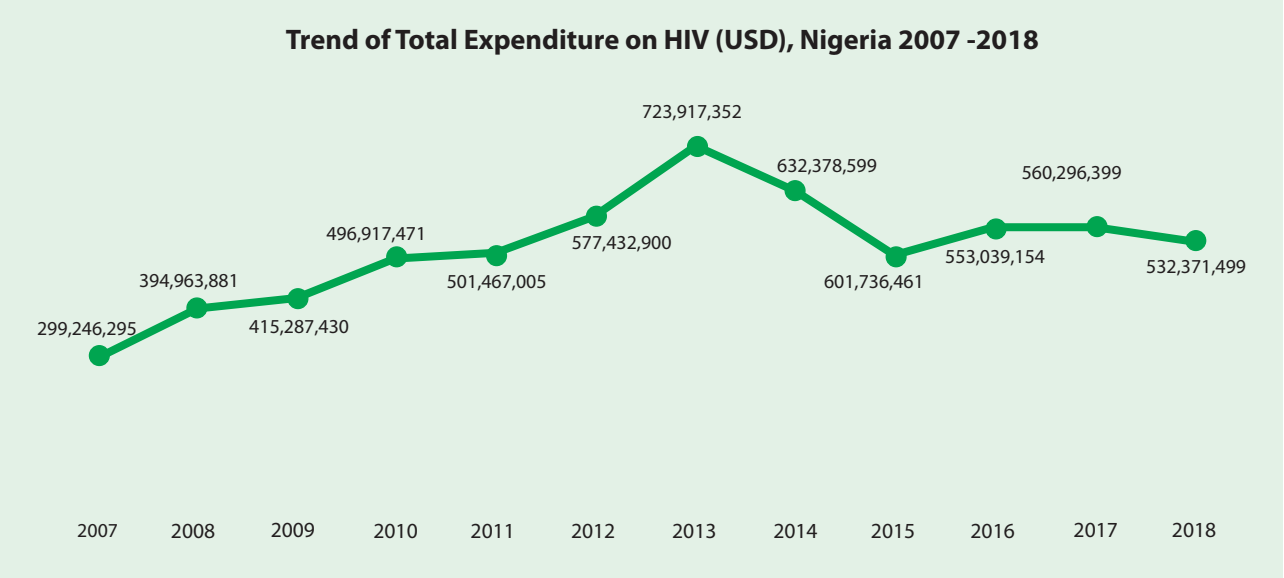


Figure 16: *Trend of Total Expenditure on HIV*

Going by what existing literature presents, budgeting to address stigma and discrimination is very strategic, however, the non-release of appropriated funds for implementing that aspect of the budget is a major set-back in efforts at addressing critical issues associated with increased vulnerability and lack of access to much needed services. Funding was persistently mentioned as a barrier to the response. From gender perspectives, however, the response seems to lack the budgetary mechanism and capacity for a gender transformative HIV response. An analysis of gender equality-related components of the budgets of NACA & Benue SACA shows that the usefulness of gender responsive budgeting is yet to be appreciated at the national and state levels, hence the poor attention given to gender equality concerns in the budgets of focus. This is reflected in the paltry amount allocated for gender equality related interventions and the little or non-release of appropriated funds. Gender-responsive budgeting seeks to ensure that the collection and allocation of public resources is carried out in ways that are effective and contribute to advancing gender equality and women's empowerment.

Respondents complained that funds are not available for virtually any and almost all activities except those that are donor driven. In Anambra State for example, some coordination meetings were said to have taken place as far back as 2017 when World Bank funding was available. The national response established the Gender and Human Rights Technical Committee (GHRTC) to support the mainstreaming of gender equality, women empowerment, and human rights in the response. This is expected to be replicated in states in form of State Response Team but again, this, it was gathered, is non-functional in most states.

In all the states, it was reported that there was no specific budget line for strategies that would reduce gender inequalities. The mode of operation is to carry out programmes on gender issues under various thematic areas. Gender is said to be mainstreamed into activities of MDAs but that is yet to be seen beginning with data that is disaggregated by sex. The need for a dedicated budget with specific gender programmes cannot be overemphasised if the response is to be gender transformative.

> *"The number one challenge is there is a need to increase gender mainstreaming budget itself to start with, number two designing programmes targeting gender-based issues which is related to fund, to increase level of awareness and then there is need for capacity building on gender mainstreaming, GBV and all the thematic areas under GBV"* KII with SACA, Lagos State

In March 2021, Nigeria and the Global Fund launched three new grants to strengthen the fight against HIV, TB and malaria and build resilient and sustainable systems for health. The new grants, covering the 2021-2023 implementation period are worth US$900 million –an increase of more than US$200 million from the previous allocation for 2018-2020. Through its Global Fund grant, Nigeria aims to intensify, modify, and/or scale up

activities to address human rights and gender related barriers and inequities to access health services particularly for men, young people, key populations, and other vulnerable populations.

Specifically, TB/HIV services will be made more male-friendly by sending services to where men congregate; there will be implementation of youth responsive interventions for AYP across HIV and TB services cascade; One-stop shops for key populations will be scaled up from 10 to 13 states; legal literacy to PLHIVs and KPs, sensitizing law agents on sexual diversity, promoting and protecting the human rights of KPs and PLHIV, and sensitizing healthcare workers will be done; Gender and HR State Response Teams will be established nationally and empowered to quickly respond to issues of intimate partner violence, gender based violence and targeted media campaigns will popularize the 2014 HIV/AIDS Anti-Discrimination Act.

On an encouraging note, PEPFAR as a major partner in the national HIV response has invested a total of $36,689,155 in gender-based violence interventions in Nigeria since 2010 and another $38,993,382 in gender equality interventions (Figure 17).

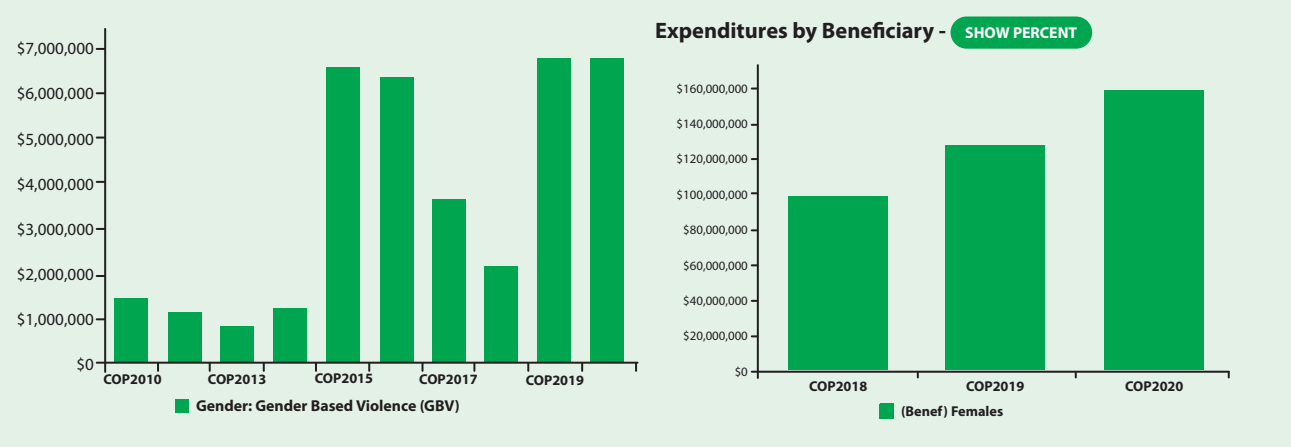


Figure 17: *PEPFAR funding for GBV and Gender Equality Interventions*

It is noteworthy however, that Nigerian government has been slowly working towards a more sustainable financing approach for HIV control that depends less on official development assistance (ODA).[134] Three examples of steps taken by the government are (1) including HIV in the benefit package of social health insurance schemes, (2) working with firms to establish a National HIV Trust Fund to increase private sector contributions to total HIV contributions (recently launched), and (3) progressive increase in government contribution to the procurement of ARV for PLHIV.[135]

Factors influencing budgeting decisions on gender and/or HIV include the dwindling donor and low government funding. There are challenges to implementing the gender and/or HIV budgets which include a lack of capacity to mainstream gender and resultant absence of specific budgets to address its gender related activities such as the needs and rights of men, women, boys and girls, and the untimely release or non-release of approved budget for gender related activities. Some of these include investing in prevention strategies that would reduce risk and vulnerabilities to HIV for boys and girls (delay in sexual debut; resocialisation of the concept of masculinity- away from power enshrined in engaging in multiple sexual relationships for boys and lack of decision making for girls; eliminating violence against women and girls; eliminating all forms of discrimination against women and girls including addressing discriminatory cultural practices; providing economic empowerment for the most vulnerable in the community to avoid engaging in sex for survival; and investing in Behaviour Change Communication for women and men, boys and girls).[136]

[134] (Olakunde & Ndukwe, Improved domestic funding enhances the sustainability of HIV/AIDS response in Nigeria. , 2015)
[135] (UNAIDS, 2020)
[136] (National Agency for the Control of AIDS, 2016)

3.4 A COMPREHENSIVE HIV TREATMENT ACCESS AND COVERAGE LANDSCAPE

3.4.1 HIV PREVENTION

It is estimated that there are about 1.7 million people in Nigeria living with HIV in 2019; about one third do not know their HIIV status resulting in a gap of about 33% to reach the target of 95 of PLHIV knowing their HIV status.

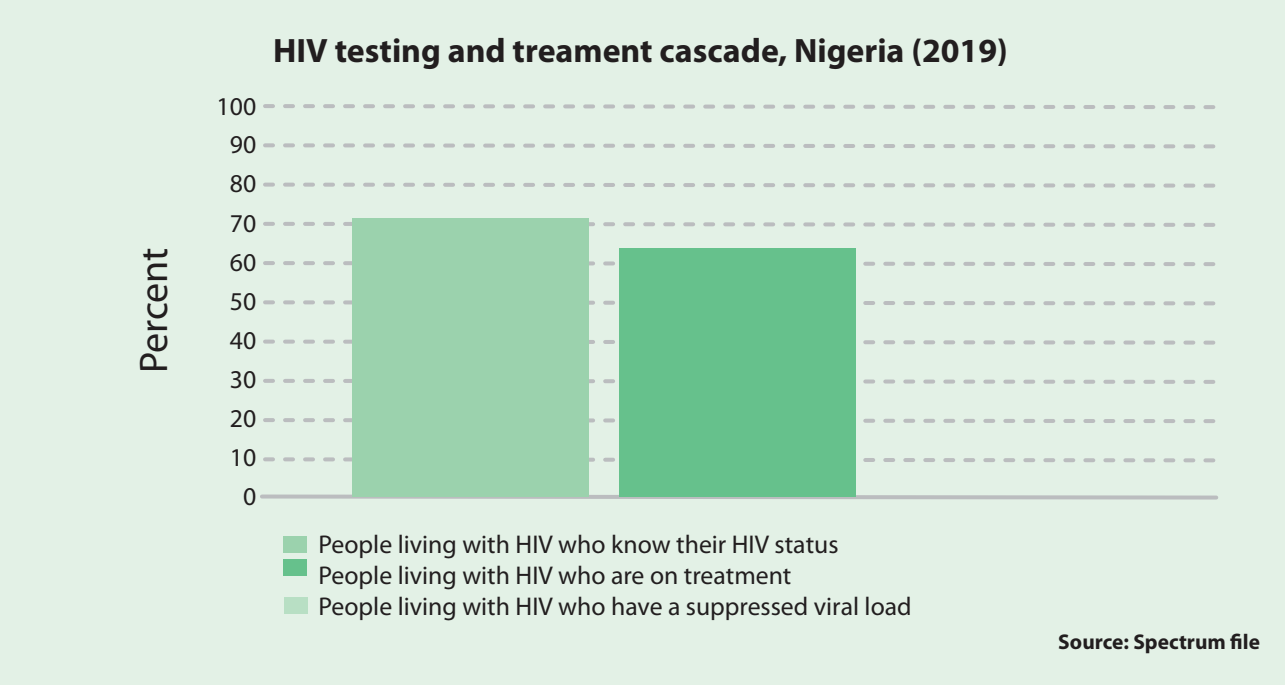


Figure 18: *HIV testing and treatment cascade 2019*

3.4.2 TREATMENT

There was a reported increase in the number of people accessing PrEP.

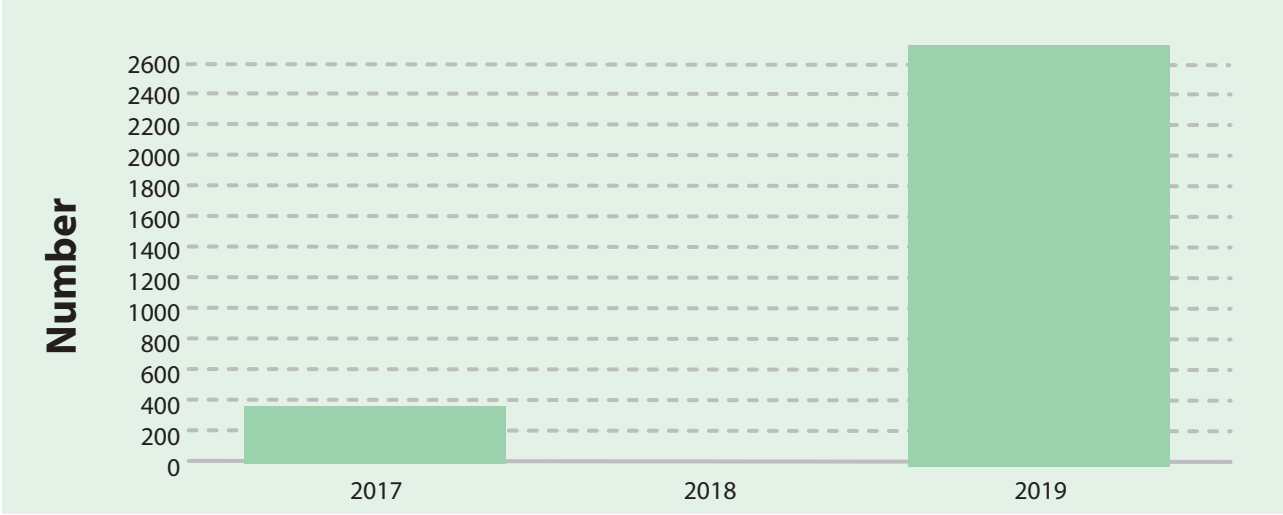


Figure 19: *Access to PrEP between 2017 and 2019*

It was also observed that it seems that attention is mostly on treatment services at the detriment of prevention services

"we know there is treatment as prevention but it means that we may drop the ball on prevention aspect, so why drop the ball on prevention aspect when we can be doing the treatment and prevention, because initially

we shouted a lot about prevention, treatment wasn't so much, now that we are doing treatment we have forgotten prevention but we need to bring these two together for us to achieve our objectives by 2030"-FGD with CSO, Anambra State

Prevention of Mother to Child Transmission of HIV (PMTCT)

PMTCT, also known as prevention of vertical transmission, refers to interventions to prevent transmission of HIV from an HIV-positive mother to her infant during pregnancy, labour, delivery, or breastfeeding.[137] The number of healthcare facilities providing PMTCT services in Nigeria increased by 875% from 690 in 2009[138] to 6,729 in 2016.[139] In 2010, PMTCT services were decentralised from tertiary and secondary healthcare facilities to primary healthcare centres.[140]

Given the significant role of the private health sector in healthcare service delivery, the Federal Government developed a framework to guide its engagement in provision of PMTCT services in 2013 and also integrated PMTCT into maternal reproductive healthcare such that antenatal care (ANC), labour and delivery, and postnatal care serve as entry points for PMTCT care.[141] However, the scale-up did not translate to commensurate increase in ARV coverage for PMTCT.

Figure 20: *indicates a decline among women who receive ART for PMTCT*

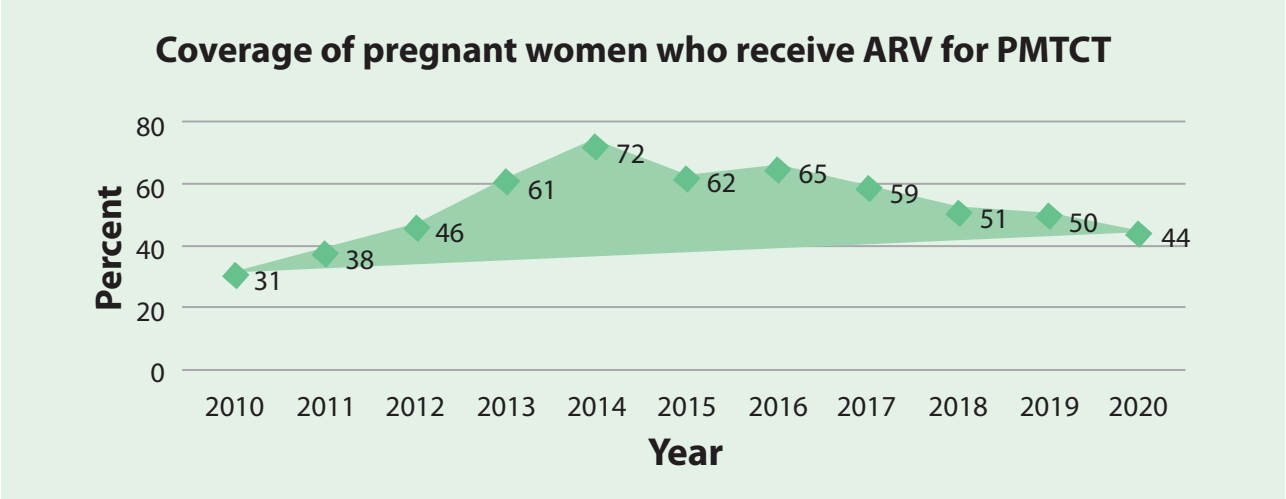


Figure 20: *Coverage of pregnant women receiving ARVs for PMTCT*

3.4.3 CHALLENGES IN ACCESSING PMTCT

Choice of birthplace plays a significant role in testing – women who use TBA do not tend to access ANC so do not have access to testing. The poor uptake of maternal healthcare services such as ANC and preference to deliver outside the health facilities such as at a TBA due to poverty results in missed opportunities for HIV testing and subsequent enrolment in care. Other challenges identified in a study by Olakunde et al, 2019 that must be overcome to increase PMTCT uptake include; lack of basic requirements for HIV testing services, absence of a counselling room, pre- and post-testing counselling not performed, national PMTCT guidelines for service delivery not available or not accessible, and the dearth of skilled healthcare workers (doctors, nurses, and midwives) available to deliver essential services including PMTCT.

Knowledge gaps and discriminatory attitudes among some HIV service providers are prevalent. Close to 70% of healthcare workers providing PMTCT services in rural areas in Oyo state did not know when to start ART for

[137] (Federal Ministry of Health, 2019)
[138] (National Agency for the Control Of AIDS, 2015)
[139] (Federal Ministry of Health., 2017)
[140] (Onwujekwe, Chikezie , & Mbachu, 2016)
[141] (Federal Ministry of Health, 2016)

pregnant women living with HIV and over 50% said they were scared to deliver an infant for fear of infection. Most HIV medical products stockouts occasionally occur with limited availability of second- and third-line antiretroviral. While antiretroviral are free, out-of-pocket expenses are common. The national health insurance system covers less than 10% of the eligible population. Maintaining high political commitment for sustained funding and effective co ordination is a crucial challenge. For example, infrequent PMTCT technical coordination meetings are due to Ministries of Health having insufficient funds.[142]

There remain barriers for PLHIV and KVPs to seek care or remaining in care. This is due to stigma which labelled the KVP; adding HIV to it and going to a public place to get medication is double stigma.

3.4.3.1 Awareness and Uptake of post exposure prophylaxis (PEP)

When administered shortly following an accidental exposure, PEP treatment has been shown to significantly reduce the risk of HIV infection. Data from IBBSS 2020 indicate a marked difference in knowledge and uptake of PEP by the different KVP groups

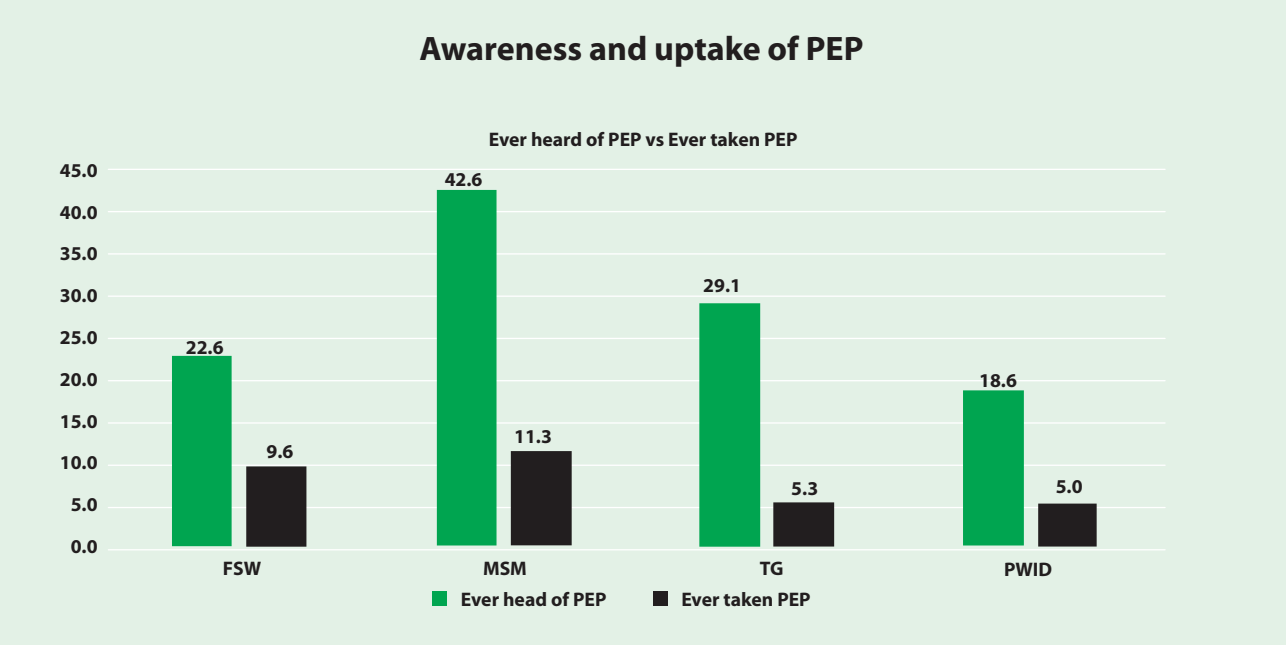
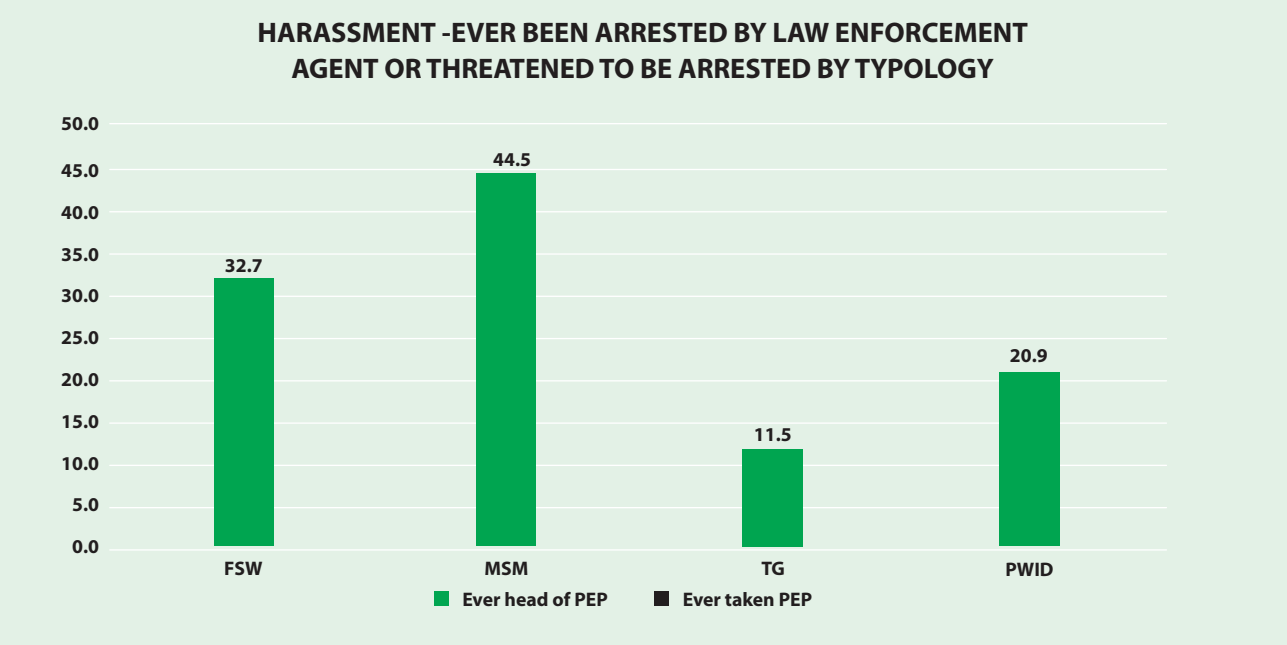


Figure 21: *Awareness and uptake of PEP*

Fear of being arrested or having been arrested before by law enforcement agents was reported in the IBBSS 2020 as a barrier to access.

Other Barriers to Accessing Care

[142] (Olakunde, et al., 2019)



Some pastors have been known to discourage PLHIV taking ARVs; there is also a common myth that ARVs are meant to kill PLHIV so that HIV is eradicated from the society; others reported believing that MSM are given HIV as a punishment for being abnormal, with some health workers discriminating against them and praying for them quoting bible passages; some treatment facilities are difficult to reach; self-denial. Although ARV are provided free of charge, particularly in donor-and government-supported facilities, PLHIV still incur high out-of-pocket (OOP) expenses for services that are not provided by the programme or are official/unofficial fees levied by the facilities or healthcare workers.

Other barriers to accessing services include user fees especially for laboratory tests and registration and geographical location necessitating need for transport fares. Stigma and discrimination especially on the part of health workers was reported to be a key barrier to accessing services especially among adolescents, young people and key population.

3.5 COVID-19 AND HIV

Nigeria saw in the wake of COVID-19, existing ODA flows to HIV being redirected to COVID-19. On April 4, 2020, the Global Fund released a Guidance Note allowing recipient countries to use HIV, TB and malaria grants to fight COVID-19 through reprogramming up to five per cent of savings under existing grants and spending underused funds.

The lockdowns in Nigeria may have inadvertently placed women already experiencing partner violence at risk of experiencing more severe violence, posing new challenges to cope with violent experiences, and other forms of violence, including violence that used the lockdown as a way to threaten women's security and ability to protect themselves from the virus:

> *"During the COVID, I can say now in Lagos office we have about 800 complaints this year already and about 500 of them around sexual and GB violence. So, during the COVID the surge was much"* - KII with NHRC, Lagos State

The COVID-19 pandemic hit the community of people living with HIV very badly. Three was a halt in social activities so people who loved outside activities like young people felt trapped at home. There were resultant mental issues including depression. Key populations who were only free when in the company of other members of the community were also not able to move freely to be with themselves. Some of them coped with social media but since livelihoods were hampered, money for purchase of data to go on social media was a bit of a challenge.

There was no transportation for drug users to get their drugs, so they had to diversify to what was available, like; snuff tobacco, sniffing pit latrines; sniffing new paint on walls; evostick. There was an increase in mental health issues including depression, and some PLHA including KPs began using drugs for the first time as coping mechanism. Adherence to ART also was affected.

> *"… a lot of people are living on daily activities and there was the lockdown, people were unable to go out to get their daily bread and even the support we got from government was just for 1000 people out of many. so there was a lot of hunger and that affected the adherence because a lot of people will say I've not eaten food I'll not be able to take drugs"*- FGD with PLHIV, Lagos State

There was a huge increase in sexual violence, particularly intimate partner violence.[143] In Akwa Ibom, FIDA recorded 300 cases of violence, 100 of which were rape in the 6 months period of lockdown in 2020.

However, in response to the challenges posed by COVID-19, there were a lot of innovations and differentiated treatment models that were adopted to ensure uninterrupted access to HIV related services. With the support by partners, through networks, ARV was delivered to homes and in advance. Case managers particularly at the OSS centres were mobilised to distribute drugs at community levels. Group collection of drugs was instituted, where one person got the card numbers and addresses of those within the vicinity and collected the drugs on behalf of families. A regional review commissioned by UNAIDS found that during COVID-19, Nigeria expanded access to 6-month ART dispensing, although coverage remains low, at 9%.

Originally, clients were expected to report to the health facility every month.

In addition, One UN COVID-19 Basket Fund was established to ensure that the financing platform put people and communities at the centre. For instance, the resources under the UN- Basket Funds were applied to support the community-led monitoring, cash transfer, social mobilisation and procurement/distribution of PPEs for PLHIV/ KP implemented by NACA/NEPWHAN. Global Fund also earmarked additional resources for COVID-19 and HIV.

3.6 HIV AND DISABILITY

Nigeria has passed into law the Discrimination Against Persons with Disability (Prohibition) Act 2018, which states, among other things, that an individual with a disability shall not be discriminated against on the grounds of his or her disability by any person or institution in any manner or circumstance. This Act provides for full integration of persons with disabilities into society, establishes the National Commission for Persons with Disabilities, and vests that Commission with responsibilities for the education, health care, and social, economic, and civil rights of persons with disabilities.[144]

Persons with disabilities face difficulties accessing adequate health services, often being limited by the availability of accessible hospitals and personnel who are aware of and specialised in disability inclusion and providing services for persons with disabilities. HIV and disability are linked in several ways. Although HIV-related data on people with disabilities is extremely limited, growing evidence suggests disabled people are more likely to experience factors that put them at higher risk of HIV infection than people who are not disabled.[145] In addition, there is a misconception that people with disabilities are sexually inactive or unlikely to use drugs or alcohol, which means they have been left out of HIV programming.[146] Data from sub-Saharan Africa suggest an increased risk of HIV infection of 1.48 times in men with disabilities and 2.21 times in women with disabilities compared with men without disabilities.[147]

Similar studies conducted in Nigeria indicate the intersection between disability and risk of HIV infection. A study of 600 learners aged -12 19 years from schools across Oyo State, Nigeria, found that those with

[143] (Fawole, Okedare, & Reed, 2021)
[144] (Human Rights Watch, 2019)
[145] (Avert, 2017)
[146] (UNAIDS, 2014)
[147] (UNAIDS, 2017)

mild/moderate intellectual disabilities were more likely to be sexually active and have inconsistent condom compared to those without disability. Girls with disability were less likely to access HIV-related information than boys. Girls with disability were also far more likely to report a history of rape (68.3%) compared to girls without disability (2.9%).[148] In another study among 360 PLHIV in Ibadan, Nigeria, more than two thirds had one form of disability, although the majority were mild. There was no significant association between disability among PLHIV and their socio-demographic variables of age, gender, and employment status.[149]

The United Nations Secretary General's 2016 report on the Fast-Track to end the AIDS epidemic and the United Nations Political Declaration on Ending AIDS recognise that people with disabilities, in particular women and girls with disabilities, experience barriers to accessing HIV services and are left behind in HIV policy-planning, programme development, service delivery and data collection. These documents also highlight that increased vulnerability and exclusion are linked to legal and economic inequalities, gender-based violence and human rights violations against people with disabilities, including the provision of health care.[150]

NDHS 2018 report on disability shows that 7% of household members aged 5 or above have some level of difficulty in at least one functional domain, while 1% have a lot of difficulty or cannot function at all in at least one domain. The proportion of household members who have difficulty in each domain generally rises with increasing age. For instance, 1% of household members below age 40 have a lot of difficulty or cannot function at all in at least one domain, as compared with 9% of those aged 60 and above.[151]

Widowed women and men are more likely to have difficulty in each of the domains than their counterparts in the other marital status categories. For example, 30% of women and 37% of men who are widowed have difficulty in seeing, while 19% of widowed women and 20% of widowed men have difficulty in walking or climbing steps.[152]

Involving PWDs in the gender assessment process in Kano for instance, was an opportunity to raise awareness and sensitise PWD communities on HIV/AIDS. Furthermore, because many of the participants present were notable members of their PWD community, they became ambassadors for HIV education.

> *"Persons with disabilities, this is the first time we have been involved in something like this, we are being brought along as human beings, people with feelings, who can have feelings for the opposite sex, who can do and undo, and we are learning about sexually transmitted disease and how to protect ourselves"* -FGD with PWD, Kano State

3.7: PROGRESS MADE AND PROMISING PRACTICES

3.7.1 GENDER STIGMA AND DISCRIMINATION

A multi-sectoral national plan of action was developed in 2015 to conduct interventions to eliminate gender inequalities and end all forms of violence and discrimination against women, girls, and PLHIV and key populations. The 3-year plan aimed at reducing the incidence of HIV by addressing GBV using a multi-sectorial approach at the national, states and local levels. The main achievements of the plan include strengthened human and institutional capacity; reviewed laws and policies; increased knowledge and awareness on GBV/HIV prevention and management; and improved information management and use. Plans are under way to expand interventions to improve outcomes of HIV prevention and impact mitigation programme towards ending AIDS by 2030.

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[148] (Aderemi, Pillay, & Esterhuizen, 2013)
https://onlinelibrary.wiley.com/doi/pdf/10.7448/IAS.16.1.17331

[149] (Olaleye, Adetoye , & Hamzat, 2017)
https://www.ajol.info/index.php/mjz/article/view/168188/157686

[150] (UNAIDS, 2017)

[151] (National Population Commission (NPC) and ICF, 2019)

[152] (National Population Commission (NPC) and ICF, 2019)

3.7.2 ENGAGEMENT OF COMMUNITIES IN THE FIGHT AGAINST THE PANDEMIC

Efforts of GHRCSS Division of Community Prevention and Care Services Department of NACA towards community engagement include providing communities with necessary tools and capacity for gender responsiveness of the national HIV programmes, technical support to networks of people living with or affected by HIV, women and young people, peer educators, counsellors, community health workers, door-to-door service providers, civil society organisations, religious and traditional leaders, policymakers and activists. Their vital roles include ensuring that HIV remains on the political agenda and galvanising international and national funding for HIV. They facilitate an enabling environment that promotes equal access to HIV prevention, treatment and care services for all; safeguarding the rights of those living with and vulnerable to HIV and holding decision-makers and implementers accountable. These efforts seem to be yielding fruits as revealed in the discussion with NEPWHAN coordinator in Anambra state

> *"Yes, some of the traditional rulers, we encourage them to involve women in their cabinet, so like three communities have done it, having female in their cabinet, where decision is being taken.... if they are there where decision is being taken, they'll be able to speak on behalf of the woman to say if you can be able to do this it will go a long way to change the things and they are adopting it"*-KII with NEPWHAN Coordinator, Anambra State

However, studies have shown that CSOs' advocacy efforts focused on community mobilization related to behaviour change, such as peer education (54.9 % of CSOs) and rallies (58.2 % of CSOs), and less on changing government policies. There may be a need for increased funding and capacity building for community-based and community-led organizations to hold government accountable for providing services or promoting policy change.[153]

3.7.3 ONE STOP SHOPS (OSS) IN LAGOS AND SOME OTHER STATES

Some Implementing Partners (IPs) are programming and delivering services through One Stop Shops (OSS) to members of the Key Populations (KP) while many CSOs are also involved in providing services ranging from sensitisation, provision of temporary shelter and skills acquisition. Designed to provide safe space from the stigmatisation and discrimination experienced by members from conventional health facilities, OSS provides the much-needed services to key populations in the states where operational.

3.7.4 ACCESS TO JUSTICE FOR KP IN KANO

The Kano State Human Rights Commission is reportedly open to supporting KPs. According to an Official from the Commission, "we treat their cases in confidence". There are support groups in place supported by KSACA and NEPWHAN, where KPs are able to voice and report any legal issues. NEPWHAN in Kano woks in partnership with the NHRC to address legal cases.

"NEPWHAN has registered with Human Right Commission we are going to get the ID cards soon, they will be helping us with all these issues" FGD with NEPWHAN, Kano State

[153] (Williamson & Rodd, 2016) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4940692/

3.8 PROGRESS AND GAPS FROM 2013 TO 2021

Table 4: *Progress and Gaps from 2013 to 2020*

2013 Recommendations	Progress	Gaps	Actions Needed
Systemic approach to deconstructing issues of masculinity and femininity **(Some of the norms and values, beliefs and myths, gender roles and stereotypes constitute gender gaps that limit maximum participation of boys and men, girls and women and others with different sexual orientation and so need to be deconstructed through gender sensitive models.)**	Pockets of programmatic interventions through NGOs working on issues around gender, OVC and male involvement.	From the findings of 2021 Gender Assessment, gender inequalities in the sociocultural and economic landscapes are still major drivers of the epidemic. National interventions to address systematically and holistically the gender inequalities that are hedged into our norms, beliefs and practices are not in place. There are few programmes particularly in schools to deconstruct masculinity and femininity. Culture still plays a huge role in enshrining power and dominance of males over females	Comprehensive programmes that address gender inequality in a holistic way. Such may include: • Engagement with traditional and religious authorities on promoting positive masculinity • Deliberate Mass media publicity targeted at different groups in the society on promoting gender equality and equity and the effects on fighting HIV/AIDS to finish • BCC through bill boards, community engagement, print media, radio and television • Synergy with National Orientation Agency (NOA) and public media • Synergy/Advocacy with Private media through their umbrella body as part of their Corporate Social Responsibility
Strengthen coordination and meaningful participation in the national response	The transgender cohort has been recognised by the national response, and the KP community is gaining traction generally Inclusion of data on prevalence for children aged 0-14years as well as transgender and incarcerated persons	PWD are still left behind in policy and programming The different cohorts of PLHIV such as ASWHAN, APYIN seems to be subsumed under the general NEPHWAN umbrella There are a lot of missed opportunities for synergies between the Umpire and MDAs both at the National and State level Coordination mechanisms remain largely non-functional due in part to lack of funding	Targeted and tailored interventions at different groups such as WLHIV through ASWHAN, AYP living with HIV through APYIN etc. • More training in understanding of the KP community • Integration of KPs and PWDs into PLHIV networks • PWD: They need to be included in policy and practice • Provide resources in plans and budgets for meetings of coordination structures • Different Ministries to be mobilised with leadership and decision-making in their role in the HIV response, for example, the Ministry of Women Affairs The Umpire bodies including NACA, SACA and LACA need to be more proactive especially in synergising with relevant MDAs by leveraging on opportunities and services available. PLHIV need more than medical intervention but also economic and social. This is because of the side effects of the drugs, need for good food, and stigmatisation from society. For other chronic illnesses, studies on them should bear that out, but for PLHIV, it is a real need
Review of laws towards ensuring human rights	Anti-Discrimination Law, 2014, VAPP	Implementation continues to be	• Training and capacity building for LEA and other stakeholders over a

and gender equality in the response	2015 in place. Policies and Guidelines published. Such include Community Care and Support Guidelines (2020-2023), Guidelines and Training Manual for Access to Justice in the National HIV/AIDS Response. Synergy between Networks and some LEA and other stakeholders is strong and could be further strengthened Gender and Human Rights Technical Committee (GHRTC) at both National and State inaugurated	challenging Synergy between LEA and other key factors such as NHRC, FIDA, Legal Aid is weak in some states. Capacity to seek justice hampered by ignorance and societal norms GHRTC is ineffective in some States Acceptance of the KPs particularly transgender people and MSMs is challenged by the Same Sex Marriage Prohibition Act The National Drug Law Enforcement Laws are also a hindrance to programming for PWID beyond criminalisation	period of time • Commitment to funding the framework/activities of human rights and gender equality by government that is not dependent on donor funding is crucial • Capacity building on legal literacy for the community and institutionalisation of a referral system • Harmonisation of laws tripartite in some states and dual in others • Dissemination of protective laws • Review of discriminatory laws and practices, for example the Same Sex Prohibition Act; practices promoting child marriage; wife inheritance practices; practices promoting female genital mutilation
Legal and social transformative interventions regarding Gender Based Violence (GBV)	GBV Plans and guidelines developed. Such include: National Guidelines and Referral Standards on Gender Based Violence In Nigeria; Mapping of Laws, Policies and Services on Gender Based Violence and its intersections with HIV in Nigeria, 2014; National Plan of Action on GBV and HIV/AIDS Intersection 2015-2017 Various Interventions on HIV and GBV intersection by partners	Incidence of sexual and gender-based violence, including intimate partner violence is high	• Advocacy for the domestication of the VAPP law in States where this is pending • Efforts at sensitising society on IPV • Synergy with NHRC, FIDA, Legal aid, and other relevant stakeholders in an effort to institutionalise the provision of free or affordable legal aid services • Proactively and intentionally programme for eliminating violence against women and girls (irrespective of sexual orientation) as a strategy for the prevention of HIV

Resource allocation/budgetary provision to specific gender-sensitive interventions	No specific line budget on gender but activities that are gender related under thematic areas are provided for Gender Assessment 2021 funded by partners and anchored by NACA	This is a huge gap. Gender at the top level of government and budgeting is supposedly expected to be under MWA hence gender budget not recognised as a stand-alone component of HIV programming but rather subsumed under budget for other thematic areas Gender indicators and tracking tools are absent in national and state HIV plans	Last mile action calls for ending inequalities in order to end AIDS and end pandemics. This cannot be achieved except a dedicated fund is allocated to interventions that will address identified gender inequalities and related issues driving the epidemic. Some of these interventions have been highlighted in the other recommendations and are summarised as: • In order to end AIDS by 2030, gender-specific indicators and targets must be integrated into all HIV plans and programmes • Activities to meet these indicators and targets identified in the planning and budgeting process • Train requisite budget and planning staff on gender budgeting • Train the legislators on analysing a budget from a gender perspective • Mass media and community advocacy for promoting gender equality and equity in the fight against HIV and AIDS including deconstructing patriarchy and promoting positive masculinity
Provision of Integrated Health Services for all including people with disabilities	Pockets of interventions including attempts at looking at comorbidities such as TB and cervical cancer screening as well as mental health of PLHIV	Acute lack of adolescent- and youth-friendly services. Most available are donor funded thus lack sustainability PWD-friendly services also in short supply where available. PWDs have been left behind Mobile and Community HIV Testing gradually fading away. We established that men do not go to clinic, hence viral load and death high amongst them. HTS is the gateway to ending AIDS. It important to increase the proportion of Nigerian population that get tested See Section 2:1 4 and Section 2:2:2:1 on low testing and accessing general HIV services when it comes to men HIV/AIDS health education and promotion not done in health services anymore	• Provide adolescent-friendly health services with trained personnel • Expand OSS facilities or ensure sustainable KP-friendly HIV services are available • Train health care providers on stigma reduction for KPs and PWDs • Encourage family/couple testing and counselling at ante-natal • Provide condoms and lubricants outside of health facilities

Institutionalisation of Gender Management System (GMS)	GMS mechanism in place Existence of Policies and Guidelines Gender Desk Officer with appropriate TOR at both national and state levels	Capacity to mainstream gender at state level weak Update GMS	• Capacity building for Gender Desk Officers • Appropriate gender indicators and tracking tools formulated, used and monitored
Monitoring, Evaluation and Research	At the national level, there are gender disaggregated data Surveys and studies also conducted such as HIV prevention among KP and prisoners	Some indicators are missing sex disaggregated data at the state level	• Provide indicators for reporting sex disaggregated data at all levels • Harmonise all national data with and among partners • The Response could benefit more from operational researches on various issues. Among those suggested in 2013 include correlation between sex education and delay in sex debut; tracking violations of the rights of KP; evidence on growing Intimate Partner Violence (IPV) and effects on education in reconstruction of social norms on boys and girls. • Documentation of success stories and what works in upholding gender equality and equity in the response
Addressing stigma and discrimination of PLHIV and other marginalised group	Anti-Discrimination Law, 2014, VAPP 2015 in place Stigma Index Survey conducted with Stigma Index Report 2021 concluded	Dissemination and popularization of the law among all especially PLHIV Stigma from healthcare providers	• Training and retraining of health workers • Capacity building for PLHIV to be able to know and claim their rights • Popularisation of the laws. Some officers of the networks at the state level have never seen though have heard about the Anti-Discrimination Law

CHAPTER

04.

CONCLUSIONS AND RECOMMENDATIONS

4.1 CONCLUSIONS

Nigeria has a clear, well-articulated legal and institutional framework to coordinate the HIV response in the country. However, lack of coordination/synergy amongst key stakeholders and lack of implementation due to ignorance of legal frameworks, combined with entrenched gender discriminatory norms such as masculinity and patriarchy, have hampered government and civil society efforts to address gender inequalities and gender-based violence. It is unfortunate that gender related factors identified in the 2013 assessment as impeding women's, girls', men's, boys', and key populations' access, utilisation and adherence to prevention services were also reported during this assessment. These are

1. Despite the Anti-Stigma Law, stigma and discrimination against PLHIV and KVP still exist and there is an inability to seek for help
2. Patriarchal nature of the society that encourages negative masculinity and femininity
3. Sexual and gender-based violence with a reported increase in IPV
4. Socio-economic barriers such as poverty with few women owning property
5. Criminalisation of some people with different sexual orientation
6. Gender-blind budgeting

Speaking on the eve of the World AIDS Day 2021, whose theme was Ending Inequalities, the DG NACA had this to say:

> ***"The challenges towards ending AIDS by 2030, include domestic resource mobilisation, and fighting stigma and discrimination. But for the stigma and discrimination, we are gradually winning. As for domestic resources, there is a lot of work to do with funding, especially contributions by the state. Also, the prevention of mother to child transmission has also been a challenge. One of the three top things that must be achieved for HIV control to be complete includes stopping mother to child transmission".***
> Dr. Gambo Gumel Aliyu - DG NACA

4.2 RECOMMENDATIONS

Based on the findings of the assessment and in order to move towards an engendered HIV response, the following are recommended:

1. As the HIV response has made strides to mainstream gender in policies, plans and programmes, the gender machinery needs to be more pro-active in mainstreaming HIV in policies, plans and programmes with verifiable indicators. One key way of doing this is to institutionalize gender-responsive budgeting nationally. There are indications that UN Women and the Federal Ministry of finance, working closely with the national assembly have made recent commitments to drive the process of mainstreaming gender equality in the budget cycle in Nigeria. This should include the HIV/AIDS response in the country.
2. Government should set the tone for and track a more gender responsive and inclusive national response by extracting commitment from donors/development partners to ensure that funds are appropriately targeted towards addressing the identified gender gaps in the national HIV response. This is in line with the Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008) that place recipient countries on the drivers' seat.
3. Resource allocation/budgetary provision and disbursement of funds by government at the national and state levels to implement specific gender sensitive Interventions - There is an urgent need for states to redeem their commitments to appropriation and release the 0.5 to 1.0 per cent of their federal monthly allocations to the HIV response in their states. This would be utilised amongst others:
    - To invest more in the procurement of HIV test kits targeted at providing every pregnant women access to know their status for PMTCT services.
    - Sustain the support towards addressing the gender gaps in the HIV response.
4. Strengthen enforcement of the legal provisions – policies and laws that promote and protect the rights of persons living with HIV across the populations through:
    - Reviewing and repeal of discriminatory laws that have adverse effects on HIV transmission, including laws that criminalize key populations.
    - Ensuring that existing legislations that protect citizens, including PLWHIV against human rights abuse and sexual and gender based violence are domesticated, disseminated, implemented and monitored. These include the Federal Constitution of Nigeria as amended, the Child Rights Act (2003), the HIV/AIDS Anti-discrimination law (2014), the Violence Against Persons Prohibition Act (2015), the Discrimination Against Persons with Disability (Prohibition} Act (2018), the Administration of Criminal Justice Act (2015) which provides for the speedy dispensation of justice and their state-level equivalents.
5. Expand investments that improves access to HIV-related legal services for women living with HIV and key populations including legal literacy, anti-stigma awareness campaign, and campaigns that address patriarchy, cultural norms and practices that increase vulnerability and risk to HIV infections
6. Existence of the Association of women living with HIV has improved engagement of women in the response. However, women are still absent at decision making levels. Going a step further, in line with the SDG 5 and the National Gender Policy provisions, facilitate the inclusion of women at the leadership tables of coordinating structures and mechanisms to increase and strengthen the voice and agency of women in relation to the HIV response.
7. Government should explore modalities to replicate, scale up and sustain good practices such as the one stop shops (OSS) that improve access to HIV services for key and vulnerable populations.
8. The national HIV response should adopt a systemic approach to tackling gender and other forms of inequalities by the issuance of clear guidelines and timelines for setting up Gender Management Systems with monitoring indicators at all levels – States, LGAs and line MDAs.
9. Institutionalise capacity building programmes to build gender and human rights programming expertise and community of practice in the various sectors and in all stages of HIV policy and programme analysis, design, planning, implementation, monitoring and evaluation.
10. Improve/expand investments in interventions that addresses male issues as identified in the assessment including capacity strengthening for male engagement and involvement in HIV programmes, tailored ART adherence programs for men, led by men living with HIV who reach out to and support their peers
11. The national HIV response should support advocacy to position and monitor gender equality and social inclusion of HIV key and vulnerable populations as component parts in the implementation of the National Development Plan including national social protection interventions for the poor and

vulnerable populations such as Village Savings and Loans, Cooperative low interest loans and vocational skill acquisition.

12. The national HIV response should plan and implement interventions that addresses young people's peculiar needs particularly the provision of youth and adolescent friendly health and other services.
13. Government should lead multi-sectoral engagement with partners including the National and State Human Rights Commissions to activate the multi-sectoral gender and human rights response to improve access to justice on HIV related human rights violations as well as document best practices for sustainability

BIBLIOGRAPHY

Lancet. (2019). *For the HIV epidemic to end so must gender inequality.* Retrieved December 15 2021, from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwiptrbmq-X0AhWFCWMBHcExDgUQFnoECAIQAQ&url=https%3A%2F%2Fwww.thelancet.com%2Fjo.

National Population Commission (NPC) and ICF. (2019). *Nigeria Demographic and Health Survey 2018.* Abuja , Nigeria and Rockville, Maryland, USA.: . Retrieved from National Population Commission (NPC) and ICF. . (2019). Nigeria Demographic and Health Survey 2018. . Abuja , Nigeria and Rockville, Maryland, USA.

UNAIDS . (2021 (A)). *AIDSinfo.* Retrieved December 15 2021, from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjY8ObDueX0AhUN3hoKHcvgDrIQFnoECAQQAQ&url=https%3A%2F%2Faidsinfo.unaids.org%2F&usg=AOvVaw0GjG7Go01Wgzepl_T.

Federal Ministry of Health. (2019). *Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) 2018.* Technical Report, Abuja.

Central Intelligence Agency (CIA). (n.d.). *The World CIA Factbook.* Retrieved December 8 2021, from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwiytaPZ-uX0AhWRHRQKHQF0DUoQFnoECAkQAQ&url=https%3A%2F%2Fwww.cia.gov%2Fthe-world-factbook%2Fcountries%2Fnigeria%2F&u.

National Agency for the Control of AIDS. (2020 (B)). *Modes of HIV Transmission in Nigeria:Application of the Incidence Patterns Model.* Abuja, Nigeria.

National Agency for the Control of AIDS. (2020 (A)). *National HIV/AIDS Access to Justice Guidelines and Capacity Building Manual.* Retrieved from https://docs.google.com/viewerng/viewer?url=https://beta.naca.gov.ng/wp-content/uploads/2021/08/NATIONAL-HIVAIDS-ACCESS-TO-JUSTICE-GUIDELINES-AND-CAPACITY-BUILDING-MANUAL.pdf.

Federal Ministry of Health. (2015). *Integrated Biological and Behavioural Surveillance Survey (IBBSS) 2014.* Abuja, Nigeria.

Federal Ministry of Health. (2021). *Integrated Biological and Behavioural Surveillance Survey (IBBSS) 2020.* Abuja, Nigeria.

UNAIDS. (2016). *Prevention Gap Report.* Retrieved October 2021, from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjtmqTV8cf3AhWfi_0HHfOTBRIQFnoECAwQAQ&url=https%3A%2F%2Fwww.unaids.org%2Fen%2Fresources%2Fdocuments%2F2016%2Fprevention-gap&usg=.

World Economic Forum. (2017). *The Global Gender Gap Report.* Retrieved October 2021, from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwiJlKvj-Mf3AhVXPcAKHfLxAKsQFnoECA0QAQ&url=https%3A%2F%2Fwww3.weforum.org%2Fdocs%2FWEF_GGGR_2017.pdf&usg=AOvVaw3Zh8W-3l6oWbyU9YuVDSsY.

Birchall, J. (2019). *Overview of Social Exclusion in Nigeria.* K4D Helpdesk Report., Institute of Development Studies. , Brighton, UK.

Cabello, F., Sanchez, F., Farre, J., & Montejo, A. (2020). Consensus on recommendations for safe sexual activity during the COVID-19 coronavirus pandemic. *Journal of Clinical Medicine, 9* (7), 2297.

Sanchez, O., Vale, D., Rodrigues, L., & Surita, F. (2020). Violence against women during the COVID-19 pandemic: An integrative review. *International Journal of Gynecology & Obstetrics, 151*(2), 180-187.

World Bank. (2021). *Nigeria Overview:Development News.* Retrieved from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwiIqN2kref0AhWq3eAKHQFcC0wQFnoECAIQAQ&url=https%3A%2F%2Fwww.worldbank.org%2Fen%2Fcountry%2Fnigeria%2Foverview&usg=AOvVaw0XvoAeCsj4lif7iUZT4LHJ

National Bureau of Statistics. (2019). *Poverty and Inequality in Nigeria: Executive Summary.*

Ozili, P. (2020). Covid-19 pandemic and economic crisis: The Nigerian experience and structural causes. *Journal of Economic and Administrative Sciences* . Retrieved from Ozili, P. (2020). Covid-19 pandemic and economic crisis: The Nigerian experience and structural causes. . Journal of Economic and Administrative Sciences .

Buba, A., Abdu, M., Adamu, I., & Jibir, A. (2018). Socio-Demographic Determinants of Poverty in Nigeria and its Gender Differentials. *European Scientific Journal, 14*(14).

Onwuka, I., Nwadiubu, A., & Isiwu, P. (2019). Poverty among Women in Nigeria–Psychological and Economic Perspective: A Study Based On South West, Nigeria. *International Journal of Business and Management, 4*(11), 90-100.

Nelson, E. (2020). Structural inequities, HIV vulnerability and women's agency: Street-based sex workers in Nigeria. *Global Public Health, 15*(12), 1800-1809.

World Bank. (2020 (B)). *Labor market impacts of COVID-19 in four African countries.*

World Bank. (2020 (A)). *Nigeria Releases New Report on Poverty and Inequality in country.* Retrieved December 8 2021, from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwi316OHsef0AhVOzhoKHf9MAWIQFnoECAIQAQ&url=https%3A%2F%2Fwww.worldbank.org%2Fen%2Fprograms%2Flsms%2Fbrief%2Fnigeria-releases-new-report-on-poverty-and-inequality-in-cou.

UNDP. (2022). *Gender Inequality Index (GII):Human Development Reports.* Retrieved from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwiRvY-0l8j3AhVWgv0HHRm3CCoQFnoECBIQAQ&url=https%3A%2F%2Fhdr.undp.org%2Fen%2Fcontent%2Fgender-inequality-index-gii&usg=AOvVaw1SZ89PtL6PmLgbfeZfmdsE.

Sasu, D. (2022, February 1). *Literacy rate in Nigeria in 2018 by area and gender.* Retrieved from https://www.statista.com/statistics/1124741/literacy-rate-in-nigeria-by-area-and-gender/.

World Bank. (2020 (C)). *Human Capital Index.* Retrieved December 8 2021, from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwj2zPS3suf0AhWvyIUKHVGbCBIQFnoECCIQAQ&url=https%3A%2F%2Fwww.alnap.org%2Fsystem%2Ffiles%2Fcon.

National Agency for the Control of AIDS. (2013). *Gender Assessment of the National Response to HIV/AIDS in Nigeria.* Abuja, Nigeria.

National Agency for the Control of AIDS. (2014). *National HIV/AIDS Epidemiology and Impact Analysis (NHEIA) Report. Abuja, Nigeria.* Abuja, nigeria.

Federal Ministry of Health. (2007). *Integrated Biological and Behavioural Surveillance Survey (IBBSS) .* Abuja, Nigeria.

Okafor, U., Crutzen, R., Ifeanyi, O., Adebajo, S., & Van den Borne, H. (2017). HIV prevalence and high-risk behaviour of young brothel and non-brothel based female sex workers in Nigeria. *BMC Reseach Notes, 10*(380).

STRIVE. (2022). *Addressing the structural drivers of HIV: A STRIVE synthesis.* Retrieved from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjq0czDpcj3AhVCQBoKHdTTD6UQFnoECAIQAQ&url=http%3A%2F%2Fstrive.lshtm.ac.uk%2Fresources%2Faddressing-structural-drivers-hiv-strive-synthesis&usg=AOvVaw1vKIPQ__SBFq0yN51G.

Mbirimtengerenji, N. (2007). Is HIV/AIDS epidemic outcome of poverty in sub-saharan Africa? *Croatian medical journal, 48* (5), 605.

Hawkers , C., & Ruel , M. (2005). The Links between agriculture and health: an intersectional opportunity to improve the health and livelihoods of the poor. *Bulletin of the world Health Organization, 84*(12).

Chacham , A., Mala , M., Greco , M., Silva , A., & Greco , D. (2007). Automony and Susceptibility to HIV/AIDS among Young women living in a slum in Belo Horizonte,. *Brazil. AIDS Care, 19*(1), 12-22.

Cluver , L., & Gardner, F. (2007). Risk and Protective factors for psychological well-being of children orphaned by AIDS in Cape Town: a qualitative study of children and caregivers' perspectives. *AIDS Care, 19*(3), 318- 325.

Foster , G. (2007). Under the radar: Community safety nets for AIDS –affected households in sub-Saharan Africa. *AIDS Care, 19: 54 63., 19*, 54-63.

Ezeokana, J., Nnedum, O., & Madu, S. (2009). Pervasiveness of poverty among people living with HIV/AIDS in South Eastern Nigeria. *Journal of Human Ecology, 25*(3), 147-159.

Oyefara, J. (2007). Food insecurity, HIV/AIDS pandemic and sexual behaviour of female commercial sex workers in Lagos metropolis, Nigeria. *SAHARA-J: Journal of Social Aspects of HIV/AIDS, 4*(2), 626-635.

Udoh, I., Mantell, J., Sandfort, T., & Eighmy, M. (2009). Potential pathways to HIV/AIDS transmission in the Niger Delta of Nigeria: poverty, migration and commercial sex. *AIDS care, 21*(5), 567-574.

Maijama'a, D., & Kachalla , M. (2013, April 25). Impact of HIV/AIDS on economic growth and development in Nigeria. .

Boyi, A. (2019). Feminization of poverty in Nigeria and Challenges of sustainable Development and National Security. . *International Journal of Development Strategies in Humanities, Management and Social Sciences, 9* (4).

Adepoju, A. (2004). Feminisation of Poverty in Nigerian Cities: Insights from Focus Group Discussions and Participatory Poverty [1] Assessment.

Aluko, O. (2020). Rural Poverty among Women in Nigeria . *Journal of Sustainable Development in Africa, 22* (3).

Andrus, E., Mojola, S., Moran , E., & Eisenberg, M. (2021). Has the relationship between wealth and HIV risk in Sub-Saharan Africa changed over time? A temporal, gendered and hierarchical analysis. *SSM-population health, 15*, 1000833.

Gillespie, S., Kadiyala, S., & Greener, R. (2007). Is poverty or wealth driving HIV transmission?. *Aids, 21*.

Bamidele, J., Abodunrin, O., & Adebimpe, W. (2009). Sexual behavior and risk of HIV/AIDS among adolescents in public secondary schools in Osogbo, Osun State, Nigeria. I. *International journal of adolescent medicine and health, 21*(3), 387-394.

Smith, M. (2002). Gender, poverty, and intergenerational vulnerability to HIV/AIDS. . *Gender & Development, 10* (3), 63-70.

Pascoe, L., Peacock, D., & Stemple, L. (2018). Reaching men: addressing the blind spot in the HIV response. I. *International Journal o f Mens Social and Community Health, 1*57-70.

Vanguard Newspapers. (2020). Supreme Court's decision on female inheritance divides Igbo,.

Urama, E. (2019, April -June). The Values and Usefulness of Same-Sex Marriages Among the Females in Igbo Culture in the Continuity of Lineage or Posterity, https://journals.sagepub.com/doi/full/10.1177/2158244019850037. *SAGE Open*, 1-9.

Genyi, G., & George-Genyi, M. (2013). Widowhood and Nigerian womanhood: Another context of gendered poverty in Nigeria. *Research on Humanities and Social Sciences, 3*(7), 68-73.

Atilola, G., Akpa, O., & Komolafe, I. (2010). HIV/AIDS and the long-distance truck drivers in south-west Nigeria: a cross-sectional survey on the knowledge, attitude, risk behaviour and beliefs of truckers. *Journal of Infection and Public Health, 3* (4), 166-178.

Apondi, R., Awor, A., Nelson, L., Cheptoris, J., Ngabirano, F., & Egbulem, C. (2021). Gender-based violence shadows COVID-19: Increased sexual violence, HIV exposure and teen pregnancy among girls and women in Uganda. *Journal of the International AIDS Society, 24* (54), 53-55.

Oluwaleye, J., & Adefisoye, I. (2021). Interrogating the Causes, Effects and Societal Responses to Rape and Child-Defilement in Nigeria. *Interdisciplinary Journal of Rural and Community Studies, 3*(2).

Cherry, A., & Dillion, M. (2014). *International handbook of adolescent pregnancy.*

Jan-Walter , D., Günther , F., Subramanian, S., Sikhulile , M., & Jacob , B. (2015, August 1). Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment. *The Lancet Global Health, 1*(3), 470-477.

World Health Organization. (2020). *Female Genital Mutilation.* Retrieved December 8 2021, from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjE3vCoxuf0AhUR8eAKHbKaBboQFnoECAIQAQ&url=https%3A%2F%2Fwww.who.in.

UNAIDS. (2014). *Reduction of HIV-related stigma and discrimination: Guidance note.* Geneva, Switzerland.

Alubo,, O., Zwandor, A., Jolayemi, T., & Omudu, E. (2002). Acceptance and stigmatization of PLWA in Nigeria. *AIDS Care, 14* (1), 117-126.

Schwartz , S., Nowak , R., Orazulike , I., Keshinro , B., Ake , J., & Kennedy , S. (2015). The immediate effect of the Same-Sex Marriage Prohibition Act on stigma, discrimination, and engagement on HIV prevention and treatment services in men who have sex with men in Nigeria:analysis of prospective data from the TRUST cohort. *Lancet HIV, 2* (7), 299-306.

Crowell , T., Keshinro , B., Baral , S., Schwartz , S., Stahlman , S., & Nowak, R. (2017). Stigma, access to healthcare, and HIV risks among men who sell sex to men in Nigeria. *J Int AIDS Soc., 20*(1), 21489.

Allman, D., Adebajo, S., Myers, T., Odumuye, O., & Ogunsela, S. (2007). Challenges for the sexual health and social acceptance of men who have sex with men in Nigeria. *Cult. Health Sex., 9*(2), 153-168.

Otive-Igbuzor, E. (2013). *Analysis of the Structural and Systemic Causes of Gender Inequality in Nigeria.*

Kavanagh, M., Agbla, S., Pillinger, M., Joy, M., Case, A., Erondu, N., . . . Graeden, E. (2021, August). Law, Criminalisation and HIV in the World: Have countries that criminalise achieved more or less successful AIDS pandemic response?. *BMJ Global Health (medRxiv)., 6*(8).

US Department of States. (2011).

Africa for Women's Rights. (2010).

Odimegwu, C., Akinyemi , J., & Alabi, O. (2017). HIV-Stigma in Nigeria: Review of Research, Studies, Policies and Programmes.

National Agency for the Control of AIDS. (2020 (C)). *National Workplace Policy on HIV and AIDS. .* Abuja, Nigeria.

International Labor Organization . (2010). *Recommendation concerning HIV and AIDS and the World of Work (No. 200). .* Geneva, Switzerland.

National Agency for the Control of AIDS. (2016). *Stigma and Discrimination Reduction in the National HIV/AIDS Response .* Abuja, Nigeria.

Chibuike, F., Chukwunyere, D., & Awonuga, O. (2019). Uptake of cervical cancer screening among HIV positive women at a tertiary healthcare center in Nigeria.

Adibe , M., & Aluh, D. (2018). Awareness, knowledge and attitudes towards cervical cancer amongst hiv-positive women receiving care in a Tertiary Hospital in Nigeria . *Journal of Cancer Education, 33*(6), 1189-1194.

National Agency for the Control of AIDS. (2019 (B)). *National AIDS Spending Assessment (NASA).*

National Agency for the Control of AIDS. (2019 (A)). *Revised National HIV and AIDS Strategic Framework (2019-2021).* Abuja, Nigeria.

Olakunde, B., & Ndukwe, C. (2015). Improved domestic funding enhances the sustainability of HIV/AIDS response in Nigeria. . *Ann Glob Health , 81*.

UNAIDS. (2020). *Closing the HIV resource gap in Nigeria with more domestic funding.* Geneva.

National Agency for the Control of AIDS. (2016). *Promoting Gender Responsive Budgeting in the National Response on HIV and AIDS in Nigeria. .* Abuja, Nigeria.

National Agency for the Control Of AIDS. (2015). *Global AIDS Response Country Progress Report.* Abuja, Nigeria.

Federal Ministry of Health. (2017). *Health sector 2016 HIV Validated Data. .* Abuja, Nigeria.

Onwujekwe, O., Chikezie , I., & Mbachu, C. (2016). Investigating client perception and attitude to decentralization of HIV/AIDS treatment services to primary health centres in three Nigerian states. . *Health Expect , 19*.

Federal Ministry of Health. (2016). *National guidelines for HIV prevention, treatment and care . .* Abuja, Nigeria.

Olakunde, B., Adeyinka, D., Olawepo, J., Pharr, J., Ozigbu, C., Wakdok , S., & Oladele, T. (2019). Towards the elimination of mother-to-child transmission of HIV in Nigeria: a health system perspective of the achievements and challenges. *International Health, 11*(4), 240-249.

Fawole, O., Okedare, O., & Reed, E. (2021). Home was not a safe haven: women's experiences of intimate partner violence during the COVID-19 lockdown in Nigeria. *BMC women's health, 21*(1), 1-7.

Human Rights Watch. (2019).

Avert. (2017). *People with Duisabilities, HIV and AIDS.* Retrieved December 16 2021, from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwiPgciF3ef0AhWCA2MBHegTCf8QFnoECAIQAQ&url=https%3A%2F%2Fwww.avert.org%2Fpeople-disabilities-hiv-and-aids&usg=AOvVaw1-EIRGUhBOGNmF6pwbr5-3.

UNAIDS. (2014). *People with Disabilities-THe GAP Report.* Retrieved December 16 2021, from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjN0cCF3uf0AhUJqBQKHWidAkwQFnoECAMQAQ&url=https%3A%2F%2Fwww.unaids.org%2Fsites%2Fdefault%2Ffiles%2Fmedia_asset%2F11_Peoplewithdisabilities.pdf&usg=AOvVaw22lPsLOOb94bWH.

UNAIDS. (2017). *Global Partnership for Action to eliminate all forms of HIV-related Stigma and Discrimination.* Retrieved December 8 2021, from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwi-pd37xuf0AhUkBGMBHT9HCEwQFnoECAIQAQ&url=https%3A%2F%2Fwww.unaids.org%2Fsites%2Fdefault%2Ffiles%2Fmedia_asset%2Fglobal-partnership-hiv-stigma-discrimination_en.pdf&us.

Aderemi, T., Pillay, B., & Esterhuizen, T. (2013). Differences in HIV knowledge and sexual practices of learners with intellectual disabilities and non-disabled learners in Nigeria. . *Journal of the International AIDS Society, 16*(1), 17331.

Olaleye, O., Adetoye , A., & Hamzat, T. (2017). Disability and Quality of Life among People Living With HIV/AIDS in Ibadan, Nigeria. . *Medical Journal of Zambia, 44*(3), 166-175.

Williamson, P., & Rodd, J. (2016, July 11). Civil society advocacy in Nigeria: promoting democratic norms or donor demands? *BMC Int Health Hum Rights, 16*(9).

UNAIDS. (2021 (B)). *Confronting Inequalities:Lessons for pandemic response from 40 years of AIDS.* Retrieved December 16 2021, from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ah

UKEwi7rrX6nuf0AhUIM-wKHS41AQIQFnoECAgQAQ&url=https%3A%2F%2Fwww.unaids.org%2Fsites%2Fdefault%2Ffiles%2Fmedia_asset%2F2021-global-aids-update_en.pdf&usg=AOvVaw1cbVhZK8rbKH5.

UNAIDS. (2019). *Women and HIV-A Spotlight on adolescent girls and young women.* Retrieved December 8 2021, from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjt5NC4oef0AhUEsKQKHUTNAFIQFnoECAMQAQ&url=https%3A%2F%.

Network of People living with HIV/AIDS in Nigeria. (2021). *Stigma Index Survey Report.* Abuja, Nigeria.

Network of People living with HIV/AIDS in Nigeria. (2014). *Stigma Index Report.* Abuja, Nigeria.

APPENDICES

Appendix 1: Definitions

For this assessment, definitions stated here are from the UNAIDS Gender Assessment Tool, 2019 unless otherwise stated**.**

Gender: The social attributes and opportunities associated with being male and female, and the relationships between women and men and girls and boys as well as the relations between women and those between men. These attributes, opportunities and relationships are socially constructed and are learned through socialization processes. They are context- and time-specific and changeable. Gender determines what is expected, allowed and valued in a woman or a man in a given context. In most societies, there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over resources and decision-making opportunities.

Gender Based Violence (GBV): Violence that establishes, maintains or attempts to reassert unequal power relations based on gender. The term was first defined to describe the gendered nature of men's violence against women. Hence, it is often used interchangeably with "violence against women". The definition has evolved to include violence perpetrated against some boys, men and transgender people because they do not conform to or challenge prevailing gender norms and expectations (for example, may have feminine appearance) or heterosexual norms.

Gender equality: The concept that all human beings, both men and women, are free to develop their personal abilities and make choices without any limitations set by stereotypes, rigid gender roles and prejudices. Gender equality, a recognised human right, means that the differences in behavior, aspirations and needs of women and men are considered, valued and favored equally. It signifies no discrimination based on a person's gender in allocating resources or benefits or in access to services. Gender equality may be measured in terms of equality of opportunity or equality of results.

Gender identity: A person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth. It includes both the personal sense of the body, which may involve, if freely chosen, modifying bodily appearance or function by medical, surgical or other means, and other expressions of gender, including dress, speech and mannerisms.

Gender-related barriers: Legal, social, cultural, or economic barriers to accessing services, participation and/or opportunities, imposed based on socially constructed gender roles.

Gender-responsive budgeting: Gender-responsive budgeting is a method of determining the extent to which government expenditure has detracted from or come nearer to the goal of gender equality. A gender-responsive budget is not a separate budget for women but rather a tool that analyses budget allocations, public spending and taxation from a gender perspective and can be subsequently used to advocate for reallocating budget line items to better respond to women's priorities as well as men's, making them, as the name suggests, gender-responsive *(19)*.

Intersectionality: The term was first coined by American sociologist Kimberlé Crenshaw in 1989. Intersectionality moves beyond examining individual factors such as biology, socioeconomic status, sex, gender and race. Instead, it focuses on the relationships and interactions between such factors, and across multiple levels of society, to determine how health is shaped across population groups and geographical contexts. Increasingly, intersectionality is seen as a promising approach to the analysis of multifaceted power structures and processes that produce and sustain unequal health outcomes.[154]

Intimate Partner Violence (IPV): Behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviour. It is one of the most common forms of violence against women.

[154] (Kapilashrami & Hankivsky, 2018)

Masculinities: Socially constructed definitions and perceived notions and ideals about how men should or are expected to behave in a given setting. Masculinities are configurations of practice structured by gender relations and can change over time. Their making and remaking is a political process affecting the balance of interests in society and the direction of social change.

Men who have sex with men: Men who have sex with men, regardless of whether they have sex with women or have a personal or social gay or bisexual identity. This concept is useful because it also includes men who self-identify as heterosexual but have sex with other men.

Reproductive health: A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life, and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as other methods of their choice for regulating fertility that are not against the law and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth, and provide couples with the best chance of having a healthy infant.

Reproductive rights: Certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, to have the information and means to do so and to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions on reproduction, free of discrimination, coercion, and violence, as expressed in human rights documents. In exercising this right, they should consider the needs of their living and future children and their responsibilities towards the community.

Sexual and reproductivehealth and rights : Women's sexual and reproductive health is related to multiple human rights, including the right to life, the right to be free from torture, the right to health, the right to privacy, the right to education and the prohibition of discrimination. The Convention on the Elimination of All Forms of Discrimination against Women and the United Nations Committee on Economic, Social and Cultural Rights have both clearly indicated that women's right to health includes their sexual and reproductive health. This means that states are obligated to respect, protect, and fulfil rights related to women's sexual and reproductive health.

The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health maintains that women are entitled to reproductive healthcare services, goods and facilities that are: (a) available in adequate numbers; (b) accessible physically and economically. accessible without discrimination; and (d) of good quality. Despite these obligations, violations of women's sexual and reproductive health and rights are frequent and take many forms, including denying access to services that only women require, poor-quality services, subjecting women's access to services to third-party authorization and performing procedures related to women's reproductive and sexual health without the woman's consent (such as forced sterilizations, forced virginity examinations and forced abortions). Women's sexual and reproductive health and rights are also at risk when they are subjected to female genital mutilation and early marriage.

Sexual and reproductive health programmes and policies: Include, but are not restricted to, services for family planning; infertility services; maternal and new-born health services; preventing unsafe abortion; post-abortion care; preventing the mother to-child transmission of HIV; diagnosing and treating sexually transmitted infections, including HIV infection, reproductive tract infections, cervical cancer and other diseases of the female reproductive system; promoting sexual health, including sexuality counselling; and preventing and managing gender-based violence.

Sexual health: A state of physical, emotional, mental, and social wellbeing in relation to sexuality and not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, and the possibility of having pleasurable and safe sexual

experiences free of coercion, discrimination, and violence. Attaining and maintaining sexual health requires respecting, protecting and fulfilling the sexual rights of all people.

Transgender people: People with a gender identity different from their sex at birth. Transgender people may be male to female (female appearance) or female to male (male appearance). It is preferable to describe them as he or she, according to their gender identity: The gender they present and not their sex at birth.

Violence against women: Any public or private act of gender based violence that results in or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts,coercion or arbitrary deprivation of liberty within the family or general community. It includes sexual, physical or emotional abuse by an intimate partner (known as intimate partner violence), family members or others; sexual harassment and abuse by authority figures, such as teachers, police officers or employers; sexual trafficking; forced marriage; dowry related violence; honour killings; female genital mutilation; and sexual violence in conflict situations.

APPENDIX II:

LIST OF CONTRIBUTORS FOR NATIONAL GENDER ASSESSMENT, OF THE HIV RESPONSE IN THE FEDERAL REPUBLIC OF NIGERIA, 2021

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APPENDIX III:

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13	Hajara Aliyu	F	Association of Women Living with HIV and AIDS in Nigeria (ASWHAN)	Coordinator
14	Hajara Muhammad	F	Association of Women Living with HIV and AIDS in Nigeria (ASWHAN)	PRO
15	Hamza Aminu Abdullahi	M	People With Disability (PWD)	
16	Hussaina Labaran	F	Association of Women Living with HIV and AIDS in Nigeria (ASWHAN)	Ast Finance
17	Ibrahim Abdullahi Yakubu	M	Chemonics	
18	Jacob Awolaja	M	-	Consultant
19	Jamila Adam	F	Network of People Living with HIV and AIDS (NEPWHAN)	Member
20	Jamilu Ahmad	M	Network of People Living with HIV and AIDS (NEPWHAN)	
21	Khadija Ahmad	F	Association of Positive Youth Living with HIV in Nigeria (APYIN)	Welfare Officer
22	Malik Haruna	M	Key Population (KP)	
23	Mohammad Yassir	M	Network of People Living with HIV and AIDS (NEPWHAN)	
24	Muhammad Mubarak Miliyasi	M	Association of Positive Youth Living with HIV in Nigeria (APYIN)	
25	Nafish Nasir Ashana	F	Women Group	-
26	Nafiu Uba Indabawa	M	People With Disability (PWD)	
27	Naimah D. Ahmed	F	Women Group	Treasurer
28	Raliya Musa	F	Association of Women Living with HIV and AIDS in Nigeria (ASWHAN)	Member
29	Safiya Lawan Abubakar	F	Women Group	-
30	Saifu Muktar Sadiq	M	People With Disability (PWD)	
31	Saleh Yassir Muhal	M	Network of People Living with HIV and AIDS (NEPWHAN)	
32	Sallau Nassir	M	Chemonics	
33	Saminlu Muhammad	M	Network of People Living with HIV and AIDS (NEPWHAN)	

34	Sani Garba Talabi	M	Network of People Living with HIV and AIDS (NEPWHAN)	
35	Sani Mohammad Jimada	M	People With Disability (PWD)	
36	Sha'awa Haruna	F	Network of People Living with HIV and AIDS (NEPWHAN)	Zonal Coordinator North West
37	Suleiman Yakubu	M	Network of People Living with HIV and AIDS (NEPWHAN)	
38	Sumayyah Karibullah Icabara	F	People With Disability (PWD)	
39	Tasnim Muhammad Tijjani	F	People With Disability (PWD)	
40	Ummi Ummar Abubkar	F	People With Disability (PWD)	
41	Zahraddeen Ahmad Gaya	M	Association of Positive Youth Living with HIV in Nigeria (APYIN)	
42	Zahrah Usman	F	Network of People Living with HIV and AIDS (NEPWHAN)	PRO II
43	Zainab Tizzani Garba	F	People With Disability (PWD)	
44	Zainab Umar	F	Network of People Living with HIV and AIDS (NEPWHAN)	Treasurer
LAGOS STATE				
1	Abiola Ayeni Ariyo	F	Association of Women Living with HIV and AIDS in Nigeria (ASWHAN)	South West Coordinator
2	Adebambo Olusola	F	Lagos State AIDS Control Agency	Chief Health Education Officer
3	Adewale Ayomide Itunu	F	Association of Positive Youth Living with HIV in Nigeria (APYIN)	Support Group Official
4	Adio Anuoluwapo	F	Royal Women Health and Right Initiative	Programme Officer
5	Anthonia Olugbeyo-Adebayo	F	GIEVA	Volunteer
6	Dr Bisayo Odetoyinbo	F	-	Consultant
7	Dr. Fisher Oladipupo	M	Lagos State AIDS Control Agency	Head, Project
8	Dr Izeduwa Derex-Briggs	F	-	Consultant
9	Emmanuela Abakpa	F	NACA	Programme Officer
10	Igoche Margaret	F	GIEVA	Accounts
11	Monica Obi	F	Association of Women Living with HIV and AIDS in Nigeria (ASWHAN)	Secretary
12	Ndidi Chukwurah	F	Heartland Alliance	Gender Focal Person
13	Odibe Oluwatoyin	F	National Human Rights Commission	Assistant Director, Investigation
14	Okeowo Taiwo	M	Association of Positive Youth Living with HIV in Nigeria (APYIN)	Support Group Official
15	Olorunfemi Oluwatoyin	F	Ministry of Women Affairs and Poverty Alleviation (MWAPA)	Director, Gender/Domestic Unit
16	Onuh Susan Iberi	F	CEE HOPE	Project Supervisor
17	Patrick Akpan N.	M	Network of People Living with HIV and AIDS (NEPWHAN)	State Coordinator, Lagos
18	Raheem Mohammed	M	NACA	NACA South West Zonal Office Coordinator
19	Rosemary Oche-Onu	F	CEE HOPE	Data Analyst
20	Seyi Jimoh	F	Network of People Living with HIV and AIDS (NEPWHAN)	Coordinator/ Support Group Rep.
21	Soares Cynthia	F	Royal Women Health and Right Initiative	Outreach Coordinator
22	Taiwo A. Alexander	M	Lagos State AIDS Control Agency	Assistant Director, AOHR
23	Tope Oyedija	F	Lagos State Domestic and Sexual Violence Response Team (DSVRT)	Case Manager
24	Victoria Mbah	F	Association of Women Living with HIV and AIDS in Nigeria (ASWHAN)	Ex Coordinator

25	Willie Workman Oga	M	CEE HOPE	Head, Programmes
TARABA STATE				
1	Amarachi Okorukwu	F	NACA	
2	Amina Inuwa	F	TACA	
3	Amina Mohammed Imam	F	Adalci Women Multipurpose Cooperative Society	
4	Barr. Shalom Mai Jankai	F	FIDA	
5	Bilkisu Timon	F	Association of Women Living with HIV and AIDS in Nigeria (ASWHAN)	Coordinator
6	Christiana Babila Jatau	F	Network of People Living with HIV and AIDS (NEPWHAN)	
7	Philomina Shiaondo	F	Association of Positive Youth Living with HIV in Nigeria (APYIN)	
8	Dame Chrisantus Isaac	M	Association of Positive Youth Living with HIV in Nigeria (APYIN)	
9	Dauda N Baade	M	SASCP/SPIU	
10	Dr. Ejiro J. Otive-Igbuzor	F	Consultant	
11	Dr. Talatu Bello	F	Taraba State University	
12	Dr. Tony Garuba	M	Equity Advocates/ Gender in the Balance	
13	Elizabeth Tongo Igbadu	F	Association of Women Living with HIV and AIDS in Nigeria (ASWHAN)	
14	Emmanuel Sale Kini	M	Key Population (KP)	
15	Faiza Mohammed Nuhu	M	People With Disability (PWD)	
16	Gaius Theophilus	M	People With Disability (PWD)	
17	Garba Abbas	M	Human Rights Commission	
18	Golgi Agnes Kiritmwa	F	People With Disability (PWD)	
19	Hadiza Idris	F	People With Disability (PWD)	
20	Hajara Adamu	F	Association of Women Living with HIV and AIDS in Nigeria (ASWHAN)	
21	Hajiya Hadiza Bello Yero	F	FHAMAS	
22	Hamida Abdullahi	F	Association of Women Living with HIV and AIDS in Nigeria (ASWHAN)	
23	Hashimu Joseph	F	Association of Positive Youth Living with HIV in Nigeria (APYIN)	
24	Hon. Patience Danjuma	F	Faith-Alive Vulnerable Foundation	Executive Director
25	Shallom .D. Maijankai	F	FIDA,Taraba St Chpt	
26	Jarah Boniface Yahaya	M	Key Population (KP)	
27	Jeremy Bulus	M	Key Population (KP)	
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29	Laraba .A.Wambai Abdul	F	NASSO	
30	Layidi Johnson	F	Network of People Living with HIV and AIDS (NEPWHAN)	Coordinator
31	Lucy Samuel	F	CISHAN	
32	Mariam Mser Doosuur	F	Association of Women Living with HIV and AIDS in Nigeria (ASWHAN)	
33	Mary Michael	F	Association of Women Living with HIV and AIDS in Nigeria (ASWHAN)	
34	Mohammed Aliyu	M	People With Disability (PWD)	
35	Mohammed Sadi H	M	Key Population (KP)	
36	Monica Asandere	F	Network of People Living with HIV and AIDS (NEPWHAN)	
37	Mr. Abubakar Adamu	M	Network of People Living with HIV and AIDS (NEPWHAN)	

38	Mr. Bitrus Usman	M	Network of People Living with HIV and AIDS (NEPWHAN)	
39	Mr. Ikpe Manja	M	Network of People Living with HIV and AIDS (NEPWHAN)	
40	Mr. Jacob Awolaja	M	Consultant	
41	Mr. John A. Adams	M	People With Disability (PWD)	
42	Mr. Paul James	M	Network of People Living with HIV and AIDS (NEPWHAN)	
43	Mr. Sale Ali Adi	M	Network of People Living with HIV and AIDS (NEPWHAN)	
44	Mr. Tobias John		North East Zonal Office	
45	Mrs Elizabeth Joshua	F	State Ministry of Women Affairs	Director Child
46	Mrs Shepuya Atiku	F	TACA	GHR FP
47	Mrs. Punarimam Atenji	F	Equity Advocates/ Gender in the Balance	
48	Mrs. Serah Ibbi	F	Women of Valour	
49	Patience Igwe	F	Association of Women Living with HIV and AIDS in Nigeria (ASWHAN)	
50	Rupa Bhadra	F	UN	
51	Ruth Emma	F	Association of Women Living with HIV and AIDS in Nigeria (ASWHAN)	
52	Shamsiya Ibrahim	F	Association of Positive Youth Living with HIV in Nigeria (APYIN)	
53	Sunday Jeremiah	M	People With Disability (PWD)	
NATIONAL/FEDERAL LEVEL				
1	Angela Agweye	F	USAID/NIGERIA	Project Management Specialist/Gender POC HIV/AIDS Office
2	Dr. Yinka Falola-Anoemuah	F	NACA	Deputy Director, Community Prevention and Care Services (Lead Gender, Human Rights and Care Support Services)
3	Bosah Edwina	F	FMOH/NASCP	Senior Scientific Officer
4	Bukola Adewumi	F	CDC, NIGERIA	GENDER, POC, CDC
5	Chigbo Chinweike		NACSWD	
6	Dooshima Uganden-Okonkwo	F	US DEPARTMENT OF DEFENSE WALTER REED PROGRAM, NIGERIA	Prevention Manager
7	Ebere Umeugwunne	F	Association of Positive Youth Living with HIV in Nigeria (APYIN)	GENDER/SRH FOCAL PERSON
8	Jeremy Bulus Su	M	International Center For Total Health And Right Advocacy Empowerment (ICTHARAE)	COMMUNITY MOBILIZER
9	Mezino Ozue	M	NIGERIA POLICE FORCE	FCT COORDINATOR
10	Nuhu Somaila		Aid	
11	Offor Chinonye B	F	Passion And Concern For Women Welfare And Empowerment Initiatives	Programme Officer
12	Olabosunde Funke	F	Heartland Alliance	Gender Advisor
13	Omotunde Ellen Thompson		CENTRE FOR PWD	
14	Tessie Kuhe	F	USAID/NIGERIA	Gender Advisor
15	Victor Adamu	M	CDC, NIGERIA	KP Specialist
16	Yarda Emmanuel	M	INTERNATIONAL CENTER FOR TOTAL HEALTH AND RIGHT ADVOCACY EMPOWERMENT (ICTHARAE)	Programme Officer Advocacy

17	Rachel Goldstein	F	USAID	Office Director
18	Dr. Erasmus Morah	M	UNAIDS	Country Director
19	Comfort Lamptey	F	UN WOMEN	Country Representative
20	Dr. Chioma Ukanwa	F	NASCP, FMOH	Gender Focal Person

APPENDIX IV:

SUMMARY OF RECOMMENDATIONS BY OBJECTIVES

S/N	Objectives	The Approach	Tools/ Data Source	Summary of Recommendations
1	To identify strategic investment areas that will improve gender responsiveness in the national HIV response.	Primary data from key informants	Key Informant Interviews with relevant implementers/experts in government, development partners/donor agencies and selected CSOs.	*Deliberate institution and/or strengthening of Gender Management Systems with its structures, processes and mechanisms in all SACAs, LACAs, line Ministries and other coordinating bodies.[155] *Implement specific gender sensitive Interventions – Please see recommendations 3, 4, 5 - for government
2	To identify the strategic planning and budget processes that have essential information surrounding the potential epidemic, context, and response from a gender perspective.	Primary data from key informants	Key Informant Interviews with relevant implementers/experts in government, development partners/donor agencies and selected CSOs.	*Stakeholders in the National Response to position and monitor gender equality and social inclusion as component parts of implementing the National Development Plan. (See recommendations for all stakeholders) *Federal Ministry of Women Affairs to work closely with NACA/SACAs, line MDAs and other stakeholders to implement provisions of the National Gender Policy as part of the HIV response. (See recommendations for Government) *Engage the UNDAF process – ensure more allocation to UN Women for specific interventions targeted at narrowing the gender gap.156 The UNCT Scorecard in its Indicator 6.1 states 'adequate resources for gender mainstreaming are allocated and tracked' and the minimum requirement is that 'the UNCT has

[155] This commitment was well stated in NSF II with indicators of success, including, Proportion of SACAs, LACAs, line Ministries and other coordinating bodies with Gender Management Systems (GMS) established and functional. Gender Management Systems offer a holistic, deliberate and systemic approach to sustainably changing the course of the epidemic through transformation of gender relations, alterations in systems and institutions, equitable distribution of resources and social justice. This commitment is not stated in the current NSF and NSP.

[156] UN Women currently engages ASHWAN through its fund envelope.

established and met a financial target for programme allocation for Gender Equality and the Empowerment of Women'. (See recommendations for Government)

*Also, working with UN Women and other stakeholders, the Ministry of Finance and the National Assembly have shown commitment to driving the process of adopting gender budgeting as a strategy to address inequality. The existing budget processes and templates do not mainstream gender. This is partly responsible for the current inadequacy in resource allocation to the fund the gender components of the HIV response. For the first time in Nigeria in 2021, the call circular requested ministries, departments, and programmes to also apply gender-responsive budgeting in preparing the budgets.[157]

*Engage the Annual Operational Plan Process at NACA with a gender lens. (See recommendations for NACA)

*NSF and NSP on HIV/AIDS expired in 2021 and are due for reviews. The recommendations of this gender assessment should be taken on board where necessary in the next review.
(See recommendations for NACA)

*The Social Intervention Projects (SIP) budget line was introduced as part of the Federal Capital Budget in 2016 with 4 components: The National Cash Transfer Programme; N - POWER; the Government Enterprise and Empowerment Programme (GEEP) and the National Home-Grown School Feeding programme (NHGSFP) and is a major milestone in macroeconomic planning with a large chunk of money set aside for initiatives that directly reduce inequality. (See recommendations for All Stakeholders)

*In 2019, UNAIDS commissioned an assessment of the HIV sensitivity of the National Social Protection Programmes with Federal Ministry of Budget and National Planning

[157] UN Women Country Representative, 2021, KII response

				and NACA as major stakeholders. The key recommendations of the assessment are pertinent and should be implemented. (See recommendations for Government.) *Recognizing poverty as a key driver of the epidemic, the Federal Ministry of Women Affairs, partnering with NACA/SACAs and civil society could engage the managers of SIP to allocate a chunk of these resources to women living with HIV.(See recommendations for Government, point 5)
3	To facilitate learning about the extent to which the national response recognises and acts on gender inequality as a critical enabler of the HIV response.	*Secondary data from desk review (populate the adapted GAT with data from desk review) *Primary data to complement findings from the desk review	*Adapted GAT *Focus Group Discussions and Key Informant Interviews with NACA/SACA staff, Key Populations, relevant development partners, People living with HIV, women's groups, selected local and international NGOs/ CSOs.	*To the end that NACA developed Guidelines and Training manual for Gender Mainstreaming in 2015 as well as Access to Justice Manual is an indication of the recognition of Gender and Human Rights as critical enabler. However, in reality mainstreaming gender is still not been effectively done in most MDAs and therefore greater involvement of the national gender mainstreaming machinery in the HIV response is needed. (See recommendations for NACA). * Other findings documented in the full report
4	To enhance monitoring and evaluation of gender management systems in the national HIV response	*Conduct a desk review of the existence, functionality and monitoring and evaluation of the core elements of Gender Management System in the National and State HIV/AIDS Responses. *Collect primary data on GMS at state and national levels.	*A self-administered, digitized questionnaire, supported by virtual or face-to-face interviews. *Respondents: Relevant staff at NACA, SACA, Ministry of Women Affairs and Social Development, People living with HIV, Legislators and/or women's groups, Legislative Aid, Civil Society.	*Adopt a systemic approach to tackling gender and other forms of inequalities – *NACA and stakeholders to lead the institutionlisation of a nation-wide gender and social inclusion architecture through – *Adoption of Gender Equality and Social Inclusion (GESI) as a goal of subsequent NSF/NSP as well as a critical lever for achieving other NSF/NSP goals. The Sustainable Development Goals (SDG) provides the example with SDG 5, elevating gender equality from a mere cross cutting theme to becoming a development goal at par with other goals. *Issuance of clear guidelines and timelines for setting up GMS mechanisms and processes at all levels – States, LGAs and line MDAs that are mutually reinforcing and directly promote GESI in the National HIV response. *Development of strategic indicators/checklists for monitoring the functionality of GMS mechanisms and processes. *Dedicating a section in NACA/SACA/LACA reporting

				templates to discuss the extent to which GMS functions at every level will keep it in the front burner. *Greater involvement of the national gender mainstreaming machinery in the HIV response – Ministries of Women Affairs at all levels, Parliamentary committees on women affairs, CSOs, the women's movement (especially the National Council for Women Societies (NCWS), networks of persons living with HIV across population groups, the Gender Technical Unit at the National Assembly (influencing gender-responsive legislation, resource allocation and oversight). *Institutionalize a capacity building programme to build gender analysis and planning expertise in the various sectors. *Include clear budget lines for the establishment and evaluation of the existence and functioning of GMS and network with donors and other partners to identify resources to drive the process and programmes
5	To understand the challenges and opportunities that could be useful in ensuring improved gender mainstreaming at the State and community levels in the HIV response.	Primary data from key informants/relevant stakeholders at national, state and community levels.	Focus Group Discussions and Key Informant Interviews with NACA/SACA staff, Key Populations, relevant development partners, People living with HIV, women's groups, selected local and international NGOs/ CSOs.	*NACA should be more proactive and synergise with MDAs such as Ministry of Justice, Ministry of Budget and National Planning etc. towards ensuring a gender transformative response. Other recommendations documented in the full report
6	To document good practices that address gender- and human rights-related barriers in the national HIV response.	Primary data – Collection of stories of change	Case study tool	Documented in the full report.
7	To examine the extent to which gender equality and women's empowerment principles are prioritized in the HIV & AIDS response to achieve a	Primary data from key informants/relevant stakeholders at national, state and community levels	Focus Group Discussions and Key Informant Interviews with NACA/SACA staff, Key Populations, relevant development partners, People living with HIV, women's groups, selected local and international NGOs/ CSOs.	*Similar to Objective 3 *Other recommendations documented in the full report

	gender transformative, equitable and rights-based approach			

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