



FEDERAL MINISTRY OF  
**HEALTH**



# FINAL REPORT

The Evaluation of Gender and  
Human Rights Approach in HIV  
Programs in Nigeria

DECEMBER 2025



# TABLE OF CONTENTS

<b>TEAM INVESTIGATORS</b> .....	<b>5</b>
<b>ACRONYMS</b> .....	<b>6</b>
<b>FOREWORD</b> .....	<b>8</b>
<b>EXECUTIVE SUMMARY</b> .....	<b>9</b>
<b>1.0 INTRODUCTION</b> .....	<b>12</b>
1.1 BACKGROUND .....	12
1.2 PROBLEM STATEMENT .....	14
1.3 JUSTIFICATION .....	15
1.4 OBJECTIVES.....	16
<b>2.0 METHODOLOGY</b> .....	<b>18</b>
2.1 DESK REVIEW .....	18
2.2 STUDY DESIGN.....	19
2.3 STUDY LOCATION & TARGET POPULATION.....	20
2.3.1 State Selection.....	20
2.3.2 Participants .....	20
2.4 INCLUSION & EXCLUSION CRITERIA .....	21
2.4.1 Inclusion Criteria.....	21
2.4.2 Exclusion Criteria .....	22
2.4.3 Criteria For Interviewers.....	22
2.5 SAMPLE SIZE DETERMINATION.....	22
2.6 DATA TOOL & VARIABLES .....	28
2.6.1 Quantitative .....	28
2.6.2 Qualitative .....	28
2.7 VARIABLES (QUANTITATIVE & QUALITATIVE).....	29
2.7.1 Socio-Demographic Characteristics.....	29
2.7.2 Other Variable .....	29
2.8 PRE-TESTING .....	29
2.9 RECRUITMENT & TRAINING OF DATA COLLECTORS .....	29

2.10	DATA COLLECTION.....	30
2.10.1	Quantitative Data Collection .....	30
2.10.2	Qualitative Data Collection.....	30
2.11	DATA MANAGEMENT & ANALYSIS .....	31
2.11.1	Data Verification And Validation .....	31
2.11.2	Data Safety And Transfer .....	31
2.11.3	Data Analysis .....	32
2.11.4	Quality Assurance Measures .....	32
2.11.5	IMPLEMENTATION STRATEGY .....	33
<b>3.0</b>	<b>ETHICAL CONSIDERATIONS.....</b>	<b>37</b>
3.1	REQUEST FOR WAIVERS & EXPEDITED APPROVAL .....	37
3.2	CONFIDENTIALITY OF DATA .....	37
3.3	BENEFICENCE TO PARTICIPANTS.....	37
3.4	NON-MALEFICENCE OF PARTICIPANTS.....	37
3.5	VOLUNTARINESS .....	37
<b>4.0</b>	<b>STUDY DISSEMINATION PLAN .....</b>	<b>38</b>
<b>5.0</b>	<b>MANAGEMENT AND ORGANIZATION OF THE STUDY.....</b>	<b>38</b>
<b>6.0</b>	<b>RESULTS .....</b>	<b>39</b>
6.1	DESK REVIEW ON EVALUATION OF GENDER AND HUMAN RIGHTS APPROACH IN HIV PROGRAMS IN NIGERIA <sup>39</sup>	
6.1.1	Background.....	39
6.2	QUANTITATIVE, QUALITATIVE, AND DESK REVIEW DATA ON EVALUATION OF GENDER AND HUMAN RIGHTS APPROACH IN HIV PROGRAMS IN NIGERIA .....	44
6.2.0	Summary Of Sociodemographic Characteristics .....	44
6.2.1	Duration Of HIV Services.....	45
6.2.2	Objective 1: Evaluate Current Access To Hiv Prevention, Treatment, Care, And Support .....	47
6.2.3	Objective 2: Evaluate Changes in Societal Norms, Behaviours, and Gender Roles Driving HIV Transmission 52	
6.2.4	Objective 3: Determine Participation of Target Groups in HIV-Related Decision-Making.....	59
6.2.5	Objective 4: Identify Contextual Factors Influencing HIV Services, GBV Response, and PLHIV.....	62
6.2.6	Objective 5: Measure Cases of GBV and Human Rights Violations Among Population Groups.....	65
6.2.7	Objective 6: Analyze Integration of Gender and Human Rights into HIV .....	76

6.2.8	<i>Objective 7: Evaluate Gender &amp; Human Rights Coordination Platforms in HIV Programs</i>	85
<b>7.0</b>	<b>CONCLUSION</b>	<b>91</b>
7.1	<i>POLICY IMPLICATIONS</i>	92
7.2	<i>POLICY RECOMMENDATION AND IMPLEMENTATION ROADMAP</i>	96
<b>8.0</b>	<b>GENDER EQUALITY CONTINUUM FRAMEWORK (GECF) ANALYSIS OF EVALUATION RESULTS</b>	<b>98</b>
<b>9.0</b>	<b>ANALYTICAL SUMMARY</b>	<b>103</b>
<b>10.0</b>	<b>BIBLOGRAPHY</b>	<b>104</b>
<b>11.0</b>	<b>APPENDICES</b>	<b>106</b>

# TEAM INVESTIGATORS

## National Agency for the Control of AIDS (NACA)

- **Principal Investigator:** Dr. Temitope Ilori  
**Email:** tilori@naca.gov.ng
- **Co-Investigator:** Francis Agbo  
**Email:** francis.agbo@gmail.com
- **Co-Investigator:** Dr. Fatimah Jajere  
**Email:** jajerefatimah@yahoo.com
- **Co-Investigator:** Dr. Obioma Uchendu  
**Email:** obioma234@gmail.com
- **Co-Investigator:** Uchenna Idoko  
**Email:** ucheidokoec@yahoo.com
- **Co-Investigator:** Dr. Idoteyin Ezirim  
**Email:** send2teyin@yahoo.com

# ACRONYMS

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ART</b>	Antiretroviral Therapy
<b>ARV</b>	Antiretrovirals
<b>CBO</b>	Community-Based Organizations
<b>DHS</b>	Demographic and Health Survey
<b>FGD</b>	Focus Group Discussion
<b>FMoH&amp;SW</b>	Federal Ministry of Health and Social Welfare
<b>FSW</b>	Female Sex Workers
<b>GBV</b>	Gender-Based Violence
<b>GF</b>	Global Fund
<b>GoN</b>	Government of Nigeria
<b>HIV</b>	Human Immunodeficiency Virus
<b>HCW</b>	Health Care Worker
<b>IMR</b>	Infant Mortality Rate
<b>IIT</b>	Interruption in Treatment
<b>IDI</b>	In-depth Interviews
<b>IP</b>	Implementing Partner
<b>KII</b>	Key Informant Interview
<b>KP</b>	Key Populations
<b>LGA</b>	Local Government Areas
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MoH</b>	Ministry of Health
<b>MSM</b>	Men who have Sex with Men

<b>NACA</b>	National Agency for the Control of AIDS
<b>NASCP</b>	National AIDS, Viral Hepatitis and STIs Control Program
<b>NEPWHAN</b>	Network of People Living with HIV/AIDS in Nigeria
<b>NGO</b>	Non-Governmental Organizations
<b>NHREC</b>	National Health Research Ethics Committee
<b>ODK</b>	Open Data Kit
<b>OR</b>	Operations Research
<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>PLHIV</b>	People Living with HIV
<b>PMTCT</b>	Prevention of Mother-to-Child Transmission of HIV
<b>PP</b>	Priority Population
<b>PWID</b>	People Who Inject Drugs
<b>RSSH</b>	Resilient and Sustainable Systems for Health
<b>SACA</b>	State Agency for the Control of AIDS
<b>SASCP</b>	State AIDS and STI Control Program
<b>SPSS</b>	Statistical Package for the Social Sciences
<b>TG</b>	Transgender
<b>TWG</b>	Technical Working Group
<b>UN</b>	United Nations
<b>UNAIDS</b>	Joint United Nations Program on HIV/AIDS
<b>UNGASS</b>	United Nations General Assembly Special Session
<b>WHO</b>	World Health Organization



# FOREWORD

The evaluation of gender and human rights approach in HIV program in Nigeria is a comprehensive assessment of our efforts in achieving gender equality in the HIV response. This report showcases our progress in promoting gender equality in HIV service uptake and protecting the human rights of persons living with HIV (PLHIV).

The evaluation details how gender considerations and human rights have been integrated into Nigeria's HIV response strategies over the past years. It highlights the strides made and the challenges that persist, offering valuable insight that will guide future initiatives. It reflects our commitment to upholding the principles of justice, dignity, and fairness for everyone, aligning with national and international standards. The insights this study provides offer a roadmap for scaling up and strengthening our interventions to achieve better outcomes

I commend the dedicated efforts of the Research Monitoring and Evaluation (RM&E) department of the agency, partners, ASHWAN, NEPWHAN, Key population and all stakeholders whose tireless work and commitment have been instrumental in the conduct of this evaluation. I also commend all stakeholders driving progress in our gender and human rights initiatives in the country. Your expertise and passion have significantly contributed to the successes highlighted in this report.

As we move forward, applying the findings of this evaluation, we expect to achieve an HIV response that is more gender and human rights transformative in its policies and practices, and more inclusive and equitable for all. We also expect to see continued progress in the elimination of gender-based violence, and increase in HIV service uptake, and care for PLHIVS

I acknowledge with gratitude the Global Fund (GFATM), whose financial support has made a significant impact in conducting this evaluation. Their dedication to advancing gender and human rights is inspiring, and we look to continued collaboration.

**DR. TEMITOPE ILORI**

**Director general**

**National Agency for the Control of AIDS**

# EXECUTIVE SUMMARY

Nigeria has made significant progress in integrating gender and human rights considerations into its national HIV response over the past decade. This evaluation, conducted across 12 states and at the federal level, provides a comprehensive assessment of how well gender equality, rights protection, and inclusive service delivery have been incorporated into HIV programming. Using a triangulated methodology that combined quantitative data from 187 respondents, qualitative evidence from 182 Key Informant Interviews (KIIs), and 30 Focus Group Discussions (FGDs), along with insights from a desk review of 34 national and global documents, the study offers an in-depth view of the current landscape, highlighting areas of progress, ongoing gaps, and priority actions needed to advance Nigeria's HIV response.

Access to HIV services across all states was reported to be high, with 97.3 percent of respondents indicating they could obtain prevention, treatment, care, and support services. However, the depth and quality of access varied greatly among men, women, and key populations (KPs). Women continued to show the highest levels of service uptake, reflecting years of targeted investments in PMTCT, community outreach, and gender-sensitive programming. Quantitative data showed significant improvements in women's access. Meanwhile, desk review evidence from sources such as the NDHS and HIV Health Sector Annual Reports confirmed that women outperform men in the HIV testing and treatment cascade. Despite these advances, women still face structural and cultural barriers, including gender-based violence, economic dependency, unequal decision-making power, and harmful sociocultural expectations that increase their vulnerability to HIV and limit their autonomy in accessing care.

Men showed increased engagement in HIV services, with many respondents recognizing greater male participation in testing, counseling, and treatment over the years. These improvements were attributed to intensified community awareness efforts, the Differentiated Service Delivery (DSD) Model, the creation of male champion models, and the involvement of religious and traditional leaders. However, the evaluation revealed that deeply rooted gender norms, such as perceptions of invulnerability, fear of stigma, and expectations of masculine stoicism, still limit men's health-seeking behaviors. These patterns lead to lower diagnosis rates and later entry into care for men compared to women, consistent with findings in national data and academic research.

For key populations including sex workers, MSM, transgender persons, and people who inject drugs, access to HIV services has improved through one-stop shops, peer-led initiatives, and community-based ART delivery models. However, significant disparities persist. Many KPs reported experiences of police harassment, extortion, arrest, and violations related to the enforcement of the Same-Sex Marriage (Prohibition) Act and other punitive legal frameworks. Although the evaluation indicated some reduction in overt stigma within communities and health facilities, structural discrimination remains a significant obstacle. Limited access to PrEP and PEP, ongoing stock-outs of essential commodities, and mistrust of formal institutions continue to obstruct KP-focused service delivery, despite these groups carrying some of the highest HIV burdens in the country.

Across all population groups, structural and economic barriers emerged as significant obstacles to equitable access to services. High transportation costs, long distances to health facilities, and frequent stock-outs of essential commodities were identified as the most critical challenges. Respondents from peri-urban and rural areas described spending hours traveling to get ART refills, while others reported repeatedly encountering shortages of condoms, test kits, PrEP, and PEP. These findings align with desk review evidence, which highlights ongoing weaknesses in supply chain systems and inequities in the geographic distribution of services. Unfriendly provider attitudes, limited confidentiality in some facilities, and lingering community stigma were also common issues, especially among women and key populations.

The evaluation also looked at changes in societal norms, behaviors, and gender roles that affect HIV vulnerability. Across different states, respondents observed gradual shifts in attitudes, such as less stigma, more acceptance of HIV as a manageable condition, and greater male participation in care. However, deeply entrenched patriarchal norms remain highly influential, especially in rural and conservative areas. Women explained ongoing expectations of sexual silence, obedience, and deference, while men discussed pressures to display dominance and avoid behaviors seen as "weak" or feminine. These patterns continue to promote risk-taking, hinder open communication, and reduce the chances of timely testing and treatment, indicating that Nigeria's progress so far reflects gender-neutral programs rather than fully gender-transformative efforts.

Participation in HIV-related decision-making processes also remains inconsistent. While many respondents observed an increase in women's involvement in community consultations and program

discussions, qualitative findings indicated that such participation is often symbolic rather than meaningful. Women rarely influence key policy or budget decisions, and key populations are mostly absent from strategic platforms that shape service design and resource allocation. Stakeholders consistently emphasized the difference between merely being present at a meeting and having the ability to influence outcomes effectively.

Gender-based violence and human rights violations continue to pose serious challenges to effective HIV programs. Women still experience intimate partner violence, coercion, and stigma, which can delay testing, reduce treatment adherence, and heighten HIV risk. Men, although less likely to report violence, share experiences of emotional abuse and discrimination related to HIV disclosure. Key populations face the highest rates of violations, often citing police brutality, extortion, sexual violence, and mistreatment by healthcare workers. While partnerships with legal aid organizations have improved access to justice and psychological support for survivors, systemic gaps in enforcement within the justice sector still hinder consistent protection of rights.

The desk review showed that Nigeria has solid policy frameworks supporting the integration of gender and human rights, including the Gender Mainstreaming Guidelines, the HIV Anti-Discrimination Act, and the VAPP Act. However, implementation remains uneven across states due to limited institutional funding, weak enforcement mechanisms, inadequate gender-responsive budgeting, and poor coordination between health, justice, and social welfare sectors. Gender and Human Rights Technical Working Groups exist in most states but differ significantly in effectiveness, with better performance seen in states like Nasarawa and Ogun, where multi-sectoral coordination and referral systems are more developed.

Overall, Nigeria has made significant progress toward establishing a fairer, rights-based response to HIV. Community resilience, peer-led advocacy, and expanded service models have improved access and reduced stigma across different population groups. However, deeply embedded socio-cultural norms, economic disparities, punitive legal systems, and weak institutional frameworks still prevent the full realization of gender and human rights commitments. To sustain progress and move toward epidemic control, Nigeria needs to shift from programs that simply recognize gender differences to initiatives that actively challenge harmful norms, address systemic inequalities, and ensure that all population groups can access HIV services without fear, discrimination, or structural barriers.

# 1.0 INTRODUCTION

## 1.1 BACKGROUND

Gender and human rights remain key factors that influence health outcomes, determining who becomes infected with HIV, who gets diagnosed, who accesses treatment, and who stays virally suppressed (1). In Nigeria, gender norms, discriminatory laws, harmful practices, and unequal power dynamics continue to impact health-seeking behaviors among men, women, girls, boys, and key population services (2,3). These structural factors intersect with socio-economic inequalities and social vulnerabilities, increasing exposure to HIV and limiting equitable access to prevention, treatment, care, and support services (4).

Nigeria's national HIV response has increasingly acknowledged the importance of tackling these inequalities, aligning with global commitments under the Sustainable Development Goals (SDGs). SDG 3 highlights universal access to health services (Good health and Well-being), SDG 5 aims to eliminate gender inequalities, and SDG 16 promotes justice and strong institutions. Reaching these goals requires integrating gender-sensitive and rights-affirming approaches into all aspects of HIV programming.

The World Health Organization (WHO) defines gender as the socially constructed characteristics, norms, and behavior associated with men, women, girls, and boys (5). The Universal Declaration of

Human Rights also states that "all human beings are born free and equal in dignity and rights", and this affirms fundamental rights to life, liberty, security, and well-being (6). The inclusion of gender and human rights considerations into health programs are important for achieving equitable health outcomes and safeguarding the rights of all individuals—including girls, women, boys, men, and key and vulnerable groups (e.g., sex workers, people who inject drugs, Men who have sex with Men, transgender people living with disabilities ,people in closed settings, survivors of gender-based violence and vulnerable children )(7) (4).

Globally, an estimated 33 million people are living with HIV. In Nigeria, the most recent data indicates that HIV prevalence among adults aged 15–49 years was approximately 1.4% as of 2021 (2,8). While there were marginal differences in AIDS-related deaths in 2020; 15,000 men compared to 13,000 women, HIV&AIDS remains the fifth leading cause of death for both genders in Nigeria. However, women demonstrate better outcomes across the testing and treatment cascade with over 98% of

women being aware of their HIV status compared to 79% of men, and more than 98% of women being on treatment compared to 73% of men. Also, 85% of women achieved viral suppression compared to 61% of men (2). These figures suggest that men may have lower rates of access to treatment or retention compared to women.

Over the past decade, NACA has worked to integrate gender and human rights into national and state HIV policies, strategies, and service delivery systems (8,9). This includes creating national guidelines, building capacity, establishing Gender and Human Rights Technical Working Groups (TWGs), and forming partnerships with government ministries, civil society organizations, and development partners. These efforts aim to ensure that women and girls, men and boys, and key and vulnerable groups, including sex workers, MSM, transgender persons, people who inject drugs, adolescents and young people, GBV survivors, persons with disabilities, and individuals in closed settings, can access HIV services without facing discrimination or violence. Gender mainstreaming, an internationally recognized strategy (ECOSOC, 1997), involves assessing and addressing the implications of planned actions on boys, girls, women and men throughout all stages of project development, implementation,

monitoring, and evaluation. This approach helps prevent the perpetuation of gender inequalities and promotes more equitable and effective HIV&AIDS responses in Nigeria.

These interventions aim to reduce gender inequalities, address harmful norms, and uphold human rights, all of which are essential for improving health outcomes and achieving epidemic control (10). Some of these programs include the implementation of several strategic interventions to address gender-based violence and human rights violations among PLHIV. Key among these is the scaling up of the Prevention of Mother-to-Child Transmission (PMTCT) programme, with accelerated efforts at both primary healthcare and community levels, particularly targeting young girls, women, key population and vulnerable groups.

Despite these efforts, gender inequality, stigma, harmful social norms, and rights violations remain deeply rooted. Women still face gender-based violence, economic dependence, and limited decision-making power. Men continue to underuse testing and treatment services because masculinity norms discourage seeking health care. Key populations encounter the greatest structural and legal barriers, including criminalization, police harassment, discrimination in healthcare, and social exclusion. These ongoing inequities highlight the urgent need to assess how well gender and

human rights principles are integrated into the national HIV response (7)(11).

## 1.2 PROBLEM STATEMENT

To ensure effectiveness, strategic partnerships have been mobilized through collaborations with faith-based organizations, women-focused NGOs, traditional rulers, and both public and private sectors, often coordinated through the offices of the First Lady and the wives of governors and local government chairmen. Additionally, reproductive health and HIV services have been integrated to holistically address gender inequality, including interventions that examine the socialization of boys and girls. Moreover, the government also promotes the involvement of gender-focused networks, including women and girls with disabilities (8). Furthermore, the ongoing institutionalization of a Gender Management System is designed to ensure a gender-responsive framework at both national and sub-national levels, supported by gender-responsive budgeting in HIV&AIDS programming.

This evaluation marks an important step in understanding the progress achieved, the remaining gaps, and the opportunities to improve Nigeria's HIV response through gender-responsive, rights-affirming strategies.

Although HIV services have expanded and new models of differentiated care have improved

access, gender inequalities and human rights violations still impede Nigeria's progress toward epidemic control. Women and girls remain disproportionately vulnerable due to harmful practices intimate partner violence, early and forced marriage, economic dependence, and limited control over sexual and reproductive health decisions. Men face gender norms that normalize risk-taking, discourage testing, and reduce health-seeking behavior. (10,12)

Despite ongoing efforts, gender and human rights issues remain significant barriers to an effective HIV response in Nigeria. Girls and Women are especially vulnerable due to gender-based violence, early marriage, harmful cultural practices, and limited decision-making power, which hinder their access to HIV services and increase their risk of infection (10,12)

Key populations face even greater vulnerabilities due to criminalization, widespread stigma, police brutality, extortion, and discrimination in healthcare settings. These issues prevent access to essential services and foster distrust of institutions. Existing laws, including the Anti-Discrimination law and the VAPP law offer protections but are often poorly enforced (13,14).

Although gender and rights principles have been incorporated into national HIV policies since

2013, their implementation in programs and services remains inconsistent. Many state-level mechanisms lack adequate funding, capacity, and coordination. As a result, the actual experiences of men, women, and key populations still expose gaps in protection, voice, agency, and equitable access to HIV services.

Therefore, it is urgent to evaluate how well the national HIV response incorporates gender and human rights principles in practice, how these approaches affect service uptake and outcomes, and which structural barriers still hinder progress (15).

### 1.3 JUSTIFICATION

Nigeria's HIV epidemic cannot be effectively addressed without confronting gender inequality and human rights abuses. These issues contribute to new infections, delay diagnosis, impede adherence to treatment, and lead to loss to follow-up. A gender-sensitive, rights-based HIV approach is essential to ensure that no population group is left behind. Although Nigeria has implemented several policies and guidelines to promote gender equality and human rights within the HIV response, their application varies across states. Many interventions remain gender-accommodating rather than gender-transformative. Limited funding for gender and human rights units, weak coordination mechanisms, and a lack of

accountability structures obstruct progress (16).

A gender and human rights approach recognize the specific vulnerabilities, social norms, and systemic inequalities that affect different groups' ability to access HIV prevention, treatment, and care services. It emphasizes not only biomedical interventions but also social justice, dignity, and rights protection, crucial components for effective and sustainable HIV responses (15)

Evaluating how well gender and human-rights approaches are incorporated into policies, institutional frameworks, and service delivery is essential for guiding strategic planning and enhancing Nigeria's HIV response. This evaluation also helps NACA and partners align with global best practices and national development goals while pinpointing actions to accelerate progress toward controlling the epidemic.



## 1.4 OBJECTIVES

The primary goal of this evaluation is to assess how effectively Nigeria's HIV policies and programs incorporate gender and human rights principles, and how well these strategies address the needs of all population groups. This evaluation seeks to monitor progress, identify gaps, and recommend actions to enhance gender equality and rights-based HIV efforts at both national and local levels.



### 1.4.1 SPECIFIC OBJECTIVES

#### EFFECTIVENESS

**Objective 1: To evaluate the current access to HIV prevention, treatment, care & support among target population in the HIV response over the years.**

- 1.1 Identify gender-specific barriers to access HIV services among target populations.
- 1.2 Assessment of service outcomes amongst different target groups

(infection rates, treatment adherence, viral load suppression).

- 1.3 Assess the provision of services in support groups (PLHIV support groups, OTZ, mother -to-mother support groups).

NB: Population groups in the HIV response (PLHIV, KPs, AYPs, Pregnant women, People in custodian and closed settings (inmates & IDPs), and survivors of GBV)

**Objective 2: Evaluate changes in societal norms, behaviours, and gender roles that drive HIV transmission.**

- 2.1 Identify societal norms, behaviours, and gender roles that drive risky behaviour
- 2.2 Assess community perception changes in norms, behaviours, and gender roles that drive HIV transmission.

## RELEVANCE

**Objective 3: Determine participation of the target groups in HIV-related decision-making processes at the household, sub-national and national levels.**

- 3.1 Document gender representation in decision-making forums.
- 3.2 Explore perceived inclusiveness.
- 3.3 Compare PLHIV and other target populations input into guidelines/program outcomes.

**Objective 4: Identify contextual factors influencing HIV services, GBV response, societal norms, and PLHIV involvement over the years.**

**Objective 5: Measure cases of GBV and human rights violations among population groups.**

- 5.1 Document reported GBV cases and human rights violations among PLHIV, KPs, and other population groups.

- 5.2 Evaluate available services for GBV cases and human rights violations

- 5.3 Map and assess referral networks.

**Objective 6: Analyze integration of gender and human rights into HIV guidelines/policies, strategies, plans, programs, and assess progress toward gender and human rights responsiveness.**

- 6.1 Review policy frameworks for gender & Human Rights responsiveness.
- 6.2 Measure gender & human rights policy, strategy, and plans implementation status.
- 6.3 Identify gaps and opportunities in the integration of gender & human rights programming.

## SUSTAINABILITY

**Objective 7: Evaluate gender & human rights co-ordination platforms in HIV programs and their role in promoting gender equality over the years.**

- 7.1 Map gender & Human rights co-ordination platforms/structures.

7.2 Measure stakeholder perceptions of impact.

**Objective 8: Identify lessons learned and provide recommendations for enhancing gender equity and human rights in HIV responses.**

8.1 Identify successes, best practices, and challenges.

8.2 Develop actionable recommendations.

## 2.0 METHODOLOGY

### 2.1 DESK REVIEW

This included reviews of published and grey literature on Gender and human rights approach programs in HIV. The thirty-two (32) materials identified and reviewed included scholarly publications, namely, journal articles. Also, reports, guidelines, policies, and policy briefs on GHR provided by NACA and stakeholders were used.

The desk review covered existing guidelines/policy documents, programme reports, and published or unpublished research provided for or sourced relevant to G&HR in the context

of HIV. This includes reports from National Demographic and Health Surveys (NDHS), the Stigma Index, eNNRIMS, DHIS, NDARS, NDR, National GBV Dashboard, GAM and NOMIS, etc., and the report of a formative assessment on the relationship between forced migration, HIV transmission, and other related public health issues. Additional sources included case management records, legal, and human rights documentation. The review synthesized evidence to highlight contextual factors, emerging patterns, and intervention outcomes.

This process was guided by a structured proforma to identify relevant information and to ensure comprehensive coverage of indicators related to gender and human rights (G&HR) violations, service provision, and programmatic responses. These sources provided quantitative and administrative evidence on service delivery, case trends, and the operational context of HIV interventions.

The aim was to identify trends, gaps, and policy implications, with particular attention to the needs and vulnerabilities of children, women, adolescents, and young people (AYP), and internally displaced persons (IDPs). Insights from this phase informed the design, targeting, and strengthening of interventions to address G&HR violations in HIV programming.

## 2.2 STUDY DESIGN

A purposive sampling approach was applied to select participants and sites across twelve (12) states in Nigeria. This approach is appropriate for the evaluation's focus on understanding how gender equality and human rights principles are integrated within the HIV response, and on capturing the experiences of populations most affected by gender-based barriers and rights violations.

The twelve states were purposively selected to ensure geographical and programmatic diversity, reflecting variations in HIV prevalence, gender norms, human rights contexts, and implementation capacity. This allowed the evaluation to capture a broad range of gender and human rights dynamics across different socio-cultural and epidemiological settings. Within each selected state, participants were purposively identified from key stakeholder categories central to the HIV response. The evaluation employed two (2) approaches to purposive sampling, which are maximum variation sampling to ensure inclusion of diverse perspectives and criterion sampling to target individuals directly involved in gender and human rights programming within the HIV response.

The evaluation employed a mixed-methods approach to strengthen triangulation and ensure a comprehensive understanding of

gender and human rights integration within the HIV response.

Both quantitative and qualitative data were collected concurrently.

- **Quantitative Component:** Structured questionnaires were administered to PLHIV and KPs to gather measurable information on the inclusion of gender and human rights in HIV policies, programs, and service delivery. Quantitative data provided descriptive statistics on coverage, policy implementation, and resource allocation.

- **Qualitative Component:** Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) were conducted with key populations, PLHIV networks, community leaders, and gender/human rights advocates. These methods explored perceptions, lived experiences, and barriers related to gender equality, stigma, discrimination, and human rights in access to HIV prevention, treatment, and care services.

Integration of both data types allowed the evaluation to compare perceptions (qualitative) with documented evidence and program data (quantitative), leading to richer insights and actionable recommendations.

## 2.3 STUDY LOCATION & TARGET POPULATION

The evaluation for the study was carried out in twelve (12) states in Nigeria (Adamawa, Nasarawa, Gombe, Akwa-Ibom, Oyo, Delta, Sokoto, Niger, Kano, Ogun, Ebonyi, Anambra), two from each geopolitical zone. This takes into consideration the geographical spread across the country.

- North-East: Adamawa, Gombe
- North-Central: Nasarawa, Niger
- North-West: Sokoto, Kano
- South-South: Akwa Ibom, Delta
- South-East: Ebonyi, Anambra
- South-West: Ogun, Oyo

### 2.3.1 State Selection

The selected states offer a mix of urban, semi-urban, and rural environments, with varying levels of HIV prevalence, service availability, and sociocultural factors. They encompass conflict-affected areas with significant humanitarian challenges and displacement, culturally and religiously conservative settings, high-burden states with concentrated epidemics among key and vulnerable populations, and economically advanced hubs with innovative service models. This diversity allowed the study to:

- Compare program responsiveness in various contexts.

- Identify challenges and best practices unique to the region.
- Develop context-specific recommendations to enhance the integration of gender and human rights in Nigeria's HIV response.

### 2.3.2 Participants

The study participants were drawn from both national and state levels to ensure perspectives are captured across the policy, programmatic, and implementation spectrum. Participants included individuals directly affected by HIV interventions, service providers, and institutional stakeholders whose roles influence the integration of gender and human rights into Nigeria's HIV response.

#### A. National-Level Participants

##### 1. Government Agencies

- National Agency for the Control of AIDS; (Chair-Person-Gender and Human right TWG).
- National AIDS and STDs Control Programme (NASCP)
- Ministry of Women Affairs
- National Human Rights Commission
- Ministry of Justice

##### 2. Development Partners

- UN agencies: UNAIDS, UNODC, UNDP, WHO, UN-WOMEN
- US government entities: CDC, PEPFAR

- Global Fund: Country Coordinating Mechanism (CCM), IHVN,
  - Implementing partners:
3. Civil Society Organizations (CSOs)
    - National networks of PLHIV (e.g., NEPWHAN, ASHWAN)
    - KP Secretariat
    - Association of Positive Youth Living with HIV/AIDS in Nigeria
  4. Traditional/Religious Leaders and Community Gatekeepers (NINERELA+)

## B. State-Level Participants

1. Primary Beneficiaries
  - People Living with HIV (PLHIV): Women, men, and adolescents living with HIV, including state-level members of NEPWHAN, APYIN, and ASHWAN.
  - Key Populations: Men who have sex with men (MSM), transgender individuals (TG), sex workers (SW), people who inject drugs (PWID)
2. Service Providers
 

Healthcare Workers/GBV Responders and Social Workers: Doctors, nurses, counselors, and community health workers.
3. Law Enforcement Agencies: Nigeria Police Force

4. State Government Agencies
  - State Agencies for the Control of AIDS (Chair State Gender and Human Rights TWG )
  - State AIDS and STI Control Programmes (SASCP)
  - State Ministry of Women Affairs
  - State Ministry of Justice.
  - State offices of the National Human Rights Commission.

## 2.4 INCLUSION & EXCLUSION CRITERIA

### 2.4.1 Inclusion Criteria

- Eligibility to participate in the assessment was defined as follows:
- People living with HIV (PLHIV) and key populations (KPs).
- Age 18 years and above for primary data collection
- Service providers in HIV&AIDS, gender, and human rights programme implementation
- Provided informed consent to participate in the assessment.
- Are mentally sound and capable of providing consent to participate
- Must understand the predominant Nigerian Languages (English and Pidgin English).

### 2.4.2 Exclusion Criteria

- Individuals who declined to participate in the study
- Persons who were newly diagnosed at the time of the study (1-6months)

### 2.4.3 Criteria For Interviewers

- The interviewer should be fluent in the local language.

## 2.5 SAMPLE SIZE DETERMINATION

### Quantitative

To generate both regionally and nationally representative data for the quantitative component, the sample size was calculated using the Leslie Kish formula to recruit PLHIV and KP.

The Leslie Kish formula for calculating sample size in cross-sectional studies is given by:

$$n = \frac{Z^2 p q}{d^2}$$

Where:

n = minimum required sample size

Z = standard normal deviate 1.96 corresponding to the desired confidence level of 95%

p = Prevalence of desired outcome – 0.54% (54%), which is the proportion of clients (PLHIV and KP) reporting respondents who had opposed, challenged, and educated someone who was stigmatizing or/discriminating against them (Lannap et al., 2023).

$$q = 1 - p$$

d = desired level of precision (2.5%)

$$n = \frac{1.96^2 \times 0.54 \times (1 - 0.54)}{0.025^2}$$

$$n = \frac{3.842 \times 0.54 \times 0.46}{0.000625}$$

$$n = 1,526.96$$

We assumed an acceptable difference and non-response rate of 5% and 10% respectively.

$$n / (1 - 0.05) \text{ and } n / (1 - 0.1) = 1,607 - 1,697$$

This gave us a minimum sample size of 134 - 141 participants per 12 states.

Assumptions:

1. The precision (d) was adjusted to 2.5% to ensure the study is adequately powered.
2. We also assumed equal proportions of participants to be selected across the states across all states.

Sample size of 134 was distributed per 12 states. However, Questionnaires were administered to a total number of 187 participants across the 12 States.

Quantitative data were collected from PLHIV and KPs using structured, pre-tested questionnaires. These instruments capture information on physical, sexual, and emotional violence; incidence of human rights violations; and relevant socio-demographic and programmatic variables. Sampling aimed at statistical representativeness within each target group, ensuring adequate coverage across geographic locations. Data was collected through face-to-face interviews administered by trained enumerators to ensure quality, consistency, and sensitivity when addressing potentially traumatic topics. The questionnaire was administered to 15 respondents, covering the PLHIV and KPs respondents in each state. For the 12 states, a total of 180 respondents were targeted for the interview, which was exceeded

<b>Quantitative sampling matrix (Per State)</b>	
<b>Respondents</b>	<b>No of Respondents</b>
<b>NEPWHAN</b>	<b>5</b>
<b>Key Population</b>	<b>5</b>
<b>ASHWAN</b>	<b>5</b>
<b>Total</b>	<b>15</b>

### **Qualitative**

The qualitative component employed purposely selected Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs).

**Interviews with key informants (KIIs):** Key Informant Interviews (KIIs) were conducted during the data collection phase by both the consultants (nationally) and data collectors (in states) to gather evidence on existing interventions, achieved results, interacting factors, and challenges encountered. These interviews engaged a diverse range of stakeholders to explore systemic, programmatic, and socio-cultural drivers of gender-based and human rights (GHR) violations. A structured interview guide was used to ensure consistency, enabling the collection of detailed insights from stakeholders on gender and human rights issues within the HIV programme context.

**Focus Group Discussions (FGDs):** FGDs were conducted with PLHIV in each state, comprising two sessions.

- One with NEPWHAN members
- One with ASWHAN members
- One Key Population members

Each FGD consisted of a homogeneous group of five participants selected based on shared characteristics or roles within the PLHIV community, fostering relatability and open dialogue. Discussions explored lived experiences, coping mechanisms, and perceptions of the responsiveness of HIV services to gender and human rights (GHR) issues. Facilitators used semi-structured guides to maintain consistency across sessions while allowing flexibility to probe emerging themes. Participant selection was guided by principles of gender sensitivity and equity to ensure inclusive and representative perspectives.

Qualitative Data collection	
Focus Group Discussions (FGDs)	
<i>State level FGD participants (Per State)</i>	<i>No of FGDs</i>
NEPWHAN	1
ASHWAN	1
KEY POPULATION	1
<b>Total</b>	<b>3</b>
Key Informant Interviews (KIIs)	
<i>State level participants</i>	<i>No to interviewed</i>
SACA	1
SASCP	1
NEPWHAN	2
Key Population Secretariat	1
ASHWAN	1
Health and Gender service providers	1
Gender and Human Rights State Response Teams	1
State Ministry of Women's Affairs	1
State Ministry of Justice	1
PACA – Police Action Committee on AIDS, gender unit representatives	1
State offices of Human Rights Commission	1
Association of Positive Youth in Nigeria (APYIN)	2
Key Population (2 FSW, 1 MSM, 1 PWID, 1 TG)	5
<b>Total</b>	<b>19</b>

<i>National level participants</i>	
UN – UNAIDS, UN Women, WHO, UNDP, UNODC	5
USG- CDC, PEPFAR	2
GF – CCM, IHVN	2
NACA	2
NASCP	1
Ministry of Justice	1
Heartland Alliance	1
Legal Aid Counsel	1
Other implementing partners	1
Human Rights Commission	1
Member of Gender and Human Right Technical Working Groups	1
<b>Total</b>	<b>18</b>
<b>Grand Total</b>	<b>37 per state</b>

Table showing number of states covered for the NACA's quantitative data collection

	State	KII	FGD
1	FCT	9	-
2	Oyo	19	3
3	Akwa-Ibom	6	1
4	Gombe	19	3
5	Kano	18	3
6	Delta	12	3
7	Ogun	18	3
8	Niger	3	-
9	Nasarawa	21	3
10	Sokoto	9	2
11	Anambra	18	2
12	Ebonyi	9	2
13	Adamawa	21	5
		Total: 182	Total:30

## 2.6 DATA TOOL & VARIABLES

Mixed methods were deployed using a questionnaire for quantitative data collection, key informant interviews and focus group discussion guides for qualitative data collection.

### 2.6.1 Quantitative

Quantitative data was collected through structured questionnaires administered by trained data collectors. Participants' responses were recorded using Open Data Kit (ODK) forms, which support both online and offline data entry. All completed forms were uploaded and retrieved by the data officer at the data management center for cleaning and analysis. The questionnaire was administered to PLHIVs and KP who are 18 years above, who access and use various HIV services.

The questionnaire had the following eight sections:

- Section 1 – Sociodemographic characteristics and general information.
- Section 2 – Level of Access to HIV Prevention, Treatment, Care & support services
- Section 3 – Influence of Societal Norms and Attitudes

- Section 4 – Decision-Making Participation
- Section 5 – Gender-Based Violence and Human Rights Violations
- Section 6 – Lessons Learned and Recommendations

### 2.6.2 Qualitative

The key informant interview (KII) and Focus-group discussion (FGD) guides were developed through the review of literature. The FGD was used to interview PLHIVs and KPs while the KII was used to interview relevant stakeholders as outlined in the table above. The guides included questions on Access, Participation & Societal Norms, Decision-Making & Contextual Factors, Violence, Human Rights & Program Effectiveness, Policy & Programming.

Qualitative data was collected through interviews conducted by an interviewer (Consultants and other data collectors), accompanied by a note-taker. With participants' consent, discussions were audio-recorded. Recordings were uploaded to a password-protected external hard drive, and a secure, password-protected online backup was created for the study. Access was restricted to the principal investigator and the Co-Investigator.

## 2.7 VARIABLES (QUANTITATIVE & QUALITATIVE)

### 2.7.1 Socio-Demographic Characteristics

This includes age, gender, educational status, employment, how long you have been receiving HIV services, duration of diagnosis/treatment (PLHIV and KP).

### 2.7.2 Other Variable

These include:

Level of Access to HIV Prevention, Treatment, Care & support services, Influence of Societal Norms and Attitudes, Decision-Making Participation, Gender-Based Violence and Human Rights Violations, Lessons Learned and Recommendations.

## 2.8 PRE-TESTING

The pretest assessed the wording of the translated questions, the comprehension of the questions, identifying any ambiguity, and the overall flow of the questionnaire.

Pre-testing was conducted during the training of data collectors. After the pre-testing, ambiguities were corrected, and the flow of questions was re-arranged based on the results of the nominal group session. After finalizing the

study instruments, the instruments were validated by stakeholders/ NACA/ IPs/ funding organizations and reviewed for suggested additions, edits, and comments. The finalized instruments were used for data collection from the respective states.

## 2.9 RECRUITMENT & TRAINING OF DATA COLLECTORS

Data collectors and field workers were recruited by the staff of NACA. Data collectors were trained for two days on the purpose of the study, methodology, obtaining consent as applicable, study population, sampling techniques, sample size, filling consent forms, data collection tools, data entry, and using the checklist that summarizes their fieldwork daily. They were also trained on obtaining informed consent and the basic ethics required in research. Below is the training agenda.

### *Training agenda*

- Purpose of the evaluation
- Study protocol
- Ethics: Confidentiality, Engaging key vulnerable groups e.g. key population groups (KPs)
- Scheduling survey administration
- Sampling technique and selection of participants

- Materials needed for survey administration
- Checklists for fieldwork
- Questions and Answer
- Data instrument: Role plays/ Simulations

The data collectors had a minimum of secondary education, were able to communicate in English and the major local language in the state where they worked, had a functional mobile phone or tablet, and had participated in a data (quantitative and qualitative) collection exercise prior to this project.

## 2.10 DATA COLLECTION

Data was collected quantitatively and qualitatively.

### 2.10.1 Quantitative Data Collection

- I. The data collector administered the questionnaire and recorded the participant's response on the ODK form with online and offline synchronization.
- II. The interviewer captured the geographical coordinates of the location on the ODK form.
- III. The data entered was retrieved at the backend in the data management centre by the data officer.

### 2.10.2 Qualitative Data Collection

- i. This comprised the interviewer who conducted the interview and recorded the discussion after obtaining consent, and the note taker.
- ii. The interview was conducted in a quiet environment where auditory and visual confidentiality was ensured (that is, where they were not seen or heard by other individuals)
- iii. Data from the recording device was uploaded to a password-protected external hard drive and a password-protected online backup server created for this research. These backups were only accessible to the Principal Investigator and Co-Investigator. The recordings were deleted from the recording devices once they had been successfully uploaded to the online backup server and external hard drive.

## 2.11 DATA MANAGEMENT & ANALYSIS

### 2.11.1 Data Verification And Validation

The consultant and the research team ensured that the entire data collection and management process aligned with the study protocol and best ethical practice and were responsible for data safety and monitoring. All data were timely, complete, accurate, and aligned with the study protocol.

Data from the ODK server was downloaded and exported to IBM SPSS Statistics for cleaning. The dataset examined for missingness, outliers, double entries, and irrelevant observations. Double entries and irrelevant observations were removed from the dataset. Missing data evaluation/analysis was conducted to examine missingness. However, significant missingness was not expected due to the rigorous process of verification that was at every level. Therefore, the method used for dealing with data missing completely at random was list-wise deletion of missing cases, employed depending on the pattern of missingness.

### 2.11.2 Data Safety And Transfer

The Consultants ensured data security by restricting access to it. In line with the Nigeria Data Protection Act (2023), the project observed the following.

- The soft data was encrypted and saved on external drives, kept safely by the investigator and the institution, based on the data safety policy of NACA.
- A copy was stored on a solid-state disk in a small Faraday bag under lock and key.
- Data access was restricted to authorized personnel only.
- Participants' data was held in sacred trust and exchanged only for the project and not for any other purpose whatsoever.
- All investigators and research assistants completed and passed the Nigerian National Code for Health Research Ethics online course.
- To transfer de-identified data, a data use agreement was required to ensure the protection of participants' data and privacy.

### 2.11.3 Data Analysis

The quantitative study data were used to compute sample statistics, to have an idea about the precision of the study, and to generalize our findings to the target population. IBM Stata version 26 was used for quantitative data analysis. The data is presented as follows:

- Frequency tables were generated for the key variables.
- Charts and other visualization methods were used to present the results in simple and understandable formats.

The qualitative data was transcribed, and transcripts were analyzed using thematic and content analysis done using Nvivo.

### 2.11.4 Quality Assurance Measures

To ensure the accuracy, reliability, and credibility of data collected during the evaluation, a comprehensive quality assurance framework was implemented across all phases of the study. The following measures were adopted:

- **Establish a Technical Committee:** Include NACA, SACAs, relevant MDAs, CSOs, academia, and international partners to promote transparency,

stakeholder engagement, and joint ownership of recommendations.

- **Tool Pilot Testing:** Before full-scale data collection began, all quantitative and qualitative tools (e.g., surveys, interview guides) were pilot tested in one selected state. This helped assess their clarity, appropriateness, and functionality, allowing for necessary adjustments to ensure they were relevant to the context and easy to administer.
- **Training of Data Collectors:** Enumerators and qualitative researchers had comprehensive training on using data collection tools, ethical practices (such as obtaining informed consent and maintaining confidentiality), gender-sensitive interviewing techniques, and the use of digital platforms like Kobo Collect. This training also featured mock sessions and practical field simulations to ensure they are prepared.
- **Built-in Checks in Electronic Tools:** The Kobo Collect platform was for digital data collection and was programmed with in-built logic checks, skip patterns, and validation rules to minimize data entry errors. These automated features flagged inconsistencies or incomplete entries in

real time, prompting corrections on the spot. Geo-coordinates algorithm was enabled on the Kobo Collect to forestall data entry manipulation.

- **Provide Strategic Oversight:** Validated data review findings and ensured alignment with national HIV goals, gender frameworks, and global commitments.
- **Daily submission of filled Kobo Collect tool:** Completed questionnaires were sent to the consultants to enable review and timely feedback while data collectors were still in the field
- **Daily submission of transcripts via emails:** Transcription of qualitative data was sent to the consultant at the end of each day for review and immediate feedback to the field workers.

## 2.11.5 IMPLEMENTATION STRATEGY

The evaluation was conducted through a structured, phased approach to ensure thorough preparation, high-quality data collection, rigorous analysis, and compliance with ethical and technical standards. Each phase was carefully planned and implemented in collaboration with relevant stakeholders, especially the National Agency for the Control of AIDS (NACA) and other implementing partners.



PHASE	FOCUS	KEY ACTIVITIES
<b>Inception Phase</b>	Laying the groundwork by ensuring clear purpose, alignment with national priorities, and readiness for fieldwork.	<p><b>Protocol Development and Development of Data Collection Tools:</b> Designed and adapted a structured questionnaire, focus group discussion guides, and key informant interview protocols using global and national best practices, ensuring relevance to Nigeria's HIV response and sensitivity to gender and human rights.</p> <p><b>Ethical Clearance:</b> Obtained approval from the National Health Research Ethics Committee (NHREC) or relevant authority, including consent procedures and data protection measures to safeguard participants' rights and confidentiality.</p>
<b>Data Collection Phase</b>	Structured and coordinated field data collection at selected sites.	<p><b>Desk Review:</b> Conducted a thorough review of literature, HIV policies (national and state), program reports, and evaluation frameworks to establish context, identify evidence gaps, and inform tool design.</p> <p>- <b>Deployment of Data Collectors: Trained</b> state-level personnel on ethical data collection, use of digital tools, and gender-sensitive interviewing to ensure consistent quality through KII, FGD, and questionnaire administration.</p> <p>- <b>Three Batches of Field Visits:</b> Conducted data collection in three sequential batches across 12 states to optimize logistics, troubleshooting issues, and support ongoing learning.</p>

<p><b>Analysis and Reporting Phase</b></p>	<p>Rigorous data cleaning, analysis, and interpretation to produce actionable findings.</p>	<ul style="list-style-type: none"> <li>- <b>Use of Digital Tools:</b> Deployed Kobo Collect or similar platforms for real-time data entry, error reduction, and remote supervision</li> <li>- <b>Quantitative Analysis:</b> Disaggregated data by sex, age, location, and key population group; use SPSS or STATA for statistical analysis; present results in tables, charts, and graphs.</li> <li>- <b>Qualitative Analysis:</b> Applied thematic analysis to FGD and KII transcripts to identify recurring patterns, stakeholder perspectives, challenges, and success factors.</li> <li>- <b>Synthesis of Findings:</b> Triangulated qualitative and quantitative insights to produce robust, evidence-based conclusions; developed a final report with actionable recommendations to improve G&amp;HR responsiveness in HIV programming.</li> <li>- <b>Validation workshop:</b> a workshop where stakeholders will meet to review, confirm and refine the findings and draft outputs before they are finalized</li> </ul>
--	---	--

These phases, within a collaborative implementation strategy, guarantee an evaluation process that is inclusive, methodologically solid, ethically compliant, and aligned with national HIV and gender policy priorities.



## 3.0 ETHICAL CONSIDERATIONS

The evaluation strictly followed ethical standards to safeguard the rights, dignity, and safety of all participants, particularly those from vulnerable or marginalized groups. The following measures ensured ethical compliance throughout the study.

### 3.1 REQUEST FOR WAIVERS & EXPEDITED APPROVAL

Notwithstanding the procedures laid out in section 3.0, we requested expedited approval from NHREC because the proposed study poses no more than minimal risk and holds out potential benefits for the health system in Nigeria.

### 3.2 CONFIDENTIALITY OF DATA

Data collected from participants in the study was treated with confidentiality. Participants were assured that their responses would be kept confidential. Codes were assigned to the questionnaires they filled out; their names or other identifiable information were not used, and the information they provided was not traceable to them. Data collected was also stored using codes or pseudonyms and used in this form solely for academic purposes, publications, and/or reports.

### 3.3 BENEFICENCE TO PARTICIPANTS

The study has long-term benefits as the findings provided information on gender and human rights issues in integration into HIV treatment services and retention. Also, it identified existing problems that Community-directed monitoring could not solve and specific strategies for removing barriers to treatment and retention for PLHIV and KP in Nigeria. This was useful in developing policies and intervention programme(s) aimed at improving treatment access and retention, thereby strengthening the National HIV response.

### 3.4 NON-MALEFICENCE OF PARTICIPANTS

The study was non-invasive, and participants were not subjected to any risk. Participants' identities were protected, and their feelings respected during and after the conclusion of the study.

### 3.5 VOLUNTARINESS

The participation of respondents in the study was entirely voluntary. Participants were assured that they could choose to withdraw from the study at any time if they deemed fit. Thus, a consent form was given to participants with content detailing consent to participate and the right to withdraw from the study. In the event of withdrawal, no participant was maligned, nor was their confidentiality and anonymity compromised.

## 4.0 STUDY DISSEMINATION PLAN

The findings/results from this research were documented and disseminated nationally via a consolidated review report. The report was developed alongside stakeholders, including government, partner representatives, and the research team, in a 5-day data analysis and report-writing workshop. The national dissemination activity was done in Abuja in a one-day event that will have critical stakeholders in attendance.

Furthermore, results were communicated to a wider audience and expanded members of the Science Community through abstract and manuscript publications in regional and international conferences and in reputable peer-reviewed journals

## 5.0 MANAGEMENT AND ORGANIZATION OF THE STUDY

The Operations Research was conducted by NACA in collaboration with the NASCP and DPRS, SACA, SASCP, NEPWHAN, KP and implementing/donor partners. Two qualified consultants were engaged to provide technical leadership and overall coordination, working together with NACA and other stakeholders. NACA set up a research team composed of key partners (including USG, UN, GF, KP groups, and NEPWHAN) who were involved in the design, implementation, analysis, finalization and dissemination of findings and recommendations. The Director of NACA's Research, Monitoring and Evaluation Department provided overall oversight on the study on behalf of the Director General, NACA, who was the Principal Investigator.

*The roles of these stakeholders included (refer to Appendix 8)*

## 6.0 RESULTS

This section offers a comprehensive overview of the quantitative, qualitative, and desk review evidence gathered for the evaluation. Findings are organized according to the seven evaluation objectives and provide a triangulated understanding of trends, gaps, and lived experiences related to gender and human-rights integration within Nigeria's HIV response. Each objective is analyzed by sex (men and women) and, where relevant, by key population groups. The revised structure improves the narrative flow of the findings and emphasizes how gender inequalities, social norms, and human-rights factors influence HIV vulnerabilities and service outcomes across different population groups.

The Desk Review covered existing guidelines, policy documents, programme reports, and both published and unpublished research related to Gender and Human Rights (G&HR) within the context of HIV. The desk review comprehensively addressed Objectives 1, 2, 5, 6, and 7, along with their specific sub-objectives. All 34 materials reviewed are listed in the accompanying table.

This evaluation was conducted across 12 states. The quantitative component utilized a structured questionnaire administered to 187

respondents. Findings are presented in tables, charts, and descriptive summaries. The Qualitative component was derived from data collected through over 30 Focus Group Discussions (FGDs) and 180 Key Informant Interviews (KIIs). Overall, this section adopts a blended reporting approach, integrating desk review, quantitative and qualitative findings in alignment with the study objectives. However, Objectives 4 and 6 were addressed solely through qualitative data.

### 6.1 DESK REVIEW ON EVALUATION OF GENDER AND HUMAN RIGHTS APPROACH IN HIV PROGRAMS IN NIGERIA

#### 6.1.1 Background

The desk review for the Evaluation of Gender and Human Rights Approaches in HIV Programs in Nigeria entails a comprehensive and systematic analysis of both published and grey literature, focusing on gender and human rights-based interventions within the context of HIV programming. This review captures the breadth of existing evidence and experiences that inform the integration of gender equality and human rights principles into Nigeria's HIV response.

The materials reviewed are peer-reviewed journal articles, which provided evidence-based insights into best practices, challenges, and outcomes of gender- and rights-sensitive HIV interventions. In addition, grey literature, such as reports, policy documents, operational

guidelines, strategic frameworks, and policy briefs, produced by the National Agency for the Control of AIDS (NACA) and other key stakeholders, including other Government institutions, Development partners, civil society organizations (CSO), and community-based groups (CBO), were critically examined.

Through this process, the desk reviews identified patterns, gaps, and lessons learned regarding the implementation of Gender and Human Rights (GHR) approaches. It assessed how these approaches have influenced HIV prevention, treatment, care, and support services across different populations, especially among key and vulnerable groups. Furthermore, the review explored the extent to which GHR principles have been institutionalized within national HIV policies, programmatic strategies, and service delivery frameworks.



Table 6.1 below shows the list of documents used for the desk review. The table also highlights the document number used for referencing during the review and the source of the document.

**Table 6.1: List of documents used for the desk review**

SOURCE DOCUMENT NUMBER	DOCUMENTS	SOURCE	PROVIDED BY
1a	Global AIDS Monitoring (GAM) Online Reporting Tool, 2023(17)	UNAIDS	NACA
1b	Global AIDS Monitoring (GAM) Online Reporting Tool, 2020 (18)	UNAIDS	NACA
1c	Global AIDS Monitoring (GAM) Online Reporting Tool, 2019 (19)	UNAIDS	NACA
1d	GAM Online Reporting Tool, 2018 (19)	UNAIDS	NACA
2a	HIV Health Sector Annual Report, 2020 (20)	Federal Ministry of Health, National HIV/AIDS, STIs and viral Hepatitis Control Programme	NACA
2b	HIV Health Sector Annual Report, 2021 (21)	Federal Ministry of Health, National AIDS, Viral Hepatitis and STIs Control Programme (NASCP)	NACA
2c	HIV Health Sector Annual Report, 2022 (22)	Federal Ministry of Health, National AIDS, Viral Hepatitis and STIs Control Programme (NASCP)	NACA
3	Nigeria Multiple Indicator Cluster Survey (MICS) 2016-2017 (23)	NACA, World Bank, WHO, UNICEF, Bill & Melinda Gates Foundation, UNFPA	NACA

4	Fact Sheet Women, Girls, Gender Equality and HIV in Nigeria, 2016 (24)	NACA, UN-WOMEN	NACA
5	Legal Environment Assessment on HIV/AIDS in Nigeria (2015) (25)	NACA, UNDP	NACA
6	National HIV/AIDS Access to Justice Guidelines and Capacity Building Manual, 2020 (25)	NACA	NACA
7	NACA Legal Environment Assessment Report, 2024 (26)	NACA	NACA
8	Guidelines for Gender Mainstreaming in the National HIV/AIDS Response, 2015 (27)	UNAIDS, UN-WOMEN, NACA	NACA
9	Mapping of Programmes To Reduce Human Rights Barriers to HIV and TB Services in Selected States in Nigeria; Final report; 2021 (28)	NACA	NACA
10	Rapid Appraisal of Gender Management System for National HIV/AIDS Response; 2015 (29)	UNAIDS, UN-WOMEN, NACA	NACA
11	Terms of Reference for the HIV Gender and Human Rights State Response Team, 2023 (30)	NACA	NACA
12	Removing Legal & Human Right Barriers to HIV and AIDS, 2017-2022 (31)	NACA, UNDP	NACA
13	Addressing GBV and HIV/AIDS intersections (2015-2017) (32)	UNAIDS, UN-WOMEN, NACA	NACA
14	Gender and Human Rights Working Committee, TOR; 2024 (32)		NACA
15	Report of the Gender Assessment of the HIV Response in Nigeria; 2022 (33)	UNAIDS, UN-WOMEN, NACA	NACA
16	Nigeria Demographic and Health Survey 2018 (34)	UNAID, The Global Fund, UNFPA, Bill & Melinda Gates	NACA

		Foundation, WHO, National Population Commission	
17	Integrated Biological and Behavioral Surveillance Survey (IBBSS) 2020 (35)	University of Manitoba, The Global Fund, NACA	CONSULTANTS
18	Stigma Index Report 2.0 Report (36)	The Global Fund, Key Populations Health Network, NEPWHAN, Global Network of People Living with HIV, UNAIDS, ICWWA, NACA, Fhi360	CONSULTANTS
19	Systematic Review on barriers and enabling structural forces affecting access to antiretroviral therapy in Nigeria; (37)	Oturu et al., 2024	CONSULTANTS
20	Systematic Review on the retention in Care Among People Living with HIV in Nigeria: (38)	Olawepo et al., 2023	CONSULTANTS
21	A Comprehensive Review; The Impact of Socioeconomic Factors on HIV Prevalence and Treatment Accessibility in Nigeria. (39)	Mugisha Emmanuel K	CONSULTANTS
22	Case-finding Effectiveness of HIV Partner Notification Service in a High-volume Facility in North-Central Nigeria (40)	Opeyemi et al	CONSULTANTS
23	Systematic review and meta-analysis assessing the knowledge and use of the female condom among Nigerians (41)	Shallie et al., 2021	CONSULTANTS
24	Understanding the role of religious beliefs in adherence to antiretroviral therapy among Pentecostal Christians living with HIV in sub-Saharan Africa: a scoping review (42)	Azia et al., 2023	CONSULTANTS

25	HIV-Stigma in Nigeria: Review of Research Studies, Policies, and Programmes; (42)	Odimegwu et al., 2017	CONSULTANTS
26	Nigeria's HIV and AIDS Antidiscrimination Act, 2014 (43)	Federal Republic of Nigeria Official Gazette	CONSULTANTS
27	National HIV/AIDS Stigma Reduction Strategy, 2016 (44)	NACA, Christian Aid, NINERELA, UKAID, UNAIDS	CONSULTANTS
28	Nigeria Demographic and Health Survey 2018 (44)	FMHSW, National Population Commission, The DHS Program ICF, Rockville.	CONSULTANTS
29	Key Population Programme Review Report; June 2024 (11)	NACA, WACPHD	CONSULTANTS

*Details of the desk review can be found in Appendix*

## 6.2 QUANTITATIVE, QUALITATIVE, AND DESK REVIEW DATA ON EVALUATION OF GENDER AND HUMAN RIGHTS APPROACH IN HIV PROGRAMS IN NIGERIA

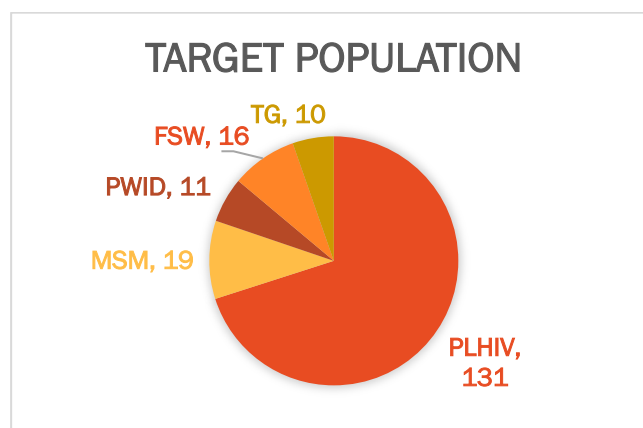
### 6.2.0 Summary Of Sociodemographic Characteristics

Table 1 shows the sociodemographic distribution of 187 respondents of the quantitative study from 12 states, 2 from each geographic zone. Each of the states had 15 respondents (8.0%), except Ebonyi and Gombe states, which had 21 (11.2%) and 16 (8.6%) respondents, respectively. Slightly more than half (53.5%) of the respondents were aged 40 years and above, while the least represented age group in the data was 25 years and below 6.4%. More than half (55.1%) of the respondents were females. Additionally, the majority (55.1%) of the respondents were not married. Almost all respondents (97.8%) had a secondary or tertiary level of education. Regarding employment status, 41% were employees.

In the qualitative study, 444 key informants participated in the study from 12 states.

Characteristic	No. of respondents	Percent
<b>State</b>		
Adamawa	15	8.0
Akwa-Ibom	15	8.0
Anambra	15	8.0
Delta	15	8.0
Ebonyi	21	11.2
Gombe	16	8.6
Kano	15	8.0
Nasarawa	15	8.0
Niger	15	8.0
Oyo	15	8.0
Sokoto	15	8.0
Ogun	15	8.0
<b>Age in years</b>		
25 or below	12	6.4
25 to 39	75	40.1
40 and above	100	53.5
<b>Gender</b>		
Male	80	42.8
Female	103	55.1
Others	4	2.1
<b>Marital Status</b>		
Married	84	44.9
Not married	103	55.1
<b>Highest Level of Education</b>		
No formal education	3	1.6
Primary	1	0.5
Secondary	58	31.0
Tertiary	125	66.8
<b>Employment status</b>		
Employee	77	41.2
Self employed	71	38.0
Not employed	39	20.9

**Table 1: Sociodemographic characteristics for the quantitative study**



**Figure 1: Description of the Respondents based on the Target Population Group**

NB: This analysis excludes the target population reached through qualitative study.

### 6.2.1 Duration Of HIV Services

Most survey respondents (89.8%) are currently receiving ART, with many receiving care for several years. Nearly one-third (29.5%) have been on treatment for 16–20 years, reflecting long-term engagement and the historical maturity of Nigeria’s HIV program. Across all states, both men and women describe ART as more accessible today than in the past, while key populations especially value community-based ART models that reduce stigma and travel burdens. Respondents receiving prevention services have also been engaged for extended periods, confirming that the dataset reflects individuals with sustained interaction with the health system, which is an important factor for

system, which is an important factor for interpreting perceptions of access, stigma, and rights protection.

**Table 2: Treatment Status and Duration of HIV Services**

Characteristic (n=187)	Frequency	Percentage
<b>Current HIV treatment (ART) status</b>		
Yes	167	89.8
No	19	10.2
<b>Number of years respondents have received HIV treatment (ART)</b>		
1-5 years	39	23.5
6-10 years	43	25.9
11-15 years	23	13.9
16-20 years	49	29.5
≥20 years	12	7.2
<b>Duration (in years) respondents have received HIV prevention and other services</b>		
1-5 years	45	28.0
6-10 years	39	24.2
11-15 years	26	16.2
16-20 years	40	24.8
≥20 years	11	6.8

## 6.2.2 Objective 1: Evaluate Current Access To Hiv Prevention, Treatment, Care, And Support

Findings from the quantitative survey, qualitative interviews, and desk review show that access to HIV services remains generally high across the twelve participating states. A total of 97.3% of respondents reported accessing at least one HIV-related service. Respondents from Ogun, Delta, and Nasarawa States, for instance, admired the regular provision of antiretroviral therapy (ART) and referred to the positive treatment received from trained personnel as reinforcing. Vulnerable Groups have access to HIV services, but access to testing is below the target 95%. This agrees with findings from a desk review, which highlights that the national goal of the 1st 95 has not been achieved, and currently only 87% of PLHIV know their status. This diagnosis gap is the single greatest structural impediment to ending the epidemic, though once linked to treatment, the success of ART use and viral load suppression is high, with 95% of those on treatment achieving viral suppression.

Women reported the most consistent improvements in access, supported by national and sub-national data indicating higher uptake across the testing and treatment cascade. Almost 9 in 10 respondents (89.3%) reported an increase in women's access to HIV services. Many women credited expanded PMTCT services, community outreach, and increased availability of ART centers for improved access.

Similarly, more than three-quarters (79.0%) of the respondents observed improved access to HIV prevention and care among men. This increase in the participation of men in HIV prevention and care activities over the last few years was primarily attributed to community advocacy, as well as spousal counselling activities by the State AIDS Control Agencies and the Ministries of Women Affairs. Male champions in the Niger and Kano States, as well as some religious leaders, were described as key motivators for men to take HIV tests and to support ART adherence among their spouses. Nonetheless, the improvement in male participation in HIV prevention and care activities is not homogeneously distributed across different locations and population groups. Although men reported increased awareness of HIV services, but emphasized ongoing barriers related to masculinity norms. Many men said they delay testing or starting

treatment out of fear of stigma, worries about appearing weak, and limited-service hours. Some also preferred confidential, male-friendly services that lower their visibility in the community.

Concerning Key populations (KPs), they reported improved access in states where differentiated service-delivery models are functioning well. Peer-led services, one-stop shops, and community ART distribution have notably increased participation among MSM, sex workers, transgender persons, and PWID. These integrated service delivery models have notably lessened waiting periods, prioritized client privacy, and strengthened the therapeutic alliance between clients and healthcare professionals. However, in states without KP-specific models, KPs described a lack of confidentiality, unfriendly provider attitudes, and fear of arrest, which discourage engagement with formal health facilities.

Most respondents (68.6%) identified the high cost of transportation as the major barrier limiting access to HIV services. Additionally, the long distance to health facilities was cited by nearly half (47.5%) of the respondents. This is further corroborated by the qualitative study, where respondents from several rural areas described the journeys of several hours and high transportation costs as a deterrent to accessing ART refills or laboratory tests. Service

availability is stronger in urban facilities, but rural and peri-urban populations, especially adolescent girls, women, and other key populations, continue to be disproportionately affected by barriers to access. The inequities reported are a product of poorly targeted socio-economic inequities and a lack of intentional socio-economic targeting policies that focus on deepening resource investments in these underserved regions, securing supply chains, and providing structural supports for transport, differentiated service models, and community health workers. One key informant expressed the situation best: **“People living with HIV are no longer dying in silence, but we still travel long distances and pay for viral load tests that should be free.”** This reflects the deep-rooted economic and structural inequities that affect the inequity in services. Structural inequities also explain the frustration of an FGD participant in Delta, **“Sometimes you get to the facility and hear that condoms or test kits are finished. You go back home feeling helpless.”** Commitment to these structural supports is what will allow Nigeria to achieve its vision of an equitable, gender-sensitive, and rights-based HIV response.

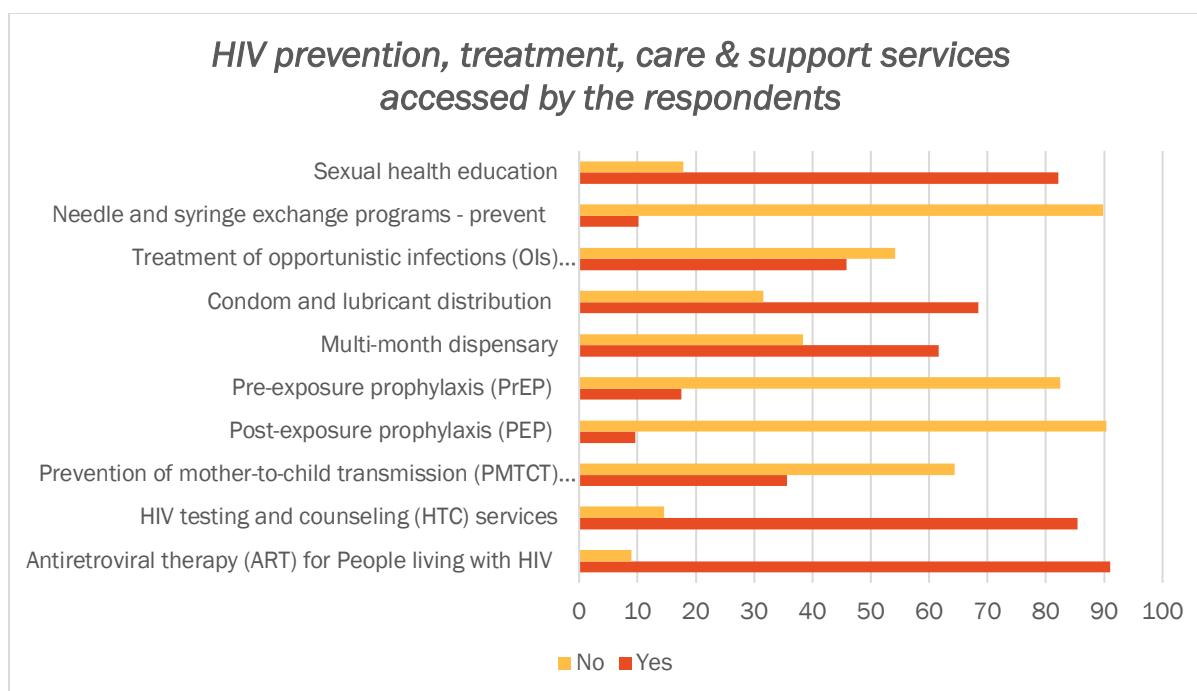
Furthermore, stigma or discrimination in the community (31.4%) and unfriendly attitudes of healthcare workers (26.3%) were highlighted as significant barriers to accessing HIV services. Only 6.6% noted spousal or family permission as a barrier. Literature extensively highlighted stigma and discrimination, especially among the key populations, as a major barrier. The Key population Programme review explicitly lists discriminatory and legal issues as limiting access to HIV services.

In the Delta, Ogun, and Kano States, there were reports of PLHIVs having to interrupt their treatments or buy condoms, lubricants, and opportunistic infection (OI) drugs at exorbitant prices due to treatment stock-outs. Only 17.5% of respondents have access to pre-exposure prophylaxis, and 9.6% have access to post-exposure prophylaxis. This is consistent with the desk review, which showed that according to the Integrated Biological and Behavioural Surveillance Survey (IBBSS) in 2020 (35), 33% of FSW and 26% of MSM, reported wanting PrEP but unavailable. This highlights that demand creation has outpaced the supply chain's ability to support prophylaxis efforts at the service delivery point.

While 78.5% indicated that the staff provided friendly services. The smallest proportion, 28.5%, reported that extended clinic hours to

accommodate men's schedules was the process they experienced when accessing HIV services.

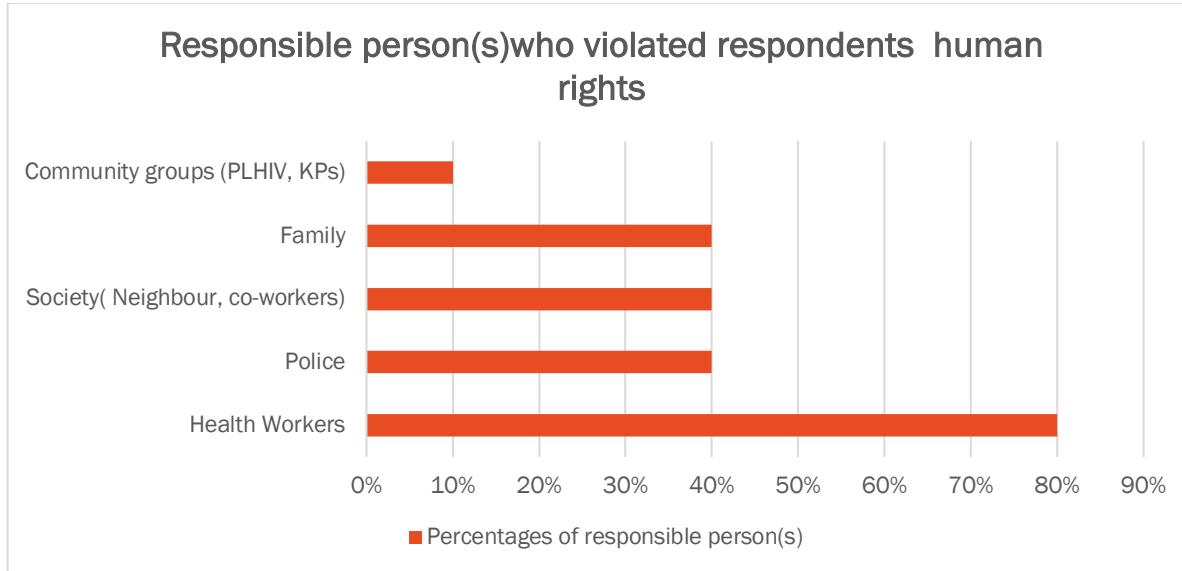
“  
**Sometimes you get to  
 the facility and hear  
 that condoms or test  
 kits are finished. You  
 go back home feeling  
 helpless**  
 ”



**Fig 2: HIV services accessed by respondents**

**Table 3: Access to HIV Services (Prevention, treatment, care, and Support)**

Characteristic (n=187)	Yes	No
<b>Respondents accessing HIV prevention, treatment, care &amp; support services</b>	182 (97.3)	5(2.7)
<b>Factors that limit access to HIV services (Select all that apply)</b>		
Long distance to the health facility	65 (47.5)	72 (52.6)
High cost of transport or services	94 (68.6)	43 (31.4)
Unfriendly attitudes of healthcare workers	36 (26.3)	101 (73.7)
Inconvenient opening hours	14 (10.2)	123 (89.8)
Need for spousal or family permission	9 (6.6)	128 (93.4)
Stigma or discrimination in the community	43 (31.4)	94 (68.6)
Fear of confidentiality breaches	29 (21.2)	108 (78.8)
Others (please specify-Q12)	10 (7.3)	127 (92.7)



**Fig 3: Proportion of person (s) violating respondents' human rights**

**Summary of findings for Objective 1:**

*In the study, Nigeria's HIV service access remains high at 97.3%, but testing lags at 87% falling short of the 95% target. Women show the most consistent improvement in access due to PMTCT expansion and community outreach, while men's participation has significantly improved but remains constrained by stigma, masculinity norms, and limited-service flexibility. Key populations benefit significantly where peer-led and differentiated service delivery models exist, but continue to face stigma, fear, and poor confidentiality in states without KP-specific services. Overall, high transport costs, distance, stigma, stock-outs, and weak supply chains disproportionately limit access for rural, peri-urban, and vulnerable groups, highlighting the need for stronger structural and socio-economic investments.*

### 6.2.3 Objective 2: Evaluate Changes in Societal Norms, Behaviours, and Gender Roles Driving HIV Transmission

Evidence from various data sources shows decreases in overt stigma but ongoing levels of subtle discrimination and negative attitudes from providers, especially toward key populations and women living with HIV. Women reported being judged for their reproductive choices, experiencing gossip from community members, and facing discriminatory remarks from service providers. Some women also reported breaches of confidentiality, particularly during antenatal visits.

Furthermore, several cultural norms continue to heighten their vulnerability to HIV. Traditional gender roles often limit women's autonomy in negotiating safer sex or condom use (Fact Sheet Women, Girls, Gender Equality and HIV in Nigeria, 2016) (22,24), while economic dependence on male partners further constrains their ability to make independent health decisions (17,24) (Fact Sheet women 2016, Global AIDS monitoring reports (GAM) 2018-2023, Cultural expectations of silence and obedience reduce women's willingness to seek HIV services or disclose their status (MICS 2016-2017, Fact sheet women 2016, Report of the Gender Assessment of the HIV Response in Nigeria; 2022). Additionally, caregiving responsibilities place women at increased risk as they care for sick relatives, sometimes with limited protection. Harmful practices such as Female Genital Mutilation (FGM), early and forced marriage, widowhood rites, and purification rituals further expose women and girls to HIV. These concerns are consistent with findings from the qualitative study, which revealed that in numerous rural and semi-urban settings, the aspects of social culture crystallize the different positions of men and women. Men are the primary decision-makers, and women are the dependents. This chronic situation imbalance determines who seeks testing, initiates treatment, and discloses status. Women from the Nigerian states of Niger, Kano, and Sokoto reported that HIV service providers often diagnosed them and issued treatment instructions without considering their input. In some cases, providers went as far as suggesting that women required their husbands' consent to continue HIV care. This dependency frequently results in delayed uptake of other essential HIV services. As one woman from Niger explained, ***“Even when we know our status, we cannot go to the hospital unless our husbands approve. Some women die in silence because they fear being accused of bringing shame.”***

In Niger, Oyo, and Delta States of Nigeria, practices such as early marriage, widow inheritance, and the “g-Bodra” blood oath associated with widow inheritance are central to early sexual initiation and the subjugation of women and adolescent girls. Adolescent girls face triple discrimination: being minors, experiencing strong normative pressures as unmarried teenagers, and enduring social stigma related to contraceptive use. Some respondents from FGD described widow cleansing rites, which are unprotected and directly undermine HIV prevention efforts. Patriarchal structures, socio-religious conservatism, and restrictive socio-cultural norms and practices are still persistent barriers that prevent the movement from achieving deeper and more transformative gender equity and equality. To reinforce this, a larger proportion of the respondents (83.4%) agreed that women are at a greater risk of HIV transmission than men, but more than three-quarters (79.0%) disagreed that men face a higher risk. Encouragingly, more than two-thirds (68.1%) believed women can now seek HIV services without needing male permission.

Similarly, key populations (KPs) reported experiencing the highest levels of stigma and discrimination. Many KPs described feeling unsafe in general health facilities due to verbal harassment, moral judgment, denial of services, and breaches of confidentiality. Some MSM and transgender respondents mentioned experiences of misgendering, hostile attitudes, or outright refusal of care. PWID described situations where providers treated them with visible discomfort or suspicion. Furthermore, power imbalances with clients limit the ability of female sex workers (FSWs) to insist on condom use, particularly when clients offer higher payment for unprotected sex. Social stigma also compels FSWs to hide their identities and avoid health facilities where they fear discrimination. For men who have sex with men (MSM), strong societal and religious condemnation forces them underground, restricting access to HIV testing, PrEP, condoms, and lubricants. Extreme stigma often discourages them from openly seeking health services, thereby increasing their vulnerability. With respect to society’s attitudes toward key populations (KPs) and people living with HIV (PLHIV), slightly more than half of respondents (52.2%) indicated that attitudes are only slightly better than before. In contrast, more than one-third (35%) believed that societal attitudes have worsened, while only 2.7% felt that attitudes are much better. Data from key informant interviews (KIIs) and focus group discussions (FGDs) suggest that changes in social attitudes, gender norms, and practices remain incremental, uneven, and context-specific across the ten study states. This aligns with the quantitative results, which were unable to demonstrate any definitive improvement in societal attitudes.

Numerous cultural norms and behaviours have been highlighted that drive HIV transmission in males, including patriarchy, male superiority, being labeled as promiscuous or irresponsible after revealing their status, the acceptance of practices such as polygamy, and certain masculinity norms that encourage men, particularly older men, to have multiple sexual partners. These norms also contribute to a lower perceived vulnerability among men compared to women. Collectively, these behaviours have been identified as major drivers of HIV transmission among men. Findings from the quantitative study show that slightly more than half of respondents (53.7%) indicated that the perception that a man should have more than one sexual partner is changing. However, this marginal shift suggests that substantive change in this norm has not yet occurred. The qualitative findings reinforce this; for example, the masculine norms prompted by the ideals of help-seeking avoidance, and dominance and control are barriers to seeking testing and treatment until symptoms have reached a dire stage. These barriers, seen particularly with respect to late seeking treatment, silence, and transmission, are, in a sense, gendered. Ultimately, such norms not only sustain HIV transmission but also contribute to persistent forms of violence and inequality experienced by women.

However, despite these peculiarities, gatekeeping influences need to be looked at more holistically. For instance, in more conservative locations, like Kano and Nasarawa, cultural norms and practices around the fasting period inhibit open conversations about sexuality, the use of condoms, and the facilitation of ART adherence and counselling. However, faith-based engagements and male champion initiatives help to shift the moral climate around HIV prevention to one of moral responsibility and not moral failure and help to reshape the narratives of the above restrictions. As one religious affairs officer in Nasarawa put it, ***“Our imams now tell men to support their wives to test. That’s progress we couldn’t imagine years ago.”***

Also, regarding HIV and AIDS-related stigma, primarily in the context of the feminine experience, it is starting to gain momentum as more and more initiatives like community radio and sensitization campaigns are developed to aid more open discussions around HIV in the community. In Oyo State, the “Awilele” program has been instrumental in creating environments for men and women to speak about prevention, stigma, and care. This is starting to become normalized, creating an important cultural shift, and one that is transformative in health decision-making at the community and household level. ***“I now speak openly about HIV in my women’s meeting; before, no one dared to mention it,” a participant in Sokoto shared.***

Only 23.7% of respondents reported that they experienced stigma or discrimination related to HIV in the last 12 months. However, more than half (52.4%) stated that they know someone who has experienced HIV-related stigma or discrimination within the same period. The majority (66.7%) agreed that people are now less likely than before to blame people living with HIV (PLHIV) for their status. Yet slightly more than



half (52.4%) still disagreed with the notion that society generally refrains from blaming PLHIV. Importantly, nearly all respondents (93.5%) acknowledged that public awareness campaigns have helped reduce stigma in their communities. These interventions over the years have contributed significantly to the decline in stigma and discrimination, consistent with findings from the desk review, which showed that sustained social and behavioural change communication efforts have gradually shifted public perceptions.

Furthermore, about two-thirds (64.7%) of respondents indicated that attitudes toward exempting community groups, such as PLHIV and key populations (KPs), from businesses and career opportunities are changing. Respondents also noted that men are no longer seen as superior and ought to make decisions for women. In addition, 56.4% reported that the belief that KPs are societal misfits with no rights is gradually shifting. Despite these encouraging signs of change, entrenched patriarchal norms and religious fundamentalism continue to influence gender relations and shape sexual behaviours, thereby affecting the use of HIV prevention and treatment services. Notably, 82% of respondents agreed that community groups now openly discuss HIV and gender-based violence (GBV) issues more than before, indicating improving awareness and action around GBV and human rights concerns. Investing in Nigeria's HIV initiatives has resulted in the community altering attitudes and stigma response, and the progress made has shifted overt displays of stigma. However, vulnerabilities attributed to yet unresolved gendered issues still surround the HIV epidemic. Continued utilization of gender-transformative, and gender-norm shifting resources, mainly focused on men, and the empowerment of women, alongside operational methods with religious and traditional frameworks, will accelerate the removal of destructive behavioral norms. This will help achieve a response that will be equitable and inclusive throughout the country.



**Table 4: Society's attitude towards KPs and PLHIV**

Characteristic (n=187)	Frequency	Percentage
<b>Respondents' description of society's attitudes toward KP's and PLHIV</b>		
Much better	5	2.7
Worse than before	65	35.0
I'm not sure / I don't know	15	8.1
Slightly better than before	97	52.2
No change	4	2.2
<b>Respondents who have experienced stigma or discrimination in the last 12 months related to HIV</b>		
Yes	44	23.7
No	142	76.3
<b>Respondents who know someone who has experienced stigma or discrimination in the last 12 months related to HIV</b>		
Yes	97	52.4
No	84	45.4

**Table 6: Perception of society towards PLHIV and KPs**

Characteristic (N=187)	No Change	Neutral	Changed
Women, girls, FSW, MSM, PWID and TG should be exempted from certain businesses and careers	50 (26.7)	16 (8.6)	121 (64.7)
Men are superior and should make decisions for women	51 (27.4)	15 (8.1)	120 (64.5)
A man should have more than one sexual partner	64 (34.4)	22 (11.8)	100 (53.7)
FSW, MSM, PWID and TGs are misfits in society and therefore have no rights	61 (32.8)	20 (10.8)	105 (56.4)

**Summary of findings for Objective 2: Nigeria shows declining overt HIV stigma, with 93.5% attributing this success to awareness campaigns over the years. However, patriarchal norms, masculinity barriers, and harmful cultural practices like early marriage and widow inheritance continue driving the transmission of HIV/AIDS. Faith-based initiatives and male champion programs are shifting attitudes by reframing HIV prevention as a moral responsibility, with 82% reporting increased open discussion of HIV and gender-based violence in gatherings. Additionally, cultural practices requiring male permission for women's healthcare, and masculinity norms delaying men's HIV services uptake, remain significant barriers, though 68.1% now believe women can access services independently. Despite improvements in reducing discrimination against PLHIV and key populations, deep-rooted gender inequality and religious beliefs remain, making continued gender-transformative actions necessary to achieve better HIV response outcomes.**

### 6.2.4 Objective 3: Determine Participation of Target Groups in HIV-Related Decision-Making.

Findings indicate that gender norms affect HIV risk, decision-making, disclosure, and service engagement for men, women, and key populations. About 90.3% of respondents reported participating in a meeting to discuss HIV services in their communities. Among those who participated, 37.6% stated that their group was rarely invited to decision-making forums. In contrast, 31.7% indicated that their community group was frequently involved in decision-making during such forums. These findings indicate that there is insufficient or inconclusive data supporting the full involvement of PLHIV and KPs in decision-making forums. Respondents from the KII and FGD reviewed that although community engagement has begun to appear in policies at both the national and subnational levels, it remains largely unimplemented, with little to no influence from targeted and affected community members on interventions designed to empower them.

It was clearly noted that engagement so far has been more consultative than shared decision-making. Although there is an obvious positive impact of community networks such as NEPWHAN, ASHWAN, and KP-led associations on service delivery, peer education, and community outreaches, respondents across

all ten States and at the national level still highlighted a critical absence of these stakeholders in higher-level decision-making, including budgeting, target setting, and evaluation.

Notable strategic insights from NEPWHAN members in Ogun State best illustrate this: **“Decisions are often made at the top and brought down to us. We are only called when it’s time to implement.”** The decision-making structure follows a top-down approach, while it involves grassroots community members mainly in a performative and implementation role.

Some mechanisms highlighted in bridging existing gaps were mentioned in both key informant interviews (KIIs) and focus group discussions (FGDs). Community Rights Advocates (CRAs), State Response Teams and Technical Working Groups (TWGs) in Gombe, Akwa Ibom and Nasarawa were mentioned as promising platforms for institutionalizing community participation. With these mechanisms, representatives of People Living with HIV (PLHIV) and gender focal persons take part in joint quarterly reviews, pinpoint human rights violations, and audit standards for service delivery. In some States, CRAs have successfully mediated discrimination in health facilities and generated evaluative feedback that informed local program revisions. Such coordination platforms, while commendable, are not fully

functional and r, under-resourced. Additionally, 88.2% of the respondents from the quantitative study identified community/ town hall meetings as a major mechanism for community feedback on HIV services in their locality. This was followed by 78.5% of the respondents who identified meetings with facility service providers/ service delivery points as the mechanism for community feedback.

From a gendered perspective, women's participation remains limited. While women living with HIV, particularly members of ASHWAN and mentor-mother networks, do a lot of work engaging and supporting community members to access HIV services, they are rarely included in the more strategic, high-level discussions where resource distribution and policy decisions are made. Several women respondents also expressed their frustration and dissatisfaction with being assigned only caregiving and mobilization tasks and not being recognized as equally important team members. As a woman in Delta explained, **"We speak to the women in our communities, we run the support groups, yet when it comes to planning, the men go to Abuja and decide for us."** Conversely in the quantitative data, 80.2% of the respondents from the quantitative study highlighted that women living with HIV are said to be most involved in decision making, and almost three-quarters (74.3%) of the respondents indicated that men do not

participate more than women in the HIV program. Similarly, 64.2% of the respondents indicated that boys do not participate more than girls in the HIV programme.

Even more, Key populations (female sex workers (FSWs), men who have sex with men (MSM), and transgender persons) reported that gender and sexual norms deeply shape their experiences in accessing HIV services and that their exclusion has reached a new, demeaning level. They face stigma, criminalization, and exposure to violence, which limit their participation in their day-to-day activities. This exclusion undermines the most fundamental right-based principle of HIV programming, which states, **"nothing for us, without us."**

Even though the majority (89.7%) stated that HIV service providers act based on feedback from any member of their community, in the quantitative study. Data from qualitative and Desk review continue to highlight an essential paradox about participation: communities are most affected by HIV and carry out grassroots HIV initiatives, yet they have very little input in policy-making and accountability frameworks. For communities to be genuinely included, systemic changes must happen that go beyond temporary solutions and move toward institutionalized, funded co-governance pathway.

**Table 7: Access to HIV services (Gender-Perspective)**

Characteristics (n = 187)	Frequency	Percentage
Achievements recorded in HIV programs within respondent's community		
<b>Increased women's access to HIV services</b>		
Yes	166	89.3
No	20	10.8
<b>Increased men's access to HIV prevention and care</b>		
Yes	147	79.0
No	39	21.0

***Summary of findings for Objective 3: Participation of Target Groups in HIV-Related Decision-Making***

*Findings from the qualitative data show that although community engagement structures exist, meaningful participation in HIV decision-making remains limited. While the quantitative data indicate high levels of engagement 90.3% of respondents reported attending HIV-related meetings, this does not consistently translate into decision-making power. Notably, 37.6% of respondents stated that their groups were rarely invited to decision-making forums, and only 31.7% reported frequent involvement, showing that PLHIV and KPs are engaged in HIV decision making.*

*The roles of networks such as NEPWHAN, ASHWAN, and key population-led groups are recognised by stakeholders. However, participation is largely consultative rather than reflective of shared decision-making.*

*Furthermore, although 80.2% of respondents in the quantitative study reported that women living with HIV are involved in decision-making, qualitative findings suggest that their involvement is often limited in scope and influence. While women and Key populations may be present in discussions, their contributions rarely shape final decisions.*

## 6.2.5 Objective 4: Identify Contextual Factors Influencing HIV Services, GBV Response, and PLHIV

The assessments indicate that access to HIV services, responses to GBV, and the engagement of PLHIV vary due to contextual variables at the State level, arising from the interplay of culture, gender, religion, poverty, and institutional factors. These closely related variables shape the experiences of vulnerability and the access, participation, and rights of individuals within the HIV response in Nigeria.

### Social and Economic Insecurities

The lack of economic resources is one of the greatest and most common obstacles to accessing and sustaining HIV treatment. Respondents from different States explained how the convergence of high transport costs, diagnostic user fees, and general livelihood instability directly undermines sustained treatment adherence and the ability to attend community meetings and advocacy participation. Caregiving responsibilities, which are disproportionately placed on women and within female-headed households, are a significant factor in this treatment burden, as women are expected to manage the household alongside the health care needs of family members.

Economic survival is a strong motivation for women, particularly ‘key populations’ who face additional economic and health risks due to

HIV. The young woman in Nasarawa captured this when she explained, **‘When transport costs rise, some women skip clinic days to feed their children instead,’** illustrating the difficult economic choices women are forced to make. A significant proportion of respondents (68.6%) highlighted high transportation costs, with 47.5% citing distance issues as a major barrier.

### Cultural and Gender Norms

Cultural and religious norms significantly influence service uptake, particularly in conservative states. Cultural patterns around female deference and male dominance, as well as sexual silence, still shape women’s health-seeking behaviour. In contrast, in Kano, Niger, and Sokoto, men perceive themselves as custodians of family honour and as gatekeepers to women’s mobility. This dynamic severely limits women’s autonomy in making health decisions, including HIV testing, disclosure, and adherence. An implementing partner in Kano remarked, **“During Ramadan, most men stop their wives from coming for ART appointments—they see it as breaking the fast.”**

Such insights illustrate how, in the name of religious and cultural observance, the integration of rigid boundaries can undermine

care. Moreover, harmful traditions, including widow inheritance, early marriage, and female seclusion, also contribute to their marginalization and heightened risk for HIV, and restricted access to prevention, treatment and care services.

### **Religious Influence**

Religion has a unique dual influence on the HIV landscape. For instance, HIV-related stigma and discrimination are closely linked to attitudes concerning sexuality, gender, and morality, and these attitudes are influenced by religious institutions. On the other hand, faith-based organizations have become powerful advocates for treatment literacy and the reduction of stigma. Akwa Ibom and Oyo States provide examples of how religious leaders, through inclusive mosque and church outreach activities as well as religious radio programming, have helped shift attitudes toward HIV from being perceived as a moral failing to being recognized as a manageable health condition. A study by Azia et al. (2023) on *Understanding the role of religious beliefs in adherence to antiretroviral therapy among Pentecostal Christians living with HIV in sub-Saharan Africa*(45) noted that the studied participants highlighted several belief-based factors that affect access to HIV services among PLHIV. These include the belief that healing can be obtained through prayers, faith healing, or “taking a step of faith”; the perception that taking ART diminishes or

belittles God’s healing power; and strong reliance on prophetic healing declarations from religious leaders. Together, these beliefs have created significant controversy and hindered consistent access to HIV services among PLHIV. This evaluation suggests the need for context-sensitive work in balancing the competing agendas of religious leaders and stakeholders in the public health field.

### **Weak Institutional and Legal Systems**

Institutional factors were equally important. Some states demonstrated strong coordination among Gender Desks, SACAs, justice sectors, and implementing partners, resulting in improved case management and referral systems. Others lacked funding, coordination capacity, and clear reporting structures, which limited their ability to uphold rights and address violations. Weak law enforcement and fragmented institutional coordination have been identified as primary barriers to justice for GBV and discrimination survivors in all the States. While the VAPP Act and the HIV Anti-Discrimination Law have been adopted in several States and protections exist on paper, enforcement is weak. Many women, key populations, and survivors who experience violations are disincentivized to report due to the culture of silence, fears of exposure and retaliation, as well as a prevalent distrust in the justice system. In rural areas, the lack of legal

aid, well-functioning GBV referral and enforcement systems, fosters violations of the law and reinforces impunity.

Additionally, gender and human rights desks set up in State Ministries and Agencies are underdeveloped and do not have the necessary resources to document cases and offer timely redress. Weak institutional mechanisms aggravate the already entrenched marginalization of PLHIV, and the lack of confidence in the public protective systems lowers the overall public trust in such systems.

Distance to health facilities and health-related infrastructure are among the most critical determinants of health service utilization in remote communities. Respondents in Gombe, Niger, and Delta reported that clients seeking ART and diagnostic services travelled up to twenty kilometers to obtain such services. These clients, particularly women who are more likely to face domestic responsibilities, are prone to drop out of the system over long distances due to poverty and the high cost of transportation. In contrast, urban areas have more service delivery points, although they still face high transportation costs and sometimes long distances. But overall, there are better developed infrastructures and more concentrated facilities, OSS, and outreach services.

The interlocking nature of these contextual dimensions of exclusion, economic and geographical inequalities, weak institutions, and gendered norms of patriarchy and associated interpretations of religion braid together most tightly to syphon the cumulative impact on women and adolescent girls and key populations who experience multiple marginalization layers as the most entrenched.

***Summary of findings for Objective 4: Access to HIV services and GBV response in Nigeria varies significantly across states due to economic insecurity, with 68.6% citing transportation costs and 47.5% reporting distance barriers that disproportionately affect women balancing caregiving and survival needs. Cultural and religious norms in conservative states enforce male gatekeeping over women's healthcare decisions, while harmful practices like widow inheritance heighten HIV vulnerability, though faith-based organizations increasingly promote treatment literacy and stigma reduction. Weak institutional coordination, inadequate funding, and poor enforcement of the VAPP Law and HIV Anti-Discrimination Law undermine justice for survivors, with underdeveloped gender desks and a lack of legal aid fostering impunity, particularly in rural areas.***

## 6.2.6 Objective 5: Measure Cases of GBV and Human Rights Violations Among Population Groups

Findings show that GBV and human-rights violations remain widespread, although their nature differs by population group. At every study location, the nexus of HIV, GBV and the potential for violation of human rights remains the most persistent and difficult issue facing the HIV response in Nigeria. The qualitative findings in KII and FGD, violence, stigma and discrimination extremely undermine women and most marginalized groups, such as Key populations, within prevention, treatment and adherence.

Generally, from the quantitative study, only 5.2% of the respondents stated that their rights were not respected and protected when accessing HIV services. Areas where human rights violations happened the most included stigmatization because of their sexual orientation (70%), Unauthorized disclosure of HIV status (40%), and the least proportion being when accessing reproductive health services. Notably, the majority of respondents (80%) identified health workers as responsible for violating their human rights, compared to other groups, such as the police, society, and family, where only 40% of respondents indicated these

groups as being responsible. This is consistent with findings from a desk review that highlighted that 25% of ART patients reported that they had experienced stigma or discrimination at family, hospital, and community levels, and at the workplace (IBBSS 2020). Healthcare workers were seen to be the main culprits in disclosing their status to other people without their consent.

The majority (26.1%) reported that they had been touched or talked to in a sexually suggestive manner without their consent within the past 12 months. This was followed by those (14.7%) who reported that their partner or anyone had or attempted to have sex with them forcefully. Smaller proportions, 6.6% reported that they have ever been denied or had their appointment terminated because of their HIV status, while 5.8% stated that they have ever been denied access to health services because they are a key population. Only 4.4 % reported that they have ever been denied access to any health services because of their HIV status. Notably, 88.7% of the respondents indicated a reduction in stigma and discrimination against people living with HIV (PLHIV), while 63.4% reported a decline in stigma and discrimination towards key populations (KPs), and 83.3% of respondents noted strengthened protection against gender-based violence within their communities. In a survey done in *GAM 2018-2023*, more than half of female respondents and

nearly half of male respondents responded that they would not buy fresh vegetables from a shopkeeper or vendor if they knew the person had HIV. Additionally, respondents reported that children living with HIV should not attend the same school as HIV- negative children. Likewise, a survey from IBBSS 2020 showed that 13.5% said they would not provide care for PLHIV while 15.8% would not work with a PLHIV, also 27.9% would not share a meal with PLHIVs. Although the quantitative study showed a reduction in GBV incidents, gender-based violence and human rights violations linked to HIV status and sexuality continue to occur.

#### 6.2.6.1 Gender-Based Violence Against Women Living with HIV

Regarding women living with HIV, violence and abuse are often both a cause and a consequence of their HIV status. Disclosure of one's HIV status, though encouraged by health programs, frequently results in domestic violence, abandonment, emotional abuse, and economic hardship. Participants from Oyo, Delta, and Niger shared stories of being beaten, chased from their homes, or publicly shamed after revealing their status to spouses or family members. As one woman in Oyo State poignantly shared, ***“After I told my husband about my status, he locked me out and told the neighbours I was cursed.”***

Women bear most of the psychological and emotional costs of disclosure as male partners disproportionately evade responsibility for the infection. The social stigma of HIV, manifested as psychological, physical and economic violence, is compounded from patriarchal norms that mandate violence toward women, route custodians of family honor, and besiege the family with negative social sanctions. Women who lack strong social safety nets are more vulnerable and face economic abuse, often staying in violent relationships as their only way to support and provide for their children.

Although policies and laws exist promoting non-discrimination towards HIV Pregnant women, FGD participants described incidences whereby pregnant women having antenatal care and treatment were denied health care and in some incidences were cared for abusively. Institutional violence, within the health care system, perpetuated by negative social norms, moral judgment, erodes the trust of women within the system. This may discourage women from seeking treatment or PMTCT services. The Stigma Index Report 2.0 showed that 24.7% of female PLHIV reported experiencing some form of HIV- related stigma/discrimination in the past 12 months.

### 6.2.6.2 Human Rights Violations Against Key Populations

Among key populations (KPs), violations are widespread and systemic. Participants described routine police harassment, unlawful arrest, extortion, and sexual assault, often justified under the Same-Sex Marriage (Prohibition) Act (SSMPA), local public-order, and byelaws. A key population leader in Niger reported, **“Police use the same-sex law to arrest us even when we are just doing outreach.”**

For FSWs, harassment frequently includes sexual coercion by security agents, confiscation of condoms as “evidence of prostitution,” and arbitrary detention. MSM and TG respondents recounted being publicly humiliated, photographed, and outed on social media platforms following police raids, acts that not only violate privacy and dignity but also deter individuals from accessing HIV prevention and treatment services. These human-rights violations create a climate of fear and invisibility, pushing many KPs underground and hindering accurate data collection, case reporting, and service delivery. The Key Population Programme Review Report (KPPR); June 2024 (II) showed comprehensive data on stigma and discrimination among Key populations; for those who have experienced stigma or discrimination in the last 12 months prior to the survey, MSM-30.9%, PWID-26.3%, FSW-24.2%

respectively, were identified. A quarter of the Key populations living with HIV reported that their HIV status was disclosed to others without their consent. Additionally, among those who have experienced forced unprotected sex without a condom, Transgender individuals were highest at 55%. While 36%, 37%, 33% for MSM, PWID and FSW respectively.

While it is understandable that legislative frameworks such as the HIV and AIDS Anti-Discrimination Act (2014) and the Violence Against Persons (Prohibition) Act (VAPP) are established and include protective legal provisions, intersectoral and inter-distributive questions remain, as do questions on their effectiveness in the enforcement and compliance. Target stakeholders from various States pointed to the lack of institutional frameworks, insufficient protection of survivors, and poor collaboration across institutional boundaries. Cultural silence, retaliation, and law enforcement reparations are prevalent in the underreporting of GBV and violations of rights, and, in many cases, survivors do not even know there are legal avenues to pursue and lack the means to access them.

### 6.2.6.3 Reporting Channels for Gender-Based Violence and Human Rights Violations:

Among all the reported cases of Gender based violence and human rights violations reported by the respondents, more than a third (36.6%) reported to their different community group leaders (NEPWHAN, ASHWAN, KP secretariat), and almost one-quarter (22%) reported to their family members. About 17.1% reported to the Health Facilities, and only 9.8% reported to the Police Stations. Furthermore, 13% of the respondents stated that they reported to other CBOs, local vigilantes, Human Rights Commissions, their boss at work, etc. Of all the respondents, more than one-third (34.2%) did not report their experiences of gender-based violence and human rights violations to anyone. From the literature, 40.8% of GBV survivors did not report because they were unaware of the appropriate place to report to and how to seek redress, while 5% felt that even though they reported, nothing would come out of it. Also, 10% reported that they felt reporting will expose their HIV status.

### 6.2.6.4 Access to Gender-Based Violence (GBV) Intervention Services

About 85.1% of the respondents who reported cases of Gender Based Violence and Human Rights Violation received counselling and

Psychosocial Support, while more than one-third (34.0%) received Health and clinical services (Screening, Emergency contraception, PEP, Referral), and a quarter of respondents (25.5%) got legal services. About 8.3% and 8.5% of respondents had shelter support and empowerment (vocational training) support, respectively. In the literature review, the National HIV Treatment & PMTCT Guidelines require that sites offering post-violence clinical care provide a full minimum package: treatment of injuries, rapid HIV testing and linkage, STI screening/treatment, PEP, emergency contraception, first-line counselling, and referral to longer-term psychosocial/GBV services. Also, Post-Exposure Prophylaxis (PEP) Services for survivors of sexual violence are offered in health facilities (24-hour access is often the goal). In addition, OSS and peer-led clinics provide integrated HIV, SRH, psychosocial and some GBV responses for KPs and PLHIV in many States; KPPR and national program documents highlight OSS as a model that increases service uptake and provides safer entry points for survivors among KPs.

Moreso, some NGOs, faith-based organisations and Spotlight/UN initiatives have invested in shelters, psychosocial counselling, MHPSS and GBV hotlines in selected states.

In one of the southern States, a gender desk officer stated that the law is effectively useless

without the allocation of resources and the enforcement of provisions. ***“Funding and follow-up are the law. Most survivors give up halfway because of a lack of transport and legal fees. Losing fuel and time is a legal death trap, and all the ‘remedies’ are simply legal mock-spirits that vanish, leaving the dead victims to their social silence.”***

#### 6.2.6.5 Emerging Good Practices and Localized Progress

Despite some challenges, the evaluation notes the emergence of some positive developments and progress in various States. Kano, Nasarawa, and Delta were consistently highlighted for having functional GBV response teams, maintaining strong linkages with the National Human Rights Commission (NHRC), and engaging collaborations with the International Federation of Women Lawyers (FIDA). These partnerships at the State level enabled survivors to receive free legal counselling, mediation, and psychosocial support. In some cases, survivors were able to have their legal issues referred to court or mediated and resolved through restorative dialogue.

Community-based structures, especially Community Rights Advocates (CRAs), and the Gender and Human Rights State Response Teams are likewise instrumental in the identification and documentation of legal and health violations and in the referral of cases to

legal and health services. These structures have worked to open accountability pathways and break the prevailing silence, particularly within PLHIV networks and the key populations.

Localized innovations in Kano, Nasarawa, and Delta demonstrate systems-level innovations. The sustainability and the potential for wider application of these innovations will be critical in reorienting Nigeria’s response to HIV from a pathological response to one that embraces equity and the intrinsic dignity and human rights of all its citizens.

***“Funding and follow-up are the law. Most survivors give up halfway because of a lack of transport and legal fees. Losing fuel and time is a legal death trap, and all the ‘remedies’ are simply legal mock-spirits that vanish, leaving the dead victims to their social silence.”***

**Table 8: Cases of GBV and human rights violations among population groups as reported by the Respondents**

<b>Characteristics (n = 187)</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Respondents' experiences of types of violence or human rights violations in the last 12 months</b>		
<b>Experienced being beaten, slapped, kicked, or hit by a partner</b>		
Yes	24	13.0
No	161	87.0
<b>Experienced being forced or attempted to have sex either by a partner or anyone</b>		
Yes	27	14.7
No	157	85.3
<b>Experienced being touched or talked in a sexually suggestive manner without your giving them consent</b>		
Yes	47	26.1
No	133	73.9
<b>Respondents or children being insulted, talk down, or threatened with physical harm e.g., hospital visits, getting a job, seeing your family</b>		
Yes	20	10.9
No	164	89.1

**Table 9: Cases of GBV and human rights violations among population groups as reported by the Respondents**

<b>Characteristics (n = 187)</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Respondents denied or had appointment terminated because of their HIV status</b>		
Yes	11	6.2
No	167	93.8
<b>Respondents being denied or had their appointment terminated because they are key population</b>		
Yes	12	7.7
No	144	92.3
<b>Respondents denied access to any health services because of their HIV status</b>		
Yes	8	4.4
No	172	95.6
<b>Respondents being denied access to any health services because they are a key population</b>		
Yes	9	5.8
No	146	94.2

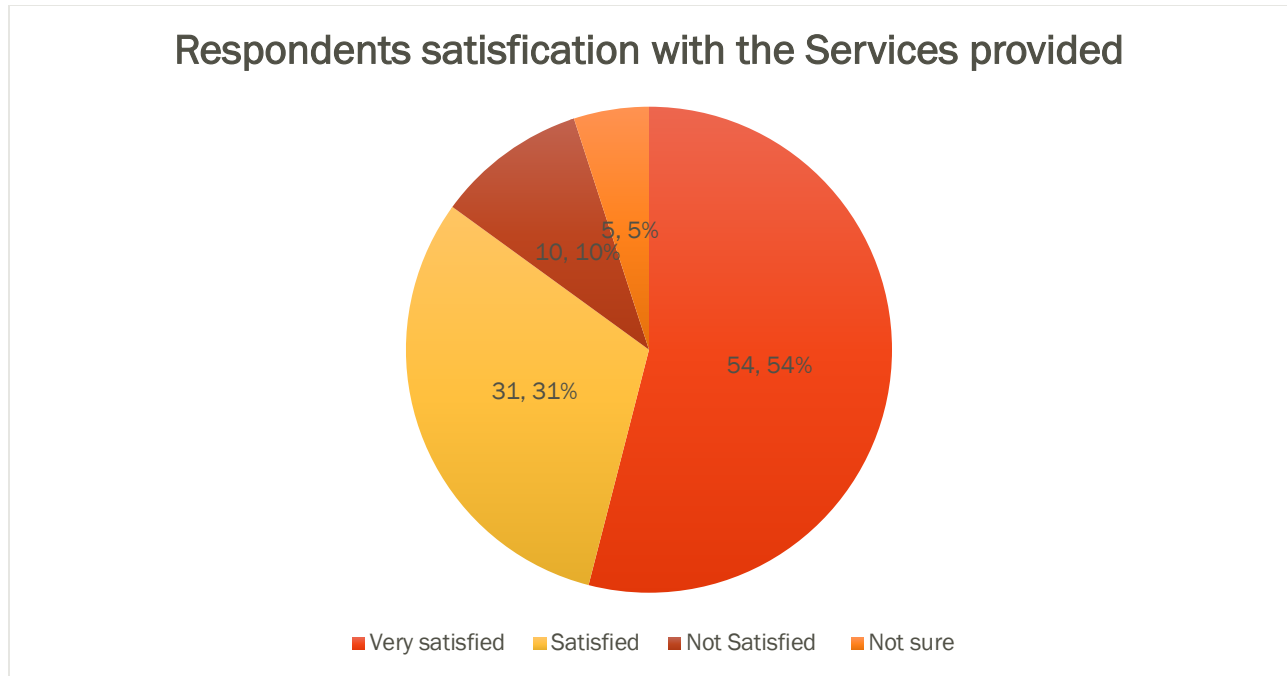
**Table 10: Areas where violations occurred**

<b>Characteristic (n=187)</b>	<b>Yes</b>	<b>No</b>
<b>Respondents rights respected and protected when accessing HIV services</b>	165 (94.8)	9 (5.2)
<b>Areas in which these violations occurred</b>		
When accessing justice and legal services	3 (30.0)	7 (70.0)
When addressing violence in all cases (including from partners, family, community, or state)	3 (30.0)	7 (70.0)

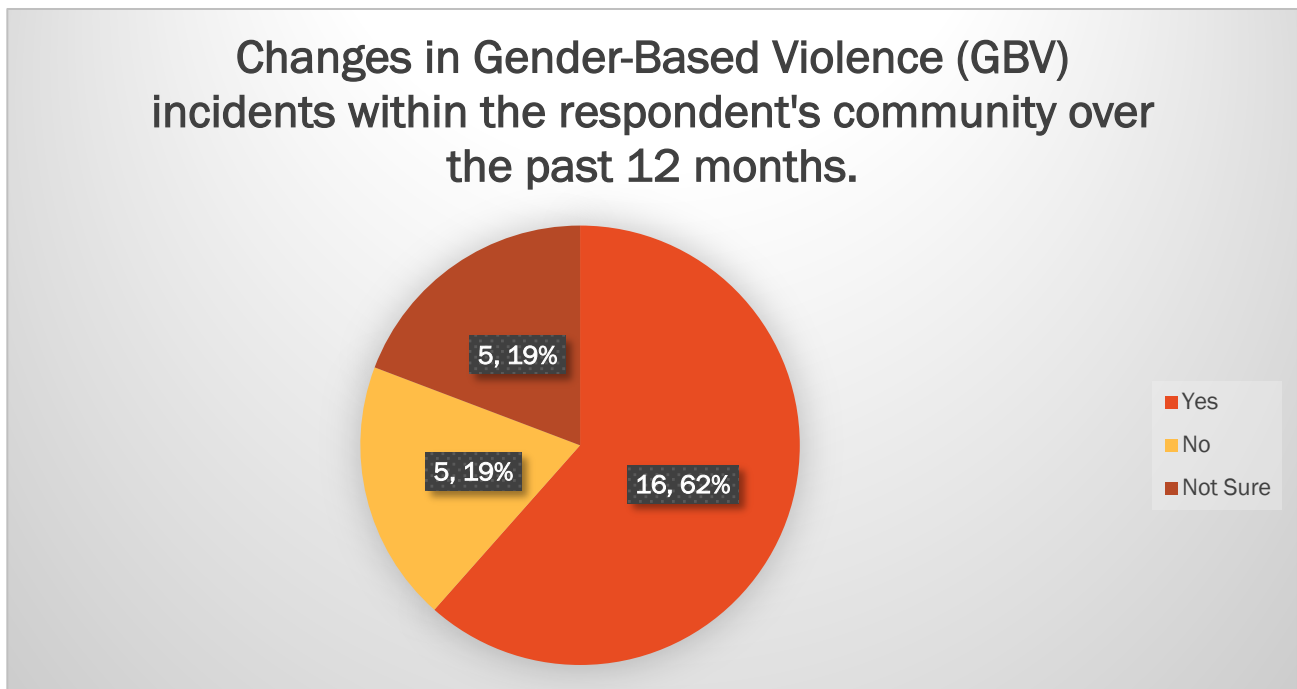
Unauthorized disclosure of HIV status	4 (40.0)	6 (60.0)
Stigmatized because of gender identity (TGs)	3 (30.0)	7 (70.0)
When accessing reproductive health services	2 (20.0)	8 (80.0)
Stigmatized because of sexual orientation (MSM, FSW)	7 (70.0)	3 (30.0)
When accessing HIV testing services and counseling	3 (30.0)	7 (70.0)

**Table 11: Perception of stigma and discrimination among PLHIVs and KPs**

<b>Characteristics (n = 187)</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Less stigma and discrimination for PLHIV</b>		
Yes	165	88.7
No	21	11.3
<b>Less stigma and discrimination KP (MSM, FSW, TG, and PWID)</b>		
Yes	118	63.4
No	68	36.6
<b>Strengthened protection from gender-based violence</b>		
Yes	155	83.3
No	31	16.7
<b>Other (please specify)</b>		



**Fig 4: Satisfaction with Received GBV Intervention Services**



**Fig 5: Perceived Changes in GBV Incidents Over the Past 12 Month**

**Table 12: Channels Through Which Respondents Reported**

<b>Characteristics (n = 187)</b>	<b>Frequency</b>	<b>Percentage</b>
Respondents reported to the following		
<b>Health Facility</b>		
Yes	14	17.1
No	68	82.9
<b>Family</b>		
Yes	18	22.0
No	64	78.1
<b>Police</b>		
Yes	8	9.8
No	74	90.2
<b>Community (NEPWHAN, ASWHAN, KP secretariat)</b>		
Yes	30	36.6
No	52	63.4
<b>Did not report</b>		
Yes	28	34.2
No	54	65.9
<b>Others (specify)</b>		
Yes	11	13
No	71	86.6

**Table 13: Services offered after reporting**

<b>Characteristics (n = 187)</b>	<b>Frequency</b>	<b>Percentage</b>
Services offered when respondents reported		
GBV intervention services received		
<b>Health and clinical services (Screening, Emergency contraception, PEP, Referral)</b>		
Yes	16	34.0
No	31	66.0
<b>Counselling/ Psychosocial support</b>		
Yes	40	85.1
No	7	14.9
<b>Legal services</b>		
Yes	12	25.5
No	35	74.5
<b>Shelter and Safety (Safe houses, relocation support)</b>		
Yes	4	8.3
No	44	91.7
<b>Police services</b>		
Yes	10	21.3
No	37	78.7
<b>Empowerment (Vocational training, Job placement)</b>		
Yes	4	8.5
No	43	91.5
<b>Others (Please specify)</b>		
Yes	3	6.5
No	43	93.5

### **Summary of Objective 5: Gender-Based Violence and Human Rights Violations**

*Findings show that GBV and human-rights violations remain widespread across all study sites, with violence, stigma, and discrimination particularly undermining women and key populations despite reported overall improvements in stigma reduction. Quantitative data indicate that 5.2% of respondents experienced rights violations when accessing HIV services, mainly due to stigmatization based on sexual orientation (70%) and unauthorized disclosure of HIV status (40%), with 80% identifying health workers as the main perpetrators. GBV remains prevalent, as 26.1% reported sexual harassment and 14.7% reported forced or attempted forced sex in the past 12 months, while denial of services due to HIV status or key population identity affected up to 6.6% of respondents.*

## 6.2.7 Objective 6: Analyze Integration of Gender and Human Rights into HIV

The evaluation findings suggest that the integration of gender and human rights (GHR) into Nigeria's HIV response has gained institutional acknowledgement and an operational base. However, the operational integration remains inconsistent and uneven across States and implementing partners. There is an evident commitment to policy integration at the national level, which is further evident in the National HIV Strategic Framework (NSF III), as well as in the National Gender Policy on HIV and the HIV and AIDS Anti-Discrimination Act (2014). However, the extent of these commitments materializing at the level of programming and service delivery at the States varies considerably, which is largely determined by the political will, resources, and technical capacity of the States.

The evaluation reports that there are structures and mechanisms in some States, such as Ogun, Akwa-Ibom, and Nasarawa States. These structures, which the evaluation reported as existing in all these States, were Gender and Human Rights Desks irrevocably attached to the State AIDS Control Agencies (SACAs) as well as the Ministries of Women Affairs (MoWA), Ministries of Justice (MoJ) and the Police. These structures are important because

they helped institutionalize the mechanisms by serving as the entry points to mainstreaming the critical components of gender and human rights in the HIV programs. These task teams have provided and are still providing critical functions of coordinating the gender and human rights trainings, receiving and handling the referral of HIV-related stigma and discrimination cases, and ensuring the use of rights-based approaches in HIV programmes.

As mentioned by some respondents, other practical innovations include Ibisadi in Ogun State and the national 6222 line, which runs in partnership with the National Human Rights Commission (NHRC), reporting and referral hotlines. These hotlines allow survivors of stigma, discrimination, and GBV to receive legal and psychosocial support without disclosing their identity. Moreover, the CRAs in Nasarawa and Delta States have emerged as vital community-level frameworks for the facilitation of access to justice for survivors with the justice system, as well as the dissemination of rights knowledge to people living with HIV and other marginalized populations.

### 6.2.7.1 Gaps and differences between States

Integration continues to be project-specific and fragmented despite these institutional achievements. In several States, gender and human rights activities are integrated into

general programme portfolios that do not have specific budget lines, nor do they have dedicated personnel. Some gender desk officers mentioned that due to a lack of funding and irregular government subsidies, they were unable to sustain the activities for which they were responsible and supported by the donor. Paraphrased, a statement from a State AIDS Control Agency captures this idea well: ***"There are frameworks, but when all is said and done, without funding, it remains on paper."***

There were also inconsistencies in documenting cases, follow-up actions, and programme outcomes. Several focal desks do not have digital systems for tracking cases of discrimination and GBV associated with HIV, and they also do not have standardized systems for documenting reports. In some cases, the collaboration of the health, justice, and social welfare ministries continues to be ad hoc, resulting in the duplication of some activities and the disaggregation of response pathways. The weak collaboration of these ministries hampers the gender and human rights framework from functioning in a holistic way and, as a result, reduces the timeliness of remedies available to the affected persons.

#### 6.2.7.2 Policy Implementation and Gender Responsiveness

Further analysis indicates a lack of implementation of gender responsive policies.

For instance, while national policies acknowledge the need for gender equity and gender responsive policies, countless actors at the state and facility levels see gender as a “soft issue.” Thus, the predominant biomedical lens focused on prevention, ART coverage and viral suppression disregards gender, rights, and equity positioning, as these policies continue to offer positional value.

Focus group discussion (FGD) participants, particularly women living with HIV, argued that the rights awareness gained through HIV sensitization programs did not translate into rights enforcement. They often expressed that ***"We know our rights now but enforcing them is another story."*** This illustrates the difference between awareness and empowerment, and the systemic issues that prevent those at the bottom of the social hierarchy from transforming their knowledge into action.

Most States have adopted policy language affirming inclusion and equality; however, none of them take a practical gender analysis approach toward programme design or evaluation. In some cases, the monitoring of interventions is lost, and is not focused on the

gendered vulnerabilities of women, men, or gender diverse people.

Integration of human rights principles, including participation, non-discrimination, confidentiality, and accountability, has been positively integrated with stronger institutional integration in partnership states. In Akwa-Ibom and Nasarawa, linkages between NHRC, FIDA, MoWA, and SACA have developed functional referral networks for survivors of stigma and abuse. These arrangements enable joint case reviews, mediation, and, when necessary, referral to formal justice mechanisms.

Nevertheless, the evaluation highlighted that such coordination seems to be reliant on individual champions more than it does on systemic mandates. In states where leaders change or donor funding is absorbed, these mechanisms get turned off. The absence of funded integration, and more so the lack of accountability frameworks for self-assessment to be sustained, results in a lack of institutional memory.

### 6.2.7.3 Community Level Engagement

The integration of gender and human rights into HIV programming manifests primarily at the community level through networks of peer educators, the Advocate-Mentors program, and

the Community Rights Advocates (CRAs) program. These structures embody the rights-based principle espoused within the community of **“nothing for us without us.”** Affected members of the community with rights and interests’ advocacy are provided avenues for rational advocacy for the rights articulation and the community services provided. There are, however, some limitations, such as their roles tend to be outreach and sensitization, where their voices are highly structured with little in community and program design and rational participation in program and budget monitoring. In the community advocacy ecosystem, there is advocacy with little evidence of the rights-policy and advocacy intersection to address rights violations of community members. Therefore, mediation is informal and at times, community professional mediation is illicit and blatant.

### 6.2.7.4 Overall Patterns

The evidence collected across the ten States and at the national level indicates that normative and institutional progress in the HIV response within the Nigerian context is significant. Patterns of policy implementation suggest progress in lateral institutional collaboration and operational inter-agency collaboration, albeit at a superficial degree. Although structural and operational weaknesses remain, pressures on policy implementation largely

stem from funding gaps, weak inter-agency collaboration, and fragmented operations

across closely related state agencies. However, the integration of gender and human rights as a core policy principle shows a shift from being a peripheral goal to a central element of Nigeria's HIV institutional and policy frameworks. Operationalization of the human rights and gender principle across the grassroots and sub-national levels lacks operational structures and is dependent on state leadership, funding, and institutional capacity.

#### 6.2.7.5 Review of Guidelines and Policy Documents Related to Gender and Human Rights Issues in HIV Programs

This session reviews guidelines and policy documents on Gender and Human Rights in HIV programs. The table below shows the list of documents used for the desk review of this section. The table also highlights the document numbers used for referencing during the review and the source of the document.

“

**We know our rights now but enforcing them is another story.**

”

The following documents were used for the review of Policy/Guidelines

**Table 6.2.7: List of documents used for the desk review of guidelines and policies**

Documents Number	Documents	Source	Provided by
1	National HIV/AIDS Community Care and Support Guidelines (2020-2023)	NACA	NACA
2	National Plan of Action: Addressing Gender Based Violence and HIV/AIDS (GBV/HIV/AIDS) Intersection 2015-2017	NACA, UNDP, UN-WOMEN, UNAIDS	NACA
3	Consolidated Service Delivery Guidelines on HIV and STIs for Key Populations in Nigeria 2021	NACA and Henry Jackson Foundation Medical Research International (HJFMRI)	NACA
4	National Guidelines of HIV Prevention, Treatment and Care: National AIDS, STIs and Viral Hepatitis Control	NASCP	NACA

The review covered Specific Objective 6: “Analyze integration of gender and human rights into HIV guidelines/policies, strategies, plans, programs, and assess progress toward gender and human rights responsiveness.”

The review of each guideline/policy was covered under the following sub-objectives:

- **Sub-objective 6.1:** Review policy frameworks for gender & Human Rights responsiveness
- **Sub-objective 6.2:** Measure gender & human rights policy, strategy, and plans implementation status.
- **Sub-objective 6.3:** Identify gaps and opportunities in integrating gender & human rights programming.

Additionally, the review was done using the following indicators

- Existence of frameworks for gender and human rights responsiveness
- Platforms existing for gender and human rights responsiveness
- Number/percentage of strategies that include gender and human rights components
- Gender and human strategies that align with international gender and human rights standards
- Stakeholders identified for gender and human rights responsiveness
- Percentage of planned gender and human rights activities implemented within HIV programs
- Proportion of budget allocated and utilized for gender and human rights interventions.
- Existence of monitoring and accountability mechanisms for gender and human rights in HIV response
- Number of gaps identified in policies, strategies, or program implementation
- Availability of sex-, age-, and key population–disaggregated data to inform programming
- Number of actionable opportunities/recommendations proposed for strengthening integration

## **Review of National HIV/AIDS Community Care and Support Guidelines (2020-2023)**

The document highlights the role of the Gender and Human Rights State Response Team (GHR-SRT) in promoting access to justice, human rights, and HIV services for key and vulnerable populations in Nigeria. It emphasizes integrating gender and human rights into HIV/AIDS community care, with strategies such as scaling up PMTCT programs, mainstreaming gender and women's empowerment, mobilizing partnerships to address inequalities, institutionalizing a Gender Management System, and implementing gender-responsive budgeting.

Key stakeholders include government agencies, law enforcement, UN and development partners, CSOs, media, academia, and KP networks. The document calls for adequate resource allocation and the development of indicators for monitoring gender and human rights mainstreaming.

Identified gaps include unclear operational definitions, weak anti-discrimination systems, limited integration of TB/HIV services, insufficient attention to mental health and key population support, and incomplete care indicators. Recommendations include midterm guideline reviews, regular stakeholder engagement, clarified government roles,

integrated TB/HIV and care services, and a continuum of care linking facilities, communities, and households. Overall, the document provides a framework for strengthening gender and human rights responsiveness in Nigeria's HIV response.

## **Review of National Plan of Action: Addressing Gender Based Violence and HIV/AIDS (GBV/HIV/AIDS) Intersection 2015-2017**

The article outlines strategies to strengthen Nigeria's response to gender-based violence (GBV) and HIV/AIDS, emphasizing the integration of gender and human rights into policies and programs. Key platforms include Technical Working Groups (TWGs), consultative meetings with the media, and engagement of community stakeholders such as CSOs, NGOs, and development partners. Strategies focus on inclusive human resource policies, eliminating gender barriers through male engagement, raising awareness of GBV/HIV services, and building institutional capacity.

Stakeholders include federal and state ministries (e.g., FMOWASD, NACA), CSOs, development partners, the National Human Rights Commission, community and religious leaders, media, private sector actors, and international organizations (UN agencies). Funding and

resource mobilization for GBV and HIV interventions are highlighted, along with the need for monitoring and evaluation systems that incorporate sex-, age-, and key population–disaggregated data.

Recommendations include developing a compendium of research, disseminating findings, conducting operations research, strengthening M&E systems, providing sensitivity training, enhancing community engagement, fostering partnerships, and implementing public awareness campaigns to improve policy implementation and service delivery.

### **Review of Consolidated Service Delivery Guidelines on HIV and STIs for Key Populations in Nigeria 2021**

The document integrates gender and human rights (GHR) considerations throughout Nigeria’s HIV guidelines rather than presenting a standalone framework. Core strategies emphasize protecting the rights of key populations, ensuring non-discriminatory access to healthcare, promoting health literacy, providing integrated services for comorbidities, and involving peers in service design and feedback.

Key platforms and activities include community paralegal support, legal hotlines, pro bono clinics, alternative dispute resolution, strategic litigation, crisis response systems, safe spaces,

and rapid reporting mechanisms. Planned GHR activities focus on addressing gender-based violence (GBV), providing legal and human rights services, preventing and redressing violence, and reforming discriminatory laws, alongside training health workers and law enforcement on rights-based care. The guidelines emphasizes accountability through monitoring indicators, budget tracking, and community participation.

Stakeholders include government ministries, public and private healthcare providers, civil society, technical specialists, academic institutions, and professional associations. While gaps exist—such as legal/policy barriers, stigma, violence, inadequate community empowerment, and fragmented service delivery—sex-, age-, and key population–disaggregated data is emphasized for monitoring.

Recommendations for strengthening integration include linking HIV services with TB, viral hepatitis, maternal and child health, sexual and reproductive health, and drug dependence treatment; providing co-located services; enhancing **program** collaboration; mobilizing resources; training and supervising health workers; ensuring proper supply management; and establishing robust monitoring and evaluation systems.

## Review of National Guidelines of HIV Prevention, Treatment and Care: National AIDS, STIs and Viral Hepatitis Control

The 2024 National Guidelines for HIV Prevention, Treatment, and Care in Nigeria align with the UN Universal Declaration on Human Rights, emphasizing access to quality healthcare as a fundamental right. Gender and human rights considerations are integrated throughout HIV strategies, including the prevention, identification, and response to gender-based violence (GBV) in healthcare settings, with health workers playing a central role in implementing gender-transformative approaches.

Key platforms include engaging communities and non-formal health actors, implementing differentiated service delivery (DSD) models, preventing and responding to GBV, and providing a comprehensive HIV prevention and care package. Strategies focus on tailored interventions for adolescent girls and young women (AGYW), integration of mental health and GBV services, addressing stigma, discrimination, legal and human rights violations, and using client-centred DSD models responsive to vulnerable populations.

Core principles emphasize human rights, equity, and gender responsiveness, including support

for PMTCT, integration of GBV, mental health, and sexual/reproductive health services, and empowering women and key populations. Key stakeholders include government health agencies, civil society, implementing partners, donors, healthcare providers, community organizations, and people living with HIV, collectively ensuring inclusive and equitable HIV service delivery (See Appendix 6).

### Summary of Objective 6: Integration of Gender and Human Rights (GHR) into Nigeria's HIV Response

*The evaluation shows that gender and human rights are firmly recognized in national HIV policies, including NSF III, the National Gender Policy on HIV, and the HIV and AIDS Anti-Discrimination Act (2014), but implementation remains uneven across States. Some States, such as Ogun, Akwa-Ibom, and Nasarawa, have functional Gender and Human Rights Desks, hotlines, and community paralegal structures that support stigma, discrimination, and GBV case management. However, integration is largely project-based, underfunded, poorly documented, and dependent on political will, donor support, and individual champions, and weak inter-agency coordination. Overall, GHR has shifted from a peripheral concern to a core policy principle in Nigeria's HIV response, but consistent operationalization at the State and community levels remains constrained by funding gaps, capacity limitations, and fragile accountability systems. In*

*summary, Nigeria's policies on Gender and Human Rights (GHR) mainstreaming in the HIV response remain largely gender-neutral rather than gender-transformative.*

### **6.2.8 Objective 7: Evaluate Gender & Human Rights Coordination Platforms in HIV Programs**

Evaluation findings indicate that Gender and Human Rights (GHR) multi-sectoral coordination within Nigeria's HIV response is foundational to the integration of the health, legal, and social protection frameworks and systems. These frameworks and mechanisms are articulated via Nigeria's national institutional response to HIV at different administrative levels (national, state, and community) and in Nigeria's response to inequitable distribution of HIV services. This human rights coordination seems to be embedded in the socio-institutional HIV response. There are, however, differing gaps and levels of functional operationalization, which appear to be driven by agency, funding, leadership, and collaboration along and within the inter-agency continuum.

From the Quantitative Data, almost all respondents (92.9%) reported being aware of a group or platform working on gender equality and human rights within their communities. Among them, 87.3% identified NEPWHAN,

while 72.2% mentioned the State Response Team as the main platforms supporting gender and human rights issues among PLHIV and key populations. Almost one-quarter (23.4%) mentioned iMonitor as a platform in this category. About 11.4% of all respondents mentioned other groups or platforms, such as CBOs, ASHWAN, Key Population core group, Key Population secretariat, and the Human Rights Commission, as platforms promoting their rights. Almost all respondents (98.8%) agreed that these groups advocate HIV/AIDS prevention and gender equality, while only 1.2% stated otherwise.



**Table 14: Groups or Platforms promoting Gender and Human Rights**

<b>Characteristics (n = 187)</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Awareness of any groups or platforms working on Gender equality and Human Rights in your community</b>		
Yes	13	92.9
No	1	7.1
<b>State response team</b>		
Yes	114	72.2
No	44	27.9
<b>iMonitor</b>		
Yes	37	23.4
No	121	76.6
<b>Others</b>		
Yes	18	11.4
No	140	88.6
<b>Groups advocating for HIV/AIDS prevention and gender equality</b>		
Yes	165	98.8
No	2	1.2

**Table 14: Platforms on gender and Human Right issues**

<b>Characteristics (n = 187)</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Frequency of engagement between these platforms and people living with HIV (PLHIV) in decision-making about services</b>		
Never	4	2.4
Sometimes	50	29.4
Often	64	37.7
Always	52	30.5
<b>Platforms promoting awareness of Gender and Human rights violations among your community</b>		
Yes	165	97.6

No	4	2.4
<b>Platform promoting knowledge of services for Gender and Human Rights</b>		
Yes	166	97.1
No	5	2.9

A comprehensive dive into levels of coordination is highlighted below;

#### 6.2.8.1 National Level

##### Coordination and Functional Institutional Arrangements

At the Federal Level, coordination is driven by the Federal Ministry of Health and Social Welfare, NACA, NASCP, Federal Ministry of Women Affairs (FMWA), and the National Human Rights Commission (NHRC), along with WHO and civil society networks NEPWHAN, ASHWAN, and Heartland Alliance as development partners.

NACA exemplifies inter-ministerial coordination by taking the lead on the National GHR Technical Working Group (TWG) while NASCP includes gender and rights principles in program frameworks, guidelines, and training materials for service providers. Justice and protection functions are anchored by the NHRC, FMWA, the Ministry of Justice, and the Nigeria Police Force. They operate complaints desks and toll-free hotlines (e.g., 6222) for survivors of stigma, discrimination, and GBV and redress.

These national mechanisms have sparked a clear and unified vision on the integration of gender

and human rights in the HIV response. Federal-level respondents noted that coordination among these institutions resulted in active information flow, survivor referrals, and collaborative monitoring of discrimination cases at the state level. National stakeholders further shared that a level of coordination ambiguity persists, specifically in the form of overlapping mandates, disparate reporting frameworks, and funding gaps, which hinder the consistency of certain operational functions and the application of best practices on a larger scale to lower levels of governance. Findings are consistent with a desk review that captured NACA, NHRC, Ministry of Women Affairs and Social Development (MWASD) as the national coordination platform.

#### 6.2.8.2 State-Level Coordination and Implementation

At the subnational level, the investigation noted considerable developments in states where the federal directives have been transformed into functioning multisectoral coordination. Nasarawa, Ogun, and Akwa Ibom states were frequently mentioned as exemplary in collaborative inter-agency partnerships. In these

cases, coordination mechanisms, often titled Gender and Human Rights Teams or State TWGs on Gender and Human Rights, assemble members from MoWA, MoJ, SACAs, NHRC, law enforcement, and civil society organizations.

Members of these teams have been described as performing their work with “unity of purpose” and meeting quarterly to conduct collaborative reviews of cases and track referrals for survivors of GBV, discrimination, or rights breaches to guarantee comprehensive coverage of the different and immediate needs of the survivors. An Akwa-Ibom respondent described achieving this synergy: **“When justice, health, and women's affairs sit at the same table, survivors get quicker help.”** In Nasarawa, coordination of efforts between SACA, NHRC, and FIDA was described as instrumental in expediting the legal redress of women and other key populations with stigma and discrimination at the workplace. Similarly, the GHR platform in Ogun enhances coordination for case management through the Ibisadi hotline, which connects survivors to healthcare, police, and psychosocial support services. This initiative has been instrumental in ensuring case closure and comprehensive follow-up.

On the other hand, states that are not involved in cooperative relations suffer from uncoordinated service delivery, confusion in the

resolution of cases, and fragmentation of referrals. Some respondents described the delivery system from health agencies, justice actors, and social services as “parallel systems” which respond to the needs of the survivors independently, and they remain *“trapped in a cycle of silence and stigma.”* Uncoordinated systems result in incomplete case documentation and weak accountability. Coordination is weak foremost because of the lack of unified standards in the protocols and systems for referrals, and an integrated system for data capture.

#### 6.2.8.3 National-State linkages and vertical coordination

This study seeks to define and identify the various aspects of the value of new linkages for the study of vertical coordination of national oversight bodies with State teams. NACA and NASCP offer guidance and capacity building to SACAs, SASCPs, and Gender Focal Desks as they adjust to the national frameworks. State-level cases are submitted for federal review through the NHRC’s national complaints desk, which helps manage the consistency of human-rights violations cases across various jurisdictions.

Limited but significant gaps remain to be closed. Federal respondents cited the irregular, anecdotal, and qualitative nature of State reporting, which impedes systematic

comparative reporting and analytical decision-making, as well as evidence-based planning. Project cycles for donor-funded coordination in some states tend to create dependency, resulting in erratic activity levels. This is a general indicator that multi-tiered coordination systems are not sustainable, primarily in the absence of dedicated government subventions.

#### 6.2.8.3 Integration of Development Partners and Civil Society

As with the civil society organizations (CSOs), developmental partners, including the WHO, UNAIDS and the UNDP, have an equally important role to play within coordinated platforms. For instance, the WHO provides technical support to SASCP and SACAs on the inclusion of gender and rights indicators within the national frameworks on M&E. At the same time, the CSOs, particularly Heartland Alliance and NEPWHAN, perform the community interface function by feeding community-level stigmatization, GBV, and other service gap data into the policy conversations. At the national level, they interface with the TWG through the coalitions, where they attend policy consultations to ensure the community voices and those of the key populations are heard during the planning and programme review cycles.

Respondents from NEPWHAN and ASHWAN

reaffirmed that through the coordination, community voices have been integrated into federal discussions, expanding the conversation to include gender, equity, and human rights. At the same time, they recognized the challenges that remain, particularly the limited national-level representation for adolescents, IDPs, and key populations, where participation is through umbrella networks and therefore not direct.

#### 6.2.8.4 Coordination Outcomes and Challenges

At the national and state level, the coordination platforms have been able to achieve the following positive outcomes:

1. GBV and discrimination cases are resolved faster.
2. Health, justice and psychosocial services now have strengthened referral systems.
3. Improved understanding among medical professionals, police officers, and community leaders on survivor-centric response.
4. Improved policy consistency through ongoing communication between MoWA, MoJ, NHRC, and SACAs.

At the same time, some structural challenges were identified. For instance, some coordination mechanisms lack permanent secretariats or data management systems to track cases. Most reporting remains manual, and the use of digital databases for real-time information sharing is nearly absent.

Additionally, the level of institutionalization of coordination efforts varies significantly. For example, some states have formal terms of reference with defined reporting channels to NACA, while others rely on informal networks and individual goodwill.

#### 6.2.8.5 National Perspective on Coordination Efficiency

From the national level, respondents noted that multi-sectoral coordination goes beyond just a procedural step, but is an issue of justice, equity, and accountability in the HIV response. The collaboration of NACA, NASCP, NHRC, and MoWA has built a base for collaboration, but the real challenge is to guarantee continuous alignment and data exchange at the state level. Federal level respondents noted that while collaboration frameworks exist, “coordination still depends on personalities rather than systems.” This suggests a desire for greater institutionalization and more proactive governance of cross-agency collaboration.

The assessment captures the various elements of the landscape of GHR coordination within the Nigeria HIV response as dynamic, although rather irregular. On the national scene, the collaboration of the principal ministries, agencies, and CSOs has built stronger oversight, policy coherence, and enforcement of rights at the coordination level. At the state level, effective collaboration, where it exists,

translates these gains into concrete

advancements in the protection of survivors, reduction of stigma, and accessibility of justice. However, where such collaboration is thin or irregular, rights abuses are perpetuated and unaddressed, deepening the gaps between policy intention and lived reality.

#### ***Summary of Objective 7: Gender & Human Rights Coordination Platforms in HIV Programs***

*Gender and Human Rights (GHR) coordination platforms are well established within Nigeria’s HIV response, linking health, justice, and social protection systems across national, state, and community levels. Quantitative findings show high community awareness (92.9%) of GHR platforms, with NEPWHAN (87.3%) and State Response Teams (72.2%) identified as the main actors, and 98.8% of respondents affirming their advocacy role in HIV prevention and gender equality. Effective coordination at national and select state levels (e.g., Nasarawa, Ogun, Akwa Ibom) has improved referrals, faster resolution of GBV and discrimination cases, and stronger survivor-centered responses. However, coordination remains largely donor dependent due to funding gaps, overlapping functions, and reliance on individual leadership, limiting sustainability and consistent impact across all states.*

## 7.0 CONCLUSION

This evaluation shows that Nigeria has made significant progress in integrating gender and human rights considerations into its national HIV response. The country has built a solid policy foundation, expanded access to HIV services across diverse populations, and introduced differentiated service-delivery models that have reduced many longstanding barriers to care. Community-led initiatives, peer networks, and targeted interventions for women, men, and key populations have also helped raise awareness, improve engagement, and reduce overt stigma in many states.

However, the evidence also shows that significant gaps still exist. Gender inequalities, harmful social norms, and systemic human rights violations continue to influence vulnerability, access, and treatment outcomes. Women face ongoing limitations related to violence, relationship power dynamics, and economic dependence. Men continue to underuse testing and treatment services due to deep-seated masculinity norms and fears of stigma. Key populations, especially MSM, transgender persons, sex workers, and people who inject drugs, experience the harshest forms of discrimination, police harassment, and social exclusion. These violations not only discourage

health-seeking behavior but also hinder Nigeria's progress toward epidemic control.

The evaluation further reveals that, while national policies demonstrate strong commitments to gender and human rights integration, their implementation varies across states. Many state-level structures lack the funding, capacity, and coordination needed to carry out these policies effectively. TWGs, when functioning, demonstrate the potential for coordinated, rights-based HIV programs, but many states still operate without regular meetings, clear reporting, or inclusive membership. The gap between policy intent and actual practice underscores the need for stronger accountability, better capacity-building, and dedicated budget lines for gender and human rights interventions.

Triangulated findings show that Nigeria's HIV response is shifting from gender-blind to gender-sensitive programming, with some areas implementing gender-transformative practices. To accelerate progress, interventions need to challenge harmful norms, expand legal protections, strengthen institutional frameworks, and address structural barriers such as poverty, transportation costs, and weak justice systems. Achieving sustainable impact requires moving from isolated efforts to systemic integration of gender and human rights throughout all levels of planning, budgeting, service delivery, and monitoring.

In conclusion, Nigeria faces a pivotal moment. The groundwork for a gender-responsive, rights-based HIV response is established, but more structural reforms and focused investments are necessary to guarantee equitable access and protection for all groups. Following the recommendations from this evaluation will help NACA, state agencies, implementing partners, and community actors promote a fair, inclusive, and effective HIV response, one that can control the epidemic and uphold the dignity and rights of everyone affected by HIV.

## 7.1 POLICY IMPLICATIONS

### 1. Enhance Localization of Gender-Sensitive and Rights-Based HIV Policies

Though Nigeria has Progressive laws like the HIV and AIDS Anti-Discrimination Act (2014), and the VAPP Law, the study indicates a lack of complete implementation at the state level. The VAPP Act has been domesticated in 32 states + FCT, while the HIV anti-stigma law has been domesticated in only 19 states. The level of awareness of the HIV anti-stigma Act and the VAPP Act is low; implementation of both laws is inadequate. This necessitates locally adapting the HIV anti-stigma act in the remaining 18 states and aggressively popularizing both Acts at the state level, including the translation of these Acts into local and sign languages that educate on the rights of PLHIV at the grassroots level.

### Policy Recommendation:

- The remaining 18 states should advocate to their state governors for the HIV Anti-Stigma Act domestication.
- Partner with relevant stakeholders to ensure popularization of the HIV Anti-Stigma Act and the VAPP Act across the country
- Strengthen the capacity of healthcare workers to deliver stigma-free HIV services at the national and state levels.
- Independent gender audits should be conducted for state HIV programmes, assessing inclusivity, quality of services, policy adherence, and resource fairness. Findings should feed into state and national planning cycles.
- NACA should institutionalize Gender and Human Rights Learning Summits into a routine event, such as WORLD AIDS day to facilitate cross-state learning, disseminate innovations, and strengthen peer review.

### 2. Strengthen Community-Led Decision-Making Mechanisms

As noted, people living with HIV (men and women), and other key populations participate in planning, implementation, and policy formulation. However, for sustained impact,

participation of PLHIV and key population need to extend beyond mere token consultations to strategic engagement for decision making.

**Policy recommendation:**

NEPWHAN, ASHWAN, APYIN, and key population networks should be strengthened to hold government and service providers accountable throughout policy formulation, planning, and implementation processes at all levels. In addition, targeted leadership development programmes should be designed to build NEPWHAN, ASHWAN, APYIN, and key population networks' capacities in advocacy, planning, budgeting, resource mobilization, monitoring, and community mobilization, enabling more effective and sustained engagement.

**3. Increase Investment in Gender and Human Rights Compliance Infrastructure**

The Gender and Human Rights Response Team has been established in 36 states and the FCT, but its effectiveness is limited. MDAs within the Gender and Human Rights Response Team are often not provided with the budgetary means and releases to effectively coordinate and report on cases of Gender-Based Violence and discrimination. This finding was also reflected in the desk review, which identified inadequate budgeting for gender and human rights as a significant barrier to addressing gender-based

violence and discrimination. Limited resources hinder their ability to engage legal practitioners and human rights activists, as well as to provide shelter and protection for PLHIV and key populations (KPs) who are in dire need or fleeing from serious harm.

**Policy recommendation:**

There is a need for a dedicated budget line for Gender and Human Rights in all MDAs that make up the response team. This will align with the country's effort to sustain HIV gender and human rights response.

**4. Integration of Gender and Human Rights across Health, Justice, and Social Welfare**

GBV is an essential component of health, justice, and social welfare services. However, policies and guidelines for Gender and Human Rights for health, justice, and social welfare are currently running in parallel based on the mandate setting up the relevant MDAs. This should not be the case because of the intersection of GBV with health, justice, and social welfare.

**Policy recommendation:** There is a need for members of GBV response team to identify components of their mandates that can be leveraged for better alignment and integration. Aligning GBV Strategy, policies and guidelines for health, Justice and social welfare MDAs will ensure collaboration and sustainability of the response. etc.

## 5. Mainstream Engagement with Traditional and Religious leaders into Policy Design

HIV service uptake is still significantly impacted by religious and cultural norms, particularly stigma, male gatekeeping, and socio-religious structures. Although there has been some improvement, with more women now seeking healthcare without requiring approval from men, certain harmful cultural practices persist. Traditional and Religious leaders wield significant influence within communities and without engaging them, harmful socio-cultural norms that hinders the uptake of HIV services cannot be effectively addressed.

**Policy Recommendation:** NACA and SACAs should strengthen engagement frameworks for faith-based and traditional leaders to address stigma, inequities, and harmful social norms that discourage testing, disclosure, and treatment adherence.

This will create, and make available, structured conversation and sermons for cultural reorientation toward greater acceptance of gender equity, and advocacy for the elimination of HIV stigma and all forms of inequalities.

## 6. Address Economic and Structural Barriers to Service Access

Rural women and youth continue to face substantial disincentives to health -seeking behavior and service adherence, including out-of-pocket payments, transportation costs, and lost income. One of the major barriers to accessing HIV services was the long distance to health facilities and the high cost of transportation. In addition, respondents reported challenges such as the need to pay out-of-pocket for certain services, as well as frequent stock-outs of lubricants and condoms. The unavailability of these essential items further strains their already limited financial resources, negatively affecting their adherence to safe sex practices, medication, and follow-up appointments.

**Policy Recommendation:** Integrate Social Protection and Livelihood Support Schemes with HIV and GBV response such as conditional transport allowance, vocational training for women living with HIV, Access to education through scholarship scheme and economic recovery packages for survivors of violence.

Furthermore, mobile ART refill services and differentiated ART models should be scaled up to reduce distance, travel time, and loss-to-follow-up, particularly in hard-to-reach Communities.

Also, strengthen the logistics system to ensure the availability of commodities at the health facilities to reduce out-of-pocket expenses.

## 7. Strengthening Targeted Programming for all groups

The findings indicate that HIV programming remains largely gender neutral rather than gender transformative. Although HIV services are targeted at key populations (FSW, MSM, PWID, TG), significant gaps persist in addressing the specific needs of men, women and young people. This has constrained the ability to effectively identify and address the barriers limiting access to HIV services for men, women and young people

**Policy recommendation:** Redesign the HIV programme to address the specific needs of men, women, young people and key population etc. Additionally, Gender-transformative modules and male-engagement curricula should be integrated into community HIV and GBV programmes, targeting young men, community leaders, and high-risk male groups.

## 8. Prioritize public enlightenment and HIV Prevention Messages

Public enlightenment on HIV/AIDS has declined over the years, resulting in reduced levels of accurate knowledge about HIV. Consequently, many young people hold persistent misconceptions about HIV, which continue to drive risky behaviors.

**Policy Recommendation:** Social and mass media, including state-level initiatives such as

*Awilele* in Oyo, should be expanded to sustain public dialogue on stigma reduction, gender equality, and rights literacy. Additionally, partnerships with the government information agency, the News Agency of Nigeria, the National Orientation Agency etc.

## 9. Reinforce Political Commitment and Leadership Accountability

The qualitative evidence points to gaps in political will to allocate adequate resources for Gender and Human Rights implementation,

**Policy Recommendation:** Advocate to the government on the impact of Gender and human rights on development and the gaps created due to dwindling donor funds for Gender and human rights.

## 10. Increase male involvement in HIV services

Although men's involvement has improved over the years. There is a disparity in the ratio of male to female involvement in HIV services, including men living with HIV.

**Policy Recommendation:** At the state and local levels, religious leaders and opinion leaders should continue to be actively engaged on the importance of male involvement in the uptake of HIV services.

Media campaigns targeting men should be made a priority by NACA and SACA

## 7.2 Policy Recommendation And Implementation Roadmap

Recommendation	Responsible Entity	Timeline
The remaining 18 states should advocate to their state governors for HIV Anti-Stigma Act domestication.	SACA (SGHR response team)	2026
Partner with relevant stakeholders to ensure popularization of HIV Anti-Stigma Act and the VAPP Act across the country.	SACA	2026
Strengthen the capacity of healthcare workers to deliver stigma-free HIV services at the national and state levels.	SACA (NACA Zonal Office)	2026
state Gender and Human Rights Compliance Index assesses the domestication and enforcement of legal tools, and enforcement and budget allocation across states.		2026
Independent gender audits should be conducted for state HIV programmes, assessing inclusivity, quality of services, policy adherence, and resource fairness. Findings should feed into state and national planning cycles.	SACA (State GHR Response Team)	2026
NACA should institutionalize Gender and Human Rights Learning Summits into routine events such as WORLD AIDS day to facilitate cross-state learning, disseminate innovations, and strengthen peer review	NACA (SACAs in 36+1 states)	2026
NEPWHAN, ASHWAN, AYPIN, and key population networks should be strengthened to hold government and service providers accountable throughout policy formulation, planning, and implementation processes at all levels. In addition, targeted leadership development programmes should be designed to build their capacities in advocacy, planning, budgeting, resource mobilization, monitoring, and community mobilization, enabling more effective and sustained engagement.	NACA (SACA)	2026
Dedicated budget line for Gender and Human rights in all MDAs that make up the response team	NACA (SACA, GHR State Response Team)	2026
There is a need for members of the GHR response team to identify components of their mandates that can be leveraged for better alignment and integration.	SACA	2026

<p>NACA and SACAs should strengthen engagement frameworks for faith-based and traditional leaders to address stigma, inequities, and harmful social norms that discourage testing, disclosure, and treatment adherence.</p> <p>This will create, and make available, structured conversation and sermons for cultural reorientation toward greater acceptance of gender equity, and advocacy for the elimination of HIV stigma and all forms of inequalities,</p>	NACA (SACA)	2026
<p>Integrate Social Protection and Livelihood Support Schemes with HIV and GBV response such as conditional transport allowance, vocational training for women living with HIV, Access to education through scholarship scheme and economic recovery packages for survivors of violence.</p> <p>Furthermore, mobile ART refill services and differentiated ART models should be scaled up to reduce distance, travel time, and loss-to-follow-up, particularly in hard-to-reach communities.</p> <p>Also strengthen logistics system to ensure availability of commodities at the health facilities to reduce out of pocket expenses</p>	NACA (NEMA, Ministry of Humanitarian Affairs, FMOH, SACA, SMOH)	2026
<p>Redesign HIV programme to address the specific needs of men, women, young people and key population etc.</p> <p>Gender-transformative modules and male-engagement curricula should be integrated into community HIV and GBV programmes, targeting young men, community leaders, and high-risk male groups.</p>	NACA	2026
<p>Mass media and radio programmes, including state-level initiatives such as <i>Awilele</i> in Oyo, should be expanded to sustain public dialogue on stigma reduction, gender equality, and rights literacy.</p>	NACA (NOA, Federal Ministry of Information, SACA, State Ministries of Information)	2026
<p>Advocate to the government on the impact of Gender and Human Rights on development and gaps created due to dwindling donor funds for Gender and human right.</p>	NACA (FMOJ, Legal AID, NHRC, SACA, SmoJ, etc)	2026
<p>At the state and local levels, Religious leaders and opinion leaders should continue to be actively engaged on the importance of male involvement in the uptake of HIV services.</p> <p>Media/ social media campaigns targeting men should be made a priority by NACA and SACA</p>	NACA (SACA)	2026

## 8.0 GENDER EQUALITY CONTINUUM FRAMEWORK (GECF) ANALYSIS OF EVALUATION RESULTS

The GECF analysis shows that Nigeria's HIV response has elements across the continuum, with most interventions classified as gender-accommodating. Programmes acknowledge gender differences and attempt to address them but seldom challenge the underlying power imbalances and social norms that create inequality. Gender-blind practices persist in settings where policies exist, but frontline implementation is weak. These include breaches of confidentiality, lack of survivor-friendly services, and provider behaviors that reflect stigma or judgment.

Some gender-transformative practices exist in pockets, particularly in peer-led KP services, survivor referral networks, community treatment groups, and male-champion initiatives. These interventions demonstrate potential to shift harmful norms and increase accountability, but they require greater investment and institutional support. Women face structural barriers such as violence, limited decision-making power, and economic constraints. Men face behavioural barriers related to masculinity norms. KPs face legal, social, and institutional barriers that fundamentally undermine their rights and safety.

Achieving a fully gender-transformative response will require deliberate efforts to address discriminatory norms, strengthen accountability, expand access to justice, and invest in rights-based, inclusive programming.

The framework classifies interventions along a continuum starting from Gender-Exploitative to Gender-Transformative, depending on how they address, reinforce, or alter gender and power relations. The analysis is based on the qualitative evidence from the Key Informant Interviews (KIIs) and the Focus Group Discussions (FGDs).



Objective	Continuum Category	Evidence from Evaluation Results	Transformative Indicators / Signals of Progress
1. Evaluate access to HIV prevention, treatment, care, and support	Gender-Accommodating → Emerging Transformative	The delivery of ART through community-based shorter surgical (OSS) services and peer-led testing initiatives has helped women and other vulnerable groups access services and benefit from confidential protection structures. However, inequalities still exist stock-outs, transportation costs, and geographical obstacles continue to limit access, and community members are still required to pay for viral load tests that should be free. <b><i>“People living with HIV are no longer dying in silence, but we still travel long distances and pay for viral load tests that should be free.”</i></b>	Focused on transformative access, programs that include male participation and peer-led service models suggest possible changes in power dynamics. Once these models are institutionalized with equitable funding and gender-responsive budgets, transformative access approaches can effectively alter access power relations.
2. Evaluate changes in societal norms, behaviours, and gender roles driving HIV transmission	Mixed Exploitative → Emerging Transformative Spectrum: Pockets	In Niger, Oyo, and Delta, early marriage, widow inheritance, and spousal consent practices remain harmful and widespread. Women’s independence is still limited by religious restrictions. However, initiatives from faith-based organizations and male champion programs are beginning to change these attitudes. <b><i>“Our imams now tell men to</i></b>	Increases in the participation of religious and customary leaders in conversations around HIV, women's organizations publicly addressing HIV, and the changing attitudes regarding male responsibility all indicate the shifting of norms.

<i>support their wives to test. That's progress we couldn't imagine years ago."</i>				
3.	Determine participation of target groups in HIV-related decision-making	Predominantly Gender-Accommodating	During the implementation stage, participation from PLHIV, ASHWAN, and Key Population Networks is limited. The policy-making process is mostly one-sided. <b><i>"Most decisions come from the top and filter down to us. We're consulted only during implementation."</i></b>	Participatory governance refers to community visibility through innovations at the community level, such as the Community Rights Advocates (CRAs), and at the state level through the GHR Technical Working Groups (TWGs).
4.	Identify contextual factors influencing HIV services, response, and PLHIV involvement	Gender-Exploitative (contextually) with Accommodating Reforms	Structural barriers like poverty, transportation costs, weak law enforcement, and restrictive gender and religious norms disproportionately exclude women and other key populations. <b><i>"During Ramadan, most men stop their wives from coming for ART appointments—they see it as breaking the fast."</i></b>	Context-sensitive reforms, such as faith-based advocacy, community outreach, and the economic empowerment of women, are still showing incremental efforts that have not yet dismantled structural inequalities.
5.	Measure cases of GBV and human rights violations among population groups	Gender-Exploitative → Accommodating	Women face domestic violence and abandonment after revealing their situations; marginalized groups suffer police harassment and extortion. "When I disclosed my status to my husband, he locked me out and told the whole neighborhood that I was	Initiatives such as the NHRC–FIDA legal linkages, GBV response teams, and peer paralegal networks are promoting organizational responsibility and adopting survivor-centered approaches.

			cursed.” <i>“Even when we are just doing outreach, police use the same-sex laws to arrest us.”</i>	
6.	Analyze integration of gender and human rights into HIV guidelines, policies, and programs	Gender-Accommodating → Partially Transformative	In implementing GHR desks and task teams in Ogun, Akwa Ibom, and Nasarawa, referral hotlines and paralegal support have been established. However, documentation remains weak, as do funding gaps and inter-ministerial silos. <i>“The framework is there, but without funds, it’s just paper.” “We know our rights now, but enforcement is another story.”</i>	As evidenced by national coordination, the existence of institutional GHR frameworks, and survivor-focused reporting channels, policy practice is gradually, albeit unevenly, changing.
7.	Evaluate gender and human rights coordination platforms in HIV programs	Gender-Accommodating → Transformative	NACA, NASCP, NHRC, and FMWA have led the national coordination. State-level GHR Teams are operating in Nasarawa, Ogun, and Akwa Ibom. Integrated joint reviews and multi-sectoral meetings improve case referrals and accountability. <i>“When justice, health, and women's affairs sit at the same table, survivors get quicker help.”</i>	Multi-sectoral platforms denote institutional cross-sector collaboration, embedding quicker redress, integrated referrals, survivor representation, restorative governance, and transformative governance.

### Summary of GECF Positioning Across Objectives

Continuum Category	Definition	Objectives Falling Within Category	Key Patterns Observed
Gender-Exploitative	Reinforces or exploits existing inequalities.	Objectives 2 (in part), 4, 5	Ongoing harm to women and key populations comes from patriarchal practices, economic exclusion, and institutional stigma.
Gender-Accommodating	Recognizes gender differences without altering systemic inequities.	Objectives 1, 3, 5, 6, 7 (in part)	Programs address gaps in inequality. Like peer models, gender desks, and GBV teams, these programs still operate within a hierarchical or donor-dependent framework.
Gender-Transformative	Challenges and changes in power relations to advance equality.	Objectives 1 (emerging), 2 (pockets), 6 (partial), 7 (substantive)	Multi-sectoral coordination, policy harmonization, and norm shifts across faith-based organizations help redefine agency and accountability for women, people living with HIV, and key populations.

## 9.0 ANALYTICAL SUMMARY

While addressing the seven objectives, Nigeria's HIV response has started shifting from gender-accommodating to more transformative programming, especially in areas like integration, coordination, community participation, and justice mechanisms. However, contextual inequities, structural violence, and patriarchal systems still tie parts of the response to exploitative and accommodating stages. These continuums in the response reveal uneven progress, and although the integration of gender and human rights has temporarily become institutionalized, more systemic transformation remains necessary.

## 10.0 BIBLOGRAPHY

1. **WHO.** Gender and health. World Health Organization; 2019.
2. **UNAIDS.** Global AIDS Update 2021: Confronting inequalities. 2021.
3. **National Agency for the Control of AIDS (NACA).** Nigeria Prevalence Rate. 2023 Jun.
4. **UNFPA & UNIFEM.** Operational Guide on Gender and HIV/AIDS: A Rights-Based Approach. 2006.
5. **WHO.** Q&A: Gender and health. World Health Organization; 2021 May 24.
6. **United Nations General Assembly.** Universal Declaration of Human Rights. 1948.
7. **Emmanuel F, Ejeckam CC, Green K, et al.** HIV epidemic among key populations in Nigeria: results of the integrated biological and behavioural surveillance survey (IBBSS), 2020–2021. *Sex Transm Infect.* 2025 Feb;101(1):10–6.
8. **NACA.** Nigeria National HIV/AIDS Indicator and Impact Survey (NAIIS) 2018/2019: Preliminary Findings. Abuja, Nigeria; 2018.
9. **NACA.** Nigeria National HIV/AIDS Indicator and Impact Survey (NAIIS) 2018 Technical Report. 2018.
10. **NACA.** Nigeria AIDS Indicator and Impact Survey (NAIIS) Plus II. 2013.
11. **NACA.** Key Population Programme Review Report; June 2024.
12. **National Population Commission (NPC) [Nigeria] and ICF International.** Nigeria Demographic and Health Survey. 2013.
13. **WHO.** Global update on the health sector response to HIV. 2013.
14. **UNAIDS.** The gap report. 2016.
15. **Ayodeji BL, Ade-Ibijola AO.** United Nations Women and Gender Equality in Nigeria. *African Journal of Stability and Development (AJSD).* 2022 Oct 31;14(1 & 2):137–68.
16. **UNAIDS.** Country progress report - Nigeria Global AIDS Monitoring 2023.
17. **UNAIDS.** Country progress report - Nigeria Global AIDS Monitoring 2020.
18. **UNAIDS.** Country progress report - Nigeria Global AIDS Monitoring 2018.
19. **Federal Ministry of Health (NASCP).** HIV Health Sector Annual Report, 2020.
20. **Federal Ministry of Health (NASCP).** HIV Health Sector Annual Report, 2021.
21. **Federal Ministry of Health (NASCP).** HIV Health Sector Annual Report, 2022.
22. **NACA.** Nigeria Multiple Indicator Cluster Survey (MICS) 2016-2017. 2016.
23. **NACA.** Fact Sheet: Women, Girls, Gender Equality and HIV in Nigeria. 2016.

24. **NACA.** National HIV/AIDS Access to Justice Guidelines and Capacity Building Manual. 2020.
25. **NACA.** Legal Environment Assessment Report. 2024.
26. **UNAIDS/UN Women.** Guidelines for Gender Mainstreaming in the National HIV/AIDS Response. 2015.
27. **NACA.** Mapping of Programmes To Reduce Human Rights Barriers to HIV and TB Services in Selected States in Nigeria; Final report. 2021.
28. **UNAIDS/UN Women.** Rapid Appraisal of Gender Management System for National HIV/AIDS Response. 2015.
29. **NACA.** Terms of Reference for the HIV Gender and Human Rights State Response Team. 2023.
30. **NACA.** Removing Legal & Human Rights Barriers to HIV and AIDS (2017-2022). 2017.
31. **NACA.** Gender and Human Rights Working Committee, TOR. 2024.
32. **UNAIDS/UN Women.** Report of the Gender Assessment of the HIV Response in Nigeria. 2022.
33. **UNAIDS.** Nigeria Demographic and Health Survey 2018.
34. **University of Manitoba.** Integrated Biological and Behavioral Surveillance Survey (IBBSS) 2020.
35. **The Global Fund/NEPWHAN.** Stigma Index 2.0 Report. 2020.
36. **Oturu K, O'Brien O, Ozo-Eson PI.** Barriers and enabling structural forces affecting access to antiretroviral therapy in Nigeria. *BMC Public Health.* 2024 Jan 6;24(1):105.
37. **Olawepo JO, O'Brien K, et al.** Retention in Care Among People Living with HIV in Nigeria: A Systematic Review and Meta-analysis. *J Res Health Sci.* 2024 Aug 1;24(3):e00618.
38. **Mugisha EK.** The Impact of Socioeconomic Factors on HIV Prevalence and Treatment Accessibility in Nigeria: A Comprehensive Review. *Newport International Journal of Research in Medical Sciences.* 2024 Sep 3;5(3):46–52.
39. **Adebayo OM.** Case-finding Effectiveness of HIV Partner Notification Service in a High-volume Facility in North-Central Nigeria. *Texila International Journal of Public Health.* 2021 Jun 30;9(2):74–84.
40. **Dauda Shallie P, Haffejee F.** Systematic review and meta-analysis assessing the knowledge and use of the female condom among Nigerians. *Afr Health Sci.* 2021 Sep 27;21(3):1362–74.
41. **Odimegwu CO, Akinyemi JO, Alabi OO.** HIV-Stigma in Nigeria: Review of Research Studies, Policies, and Programmes. *AIDS Res Treat.* 2017;2017:1–13.
42. **Federal Republic of Nigeria.** Official Gazette: Nigeria's HIV and AIDS Anti-discrimination Act, 2014.
43. **Federal Ministry of Health.** Nigeria Demographic and Health Survey 2018.
44. **Azia IN, Nyembezi A, et al.** Understanding the role of religious beliefs in adherence to antiretroviral therapy among Pentecostal Christians living with HIV in sub-Saharan Africa. *BMC Public Health.* 2023 Sep 11;23(1):1768.

## 11.0 APPENDICES

### Appendix 1: Questionnaire on Evaluation of Gender and Human Rights Approach in HIV Programs in Nigeria

#### Dear Participant,

You have been selected for this interview because you play an important role in helping us evaluate the gender and human rights approach in HIV programs in Nigeria. I assure you that none of the information you give to us will be traced back to you. The interview will take about 20 to 25 minutes of your time. Your participation is voluntary, and you can refuse to participate or withdraw your consent at any time during the interview.

Should you have any questions or concerns, kindly contact the Study Co-Investigators...

#### Having explained the purpose of the study, are you willing to participate?

1. Yes
2. No

#### Select State:

1. Adamawa | 2. Akwa-Ibom | 3. Anambra | 4. Delta | 5. Ebonyi | 6. Gombe | 7. Kano | 8. Ogun | 9. Nasarawa | 10. Niger | 11. Sokoto | 12. Oyo

**LGA:** \_\_\_\_\_ **Location:** 1. Urban | 2. Peri-Urban | 3. Rural **Name of support group/OSS/CHSC/Healthcare facility:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Interviewer's name:** \_\_\_\_\_

#### Section 1: Socio-demographic Information

1. **Age as at last birthday:** \_\_\_\_
2. **Gender:** (1) Male (2) Female (3) Others (please specify): \_\_\_\_\_
3. **Marital Status:** (1) Single (2) Married (3) Widowed (4) Divorced/Separated
4. **Highest level of education?** (1) No formal education (2) Qur'anic (3) Primary (4) Secondary (5) Tertiary
5. **Religion:** (1) Christian (2) Islam (3) Traditional (4) Others (please specify) \_\_\_\_\_
6. **Employment status:** (1) Employed (2) Not employed
7. **Focus Population Status:** (1) People Living with HIV (PLHIV) (2) Men who have sex with men (MSM) (3) People who inject drugs (PWID) (4) Female Sex workers (FSW) (5) Male sex

workers (6) Transgender (7) Survivors of GBV (8) Adolescents (9) Others (please specify):  
\_\_\_\_\_

8. **Year of HIV+ diagnosis:** -----  
9. **Are you currently on HIV treatment (ART)?** (1) Yes (2) No

---

**Section 2: Level of Access to and HIV Prevention, Treatment, Care & support services (Objective 1)**

10. **Are you currently accessing HIV prevention, treatment, care & support services?** (1) Yes (2) No
11. **Which of the following HIV treatment, prevention, treatment, care & support services have you accessed? (Select all that apply)** (1) Antiretroviral therapy (ART) for People living with HIV (2) HIV testing and counseling (HTC) services (3) Prevention of mother-to-child transmission (PMTCT) programs (4) Post-exposure prophylaxis (PEP) (5) Pre-exposure prophylaxis (PrEP) (6) Multi-month dispensary (7) Condom and lubricant distribution (8) Treatment of opportunistic infections (OIs) (cotrimazole, isoniazid) (9) Needle and syringe exchange programs (10) Sexual health education (11) Others (please specify) \_\_\_\_\_
12. **Which of the following limit your access to HIV services? (Select all that apply)** (1) Long distance to health facility (2) High cost of transport or services (3) Unfriendly attitudes of healthcare workers (4) Inconvenient opening hours (5) Need for spousal or family permission (6) Stigma or discrimination in the community (7) Fear of confidentiality breaches (8) Other (please specify): \_\_\_\_\_
13. **Was your right respected and protected when accessing HIV services?** (1) Yes (2) No (*If yes Skip Q15*)
14. **If No to 13, indicate areas in which these violations occurred:** (1) When accessing justice and legal services (2) When addressing violence in all cases (including from partners, family, community or state) (3) Unauthorized disclosure of HIV status (4) Stigmatized because of gender identity (TGs) (5) When accessing reproductive health services (7) Stigmatized because of sexual orientation (MSM, FSW) (8) When accessing HIV testing services and counseling
15. **If Yes, who was responsible for violating your human right?**
1. Health workers
  2. Police
  3. Society (Neighbours, family members, co-workers)
  4. Community Groups (PLHIV, KPs)
  5. Others (please specify) \_\_\_\_\_
16. **Which of the following practices have you observed when accessing HIV services? Select all that applies:** (1) Private consultation spaces to ensure confidentiality (2) Separate clinic days or hours for your community (3) Integration of PMTCT services into antenatal and postnatal care. (4) Routine screening for gender-based violence (GBV) during antenatal or HIV care visits. (5) Referral for GBV survivors (6) Extended clinic hours (evenings/weekends) to accommodate men's schedules. (7) Access to contraception and reproductive health services alongside HIV

care for women and girls. (8) Staff provide friendly services. (10) Other (please specify):

- \_\_\_\_\_
17. **Are you volunteering in any HIV program in your community?** (1) Yes (2) No (*if No, proceed to Q20*)
18. **If yes, how long have you been involved in the HIV programme?** \_\_\_\_\_
19. **What is your current role in the HIV programme?** (1) Community monitoring member (2) Case managers (3) Mentors Mothers (4) Community Pharmacists (5) Peer educator (6) Other (please specify) \_\_\_\_\_
20. **Do men participate more than women in the HIV programme in your area?** (1) Yes (2) No (3) Not sure
21. **Do boys participate more than girls in the HIV programme in your area?** (1) Yes (2) No (3) Not sure

---

### Section 3: Influence of Societal Norms and Attitudes (Objective 2)

22. **Over the past years, how would you describe changes in society's attitudes toward gender roles and HIV?** (1) Much better | (2) Slightly better than before | (3) No change | (4) Worse than before | (5) I'm not sure / I don't know
23. **Have you experienced stigma or discrimination in the last 12 months related to HIV?** (1) Yes (2) No
24. **Has anyone you know experienced stigma or discrimination in the last 12 months related to HIV?** (1) Yes (2) No (3) Not Sure
25. **Please indicate your level of agreement with the following statements: (1=Strongly disagree, 2=disagree, 3=neutral, 4=agree, 5=Strongly agree)**

Statement	1	2	3	4	5
1. Women are more at risk of HIV transmission than men					
2. Men are more at risk of HIV than women					
3. It is now more acceptable for women to seek HIV services without male permission					
4. Women need permission from men to seek HIV services					
5. People in this society are less likely now than before to blame PLHIV for their HIV status					
6. People in this society blame PLHIV for their HIV status					
7. Public awareness campaigns in this community have helped reduce stigma against PLHIV					
8. Public awareness campaigns have increased stigma against PLHIV					

Statement

1 2 3 4 5

9. Community members openly discuss HIV and GBV issues more than before

26. **In your opinion, which of these cultural beliefs and behaviors affecting HIV are changing?** (1) Women, girls, FSW, MSM, PWID and TG should be exempted from certain businesses and career; - Is it changing? (2) Men are superior and should make decisions for women – Is this changing? (3) A real man should have more than one sexual partner- is this changing? (4) FSW, MSM, PWID and TGs are misfits in the society and therefore have no rights -is this changing?

---

#### Section 4: Decision-Making Participation (Objective 3)

27. **In the past 12 months, have you participated in any meeting or forum to discuss HIV services in your community?** (1) Yes (2) No
28. **How often is your group represented in decision-making forum regarding HIV programs in your community?** (1) Never | (2) Rarely | (3) Occasionally | (4) Frequently | (5) Always
29. **What mechanism(s) is/ (are) in place for community feedback on HIV services in your area? (Select all that apply)** (1) Regular community meetings/ town hall meetings among ourselves (2) Regular meetings with government stakeholders (3) Regular meetings with IPs (4) Regular meetings with facility service providers/ service delivery points (5) Suggestion boxes at service delivery points (6) Functional Hotline numbers
30. **Do you think that HIV care service providers in your community act based on feedback from any member of your community (PLHIV and KP)?** (1) Yes (2) No
31. **Which of the following groups do you think are more involved in HIV-related decision-making processes? Select all that apply:** (1) Men living with HIV (PLHIV) (2) Women living with HIV (PLHIV) (3) Key population men (e.g., men who have sex with men, male sex workers) (4) Key population women (e.g., female sex workers, transgender women) (5) Boys (6) Girls (7) Other (please specify): \_\_\_\_\_

---

#### Section 6: Gender-Based Violence and Human Rights Violations (Objective 5)

Statement/Question

Yes No

1. Has your partner ever beaten, slapped, kicked or hit you?

2. Has your partner or anyone ever had or attempted to have sex with you forcefully?

- | 32. <b>Have you</b> | Statement/Question   | Yes No |
|---------------------|--|--------|
|                     | 3. Has anyone ever touched you or talked to you in a sexually suggestive manner without you giving them consent?   |        |
|                     | 4. Does your partner insult you, talk down at you or threaten you or your children with physical harm?   |        |
|                     | 5. Have you ever been denied or had your appointment terminated because of your HIV status?  |        |
|                     | 6. Have you ever been denied or had your appointment terminated because you are a key population?  |        |
|                     | 7. Have you ever been denied access to any health services because of your HIV status?   |        |
|                     | 8. Have you ever been denied access to any health services because you are a key population?   |        |
|                     | <b>experienced or witnessed gender-based violence or human rights violations in the last 12 months?(1) Yes (2) No (If No, Skip Q38)</b>  |        |
|                     | <b>33. If yes, please specify type(s) of violence or human rights violation you have experienced in the last 12 months (Select all that apply):</b>  |        |
|                     | <b>34. Who did you report it to? (Choose as many that apply) (1) Health facility (2) Police (3) Community (NEPWHAN, ASWHAN, KP secretariat) (4) Others (specify) _____ (5) Did not report (If 5 was selected Skip to Q37)</b>  |        |
|                     | <b>35. When you reported, were you offered any services? (1) Yes (2) No (If No Skip to Q38)</b>  |        |
|                     | <b>36. Which of the following GBV intervention services did you receive? (Select all that apply.) (1) Health and clinical services (Screening, Emergency contraception, PEP, Referral) (2) Counseling/ Psychosocial support (3) Legal services (4) Shelter and Safety (Safe houses, relocation support) (5) Police services (6) Empowerment (Vocational training, Job placement) (7) Others (Please specify) _____</b> |        |
|                     | <b>37. Were you satisfied with the services provided above? (1) Not sure   (2) Not Satisfied   (3) Satisfied   (4) Very Satisfied</b>  |        |
|                     | <b>38. Has there been any change in GBV incidents in your community in the last 12 months? (1) Yes   (2) No   (3) Not sure</b>   |        |

---

### Section 8: Contribution of Gender Platforms (Objective 7)

- 39. Are you aware of any groups or platforms working on Gender equality and Human Rights in your community? (1) Yes (2) No (If No Skip 45)**

40. **If yes, which of the following types of Gender and Human Rights groups /platforms are present in your community? (Select all that apply)** (1) State response team (2) NEPWHAN (3) iMonitor (4) Other (please specify): \_\_\_\_\_
41. **Do these groups advocate for the HIV/AIDS prevention and gender equality?** (1) Yes (2) No
42. **How frequently do these platforms engage with people living with HIV (PLHIV) in decision-making about services?** (1) Never | (2) Rarely | (3) Sometimes | (4) Often | (5) Always
43. **Are the platforms promoting awareness of Gender and Human rights violations among your community?** (1) Yes (2) No
44. **Is the platform promoting knowledge of services for Gender and Human Rights?** (1) Yes (2) No
45. **How often are community engagement meetings on HIV and GBV held?** (1) Never | (2) Occasionally | (3) Regularly

#### Section 9: Lessons Learned and Recommendations (Objective 8)

46. **In your opinion, do you think HIV program is accessible to all in your community?** (1) Yes (2) No
47. **Which of the following have been achieved in HIV programs in your community? (Select all that apply)** (1) Increased women's access to HIV services (2) Increased men's access to HIV prevention and care (3) Less stigma and discrimination for PLHIV (4) Less stigma and discrimination KPs (MSM, FSW, TG and PWID) (5) Strengthened protection from gender-based violence (6) Other (please specify): \_\_\_\_\_

**Thank you for participating!**

## Appendix 2: IDI and KII Guides for Implementing Partners or Stakeholders

**Title of the Research:** Operations Research on Community-led Monitoring (CLM) and its Effect on National HIV Response.

**Principal Investigator (PI):** Dr. Temitope Ilori

**Institution:** National Agency for the Control of AIDS (NACA)

### Introduction

Thank you for accepting to talk to me today. My name is..... and I am here on behalf of the National Agency for the Control of AIDS (NACA). I would like to invite you to take part in this FGD.

- Before you decide whether to participate, you should understand why the research is being done and what it would involve. Please take the time to listen as I read the following information. You are being invited to participate in a focus group discussion (FGD) as part of the study.
- Your participation in this FGD is completely voluntary and you may choose to end your participation at any time.
- The purpose of this study is to evaluate the gender and human right approach in the HIV Program. It will help to assess policies and programs from a gender perspective and determine the extent to which HIV policies and programs addressed the needs and priorities of all target groups. In summary, this evaluation will measure progress of the HIV response towards gender equality.
- Your participation in this activity will last approximately 30 - 45 minutes.
- You do not have to respond to any question that makes you uncomfortable. You may end your participation in the discussion at any time without any penalty. During the FGD, no personal information will be collected and any information that is collected will be kept confidential. However, we seek your permission to audio record the discussion to ensure accurate data collection. Only researchers will have access to this information and the recordings will be destroyed after the study is completed.
- Please ask me if there is anything that is not clear, or if you would like more clarification.
- At this point, I would like to ask if you are interested in participating in the FGD, and if you agree, please sign this form. You will also be given a signed copy to keep.

---

### Purpose of the Study and Study Requirements

**What is the study?** The study is to evaluate the gender and human right approach in the HIV Program. It will help to assess policies and programs from a gender perspective and determine the extent to which HIV policies and programs addressed the needs and priorities of all target groups. Findings from this assessment will inform strategies to improve HIV service delivery especially putting into context the

gender and human right perspective. To accomplish these goals, this activity will employ a combination of survey and qualitative interviews.

**Why have I been invited to take part?** You have been invited to participate in the study because you are someone who might have important information regarding the context of this study.

**What will happen if I take part?** If you agree to take part in the study, you will take part in an interview, during which we will ask you about your views and knowledge about HIV service delivery and the mainstreaming of gender and human right in HIV service delivery. The discussion will be like a conversation in a manner designed to make you feel comfortable. You will be expected to give your honest opinion or response and participate openly without fear of victimization.

**How long will the interview last?** This will take about 30-45 minutes.

---

## Risks and Benefits

**What are the risks of the study?** A risk of participating in this study may be that a piece of information that you give during the interview will be shared with others. We will take precautions to ensure that this does not happen. We prevent this by not collecting any identifying information from you and we will not share any information you provide with anyone apart from the research team.

**What are the benefits of participating?** There are no direct benefits to you for your participation in the study. The benefit of your participation is that you will give useful information that will help us to better understand how to improve service delivery and client outcomes for end users of HIV services at the facility and community levels. The information obtained will also be used to submit strong recommendations to the government and development partners to better guide program policies.

---

## Confidentiality and Voluntariness

**Will my participation in the study be kept confidential?** Privacy of records will be maintained by making sure that your responses do not have any information that would identify who you are and that nobody would know your responses other than the interviewer.

**What are my rights as a research participant/subject?** Your participation in this study is completely voluntary. If you decide not to participate, you will not lose any existing benefits. If you agree to participate in this study, you may end your participation at any time without penalty and leave. If you decide to take part, you are free to refrain from answering any questions. You are free to withdraw at any time without affecting your relationship with the study team and the organization or individual that recommended you.

## Additional Information

**What will I receive for participating?** Your participation in the study is voluntary. There is no cost for participating in the study and you will not be required to pay any money or anything to participate. No monetary gain will be given for participating in this study.

**What will happen to the results of the research study?** The results of the study will be presented in a report and published in a journal. We will use the findings to help us design programs that would improve service delivery and client outcomes for end users of HIV services at the facility and community levels for PLHIV and KPs.

**Who has reviewed the study for ethical issues?** This study has been reviewed by the National Health Research Ethics Committee (NHREC) of the Federal Ministry of Health.

---

## Contact Information

If you need more information or have a concern, please contact:

<b>Dr. Fatimah Jajere</b>	<b>Obioma Uchendu</b>	<b>Uchenna Idoko</b>
NACA	University of Ibadan	House 2 Adonai Court
No.3 Ziguinchor street, Wuse Zone 4	College of Medicine, Ibadan	Off Freedom Way, Lekki Phase 1
Abuja, Nigeria	Oyo State, Nigeria	Lagos, Nigeria
Tel: +2348035027050	Tel: +2348066717229	Tel: +2348061314466
jajerefatimah@yahoo.com	obioma234@gmail.com	ucheidokoec@yahoo.com

---

**Participant Statement**

I have read and understood the Informed Consent for this FGD. I have received an explanation of the planned research, benefits and privacy of my personal information and all my questions have been answered to my satisfaction. I understand that my participation in this FGD is voluntary and at any stage, I can withdraw my consent and participation. I voluntarily agree to participate in this FGD.

**Your signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

---

**Researcher Statement**

I confirm that I have explained the nature and extent of the planned research, benefits, and confidentiality of personal information.

**Name of person obtaining consent:** \_\_\_\_\_

**Signature of person obtaining consent:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Appendix 3: Informed Consent for Key Informant Interview (KII)

**Title of the Research:** Evaluation of Gender and Human Rights Approach in HIV Programs in Nigeria

**Principal Investigator (PI):** Dr. Temitope Ilori

**Institution:** National Agency for the Control of AIDS (NACA)

### Introduction

Thank you for accepting to talk to me today. My name is..... and I am here on behalf of the National Agency for the Control of AIDS (NACA). I would like to invite you to take part in this Key Informant Interview (KII).

- Before you decide whether to participate, you should understand why the research is being done and what it would involve. Please take the time to listen as I read the following information. You are being invited to participate in a Key Informant Interview (KII) as part of the study.
- Your participation in this KII is completely voluntary and you may choose to end your participation at any time.
- The purpose of this study is to evaluate the gender and human right approach in the HIV Program. It will help to assess policies and programs from a gender perspective and determine the extent to which HIV policies and programs addressed the needs and priorities of all target groups. In summary, this evaluation will measure progress of the HIV response towards gender equality.
- Your participation in this activity will last approximately 30 - 45 minutes.
- You do not have to respond to any question that makes you uncomfortable. You may end your participation in the discussion at any time without any penalty. During the KII, no personal information will be collected and any information that is collected will be kept confidential. However, we seek your permission to audio record the discussion to ensure accurate data collection. Only researchers will have access to this information and the recordings will be destroyed after the study is completed.
- Please ask me if there is anything that is not clear, or if you would like more clarification.
- At this point, I would like to ask if you are interested in participating in the KII, and if you agree, please sign this form. You will also be given a signed copy to keep.

### Purpose of the Study and Study Requirements

**What is the study?** The study is to evaluate the gender and human right approach in the HIV Program. It will help to assess policies and programs from a gender perspective and determine the extent to which HIV policies and programs addressed the needs and priorities of all target groups. Findings from this assessment will inform strategies to improve HIV service delivery especially putting into context the gender and human right perspective. To accomplish these goals, this activity will employ a combination of survey and qualitative interviews.

**Why have I been invited to take part?** You have been invited to participate in the study because you are someone who might have important information regarding the context of this study.

**What will happen if I take part?** If you agree to take part in the study, you will take part in an interview, during which we will ask you about your views and knowledge about HIV service delivery and the mainstreaming of gender and human right in HIV service delivery. The discussion will be like a conversation in a manner designed to make you feel comfortable. You will be expected to give your honest opinion or response and participate openly without fear of victimization.

**How long will the interview last?** This will take about 30-45 minutes.

---

### Risks and Benefits

**What are the risks of the study?** A risk of participating in this study may be that a piece of information that you give during the interview will be shared with others. We will take precautions to ensure that this does not happen. We prevent this by not collecting any identifying information from you and we will not share any information you provide with anyone apart from the research team.

**What are the benefits of participating?** There are no direct benefits to you for your participation in the study. The benefit of your participation is that you will give useful information that will help us to better understand how to improve service delivery and client outcomes for end users of HIV services at the facility and community levels. The information obtained will also be used to submit strong recommendations to the government and development partners to better guide program policies.

---

### Confidentiality and Voluntariness

**Will my participation in the study be kept confidential?** Privacy of records will be maintained by making sure that your responses do not have any information that would identify who you are and that nobody would know your responses other than the interviewer.

**What are my rights as a research participant/subject?** Your participation in this study is completely voluntary. If you decide not to participate, you will not lose any existing benefits. If you agree to participate in this study, you may end your participation at any time without penalty and leave. If you decide to take part, you are free to refrain from answering any questions. You are free to withdraw at any time without affecting your relationship with the study team and, the organization or individual that recommended you.

---

## Additional Information

**What will I receive for participating?** Your participation in the study is voluntary. There is no cost for participating in the study and you will not be required to pay any money or anything to participate. No monetary gain will be given for participating in this study.

**What will happen to the results of the research study?** The results of the study will be presented in a report and published in a journal. We will use the findings to help us design programs that would improve service delivery and client outcomes for end users of HIV services at the facility and community levels for PLHIV and KPs.

**Who has reviewed the study for ethical issues?** This study has been reviewed by the National Health Research Ethics Committee (NHREC) of the Federal Ministry of Health and Social Welfare.

---

## Contact Information

If you have a concern about any aspect of the study, you should ask to speak to the researchers who will do their best to answer your questions. You may contact the following people:

Dr. Fatimah Jajere	Dr. Obioma Uchendu	Uchenna Idoko
National Agency for the Control of AIDS	University of Ibadan	House 2 Adonai Court
No.3 Ziguinchor Street, Wuse Zone 4	College of Medicine, Ibadan	Off Freedom Way, Lekki Phase 1
Abuja, Nigeria	Oyo State, Nigeria	Lagos, Nigeria
Tel: +2348035027050	Tel: +2348066717229	Tel: +2348061314466
jajerefatimah@yahoo.com	obioma234@gmail.com	ucheidokoec@yahoo.com

---

## Statements of Consent

**Participant Statement:** I have read and understood the Informed Consent for this KII. I have received an explanation of the planned research, benefits and privacy of my personal information and all my questions have been answered to my satisfaction. I understand that my participation in this KII is voluntary and at any stage, I can withdraw my consent and participation. I voluntarily agree to participate in this KII.

**Your signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Researcher Statement:** I confirm that I have explained the nature and extent of the planned research, benefits, and confidentiality of personal information.

**Name of person obtaining consent:** \_\_\_\_\_

**Signature of person obtaining consent:** \_\_\_\_\_ **Date:** \_\_\_\_\_

---

## Appendix 4: Key Informant Interview Guide for Stakeholders

### Key Informant Interview (KII) Guide on Evaluation of Gender and Human Rights Approach in HIV Programs in Nigeria

**Dear Participant,** You have been selected to participate in this interview because you play a crucial role in helping us assess the gender and human rights approach in HIV programs in Nigeria. I assure you that none of the information given to us will be used for any purpose other than for this study, and it will not be traced back to you. Your participation will take about 25 to 35 minutes of your time with no harm or risk. Your participation is voluntary, and you can refuse to participate or withdraw your consent at any time during the interview.

Should you have any questions or concerns, kindly contact the Study Co-Investigators...

**Are you willing to participate?** [ ] Yes [ ] No

---

#### Administrative Details

- **Date of interview:** \_\_\_\_\_
- **Start time:** \_\_\_\_\_
- **Gender:** \_\_\_\_\_
- **Age:** \_\_\_\_\_
- **State:** \_\_\_\_\_
- **Organization:** \_\_\_\_\_
- **Position:** \_\_\_\_\_

**Interviewer Note:** If the respondents agree to be audio recorded, start the recorder, and say: *"Respondent has consented to this interview."*

---

#### Section 1: Access, Participation & Societal Norms (Objectives 1 & 2)

1. What societal norms and practices may contribute to increased risk of HIV transmission among KP, IDP, Positive Pregnant Women, PLHIV, AYP?
2. Have you seen shifts/changes in societal norms or stigma affecting HIV uptake?
  - **Probe:** Describe some of the shifts you have seen.
3. What strategies have been most effective in changing societal norms and reducing stigma?
4. How are societal norms and stigma affecting HIV monitored in your organization?
5. What are your perceptions on equitable access to HIV among KP, IDP, Positive Pregnant Women, PLHIV, AYP?
  - **Probe:** What types of services are offered, and what methods were used to assess whether access is equal?

6. What are barriers limiting access to HIV services among KP, IDP, Positive Pregnant Women, PLHIV, AYP?
- 

## Section 2: Decision-Making & Contextual Factors (Objectives 3 & 4)

7. In what ways are KP, IDP, Positive Pregnant Women, PLHIV, AYP engaged in planning, implementation, and evaluation of HIV programs?
  8. What platforms exist for their participation?
  9. How could their involvement be strengthened?
- 

## Section 3: Violence, Human Rights & Program Effectiveness (Objectives 5a & 5b)

10. How have HIV programs addressed gender equality and human rights in your state/organization?
  11. How are GBV and Human Rights violations addressed within HIV programs that you oversee or support?
  12. What mechanisms exist for gender and human rights reporting and monitoring?
  13. What systems/structures are in place to report and respond to GHR violations?
  14. How effective are these systems/structures?
  15. What challenges exist in integrating GHR services into HIV programs?
- 

## Section 4: Policy & Programming (Objectives 6 & 7)

16. How have national/state HIV policies integrated gender perspectives?
  17. Have these policies been implemented effectively?
    - **Probe:** Give examples of implementation strategies your organization has been involved with.
  18. What policy gaps remain?
- 

## Section 5: Lessons & Recommendations (Objective 8)

19. What best practices have emerged from your work?
20. What lessons should guide future HIV programming in Nigeria?
21. What are the recommendations for strengthening gender and human rights in HIV programs?
22. What are the recommendations for ensuring sustainability in gender and human rights in HIV programs?

## Appendix 5: Tables Showing Details of Desk Review for Section A (Objectives 1, 2, 5 and 7)

*Table 6.1.2 Details of desk review to evaluate the current access to HIV prevention, treatment, care & support among the target population in the HIV response over the years (Specific Objective 1)*

S/N	Objectives	Findings	Explanation	Source Number	Document	Remarks
1	Sub-objective 1.1: <i>Assess the provision of services in target groups</i>	-Services include PMTCT, PEP/PrEP, condom use, ART use, viral load testing, differentiated service delivery models, capacity building and training programs for PLHIV and key populations on their rights.		1a -1d, 2a - 2c, 3,6 17,28,29		
		<p><b>PMTCT:</b></p> <p>-In 2013, only 58% of pregnant women received antenatal care and 39% were assisted by skilled birth attendants at delivery with the situation of poor and rural based women being particularly worse than that of women in the urban areas. However, the percent of pregnant women receiving ANC from a skilled provider has increased to 67 and 68% in 2018 and 2023 respectively. Likewise, the percentage whose birth was assisted by a skilled birth attendant delivered by birth has also</p>	<p>-ANC is the entry point into PMTCT</p> <p>-This shows adoption of strategies that have increased access to health facilities for safe delivery, hence reducing the transmission of HIV from mother to child.</p> <p>-PMTCT ARV coverage remains a substantial challenge and the reason for poor indices over the years is essentially due to poor access to HIV services (identification of positive pregnant women, Positive pregnant women on ART and</p>			<p>-Nigeria is intensifying its elimination efforts, driven by the Global Alliance to End AIDS in Children by 2030, which the country adopted in August 2022.</p> <p>Adoption of the National Paediatric Alliance Plan in November 2022 which was built on four core pillars:</p> <ul style="list-style-type: none"> <li>•Early testing, optimized treatment, and high-quality care for infants, children, and adolescents living with or exposed to HIV.</li> <li>•Closing the treatment gap for pregnant and breastfeeding women to eliminate vertical transmission.</li> </ul>

		<p>increased to 43% and 53% in 2018 and 2023 respectively</p> <p>-In 2022, the 2,148,129 pregnant women who enrolled for ANC represented only about 27% of the estimated 8 million annual pregnancies in Nigeria</p> <p>-PMTCT ARV Coverage has remained low and inconsistent, dropping from 45% in 2020 to 32% in 2021, and resting at 34% in 2023</p> <p>- Based on 2023 Spectrum data, out of 7.7 million pregnant women studied, only 36% were reported to have been tested for HIV and received their results (up from 27% in 2022)</p> <p>-Percentage of pregnant and breastfeeding women receiving Antiretrovirals (ARVs) to prevent MTCT has remained low, hovering around 30% between 2020 and 2023.</p> <p>- In the 2021 annual HIV health sector report, 1.8% of previously</p>	<p>viral load suppression), including other safe delivery measures during labour and breastfeeding.</p> <p>-Additionally, identification of number of positive pregnant women is also low due to contextual issues regarding access to ANC (<i>this will be discussed when handling barriers to HIV services</i>)</p> <p>- In order to improve access to HIV services, hence PMTCT coverage, the National AIDS and STIs Control Programme (NASCP) successfully mapped and trained over 40,000 service delivery points (SDPs), including traditional birth attendants (TBAs), birth homes, and health facilities to provide comprehensive HIV testing services to pregnant women.</p> <p>-While the contraceptive prevalence rates target was missed in 2018, the current Modern CPR (mCPR) stood at only 12% in 2018, the rate is gradually increasing, currently estimated between 13.3% and 14.2%.</p>		<ul style="list-style-type: none"> <li>•Preventing and detecting new HIV infections among pregnant and breastfeeding adolescents and women.</li> <li>•Addressing social and structural barriers that impede access to services.</li> </ul> <p>-With the adoption of these strategies , identification of positive pregnant women, treatment access to prevention services and the effectiveness of the targeted strategies are showing initial improvements.</p> <p>-Adoption of these strategies has further increased the access of HIV services among pregnant women and this has resulted to a gradual improvement in PMTCT coverage, contraceptive prevalence, and percentage in children living with HIV/AIDS.</p>
--	--	--	--	--	--

		<p>HIV-negative pregnant women were retested, and 0.6% of those retested turned positive. Retesting was highest at ANC 56%, which is vital for catching seroconversions early and reducing MTCT risk</p> <p>-The National Strategic Framework (NSF) targeted an increase in the Contraceptive Prevalence Rate (CPR) to 36% by 2018 (up from 10% in 2013)</p>			
		<p><b>PrEP</b></p> <ul style="list-style-type: none"> <li>- The 2016 National Guidelines for Prevention, Treatment and Care recommended daily oral PrEP for sero-discordant couples and key populations.</li> <li>- In the 2020 guidelines, the recommendation was updated to include event-driven PrEP. Recently, injectable formulations for PrEP were approved for use globally however this is not yet recommended for use in Nigeria</li> <li>- Currently Oral PrEP is being implemented by the Government of Nigeria (GoN) in collaboration with partners, primarily in one-stop shops for KPs alongside STI, tuberculosis, and other HIV services</li> </ul>	<ul style="list-style-type: none"> <li>- PrEP is for use during periods of substantial risk of HIV acquisition, this may vary greatly by individual, and at varying times of life for different lengths of time.</li> <li>-PrEP was initially targeted towards KPs and other high risk PLHIV, it has now been expanded to be offered as an additional HIV prevention option for HIV negative person who are considered at substantial risk of acquiring HIV infection</li> <li>- Across all KP groups and AYP, there is a large drop-off between awareness and actual uptake ("Ever Taken PrEP"),</li> </ul>		<ul style="list-style-type: none"> <li>-Though oral PrEP service provision is mainly targeted at KPs as stipulated in the National Guidelines for HIV Prevention, Treatment and Care, other high-risk individuals such as HIV-negative individuals in serodiscordant sexual relationship and high-risk AYP are also eligible.</li> <li>-There have been increased access to PrEP over the years evidence by the available data.</li> <li>-Improved awareness and perception on the use of PrEP among PLHIV and KPs</li> <li>-However, limitations to access still exist as many data suggests unavailability of PrEP in service delivery points.</li> </ul>

	<p>-The PrEP data collection tools is yet to be integrated into the electronic medical records however, efforts are in place to integrate systems for PrEP data into the electronic reporting channels</p> <p>- 229,083 individuals were initiated on PrEP between January to December 2022 with the highest initiations in Lagos (52,258)</p> <p>-According to IBBSS 2020, PrEP awareness and uptake among key populations show significant variation, with 47.9% of MSM aware and 25.3% having ever taken it; awareness among TGs was not recorded but 28.1% have taken PrEP—the highest among KPs; 19.8% of FSW are aware with 14.4% having used it; 18% of PWID have taken PrEP; and among AYPs, overall awareness stands at 36.1% with 24.5% uptake</p> <p>- 38% of Female Sex Workers (FSW) took PrEP in the last 12 months, 27% are currently on PrEP, and 33% wanted to take PrEP in the last 12 months but it was not available</p>	<p>indicating barriers in accessing or adhering to the medication</p> <p>- MSM demonstrated the highest awareness of PrEP, suggesting more effective targeted outreach to this group</p> <p>-Its utilization in the HIV programme especially among KPs has been sub-optimal, with many OSS clinics and KP-friendly facilities report inconsistent availability of PrEP kits.</p> <p>-Some of the challenges with access to PrEP highlighted in some studies include poor awareness to availability of PrEP among KPs, Restricted operating hours and poor geographical coverage, delayed presentation due to costs or transport barrier</p>		
--	--	---	--	--

	<p>- 45% of Men who have Sex with Men (MSM) took PrEP in the last twelve months, 37% of MSM are currently on PrEP, and 26% of MSM wanted to take PrEP in the last 12 months but it was not Available</p> <p>- 43% of Transgender persons (TG) took PrEP in the last 12 months, 38% of TG are currently on PrEP, and 27% of TG wanted to take PrEP in the last 12 months but it was not available</p> <p>- Generally, the use of PrEP among key populations remains low (&lt;30%), particularly among PWID (11%)</p>			
	<p><b>PEP</b></p> <p>- Post-Exposure Prophylaxis (PEP) is one of the prevention strategies employed by the national HIV programme to limit the transmission of the virus.</p> <p>-PEP is the short-term use of ARVs to prevent HIV infection among people exposed to HIV. This applies usually to accidental exposure to HIV either in the course of legitimate work as could occur among health workers who</p>	<p>-Its utilization in the HIV programme especially among KPs has been sub-optimal, with many OSS clinics and KP-friendly facilities report inconsistent availability of PEP kits</p> <p>-Some of the challenges with access to PrEP highlighted in some studies include poor awareness to availability of PrEP among KPs, Restricted operating hours and poor</p>		<p>-Although Studies on PEP (Post-Exposure Prophylaxis) show it remains an underutilized prevention strategy in Nigeria despite being included in national guidelines</p> <p>-There have been increased access to PEP over the years evidence by the available data.</p> <p>-Improved awareness and perception on the use of PrEP among PLHIV and KPs</p> <p>-However, limitations to access still exist as many data suggests unavailability of</p>

	<p>are vulnerable to needle stick injuries or contact with infectious body fluids. Additionally, it also applies to sexual assault victims especially in cases where the HIV status of the perpetrator cannot be readily determined</p> <ul style="list-style-type: none"> <li>- The PEP data collection tools are yet to be integrated into the electronic medical records however, efforts are in place to integrate systems for PEP data into the electronic reporting channels.</li> <li>-A total of 4,498 persons were initiated on PEP between January to December 2022</li> <li>- Twenty per cent (20%) of Female Sex Workers took PEP, and 19% wanted PEP but couldn't access it</li> <li>- 25% of Men who have Sex with Men</li> </ul> <p>took PEP, and 19% wanted to take PEP but it was not available</p> <ul style="list-style-type: none"> <li>- 22% of Transgender</li> </ul> <p>persons (TG) took PEP, and 24.2% wanted PEP but it was not available 12 months prior to the survey.</p>	<p>geographical coverage, delayed presentation due to costs or transport barrier</p>		<p>PrEP in service delivery points, restricted operating hours and poor geographical coverage, delayed presentation due to costs or transport barrier</p>
--	--	--	--	---

	<p><b>Condoms</b></p> <p>-Consistent and correct condom use is one of the components of comprehensive service package in community and health facilities (One-stop shop and public /private health facilities) to prevent transmission of HIV infections especially among KPs and high risk PLHIV</p> <p>- FSW (84.3%), MSM (56.5%), PWID (69.4%) and TG (51.9%) reported condom use at last sex with paying clients, compared with the IBSS 2020 with 91%,82.9%,79.8%,79.1% respectively</p> <p>- Forty-two percent (42%) of Female Sex Workers (FSW) reported that condoms were unavailable for use at a time they wanted to use it in the last three months</p> <p>- 47% of Men who have Sex with Men (MSM) reported condom unavailability</p> <p>- 56% of People Who Inject Drugs (PWID) reported unavailability of the condom</p>	<p>-This shows an obvious drop in the utilization of condoms among the KPs from 2020 till 2024.</p> <p>-However, awareness on use condoms have improved over the years with more KPs requesting and accessing the condoms.</p> <p>-Data suggests increasing unavailability of condoms in oss and other service delivery points.</p>	<p>KEY POPULATION PROGRAMME REVIEW IN NIGERIA 2024, IBBS 2020</p>	<p>-Despite increase awareness and perception among KPs on the use of condoms, its access has been limited by factors such as unavailability in oss and other service delivery points.</p>
--	--	---	---	--

	<p>- 53% of Transgender persons reported unavailability of condoms at a time they want to use it in the last three months</p> <p>-66% of MSM reported condom use at last anal sex with a non-regular partner while 73.5% of them reported use of lubricant at last anal sex with a non-regular partner.</p> <p>- 82% of FSW had access to free condoms, 74% had access to education on safe sex, 31% had referral for STI services and 30% referral for HTS services.</p> <p>-63% of PWID accessed free condoms, 51% had access to education on safe sex, 12 % referral for STI services, 16% referral for HTS services</p> <p>-80% of MSM accessed free condoms, 76% safe sex, 31% referral for STI services, and 32% for HTS services</p> <p>-83% of TGs have access to free condoms, 81% to education on safe sex, 22% for STI referral, 24% for HTS services</p>			
--	--	--	--	--

		<p><b>Use of Syringes/ injectables</b></p> <p>-A component of harm reduction strategies for PWID</p> <p>-In IBBS 2020-2021, about 33.3% of PWID reported always using a sterile / new syringe in the last month during the survey and 59.3% reported ever sharing a syringe in the last month.</p> <p>- However, in KPPS 2024, 83% reported having injected heroin or a narcotic drug in the last 1 month prior to the survey</p> <p>-21% reported sharing an injecting needle with another person in the last 3 months</p> <p>-82.9% of PWID reported using new (unused) needles and syringes the last time they injected</p> <p>-45.5% of PWID said that clean needles were not available in the month prior to the survey</p>	<p>-From the data shown, distribution of needles to CBOs/CSOs for PWID exist, however, data shows stock out, unavailability when needed.</p> <p>-Additionally, there is still improved awareness and perception among PWID on the access, availability and use of clean syringe.</p>		<p>-This shows that the KP program has been effective towards promoting awareness among PWID on the use of clean syringe, hence increasing the access to the syringes.</p> <p>-Nonetheless, there are still challenges of unavailability and stock out of syringes and other harm reduction kit, hence limiting the access to HIV services</p>
--	--	--	--	--	--

		<p><b>Access to HIV testing and treatment</b></p> <ul style="list-style-type: none"> <li>- Nigeria adopted the test and treat approach for HIV/AIDS in 2016</li> <li>- Of the 1.8million PLHIV in 2019, one-third do not know their HIV status resulting in a gap of about 23% to reach the target of 90% of PLHIV knowing their status (90:90:90)</li> <li>- In achieving the 2020 target for 90:90:90, at the end of 2020, Nigeria's score card stood at 89:92:59 which showed that Nigeria did not meet the global target</li> <li>-The current global target is 95:95:95 and currently, 87:98:97</li> <li>- For more access to HIV services, the National strategic framework 2017-2021 recommended that at least 30% of HIV services should be community led through CSOs and CBOs</li> <li>- In 2016, the number of people counseled and tested for was over 11. 3 million, and only 360,941 people tested HIV-positive. With approximately 3.2 positivity yield</li> </ul>	<p>A. Before 2018, general population HIV testing approach was implemented with just less than 1% HIV positivity yield. Due to this low outcome; the country adopted <b>Differentiated HIV testing strategies that included;</b></p> <ul style="list-style-type: none"> <li>-<i>Provider initiated testing and counselling</i></li> <li>-<i>Index case testing</i></li> <li>-<i>KP sexual network testing</i></li> <li>-<i>HIV testing for TB patients</i></li> <li>-<i>Targeted community testing</i></li> <li>-<i>HIV self-testing for KPs and male partners of HIV positive women</i></li> </ul> <p><b>B. Adoption of Differentiated ART services delivery which include;</b></p> <ul style="list-style-type: none"> <li>-<i>Case management</i></li> <li>-<i>Multi-month dispensing (MMD) of ARVs for first line ART regiment to stable clients</i></li> <li>-<i>Community-based refill/distribution of ARVs plus adherence support</i></li> </ul>		<ul style="list-style-type: none"> <li>-Ultimately, the access to HIV testing and treatment has improved especially with the adoption of innovations and strategies that ensures target testing among high risk individuals.</li> <li>-Challenges and barriers exist, and will be discussed later.</li> </ul>
--	--	---	--	--	---

		<p>-Since 2018, several strategies have been adopted to ensure target testing, more testing among higher-risk populations and the current positivity yield is approximately 4-5%</p>	<p><i>-Management of co-morbidities (TB, STIs, fungal infection, HBV, HCV, HPV, and mental health</i></p> <p><i>-Management of advanced HIV disease</i></p> <p><i>-Third line therapy for those who fail second line and salvage regimens</i></p> <p>C. Data on the number of CSOs/CBOs involved in HIV services cannot be gotten. However, several literatures suggest an increase the number of communities led programmes which have ultimately improved HIV service delivery in Nigeria, reducing discrimination and human rights violations.</p>		
2.	<p>Sub-objective 1.2:</p> <p><i>Identify gender-specific barriers to access HIV services among target population</i></p>	<p><b>Girls/Women</b></p> <p>-Globally, over 50% of PLHIV are females, and these figures are much more (&gt;60%) in sub-Saharan Africa.</p> <p>- In sub-Saharan Africa, adolescent girls and young women (15-24years) accounts for 25% of</p>	<p>-Women make up large burden of HIV/AIDS globally and in Nigeria and it is of greatest importance that they access HIV services to help reduce transmission.</p> <p>- There are multiple factors that limits women's access to HIV services as highlighted in the findings.</p>	1a-1d, 2a-2c,3,4,5, 67, 8,15,16,17,18,,21,22,26, 27,28,29	<p>-More HIV policies must prioritize gender-sensitive programming, addressing the specific needs of women and girls, particularly in high-risk groups such as adolescents and widows.</p> <p>-Socioeconomic empowerment programs and safe access initiatives (e.g., mobile clinics, community-based services) are crucial to overcome financial, safety, and stigma-related barriers</p>

	<p>HIV in 2020, despite being just 10% of the population</p> <p>-In 2018, 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). 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%) NAHS, 2018</p> <p>- Currently HIV prevalence stands at 1.3% nationally, with women aged 15–49 years still more than twice as likely to be living with HIV than men (1.9% vs 0.9%)</p> <p>-Several studies have linked GBV and HIV infection with violence as a major factor for HIV transmission and women are the most affected as they experience more violence (physical or sexual) etc</p> <p>- Data shows that women face multiple sociocultural, economic, political, environmental and health challenges throughout their life cycles which ultimately limits</p>	<p>-In many regions of Nigeria, cultural norms often prioritize boys' education over girls, and women are frequently valued primarily for childbearing and sexual roles. Limited access to education among women is a major barrier to health-seeking behavior, which can perpetuate an intergenerational cycle, uneducated women with poor health practices are more likely to raise children who also adopt poor health-seeking behaviors.</p>		<p>-Insecurity should be addressed fiercely as an infected mother with limited access to HIV services further worsens the MTC transmission as well as transmission to other sexual partners.</p> <p>-Programs to promote female education especially in rural and underserved regions.</p>
--	---	--	--	--

them from accessing HIV services.

-The ongoing insecurity in Nigeria has heightened women's vulnerabilities, leaving many widowed, impoverished, and socially marginalized. Economic hardship and exposure to sexual violence, including rape and transactional sex, not only increase their risk of HIV but also limit access to HIV services, as women face financial, safety, and stigma-related barriers that reduce their ability to seek testing, treatment, or prevention care.

- Women and girls bear the burden of care for members of their families that are positive when they become ill. The implication of this is that women and girls have higher risk of exposure to infection than their male counterparts. Additionally, there is restricted mobility during child-care activities.

- The traditional subordinate status of women in many cultures in Nigeria as well as the unequal power relations between them and their male counterparts often make

	<p>it very difficult for women to negotiate safer sex in marital and other forms of relationships, thereby increasing their level of vulnerability to HIV infection.</p> <ul style="list-style-type: none"> <li>- Women reporting inability to negotiate condom use with partners and concerns about the length and aesthetic appearance of the female condoms were found to be a major barrier to poor usage of female condoms</li> <li>-Evidence shows that lack of education can prevent women from accessing HIV information and services. Correct knowledge of HIV and prevention in the country among young persons (20 – 24) is low (24.4%)</li> <li>- Religious beliefs as barriers to ART: the belief in obtaining healing through prayers, the belief in faith healing or taking a step of faith, the belief that taking ART is belittling the healing power of God, and the belief in the prophetic healing words from religious leaders</li> </ul>			
--	--	--	--	--

	<p><b>Boys/Men</b></p> <p>-Men and boys are affected by gender expectations that may encourage risk-taking behavior, discourage accessing health care services.</p> <p>- Several data suggest that rates of HIV testing and treatment tend to be lower among men compared to women.</p> <p>-In Nigeria, masculinity norms impress on men to have more than one sexual partner and it is common for older men to have unprotected sexual relationship with much younger women (these younger women have three times higher infection rate compared to young men of the same age).</p> <p>-Socialization of men may mean that they will not seek HIV services due to fear of stigma and discrimination, losing their jobs and not being able to play their bread-winning role.</p> <p>-Religious beliefs as barriers to ART: the belief in obtaining healing through prayers, the belief in faith healing or taking a step of</p>	<p>- The Patriarchal norms affect boys and men, which has been evidently connected to their poor health-seeking behaviors and an increase in engaging in intimate partner violence and other forms of risky behaviour.</p>		<p>-Need for more men-friendly clinic</p> <p>-Need for increase in awareness and promotion of policies and laws that discourage harmful patriarchal practices.</p> <p>.</p>
--	---	--	--	---

		<p>faith, the belief that taking ART is belittling the healing power of God, and the belief in the prophetic healing words from religious leaders</p>			
		<p><b>Key Populations</b></p> <p>-The major barrier to accessing HIV services remains stigma and discrimination which has been evidently seen to discourage people from wanting to access HCT services.</p> <p>- Negative attitudes and discriminatory practices by healthcare providers and society remain a very significant barrier</p> <p>-Behaviours associated with KPs (e.g., same-sex behavior, sex work) are criminalized. KPPR explicitly lists legal issues as limiting access to HIV services.</p>			<p>-SACA should have access to resources backed by law in order to guarantee consistency in response interventions in their various states and discourage total dependence on the federal institutions</p>

		<p>-KPPR notes concern about sustainability, lack of government ownership of KP-specific programs and OSS (one-stop shop) services.</p> <p>-Inconsistent funding, insufficient trained personnel, and limited supplies are cited in the KPPR</p> <p>-lack of funds to pay for prevention materials (condoms, PrEP, syringes), transport to service sites, etc</p> <p>-lack of OSS (one-stop shops) in some states, and services offered in OSS for KPs</p>			
3	<p>1.3. Sub-objection- <i>Assessment of service outcomes amongst different target groups (infection rates, treatment adherence, viral load suppression</i></p>	<p><b>General population</b></p> <p>-National prevalence decreased from 3.6% (2007) to 1.3% (2023)</p> <p>- 1.9million people was infected with HIV with a prevalence of 1.4%,</p> <p>- Of the 1.9 million PLHIV in 2019, one-third do not know their HIV status resulting in a gap of about 23% to reach the target of 90% of PLHIV knowing their status</p>	<p>-National prevalence declined from 3.6% (2007) to 1.3% (2022–2023), this indicates a slowing epidemic, improved prevention, and better access to ART</p> <p>- The improvement in the scorecard indicates expansion of community-led testing, Scaling HIV self-testing, Increased testing among key populations, adolescents, and men, remarkable achievement, showcasing improved linkage-to-care, multi-month</p>	1c-1d, 2a - 2c,16,17,28,29	<p>Sustained efforts are needed to strengthen testing, retention, and equitable service delivery toward achieving the UNAIDS 95-95-95 targets</p>

		<p>- In 2022-2023, the national HIV prevalence dropped to 1.3%, with 2,002,624 PLHIV (739,778 males, and 1,262,847 females), out of the 2million PLHIV, 1.17million (58.7%) were adult females (&gt;15years) and 649,762 (33.2%) were adult males (aged 15years and above) and 177,131 (8.8%) were children aged 0-14years</p> <p>- GAM 2023 showed a score card of 87:99:96 (against 95:95:95 in 2030) an improvement from GAM 2019 with score card of 67:63:75 (against 90:90:90 for 2020)</p> <p>- Viral load suppression increased from 35% to 61% among men between 2018 to 2020</p> <p>-Viral load suppression increased from 58% to 85% among women between 2018 to 2020</p>	<p>dispensing, and decentralization of treatment services, Improved adherence support and Expanded viral load testing coverage</p> <p>-First 95 Still Below Target, Remaining gaps are highest among:</p> <p>Men, Adolescents and young people (AYP), Rural communities, Key populations with high mobility or stigma challenges.</p> <p>-This score cards is being driven by gender disparities, religion, and cultural factors.</p>		
		<p><b>PMTCT</b></p> <p>-A meta-analysis of 23 studies involving 72,728 pregnant women in Nigeria found a pooled HIV prevalence of ~7.22% (95% CI: 5.64–9.21)</p>	<p>-There has been an improvement in PMTCT. This shows that the strategies adopted is gradually bringing about good outcomes. However, more work should be done to identify positive pregnant women to reduce the</p>		

	<p>-Old data showed antenatal clinic prevalence at ~3.6%</p> <p>- ~77% of HIV-positive pregnant women were already on ART before pregnancy, and 23% were newly initiated during antenatal care or labor.</p> <p>- ART uptake increased from 71% in 2015 to ~88% in 2020</p>	<p>transmission of HIV from mother to child.</p>		
	<p><b>Key Populations:</b> In Nigeria, the KPs make up only 3.4% of the population, yet account for around 32% of new HIV infections</p> <p><b>-FSW:</b></p> <p>-HIV prevalence currently stands at 15.5% a marginal increase from a 2016 study by NACA with prevalence of 14.4%</p> <p>-26.7% have been diagnosed and know their status</p> <p>-of the 26.7% who know their status, 86% of those are on ART with 86% virally suppressed.</p> <p>- In the KPPR survey 2024, 14% of the FSW respondents reported currently using ART</p>	<p>Generally, this shows an increase in testing, retention to care and virally suppressed KPs</p> <p>-From the data, there is a sharp increase in prevalence of HIV among PWID from 3.4% to 10%. This shows gaps in HIV services and a need for more targeted testing and other services to reduce the prevalence among this group.</p> <p>-Generally, there is poor ART uptake and suppression rate across all KP group</p>		

	<p><b>MSM</b></p> <ul style="list-style-type: none"> <li>-Prevalence rate of 25%</li> <li>-38% have been diagnosed and know their status</li> <li>- of the 38% who know their status, 90% of those are on ART with 78% virally suppressed.</li> <li>- In the KPPR survey 2024, 25% of the MSM respondents reported currently using ART</li> </ul> <p><b>TG:</b></p> <ul style="list-style-type: none"> <li>-HIV prevalence of 28.8% (highest among KPs)</li> <li>-19% have been diagnosed and know their status</li> <li>- of the 19% who know their status, 84% of those are on ART with 75% virally suppressed.</li> <li>- In the KPPR survey 2024, 25% of the TGs respondents reported currently using ART</li> </ul> <p>PWID:</p>			
--	---	--	--	--

	<ul style="list-style-type: none"><li>-HIV prevalence of about 10%, prevalence was just 3.4% in 2014</li><li>-12% have been diagnosed and know their status</li><li>- of the 12% who know their status, 68% of those are on ART with 75% virally suppressed.</li> <li>-Only 42% have been tested for HIV within the last 12months</li><li>- In the KPPR survey 2024, 16% of the MSM respondents reported currently using ART</li></ul>			
--	--	--	--	--

Table 6.1.2.2 Evaluate changes in societal norms, behaviours, and gender roles that drive HIV transmission (Specific Objective 2)

S/N	Objectives	Findings	Explanation	Source Document Number	Remarks
2	2.1 Sub-objective: <i>Identify societal norms, behaviours, and gender roles that drive risky behaviour</i>	<p><b>Men/Boys</b></p> <ul style="list-style-type: none"> <li>-Patriarchy and its attendant narratives of male superiority, power, and dominance in regulating sexual behavior play a central role in promoting gender inequalities and fuel the risk of HIV transmission</li> <li>-Acceptance of practices like polygamy which exposes them to more than one sexual partner.</li> <li>- Masculinity norms impress on men to have more than one sexual partner and it is common for older men to have unprotected sexual relationship with much younger women (these younger women have three times higher infection rate compared to young men of the same age).</li> <li>- Perception of invulnerability is lower compared to women and causes men to underestimate their HIV risk. This leads to poor use of condoms.</li> </ul>		1a-1d, 2a-2c,3,4,5, 6, 7,8,15, 16,17, 18,,21,22,26,27,28,29	- Patriarchal norms that reinforce male dominance and control over sexual behavior continue to drive gender inequalities and heighten HIV vulnerability among women.

		<p><b>Girls/Women</b></p> <ul style="list-style-type: none"> <li>- Traditional gender roles limit women's autonomy in negotiating safer sex or condom use</li> <li>- Economic dependence on male partners restricts their ability to refuse risky sexual practices</li> <li>-Cultural norms around silence and obedience reduce women's willingness to seek HIV services or disclose status</li> <li>-High levels of GBV increase HIV acquisition and deter women from seeking care or reporting risky exposures</li> <li>- Expectations of caregiving burden women, exposing them to health risks while caring for sick relatives</li> <li>-Cultural practices such as Female Genital Mutilation (FGM), Early and Forced Marriage, Widowhood Practices, Harmful Mourning and Purification Rites all exposes a woman to HIV.</li> </ul>		8, 15, 21	<ul style="list-style-type: none"> <li>- Cultural acceptance of practices like polygamy, coupled with women's economic dependence and engagement in transactional or survival sex, further increases their risk of infection and limits their ability to negotiate safer sexual practices</li> </ul>
		<p><b>Key Populations</b></p> <p><b>FSW:</b></p>		10, 15, 17	

		<ul style="list-style-type: none"> <li>- Power imbalances with clients limit their ability to insist on condom use, especially when clients offer higher pay for unprotected sex</li> <li>- Criminalization and police harassment force FSW to operate secretly, reducing access to HIV services and safe-sex commodities</li> <li>- Social stigma pushes FSW to hide their identity and avoid facilities where they fear judgment</li> <li>- Violence from clients or partners increases vulnerability to forced, unprotected, or unsafe sex.</li> </ul> <p><b>MSM:</b></p> <ul style="list-style-type: none"> <li>- Strong societal and religious condemnation of same-sex relationships forces MSM underground, limiting access to HIV testing, PrEP, condoms, and lubricants</li> <li>- Criminalization under the Same-Sex Marriage Prohibition Act drives avoidance of health facilities</li> <li>- Internalized stigma increases risky behaviours such as secrecy, multiple partners, or inconsistent condom/lubricant use</li> </ul>			
--	--	---	--	--	--

		<p>- Fear of exposure encourages hidden, high-risk sexual networks and prevents partner notification</p> <p><b>TGs</b></p> <p>-Extreme stigma and discrimination discourage them from openly accessing health services.</p> <p>-Social exclusion and lack of legal recognition push many TG individuals into transactional sex or unsafe networks for survival.</p> <p>-Violence and harassment, often from police or community members, prevent TG persons from seeking prevention services.</p> <p>-Limited provider competency leads to judgmental or hostile treatment, discouraging routine care</p> <p><b>PWID</b></p> <p>-Criminalization of drug use reduces access to harm-reduction services and sterile syringes.</p> <p>-Peer pressure in drug networks normalizes needle sharing.</p> <p>-Stigma and fear of arrest push PWID away from health facilities.</p>			
--	--	---	--	--	--

		<p>-Poverty and homelessness hinder consistent access to HIV testing, ART, and counselling.</p> <p>-Limited availability of harm-reduction services (needle exchange, opioid substitution therapy) forces reliance on unsafe injection practices.</p>			
		<p><b>AYP</b></p> <p>- Strong influence from peers encourages risky sexual behaviour, including early sexual debut, multiple partners, and inconsistent condom use</p> <p>- “Proving maturity” through sex is normalized among many young males.</p> <p>-Pressure to conform to risky recreational behaviours, including alcohol and drug use, which heightens vulnerability to HIV.</p> <p>-Young girls have limited power to negotiate safer sex, especially with older partners (“sugar daddies”) and male dominance in relationships encourages risky patterns such as refusal to use condoms.</p> <p>- Cultural and religious expectations that girls remain submissive discourage them from seeking information or services.</p>			

		<ul style="list-style-type: none"> <li>- Cultural norms supporting early marriage expose girls to unprotected sex, older spouses, and early childbearing, all high-risk for HIV</li> <li>- Many communities consider sex education as promoting promiscuity, leading to limited knowledge of HIV prevention, Myths and misconceptions about HIV/AIDS, Poor awareness of condoms, PrEP, and reproductive health</li> <li>-Adolescents avoid HIV testing or contraception because providers often shame or judge them.</li> <li>-Lack of youth-friendly services discourages repeated use of HIV and SRHR services</li> </ul>			
2.2 sub-objectives <i>Assess community perception, changes in norms, behaviours, and gender roles that drive HIV transmission</i>	<p><b>Boys/Men</b></p> <ul style="list-style-type: none"> <li>-Generally, men have poor perception of risks of HIV compared to women. This is worsened by masculinity and patriarchal norms which remains dominant in Nigeria.</li> <li>- These norms (multiple concurrent sexual partnerships, early sexual debut, and low consistent condom use) drive harmful sexual behaviours that drive HIV transmission.</li> </ul>	<ul style="list-style-type: none"> <li>-These enshrined norms ultimately result to delayed testing and treatment compared to women, inconsistent condom use, and maintenance of high-risk networks sustain onward transmission.</li> <li>-Men's low engagement with prevention (PrEP, STI services) also reduces opportunities to interrupt chains of transmission</li> </ul>	16, 17,18,28,29	<ul style="list-style-type: none"> <li>-Need to Scale male-friendly services (after-hours clinics, workplace testing)</li> <li>-Promote behavior -change interventions that challenges masculinity and the harmful patriarchy system.</li> <li>Need for upgrading targeted partner-notification/index testing</li> </ul>	

		<p><b>Girls/Women</b></p> <ul style="list-style-type: none"> <li>-Good perception compared to men on risk of HIV.</li> <li>-However, this perception is influenced by several factors such as education, awareness, socioeconomic factors.</li> <li>- Generally, Women are often seen primarily in reproductive/caretaking roles and this somewhat increases health seeking behaviour</li> <li>-Nonetheless, certain structural system such as patriarchy exist, including insecurities which exposes women to risky behaviour. Such as transactional sex and survival strategies among some women, reinforcing exposure risk.</li> </ul>	<ul style="list-style-type: none"> <li>-Power imbalance prevents condom negotiation; GBV increases forced/unsafe exposure; caregiving and household responsibilities delay/limit service access and adherence. These structural factors further worsen vulnerability among women hereby leading to behaviours that drive HIV transmission.</li> </ul>	<ul style="list-style-type: none"> <li>-Integrate GBV response and socioeconomic support into HIV services; expand female-controlled prevention (PrEP, female condoms)</li> <li>-Expand the scope of CSOs to protect and empower survivals of GBV.</li> </ul>
		<p><b>Key Populations</b></p> <ul style="list-style-type: none"> <li>-Risk perception of contracting HIV is generally high among the KPs</li> <li>-MSM (43%), FSW (39%), PWID (29.3%), TGs (24%)</li> <li>-There is a gradual change in the way the KP community perceive themselves as out-cast and evil. Over</li> </ul>	<ul style="list-style-type: none"> <li>-There is a gradual positive change in perception of risks of HIV across all groups of KPs</li> <li>- Generally, there has been more awareness on harmful behaviour practices and adoption of safe practices have increased among KPs.</li> </ul>	<ul style="list-style-type: none"> <li>-Review of policies and laws decriminalizing KPs and provide a framework where they can have access to provide legal protections; scale peer-led OSS, harm reduction (NSP, OAT), and ensure KP commodities (condoms, lube, syringes, PrEP) are universally available</li> </ul>

		<p>time, professionals among the KPs have argued that their sexuality is by choice and not pathological.</p> <p>-KPs are beginning to develop internal mechanism which has been enhanced by the OSS and support groups, where they get support and encouragement. Rates of suicides have reduced, rate of self-infliction or not adherence to medications as a way of punishment for choosing to be a key population.</p> <p>- Norms and behaviours within KP networks are also changing. Peer educators and KP-led organizations have promoted safer sex practices, increased condom and lubricant use, and encouraged HIV self-testing, PrEP uptake, and consistent ART adherence</p> <p>- Despite these improvements, gendered vulnerabilities such as client-driven pressure on FSW for condomless sex, violence against MSM and TG persons, and economic coercion continue to shape risk behaviours and sustain HIV transmission.</p>	<p>-However, societal issues such as discrimination and stigma still exist and discriminatory laws have further pushed the KPs into isolation and not accessing HIV services, ultimately worsening HIV transmission.</p>		
		<p>-Fear of facility-based stigma; reliance on informal/semi-clinical care; inconsistent condom negotiation due to economic pressures and client</p>			<p>- Strengthening the capacity and coverage of peer educators is crucial to improving knowledge, risk perception, and safe practices</p>

		<p>dynamics, which led to poor HIV services uptake among PLHIV and KPs.</p> <ul style="list-style-type: none"> <li>- Gradual increase in the perception that services are confidential and non-judgmental when provided at models by trained staff and peers (OSS, community HIV services, DDS)</li> <li>-Generally, risk perception was low. However, the risk of contracting HIV was highest amongst MSM (43%), while it was 39% among FSW, 29% among PWID, and the lowest of 24% among Transgender persons</li> <li>- Frequent change of sexual partners and inconsistent use of condoms were major reasons for increased transmission of HIV</li> <li>-</li> </ul> <p>In the last 6months, despite having access to condoms, only 34% of FSW used condoms consistently with regular partners, and 58% used condoms for casual partners. 70% use condoms for clients</p> <ul style="list-style-type: none"> <li>- In the last six months, consistent condom uses among PWID remained low, 16% with regular partners, 32%</li> </ul>			
--	--	--	--	--	--

		<p>with casual partners, and 72% with clients.</p> <ul style="list-style-type: none"><li>- In the last six months, only about 34% of MSM consistently used condoms with regular partners.</li><li>- In the last six months, about 41% of transgender persons consistently used condoms with regular partners.</li></ul>			
--	--	---	--	--	--

**Table 6.1.2.3 Measure cases of GBV and human rights violations among population groups (Specific Objective 5)**

S/N	Objectives	Findings	Explanation	Source Document Number	Remarks
5	5.1 sub-objectives <i>Document reported GBV cases and human rights violations among PLHIV, KPs, and other population groups</i>	<p>- Reports are made to the Human Rights Commission to record and address cases of HIV-related discrimination (based on perceived HIV status and/or belonging to any key population)</p> <p>-In a survey done in GAM 2018-2023, more than half of female respondents and nearly half of male respondents responded that they would not buy fresh vegetables from a shopkeeper or vendor if they knew the person has HIV.</p> <p>-Similarly, respondents reported that children living with HIV should not attend same school as HIV- negative children.</p> <p>-24.7% of female PLHIV and ~22.6% of male PLHIV reported experiencing some form of HIV-related stigma/discrimination in the past 12 months.</p>	<p>-Statutory, the human rights commission has been tasked to record and address cases of HIV-related discrimination. They have been some progress.</p> <p>-Despite legal protections (e.g., HIV anti-discrimination Act), many PLHIV are unaware of their rights: around 72% of clients of HIV treatment facilities / OSS did not know about the Patient Bill of Rights.</p> <p>-Gender-Based violence towards Women living with HIV, FSW, MSM, TGs has been extensively documented in IBBS, Stigma index, and Key Population programme review.</p> <p>-Penetrators of discrimination, abuse was seen committed by healthcare workers, law</p>	1a-1d, 4,12,14,15,16, 17,25,27,28,29 27	<p>- Gender and human rights-focused national policies and guidelines have been developed, disseminated, and are actively being implemented</p> <p>- To promote equitable access to HIV programs enhanced through the recognition of gender differences that may serve as barriers to access of programs and commodities or hamper effective programming across the continuum of HIV prevention, testing, treatment, and care and support.</p> <p>-There are several policies and legal provisions but they have been very poor enforcement of these laws to protect PLHIV and KPs</p> <p>- Adopt more systematic approach to tackling gender and other forms of inequalities by issuance of clearer guidelines and timelines for setting up gender management systems with monitoring indicators at all levels</p>

		<ul style="list-style-type: none"> <li>- In a survey from IBBSS 2020,13.5% said they would not provide care for PLHIV</li> <li>- 15.8% would not work with a PLHIV; 27.9% would not share a meal with them.</li> <li>-16.3% believed PLHIV should be quarantined.</li> <li>- 25% of ART patients reported that they had experienced stigma or discrimination at family, hospital, and community levels, and at the workplace</li> <li>-A total of 25% of all respondents in the Stigma index survey reported that their HIV status was disclosed to others without their consent. Among these, HCWs disclosed their status to other people was the most reported stigma issue, 7% reported.</li> <li>- Those who have experienced stigma or discrimination in the last 12 months: PLHIV(Non-KPs)-20.3%, MSM-30.9%, PWID-26.3%, FSW-24.2%.</li> <li>-40.8% of GBV survivors did not report because they were unaware of the appropriate place to report to and how to seek redress. 5% felt even-though they reported, nothing will</li> </ul>	<p>enforcement agencies and families.</p> <ul style="list-style-type: none"> <li>-Progress has been made so far, Integrated Biological and Behavioural Surveillance Surveys (IBBSS) of 2020 included the transgender population for the first time, this shows an increasing recognition and attention to the key population community within the national HIV and AIDS response</li> <li>-A significant barrier to seeking justice is that survivors of gender-based violence often don't report incidents due to fear of exposure, police harassment, and a lack of awareness of reporting mechanisms, including lack of trust in the legal system.</li> </ul>		
--	--	---	--	--	--

		<p>come out of it while 10% reported that they felt reporting will expose their status</p> <ul style="list-style-type: none"> <li>- Violence (forced unprotected sex without condom) was reported to be highest among TG at 55%, 36%, 37%, 33% for MSM, PWID and FSW respectively</li> <li>- Lesbians and Women who have sex with women reported physical abuse, while PWID reported gossips and discriminatory comments by family members as the most form of abuse</li> <li>-Blackmail was reported to be the highest among bisexual and respondents with different gender identity different from gender at birth.</li> <li>- MSM/FSW reported verbal harassment as the most stigma</li> <li>-Discriminatory practices against PLHIV in hospitals (selective use of gloves, poor quality care, and isolation from other patients)</li> <li>- Discriminatory practices against PLHIV in society (social isolation, restriction in family events, and hostility)</li> <li>-Discriminatory practices against PLHIV in Families (not sharing of</li> </ul>			
--	--	---	--	--	--

		<p>cutlery and toilet facilities, breach of confidentiality)</p> <ul style="list-style-type: none"> <li>- Discriminatory practices against PLHIV at the workplace (threat of employment termination, isolation by coworkers).</li> </ul> <p>--North Eastern part of Nigeria had the highest proportion of stigma and discrimination among PLHIV (KPs and Non-KPS) of 37.5% while North West has the least of 14.4%. This could be from fear of arrest, police harassment, HISBAH enforcement)</p>			
	<p>5.2 Sub-objective: Evaluate available services for GBV cases and human rights violations</p>	<ul style="list-style-type: none"> <li>-The National HIV Treatment &amp; PMTCT Guidelines require that sites offering post-violence clinical care provide a full minimum package: treatment of injuries, rapid HIV testing and linkage, STI screening/treatment, PEP, emergency contraception, first-line counselling, and referral to longer-term psychosocial/GBV services</li> <li>- Integration of GBV Screening and Referral into HIV service delivery points (SDPs), including ART clinics and PMTCT sites</li> </ul>		1c-1d, 4, 5, 7, 12, 22	

		<ul style="list-style-type: none"> <li>- Post-Exposure Prophylaxis (PEP) Services for survivors of sexual violence, offered at health facilities (24-hour access is often the goal).</li>   <li>-OSS and peer-led clinics provide integrated HIV, SRH, psychosocial and some GBV responses for KPs and PLHIV in many states; KPPR and national program documents highlight OSS as a model that increases service uptake and provides safer entry points for survivors among KPs</li>   <li>-Some NGOs, faith-based organisations and Spotlight/UN initiatives have invested in shelters, psychosocial counselling, MHPSS and GBV hotlines in selected states</li>   <li>-Community Eye Monitor application" (NEPHWAN) for reporting stigma and locating facilities</li>   <li>-Incorporation of PNS into the structure, Enhanced Adherence Counseling (EAC) is noteworthy</li> </ul>			
--	--	--	--	--	--

		<p>-Psychosocial support as part of PLHIV needs compensation and rehabilitation mentioned in the VAPP Act</p> <p>- Promotion of legal aid and referral pathways to police/justice system for prosecution of perpetrators</p> <p>-Establishment of toll-free hotlines" with a budget of #5,000,000 (2015-2017). Toll-free line among PLHIV and KP" recommended for emergency settings. However, data could not be found that evaluates its effectiveness and continuity.</p> <p>-Violence protection programs address intimate partner violence, workplace violence, police abuse, and prison torture</p> <p>-Legal provisions prohibit violence against people based on HIV status or key population membership</p>			
--	--	---	--	--	--

					- Other available services operate through multi-sectoral collaboration with relevant stakeholders, reflecting efforts to strengthen coordinated responses.
					A phone app developed to aid the reporting of gender and human rights violations
	5.3 sub-objective; <i>Map and assess referral networks</i>	<p>-Provision of gender focal person in all CBOs/CSO, law enforcement agencies where cases of GBV and violations are reported and then they are either handled locally or referred to other stakeholders eg. NHRC.</p> <p>-Reports are made to the Human Rights Commission to record and address cases of HIV-related discrimination (based on perceived HIV status and/or belonging to any key population) from CSOs/CBOs or even law enforcement agencies. The NHRC work to ensure human rights are protected and defended, however, they have high case-loads, and are unable to provide timely remedies</p> <p>-State Response Teams in some locations provide platforms for</p>	<p>-Referral network exist in subnational and national offices especially those providing HIV services.</p> <p>-The NHRC are encumbered by lots of cases and with the few resources available, interventions have been seen to be slow.</p> <p>-Some barriers highlighted that hinders referral network include, cost of legal processes, lack of awareness, financial barriers, Limited availability of legal service providers due to high case load.</p> <p>-Fear of further reprisal or exposure through legal process</p> <p>Services are often not well coordinated</p>	5,7,8,10	<p>-There are established referral networks at both national and subnational levels</p> <p>- However, their structure and effectiveness vary across states, largely influenced by political and cultural factors.</p> <p>- Moreover, these networks are severely constrained by inadequate financial support and a shortage of skilled human resources.</p>

		<p>engagement, Police Action Committees on AIDS</p> <p>-Legal Aid Council discussed Pro bono services mentioned (FIDA, COLAHR, Lawyers Alert)</p> <p>-FIDA, Lawyers Alert - fill gaps but "struggle with limited capacity and funding"</p> <p>-Paralegals - deployed in selected states where funded</p> <p>State Response Teams</p>			
				9, 21,27	
		-			

Table 6.1.2.4 Evaluate gender & human rights co-ordination platforms in HIV programs and their role in promoting gender equality over the years (Specific Objective 7)

S/N	Objectives	Findings	Explanation	Source Document Number	Remarks
7	7.1 sub-objective <i>Map gender &amp; Human rights co-ordination platforms/structures</i>	<ul style="list-style-type: none"> <li>-National level: NACA, NHRC, Ministry of Women Affairs and Social Development (MWASD)</li> <li>-Referral networks have been established to ensure legal protection for PLHIV and key populations</li> <li>-National level: NACA, NHRC, Ministry of Women Affairs and Social Development (MWASD)</li> <li>-State level: State Agencies for Control of AIDS (SACA, BENSACA, OYSACA, etc.)</li> <li>-Specific mention: "Justice and Human Rights Watch Group" (Lagos State)</li> <li>-State level: Gender and Human Rights State focal persons</li> </ul>		1a-1d, 7, 8, 9, 10	<ul style="list-style-type: none"> <li>- There are established structural platforms at both national and subnational levels that facilitate the coordination of gender-related issues within HIV/AIDS programs.</li> <li>- However, these structures face significant challenges, further complicated by individual, cultural, religious, and systemic factors.</li> </ul>
		<ul style="list-style-type: none"> <li>-Technical Working Groups (TWGs)</li> <li>--Community Eye Monitor app for facility location</li> </ul>			
		<ul style="list-style-type: none"> <li>-Legal Aid Council</li> <li>-Legal Aid Council, Court System, NAPTIP, Police as interconnected hubs</li> <li>-Ministry of Justice structures</li> <li>-CSOs and NGOs (multiple)</li> <li>Community-based support groups; Traditional and Indigenous Justice Systems (TIJS)</li> </ul>		5,7 9, 10	
		<ul style="list-style-type: none"> <li>-KP Networks (sex workers, MSM, PWUID); Service Providers: One-Stop-Shop (OSS) centres</li> <li>--One-Stop Shops (OSS) serve as comprehensive care</li> </ul>		9, 10,11,25	

## Appendix 6: Tables Showing Details of Desk Review for Section B (Objectives 6)

Table 6.1.3.1.1 Details of the review to evaluate the National HIV/AIDS Community Care and Support Guidelines (2020-2023)

S/N	Objectives	Indicators	Source: Document 2	Findings	Comments
1.	Sub-objective 6.1:  <i>Review policy frameworks for gender &amp; Human Rights responsiveness</i>	Existence of frameworks for gender and human rights responsiveness	Pg. 39-45	Document addresses framework existence for G&HR responsiveness	1. It discusses the role of the Gender and Human Rights State Response Team (GHR-SRT), which is designed to support access to justice and promote human rights for key and vulnerable populations. 2. The recommendations also emphasize the need of domesticating and popularizing HIV/AIDS anti-discrimination legislation, promoting gender equality, and combating human rights breaches. Overall, it provides a framework for incorporating gender and human rights into HIV/AIDS community care and assistance in Nigeria.
		Platforms existing for gender and human rights responsiveness	Chpt 5	This was stated in the document.	Document specifically referenced the “Gender and Human Rights State Response Team (GHR-SRT). This team is designed to support access to justice, HIV services, and the promotion of human rights for key and vulnerable populations in Nigeria.
		Number/percentage of strategies that include gender and human rights components		Explicit percentage of strategies not present but	Although the number of percentages were not mentioned, various strategies that include gender and human rights

				emphasis on the components is evident	<p>components, particularly in Chapter 5: Positive Health Dignity and Prevention (PHDP) and Chapter 4: Provision and Retention in Care of PLHIV were outlined. Gender equality a key aspect of national HIV response was highlighted in section 5.3.7. Strategies mentioned include:</p> <ol style="list-style-type: none"> <li>1. Scaling up of Prevention of Mother-to-Child Transmission (PMTCT) programs.</li> <li>2. Mainstreaming gender issues and women empowerment in all HIV efforts.</li> <li>3. Mobilization of partnerships with various stakeholders to tackle gender norms and inequalities.</li> <li>4. Institutionalization of the Gender Management System to ensure a gender-responsive approach in HIV programming.</li> <li>5. Gender-responsive budgeting in HIV/AIDS programming.</li> </ol>
		Gender and human strategies that align with international gender and human rights standards		Document outlines several gender and human rights strategies that align with international standards	These strategies majorly appear in Chapter 5: Positive Health Dignity and Prevention (PHDP), specifically under the components related to Gender Equality (5.3.7) and the Discrimination Response System (DRS) (5.5).
		Stakeholders identified for gender and human rights responsiveness		Stated in document	<p>The stakeholders identified include:</p> <p>State Ministries, Departments, and Agencies (MDAs), Law Enforcement Institutions, UN Agencies, Development and Implementing Partners, Nigerian Civil Society Organizations (CSOs) and Networks, The Media, Academia, Private Sector and Relevant Experts</p>

	Sub-objective 6:2: <i>Measure gender &amp; human rights policy, strategy, and plans implementation status.</i>	Percentage of planned gender and human rights activities implemented within HIV programs.		Specific percentages related to implementation are not detailed.	The document however, includes targets such as mobilizing and advocating for resource allocation in a gender and human rights-responsive manner and developing indicators for monitoring and evaluation of gender and human rights mainstreaming efforts.
		Proportion of budget allocated and utilized for gender and human rights interventions.		Specific figures not stated	Specific figures on proportion of budget allocated for G&HR interventions not detailed, however, the need for appropriate allocation of resources in a gender and human rights responsive manner and advocacy efforts of the Gender and Human Rights State Response Team (GHR-SRT) to ensure resource allocation was highlighted.
		Existence of monitoring and accountability mechanisms for gender and human rights in HIV response	Chpt 5 and 8	Stated in document	Specifically, the Gender and Human Rights State Response Team (GHR-SRT) is tasked with supporting access to justice, HIV services, and promoting human rights for key and vulnerable populations. The document also emphasizes the need for gender and human rights responsive monitoring systems at various levels, as well as the development of indicators for monitoring and evaluating gender and human rights mainstreaming efforts.

	<p>Sub-objective 6.3:</p> <p><i>Identify gaps and opportunities in the integration of gender &amp; human rights programming.</i></p>	<p>Number of gaps identified in policies, strategies, or program implementation</p>		<p>The document identifies several gaps in the policies, strategies, and program implementation related to HIV/AIDS community care and support services.</p>	<p>Specifically, it mentions the following:</p> <ol style="list-style-type: none"> <li>1. Lack of clear operational definitions of concepts and terminologies.</li> <li>2. Inadequate explanation of the continuum of care at the community level.</li> <li>3. Absence of a clearly defined anti-discrimination response system.</li> <li>4. Lack of guidelines addressing human rights and the legal environment.</li> <li>5. Insufficient elaboration on the care and support needs of key populations.</li> <li>6. Omission of Mental Health Disorders (MHD) detection and counseling.</li> <li>7. Non-integration of TB and HIV services at the community level.</li> <li>8. Absence of a national training manual for community structures on Income Generating Activities (IGA).</li> <li>9. Incomplete indicators covering all aspects of care and support services for PLHIV, PABA, and other vulnerable populations.</li> </ol>
		<p>Availability of sex-, age-, and key population-disaggregated data to inform programming</p>		<p>Yes, the document highlights the importance of collecting sex-, age-, and key population disaggregated data to inform programming.</p>	<p>Specific indicators within the monitoring and evaluation framework include data disaggregated by age and sex for various services provided to People Living with HIV (PLHIV) and those affected by AIDS (PABA).</p>

		<p>Number of actionable opportunities/recommendations proposed for strengthening integration</p>	<p>(Page 5; 11-12)</p>		<p>Below are key recommendations along with their locations provided:</p> <p>Provision for Midterm Review of HIV and AIDS Community Care and Support Guidelines – (Page 5)</p> <p>Periodic interface for all actors - Suggests regular meetings for sharing experiences, best practices, and challenges among stakeholders, including fixed periods and Terms of Reference for Technical Working Group (TWG) meetings. (Page 5)</p> <p>Clear guidelines on the role of government agencies - (Page 5)</p> <p>Integration of TB and HIV at the community level - (Page 5)</p> <p>Integrated approach to care and support services - Advocates for a continuum of care linking facility, community, and household services while addressing comorbidities. (Pages 11-12)</p>
--	--	--	------------------------	--	--

Table 6.1.3.1.2 Details of the review to evaluate the National Plan of Action: Addressing Gender Based Violence and HIV/AIDS (GBV/HIV/AIDS) Intersection Policy (2015-2017)

S/N	Objectives	Indicators	Source: Document 2	Findings	Comments
1.	Sub-objective 6.1: <i>Review policy frameworks for gender &amp; Human Rights responsiveness</i>	Existence of frameworks for gender and human rights responsiveness	Pg 37	Document mentions the existence of frameworks for gender and human rights responsiveness.	It states the strategies aimed at improving the response to gender-based violence (GBV) and HIV/AIDS, highlighting the need for policies and frameworks that are inclusive of gender issues.
		Platforms existing for gender and human rights responsiveness	Pg. 35-36	Document mentions platforms for gender and human rights responsiveness, primarily found within listed strategies.	Key platforms mentioned include: 1. Technical Working Groups (TWGs): the formation and strengthening of TWGs at different levels to address GBV/HIV issues. 2. Consultative Meetings with the Media: These meetings were on the implementation of the Plan of Action (POA). 3. Involving community stakeholders and organizations (e.g., CSOs, NGOs, Development Partners)
		Number/percentage of strategies that include gender and human rights components	Pg. 40- 43	No explicitly stated number however a few strategies (about 4) were mentioned.	Different strategies addressed G & HR components, particularly under the headings of “Human Resource Development” and “Eliminating gender barriers/strategic male engagement.  Strategy 3.2 addresses the inclusivity of HR policies concerning gender, GBV (gender-based violence), and HIV issues. Additionally, Strategy

					<p>3.5 focuses on engaging men and eliminating gender barriers.</p> <p>Other strategies like 3.4 and 3.6 focus on increasing awareness and disseminating information about Gender-Based Violence (GBV) and HIV/AIDS services and enhancing the capacity of institutions to respond effectively to GBV and HIV-related issues</p>
		Gender and human strategies that align with international gender and human rights standards	Pg. 36, 38 & 40	Document outlines several strategies aligning with international G&HR gender and human rights standards, especially in the context of gender-based violence (GBV) and HIV/AIDS.	The Specific strategies that align with international gender and human rights standards can be found across various sections, particularly those emphasizing policy improvement, advocacy, and integration of gender issues into health and social services (strategies 1.4, 3.2, & 3.3).
		Stakeholders identified for gender and human rights responsiveness	Pg. 35,38, 50-56	Document identifies various stakeholders	The key stakeholders include Federal and State Ministries (FMOWASD, NACA), Development partners (NGOs and CBOs), Civil Society Organizations (CSOs), the National Human Rights Commission, community and religious leaders, the private sector, media organizations, and international organizations (UN agencies, including UNAIDS, UNDP, and UN Women).

	Sub-objective 6.2: <i>Measure gender &amp; human rights policy, strategy, and plans implementation status.</i>	Percentage of planned gender and human rights activities implemented within HIV programs		The document does not explicitly mention the percentage of planned gender and human rights activities implemented within HIV programs.	
		Proportion of budget allocated and utilized for gender and human rights interventions.	Pg. 44	Not clearly stated	However, strategy 4.1 discusses funding and resource mobilization strategies in budget allocation and utilization for gender-based violence (GBV) and HIV interventions.
		Existence of monitoring and accountability mechanisms for gender and human rights in HIV response	Pg. 47	Document shows a plan portraying this context	The document appears to display a table of monitoring and accountability mechanisms related to gender and human rights in the context of the HIV response, particularly under Strategy 5.2: Development of M&E plan. The plan does not clearly discuss the existence of the mechanisms.
	Sub-objective 6.3: <i>Identify gaps and opportunities in the integration of gender &amp; human rights programming.</i>	Number of gaps identified in policies, strategies, or program implementation		No specific count of the gaps identified.	Although the exact number of gaps identified in policies, strategies, or program implementation was not mentioned, activities such as assessing the availability of HR policies inclusive of gender, GBV, and HIV issues, and developing a compendium of existing studies on the intersection of GBV and HIV/AIDS to identify research gaps were identified.
		Availability of sex-, age-, and key population-disaggregated data to inform programming		No explicit assurance of this data, but strategies for collecting and analyzing this data were documented.	The document noted the importance of integrating sex-, age-, and key population-disaggregated data into programming for GBV (Gender-Based Violence) and HIV interventions. This disaggregated data is vital for enhancing monitoring, reporting, and data utilization within

					the National Health Management Information System. Ensuring the availability of such data helps in effectively understanding the needs of various populations, guiding policy-making, and improving the design and delivery of targeted health services.
		Number of actionable opportunities/recommendations proposed for strengthening integration		Number not stated in document	<p>However, recommendations to improve programming, monitoring and overall response to GBV and HIV issues were mentioned. This includes:</p> <ol style="list-style-type: none"> <li>1. Development of a compendium</li> <li>2. Dissemination of research findings</li> <li>3. Conduct operations research</li> <li>4. Enhancement of monitoring and evaluation (M&amp;E) systems</li> <li>5. Sensitivity training</li> <li>6. Community engagement initiatives</li> <li>7. Strengthening partnerships</li> <li>8. Public awareness campaigns</li> </ol>

**Table 6.1.3.1.3 Details of the review to evaluate the Consolidated Service Delivery Guidelines on HIV and STIs for Key Populations in Nigeria 2021**

S/N	Objectives	Indicators	Source Document 2	Findings	Comments
1.	Sub-objective 6.1: <i>Review policy frameworks for gender &amp; Human Rights responsiveness</i>	Existence of frameworks for gender and human rights responsiveness		Not clearly stated	The document does not appear to contain a single, consolidated "framework for gender and human rights responsiveness". The gender and human rights elements are integrated throughout the guidelines rather than presented as a standalone framework.
		Platforms existing for gender and human rights responsiveness	Pg. 126,128, 136	Several existing platforms and mechanisms for gender and human rights responsiveness were identified	Legal and human rights support platforms such as community paralegal support, legal hotlines, internet-based advice, legal information and referrals, pro bono clinics, alternative and community dispute resolution, and strategic litigation; program platforms, crisis response system and safe spaces, reporting mechanisms and early warning/rapid response mechanisms
		Number/percentage of strategies that include gender and human rights components	Pg. 112, 129, 133	Out of the strategies provided, about six were gender & human rights-focused	Under the core HIV strategy, the cross-cutting strategy explicitly integrates gender and human rights responsiveness, while all 5 enabling environment strategies are directly tied to gender and/or human rights.
		Gender and human strategies that align with international gender and human rights standards	(Pg. 22-23, 33-38, 125-130, 125-139)	Document explicitly mentions gender and human rights strategies that align with international gender and human rights standards.	These strategies are grounded in principles such as: Protection of the human rights of members of each key population typology, Access to quality healthcare services free of discrimination, Access to justice, including freedom from arbitrary arrest, torture, and the right to the highest attainable standard of health,

					<p>Acceptability of services tailored to key populations with peer involvement and regular feedback,</p> <p>Health literacy improvement among key populations,</p> <p>Integrated service provision for comorbidities and social services.</p>
		Stakeholders identified for gender and human rights responsiveness	Pg. 168-170		<p>They include:</p> <ol style="list-style-type: none"> <li>1. Program experts, managers, and healthcare workers from public and private sectors involved in HIV programs.</li> <li>2. Civil society organizations, including people living with HIV, women's and youth groups, religious leaders, and people with disabilities.</li> <li>3. Technical specialists</li> <li>4. Government partners from relevant ministries</li> <li>5. Non-governmental organizations</li> <li>6. Finance and budget experts</li> <li>7. Academic institutions with expertise in research, implementation science, ethics, training, and supervision.</li> <li>8. Professional associations of health workers, including physicians, nurses, and community health workers.</li> </ol>
	Sub-objective 6:2: <i>Measure gender &amp; human rights policy, strategy, and plans implementation status.</i>	% of planned gender and human rights activities implemented within HIV programs	(Pg. 126–128; 126-128; 215-218; 139-141; 130-133)	The document does not provide any percentage figure for the implementation of planned gender and	<p>However, here are some of the planned gender and human right activities mentioned:</p> <ol style="list-style-type: none"> <li>1. Addressing gender-based violence (GBV): Programs should educate key populations on their rights, the link between violence and HIV, and available response services. They also stress</li> </ol>

				human rights activities within HIV programs.	<p>integrating gender norms and human rights (including sexual orientation and gender identity) into healthcare, training providers to detect/respond to violence, and creating crisis response systems (pp. 126–128)</p> <p>2. Legal and human rights services: Planned activities include training on legal rights, community paralegal support, legal hotlines, referrals, pro bono legal aid, dispute resolution, engaging traditional/religious leaders, and strategic litigation to challenge harmful practices (pp. 215–218)</p> <p>3. Violence prevention and redress: The guidelines emphasize documenting and reporting violence, training law enforcement and healthcare providers on human rights, creating safe spaces, establishing rapid response mechanisms, and ensuring survivors have access to comprehensive post-rape care (pp. 139–141)</p> <p>4. Policy and advocacy: Recommendations include reforming laws that criminalize or stigmatize key populations, training law enforcement to respect rights, and strengthening accountability systems to reduce discrimination and improve access to justice and health services (pp. 130–133)</p>
		Proportion of budget allocated and utilized for gender and human rights interventions.	Pg. 215-218	Not stated explicitly	The guidelines recommend tracking the proportion of budget allocated and utilized for gender and human rights interventions through specific indicators (such as referrals and legal service uptake), ensuring accountability in how resources are directed to protect key populations' rights.
		Existence of monitoring and accountability mechanisms for gender and human rights in the HIV response	Pg. 133-134, 139-141, 167-173, 215-216.	The guideline acknowledges the existence of monitoring and accountability mechanisms for gender and human rights within	These include systems to monitor and document stigma, discrimination, and violence against key populations, as well as redress mechanisms to ensure access to justice. They emphasize accountability of law enforcement and health providers through training, oversight, and

				Nigeria's HIV response.	reporting structures, while incorporating gender and human rights indicators such as access to legal support into the monitoring and evaluation framework. Community participation is also highlighted as central to ensuring accountability and rights-based implementation of HIV programs
	Sub-objective 6.3: <i>Identify gaps and opportunities in the integration of gender &amp; human rights programming.</i>	Number of gaps identified in policies, strategies, or program implementation	Pg. 34, 129-131	Document identifies gaps	The guidelines identify multiple gaps in policies, strategies, and implementation, but they do not quantify them.  The main areas of gaps include legal/policy barriers, stigma and discrimination, violence, inadequate community empowerment, and fragmented service delivery.
		Availability of sex-, age-, and key population-disaggregated data to inform programming	Pg. 173-213	Stated in the document	The requirement for sex-, age-, and KP-disaggregated data is consistently applied across monitoring indicators
		Number of actionable opportunities/recommendations proposed for strengthening integration	Pg. 142-143	Seven recommendations are stated in the document	The guidelines outline seven main actionable recommendations for strengthening integration, which include: 1. Integrating HIV services with TB, viral hepatitis, maternal and child health, sexual and reproductive health, and drug dependence treatment. 2. Providing related services in a single setting and linking systems for referrals and information sharing. 3. Strengthening collaboration across programs and at all levels of the health system. 4. Mobilizing and allocating resources effectively. 5. Training, mentoring, and supervising health workers. 6. Ensuring proper procurement and management of drugs and medical supplies. 7. Establishing monitoring and evaluation systems to track integration outcomes

Table 6.1.3.1.4 Details of the review to evaluate the National Guidelines of HIV Prevention, Treatment and Care: National AIDS, STIs and Viral Hepatitis Control

S/N	Objectives	Indicators	Source Document	Findings	Comments
1.	Sub-objective 6.1: <i>Review policy frameworks for gender &amp; Human Rights responsiveness</i>	Existence of frameworks for gender and human rights responsiveness	Pg. 177	The document mentions the existence of frameworks for gender and human rights responsiveness in the context of HIV guidelines	Under the introduction, the 2024 National Guidelines for HIV Prevention, Treatment, and Care is said to align with the United Nations Universal Declaration on Human Rights and promote access to quality health care services as a basic human right.  Also, where gender-based violence (GBV) was addressed, the need for prevention, identification, and response to GBV in healthcare settings, underscoring the role of health workers in implementing gender-transformative approaches, was mentioned.
		Platforms existing for gender and human rights responsiveness	Pg. 80-81, 177-182, 90-99	Stated in the document in the context of HIV service delivery	The key platforms include engaging community and Non-Formal Health Actors (NFHA), implementing Differentiated Service Delivery (DSD) models, preventing and responding to Gender-Based Violence (GBV), and providing a Comprehensive HIV Prevention and Care Package.
		Number/percentage of strategies that include gender and human rights components	Pg 88 to 182	The document does not provide an explicit overall number or percentage of strategies that include gender and human rights components	However, there are numerous gender and human rights considerations integrated into various HIV prevention, treatment, and care strategies. Key examples include:  1. Tailored approaches for adolescent girls and young women (AGYW) to prevent vertical HIV transmission, with gender-sensitive case finding, treatment initiation, and support models.  2. Integration of mental health screening and gender-based violence (GBV) prevention,

					<p>identification, and response within healthcare services.</p> <p>3. Structural interventions addressing stigma, discrimination, legal and human rights violations, and gender inequality as part of combination prevention strategies</p> <p>4. Differentiated service delivery models that are client-centered and responsive to the diverse needs of vulnerable populations, including gender considerations.</p>
		Gender and human strategies that align with international gender and human rights standards	pages 1-3, 71-89, 111-115	Document integrates gender and human rights strategies aligned with international standards.	<p>These include:</p> <ol style="list-style-type: none"> <li>1. Promotion of human rights and equity as a core guiding principle, ensuring access to quality HIV services without discrimination based on sex, sexual orientation, ethnicity, race, religion, or other status.</li> <li>2. Emphasis on gender responsiveness in HIV prevention and treatment, particularly addressing disparities where HIV prevalence is higher among females of reproductive age.</li> <li>3. Support for prevention of mother-to-child transmission (PMTCT) that empowers women with HIV to access comprehensive care, and the integration of services for gender-based violence (GBV), mental health, and sexual and reproductive health.</li> <li>4. Community engagement and the empowerment of women and key populations to uphold their rights and improve health outcomes.</li> </ol>
		Stakeholders identified for gender and human rights responsiveness	Pg vi and vii	Stakeholders identified in the document	Key stakeholders for gender and human rights responsiveness are government health agencies, civil society groups, implementing partners, donor agencies, healthcare providers, community organizations, and persons living with HIV who collectively contribute to inclusive, equitable HIV service delivery in Nigeria

	Sub-objective 6.2: <i>Measure gender &amp; human rights policy, strategy, and plans implementation status.</i>	% of planned gender and human rights activities implemented within HIV programs	Pg 176	The percentage of planned gender and human rights activities implemented within HIV programs is reported as 60% implementation.	
		Proportion of budget allocated and utilized for gender and human rights interventions.		exact numeric proportions or percentages for budget allocation and utilization specific to gender and human rights interventions, are not explicitly detailed	
		Existence of monitoring and accountability mechanisms for gender and human rights in the HIV response	(Page 2, 4, 7, 177).	Monitoring and accountability mechanisms for gender and human rights in the HIV response exist as integral components of the national HIV guidelines and implementation framework	These guidelines explicitly promote the equitable provision of quality HIV services irrespective of sex, sexual orientation, or other social determinants, emphasizing minimal stigma and discrimination. Additionally, the document highlights the integration of gender considerations and human rights principles into service delivery, with actions to facilitate the engagement of vulnerable groups, including women, adolescent girls and young women, and key populations, ensuring accountability through programme monitoring, community involvement, and cross-sector collaborations
	Sub-objective 6.3: <i>Identify gaps and opportunities in the integration of gender &amp; human rights programming.</i>	Number of gaps identified in policies, strategies, or program implementation	Pg. 71	Stated in the document	Five main gaps were identified hindering policy, strategy, and program implementation, including low antenatal care attendance, low contraceptive use, suboptimal HIV transmission knowledge, low HIV status awareness among pregnant women, and suboptimal PMTCT integration into mainstream services. (
		Availability of sex-, age-, and key population-disaggregated data to inform programming	Pg. 233	The document mentions the availability of sex-, age-, and key population-disaggregated data to	It states that reliable data disaggregated by sex, age, and key populations is critical for informing HIV program planning, monitoring, and evaluation to ensure targeted and effective interventions serve all populations equitably. This disaggregated data

				inform programming succinctly.	serves to address varying vulnerabilities, optimize resource allocation, and enhance outcomes across diverse groups within the epidemic context.
		Number of actionable opportunities/recommendations proposed for strengthening integration	Pg. 3, 69, 81, 102, 112, 114	Succinctly stated in the document	<p>The specific actionable opportunities/recommendations proposed for strengthening integration in the document amount to 8 key points. They include:</p> <ol style="list-style-type: none"> <li>1. Integration of screening for and management of hypertension, diabetes, cervical cancer, and mental health into the routine care of People Living with HIV (PLHIV) (pg. 3).</li> <li>2. HIV service integration within Differentiated Service Delivery (DSD) models to improve efficiency and decentralize services (pg. 3).</li> <li>3. Engagement of non-formal health actors in referral and linkage for PMTCT services to address gaps in these services (pg. 81).</li> <li>4. Integration of family planning services into ART services for HIV positive women to prevent unintended pregnancies (pg. 69).</li> <li>5. Integration of HIV prevention, testing, care, and treatment services with other health services such as Tuberculosis (TB), Viral Hepatitis, Sexual and Reproductive Health, Maternal, Newborn and Child Health services (pg. 2).</li> <li>6. Expansion of harm reduction services at all levels of care for Key Populations (KPs), including needle and syringe programs and medication-assisted treatment (pg. 114).</li> <li>7. Integration of HIV testing and counselling into various community-based and health facility service delivery points like ANC, STI, FP, KP-friendly facilities, and community models for Pre-Exposure Prophylaxis (PrEP) (pg. 102).</li> <li>8. Strengthening referral and linkage services, including to psychosocial and legal support, for clients from key populations (pg. 112).</li> </ol>

## Appendix 7: Data Analysis Plan Table

S/N	Objectives	Indicators/ Measures	Data Sources	Analysis Method	Expected Outcomes
1	Assess gender and human rights responsiveness of HIV interventions	-Access to prevention, treatment, care by gender	Quantitative (Primary, review of reports and documents)	Descriptive and Qualitative Thematic analysis	Identification of gender gaps and disparities in access and participation
		-Participation levels in HIV programs by gender issues	Qualitative (primary)		
2	Assess societal norms and attitudes affecting HIV prevention, service access, treatment, care cost and transmission	-Changes in attitudes towards gender roles, GBV, key populations	KAP Surveys (quantitative) and	Descriptive and	Insights into progress in shifting norms and persistent barriers
		-Prevalence of discriminatory norms	Qualitative interviews	Qualitative Thematic analysis	
3	Evaluate participation of PLHIV in decision-making	-Involvement in policy development–	Quantitative and	Descriptive and	Understanding of PLHIV's empowerment and influence in decision-making processes

		Engagement in community and program planning	Qualitative interviews	Qualitative Thematic analysis	
4	Assess contextual factors influencing access and GBV program implementation	- Societal norms and cultural factor	Reports and Policy review, Questionnaires and Qualitative interviews (primary)	Descriptive and Qualitative Thematic analysis	Identification of enablers and barriers to effective access and program success
		-Level of community engagement			
		-Availability of gender-sensitive policies			
5a	Determine gender-based violence and rights violations	- Number and type of GBV/rights violations identified	Qualitative interviews	Descriptive and Qualitative Thematic analysis	Identification of interventions used in GBV and right violations
		- Screening and reporting mechanisms established			
		Interventions implemented			
		Outcomes and survivor			

		support provided			
		- Reduction in GBV incidents			
5b	Assess the implementation of GBV and rights violations interventions	-Interventions implemented	Qualitative interviews	Thematic analysis	Evidence of GBV and rights violation intervention or program impact
		-Outcomes and survivor support provided			
		-Reduction in GBV incidents			
6	Evaluate the integration of gender in HIV policies	-Gender considerations included in key strategies -Gender-specific targets and indicators	Policy documents review	Content analysis , gap analysis	Degree of gender mainstreaming and policy responsiveness
7	Assess the contribution of gender platforms to HIV responsiveness	-Establishment and activities of gender platforms	Quantitative and Qualitative interviews	Descriptive and qualitative analysis	Role of intervention platforms in improving gender mainstreaming in the HIV response
		- Gender responsiveness indicators			

		-Stakeholder engagement levels			
8	Lessons learned and recommendations	-Documented successes, challenges, and best practices	Evaluation reports: Quantitative and Qualitative data	Synthesizing qualitative data; thematic analysis	Actionable recommendations for strengthening gender and human rights in HIV responses
		Stakeholders feedback			

## Appendix 8: Roles of stakeholders

### 1. *National Agency for the Control of AIDS (NACA)*

- Provided overall guidance and oversight to the study.
- Ensured that the study aligned with National HIV response strategies.
- Provided technical support and resources for the study.
- Hosted meetings/workshops – Planning, Protocol development, Data analysis and Report writing, Validation, and Dissemination meetings, and Manuscript development workshop.
- Participated in data collection, analysis, interpretation, and report development.
- Participated in stakeholder meetings and provide input on study design, implementation, and dissemination of the study report.
- Participated in the development of scientific products.

### 2. *National AIDS, Viral Hepatitis and STIs Control Programme (NASCP)*

- Worked with NACA to provide guidance and oversight to the study.
- Worked with NACA to ensure that the study is aligned with National HIV response strategies.
- Participated in planning, protocol and tools review, data collection, analysis, interpretation, and report development.
- Participated in stakeholder meetings and provided input on study design, implementation and dissemination of the study report.
- Facilitated collaboration with states – SASCP/facilities.
- Participated in the development of scientific products.

### 3. *Department Planning Research and Statistics, FMOH & SW*

- Ensured that the study was responsive to the needs and concerns of PLHIV and KPs at the state level.
- Participated in planning, protocol and tools review, data collection, analysis, interpretation, and report development.
- Ensured ethical consideration is well observed in the protocol and study participants were duly protected.
- Facilitated the approval of the study protocol by ethics review board.
- Participated in stakeholder meetings and provide input on study design, implementation and dissemination of the study report.
- Participated in the development of scientific products.

### 4. *State Agency for the Control of AIDS (SACA/SASCP)*

- Facilitated study implementation at the state level.
- Provided state-specific data and information for the study.

- Ensured that the study was responsive to the needs and concerns of PLHIV and KPs at the state level.
- Participated in planning, protocol and tools review, data collection, analysis, interpretation, and report development.
- Participated in stakeholder meetings and provide input on study design, implementation and dissemination of the study report.

#### *5. People Living with HIV (PLHIV) Networks and KPs*

- Provided inputs on study design, implementation, data, and dissemination.
- Ensured that the study was responsive to the needs and concerns of PLHIV and KPs.
- Participated in planning, protocol and tools review, data collection, analysis, interpretation, and report development.
- Participated in stakeholder meetings and provided input on study design, implementation and dissemination of the study report.
- Facilitated access to study participants in the study.
- Participate in the development of scientific products.

#### *6. Implementing Partners (IPs)*

- Provided technical support and resources for the study.
- Participated in planning, protocol and tools review, data collection, analysis, interpretation, and report development.
- Participated in stakeholder meetings and provide input on study design, implementation and dissemination of the study report.
- Facilitated study implementation in the states.
- Participated in the development of scientific products.

#### *7. Study Consultant/Researcher*

- Provided technical expertise and oversight for the study.
- Participated in stakeholders' planning meeting.
- Developed the study protocol and instruments, implementation plan, data collection tools, and analysis plan.
- Conducted data analysis and interpretation, alongside stakeholders.
- Developed the study report and recommendations.
- Facilitated the development of scientific products.

## Appendix 9: Report Writing Team

S/No	NAME	ORGANIZATION
1.	Dr Obioma Uchendu	Consultant /University of Ibadan/UCH Ibadan
2.	Mrs. Uchenna Idoko	Consultant/ CGE Africa
3.	Mr. Francis Agbo	NACA
4.	Dr. Fatimah Jajere	NACA
5.	Dr. Idoteyin Ezirim	NACA
6.	Dr. Nelson Victor	UCH Ibadan
7.	Regina Solomon	CGE Africa
8.	Perpetual Nwankwo	University of Ibadan
9.	Mr Michael Oluwalana	NACA
10.	Mr Collins Anieke	NACA
11.	Mr Yomi Olatunji	NACA/GF
12.	Mrs Favour Iyamu	NACA
13.	Mrs Rosemy Obiowu	NACA
14.	Mr Ejembi Omega Emmanuel	NACA
15.	Mrs Glory Evans	NACA
16.	Mrs Aisha Ahmed	NACA
17.	Ms Maryam Sani Haske	NACA
18.	Mrs Patricia Apeh	NACA
19.	Mrs Celestine Loveth	NACA
20.	Mr Andrew Abraham	NACA
21.	Mr Samuel Uwa	NACA
22.	Ms Adamu Queen Nefisat	NACA
23.	Mr Sunday S-Agbabiaka	FMOWA
24.	Mrs Muhammed Ramat	NASCP
25.	Dr Ugwueze Chidinma	UCH Ibadan
26.	Dr Okoro Stephen	UCH Ibadan
27.	Collins Ozoadibe	University of Ibadan
28.	Elizabeth Oyewole	University of Ibadan

