GENDER ASSESSMENT OF THE NATIONAL RESPONSE

TO

HIV/AIDS IN NIGERIA

NACA

NATIONAL AGENCY FOR THE CONTROL OF AIDS (NACA)

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For further information, contact:

The Director General
823, Ralph Shodeinde Street
Central Business District,
Abuja, Nigeria
E-mail: info@naca.gov.ng
Website: http://www.naca.gov.ng
Tel: +234- 9-4613726-9
Fax: +234-9-4613700

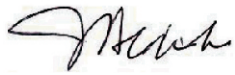
FOREWORD

In many Nigerian societies today, women and girls constitute one of the most vulnerable groups to the HIV/AIDS epidemic. Gender inequality has been identified as a key driver influencing the vulnerability of women and girls to HIV infection. This is evident in the current HIV prevalence among the general population in Nigeria (4.1%)[1] of which women constitute 58%. The prevalence rate among young women between the ages of 15 and 24 years is estimated to be three times higher than among men of the same age in the country.[2]

Notably, gender inequalities and low socio-economic status of women continues to fuel women's susceptibility to HIV infection. Concerns about the legal, social, economic and cultural factors that make women both susceptible and vulnerable to HIV infection have attracted global attention in the last few years. Gender equality priorities are still generally neglected in most service delivery modalities; this is largely due to weak support and coordination mechanisms necessary for the achievement of more effective results. In recognition of these facts, National Agency for the Control of AIDS (NACA) inaugurated the Gender Technical committee (GTC) to support the mainstreaming of gender equality and women empowerment in the national response as outlined in the HIV/AIDS Policy and the National Strategic Framework and Plan (NSF &NSP).

In October 2013, I inaugurated a Gender Assessment Team (GAT) to facilitate this national gender assessment. The assessment is geared towards identifying structural issues that are needed to be critically addressed in order to strengthen the national HIV/AIDS response as prescribed by the National Strategic Plan (2010 to 2015) and the Presidents Comprehensive Response plan (PCRP) for HIV/AIDS in Nigeria.The gender assessment findings will inform the successful implementation of the Presidential Plan.

We now invite all HIV/AIDS stakeholders to use the findings of this assessment to improve our strategies to end HIV and AIDS in Nigeria. Through multi-sectoral partnership, we have learnt that by working together, we can achieve better results.



Professor John Idoko
Director General,
National Agency for the Control of AIDS (NACA)
2013

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[1] Federal Ministry of Health (FMOH) (2010). National HIV Sero-prevalence Sentinel Survey 2011.
[2] National Agency for the Control of AIDS (NACA- Nigeria). Spectrum Modelling.

PREFACE

With an estimated 3.4 million people living with HIV and AIDS, Nigeria ranks second only to South Africa, in terms of countries with the highest HIV and AIDS disease burden in Africa. The country has continuously stepped-up its response to the pandemic. In the past three months, National Agency for the Control of AIDS (NACA) in collaboration with the Joint United Nations Programme on HIV/AIDS (UNAIDS), Nigeria Office and other partners conducted the gender assessment of the National HIV Response in Nigeria. The assessment, aimed at understanding gender dynamics critical for successful implementation of HIV and AIDS programmes in Nigeria, is to complement the National Strategic Plan (NSP) 2010-2015. Findings will be used to strengthen and consolidate existing HIV and AIDS control efforts at all levels and contribute to the implementation of the NSP and PCRP (President's Comprehensive Response Plan for HIV/AIDS in Nigeria).

This national gender assessment on HIV/AIDS report provides us yet another opportunity to identify current gaps and help us strengthen our service delivery capabilities. It equally lends credence to our goal of halting and reversing the HIV epidemic as outlined in the NSP. I wish to acknowledge the strong support of our partners who have remained committed to the national response to date. In this regard, I want to thank UNAIDS for their financial and technical support for this assessment.

The government remains committed to averting the potential negative effects of HIV and AIDS and bringing it under control. This is demonstrated in the timely completion of the gender assessment. The process adopted that involved all stakeholders including development partners, civil society, public and private sectors, and PLHIV also indicated government strategy of inclusive and collaborative partnership in its strategies to fight HIV/AIDS.

The understanding of the gender dynamics of the HIV transmission and its interplay will significantly increase gender sensitivity of the national HIV and AIDS response. We all share common aspiration for a successful national response and we can accomplish it if we resolve and commit to further improve upon our existing strengths. Success is possible through systematic sensitization and adoption of best practices in gender equality. Inaction will continuously impede progress towards achievement of our national HIV/AIDS objectives and priorities.

Dr. Priscilla Ibekwe
Acting Director, Programme Coordination
NACA

Acknowledgments

This gender assessment was inspired by the need: to identify strategic investment that will enable gender mainstreaming in the National HIV/AIDS response;and to understand the challenges and opportunities that could be useful in ensuring gender mainstreaming at the state and community levels in the HIV response. The three-month (October-December, 2013) gender assessment was conducted using technically sound and tested strategies adapted from the UNAIDS standardised gender assessment tool.

We are grateful to the National Gender Technical Committee (GTC) through the efforts of the Gender Assessment Team (GAT) for their genuine commitment to gender mainstreaming of the HIV/AIDS response. This is indicated in their unflinching support to the entire process leading to the timely conclusion of the process that led to this Gender Assessment Report.

Sincere appreciation goes to the staff of UNAIDS, Nigeria, Senegal and Geneva Offices for their financial and technical support for the assessment. We highly appreciate the hard work and technical leadership of the national consultant, Dr.BisayoB. Odetoyinbo and international consultant, Ms,KibibiMbawvi. We are also grateful to the following for providing technical assistance throughout the process of the gender assessment: staff of United Nations Development Programme (UNDP) in Nigeria; Federal Ministry of Women Affairs and Social Development (FMWASD);Federal Ministry of Education (FMOE); Federal Ministry of Health (FMOH); Federal Ministry of Agriculture and Rural Development (FMARD); United States Agency for International Development (USAID); Centre for Disease Control (CDC); Enhancing Nigeria's Response to HIV (ENR); Society for Family Health (SFH); USAID Projects of FHI 360;Deloitte (ENCAP); Heartland Alliance; Association of Women living with HIV/AIDS in Nigeria (ASWHAN); Federation of Women Lawyers (FIDA); and National Association of Women Journalists (NAWOJ).The collaboration of Departments of Programme Coordination, Strategic Knowledge Management (SKM), Policy and Strategic Planning and Finance and Accounts of NACA is commendable in ensuring timely and successful completion of this assessment.

Finally, the many individuals and organisations whose contributions made this product possible, by all means, receive special mention here. We extend sincere compliments of our deepest respect and thanks for your invaluable contributions and support.

Dr.Yinka Falola-Anoemuah
Assistant Director (Gender & OVC)
NACA

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante Natal Clinic
ART	Anti-Retroviral Therapy
ASWHAN	Association of Women Living with HIV/AIDS in Nigeria
BCC	Behaviour Change Communication
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CISHAN	Civil Society on HIV & AIDS in Nigeria
CRA	Child Rights' Act
CSO	Civil Society Organization
DfID	Department for International Development
DHS	Demographic and Health Surveys
ENR	Enhancing National Response
FGN	Federal Government of Nigeria
FIDA	International Federation of Women Lawyers
FLHE	Family Life and HIV/AIDS Education
FMWASD	Federal Ministry of Women and Social Development
FSW	Female Sex Worker
GARPR	Global AIDS Response Progress Report
GAT	Gender Assessment Team
GBV	Gender Based Violence
GTC	Gender Technical Committee
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with HIV/AIDS
HCT	HIV /AIDS Counselling and Testing
HIV	Human ImmunodeficiencyVirus
IBBSS	Integrated Biological and Behavioural Surveillance Survey
IDU	Injecting Drug Users
IEC	Information, Education, Communication
IPV	Intimate Partner Violence

JAR	Joint Annual Review
MARPS	Most At Risk Populations
MOT	Mode Of Transmission
MSM	Men who have Sex with Men
MTR	Mid Term Review
NACA	National Agency for the Control of AIDS
NAPTIP	National Agency for Prohibition of Traffic in Persons
NARHS	National HIV/AIDS Reproductive Health Survey
NASA	National AIDS Spending Assessment
NAWOCA	National Women Coalition on AIDS
NEPWHAN	Network of People Living with HIV/AIDS in Nigeria
NSF	National Strategic Framework
NSP	National Strategic Plan
NDHS	Nigeria Demographic and Health Survey
OVC	Orphans and Vulnerable Children
PCRP	President's Comprehensive Response Plan for HIV/AIDS in Nigeria
PEPFAR	U. S. President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PWID	People Who Inject Drug
SACA	State Agency for the Control of AIDS
SFH	Society for Family Health
SKM	Strategic Knowledge Management
SRHR	Sexual and Reproductive Health and Rights
SWAAN	Society for Women and AIDS in (Nigeria)
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UN WOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
USG	United States Government
VAW	Violence Against Women
WHO	World Health Organization

CONCEPTS AND DEFINITIONS

For the purpose of this work, definitions stated here are as used, majority of which are from the UNAIDS Terminology Guidelines unless otherwise stated.

Discrimination: Refers to any form of arbitrary distinction, exclusion, or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group—in the case of AIDS, a person's confirmed or suspected HIV-positive status—irrespective of whether or not there is any justification for these measures. The term 'stigmatization and discrimination' has been accepted in everyday speech and writing and may be treated as plural.

Empowerment: Empowerment is action taken by people to overcome the obstacles of structural inequality that have previously placed them in a disadvantaged position. Social and economic empowerment is a goal and a process aimed at mobilizing people to respond to discrimination and achieve equality of welfare and equal access to resources and become involved in decision-making at the domestic, local, and national level.

Enabling Environment: There are different kinds of enabling environments in the context of HIV. An enabling legal environment is one in which laws and policies against discrimination on the basis ofHIV status, risk behaviour, occupation, and gender are in place and are monitored and enforced. An enabling social environment is one in which social norms support healthy behaviour choices.

Gender: Refers to differences in social roles and relations. Gender roles are learned through socialization and vary widely within and between cultures. Gender roles are also affected by age, class, race, ethnicity, and religion, as well as by geographical, economic, and political environments. Moreover, gender roles are specific to a historical context and can evolve over time, in particular through the empowerment of women.

Gender Based Violence: Refers to violence perpetrated against any individual because of their gender identity or sexuality. This includes violence against women and girls. The term is often used to make a distinction between violence against women and violence against an individual who does not conform to a society's gender norms. (Source: UNAIDS' Gender Assessment Tool)

Gender Equality (or equality between men and women):Entails the concept that all human beings, both men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, and prejudices. Gender equality means that the different behaviours, aspirations, and needs of women and men are considered, valued, and favoured equally. It signifies that there is no discrimination on the grounds of a person's gender in the allocation of resources or benefits, or in access to services. Gender equality may be measured in terms of whether there is equality of opportunity or equality of results.

Gender Mainstreaming: Refers to the process of assessing the implications for women and men of any planned action (including legislation, policies and programmes) in any sector and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation. monitoring and evaluation of policies and programmes in all political, economic and societal spheres. This is to ensure that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality (Source: UN Economic and Social Council Report).

Gender Norms: Refer to learned and evolving beliefs and customs in a society that define what is "socially acceptable" in terms of roles, behaviours and status for both men and women. In the context of the HIV epidemic, these gender norms strongly influence both men's and women's risk taking behaviour, expression of sexuality, and vulnerability to HIV infection and impact, including their ability to take up and use HIV prevention information and commodities, as well as HIV treatment, care and support.Gender norms can also be the basis of discrimination and violence against men who have sex with men, lesbians and transgendered people, placing them at higher risk of HIV infection and impact.

Gender-Sensitive: Gender-sensitive policies, programmes or training modules recognize that both women and men are actors within a society, that they are constrained in different and often unequal ways and that consequently they may have differing and sometimes conflicting perceptions, needs, interests and priorities.

Gender-Specific: The term 'gender-specific' refers to any programme or tailored approach that is specific for either women or men. Gender-specific programmes may be justified when analysis shows that one gender has been historically disadvantaged socially, politically, and/or economically.

Gender-Transformative: A gender-transformative HIV response seeks not only to address the gender-specific aspects of HIV but also to change existing structures, institutions, and gender relations into ones based on gender equality. Gender-transformative programmes not only recognize and address gender differences but go a step further by creating the conditions whereby women and men can examine the damaging aspects of gender norms and experiment with new behaviours to create more equitable roles and relationships.

Harmful Masculinities: Social and cultural norms of masculinity that cause direct or indirect harm to women and men, for example, norms of masculinity that contribute to women's risk and vulnerability to HIV, and that hinder men from seeking information, treatment and support or assuming their share of the burden of care. (Source: UNAIDS' Gender Assessment Tool)

Incidence: HIV incidence is the number of new cases arising in a given period in a specified population. UNAIDS normally refers to the number of adults aged 15-49 years or children (aged 0–14 years) who have become infected during the past year.

Key Populations: Refers to those most likely to be exposed to HIV or to transmit it. Their engagement is critical to a successful HIV response i.e. they are key to the epidemic and key to the response.

Know Your Epidemic, Know Your Response: Refers to the combination of modes of transmission exercises, resource tracking, and programmatic gap analysis to informtailored programme planning.

Marginalized Populations: Marginalization refers to social exclusion, and the inability of certain individuals or groups to participate fully in the economic, social and political life of a particular society. Populations may also be marginalized in terms of access to healthcare services and resources, making a person more susceptible to HIV infection and to developing AIDS. This can include groups marginalized because of their gender and/or sexuality (e.g. men who have sex with men, sex workers). (Source: UNAIDS' Gender Assessment Tool)

Meaningful Participation: Going beyond the inclusion of relevant populations in relevant debates, discussion and decision-making processes, to ensure their active participation and voice in these events. (Source: UNAIDS' Gender Assessment Tool)

Patriarchy: Defined as control by men. It is a societal construct in which men are the dominant elements in public affairs. Under this arrangement, certain elements are dominant and include: women's economic dependence on men, female child rearing and men's access to women's bodies for sex (UN Women on Mainstreaming Gender Equality into National Response to HIV/AIDS, 2006)

Prevalence: Usually given as a percentage, HIV prevalence quantifies the proportion of individuals ina population who are living with HIV at a specific point in time.

Sex refers to biologically determined differences.
Sexual and Reproductive Health Programmes and Policies: Sexual and reproductive health programmes and policies include, but are not restricted to services for family planning; infertility services; maternal and newborn health services; prevention of unsafe abortion and post-abortion care; prevention of mother-to-childtransmission of HIV; diagnosis and treatment of sexually transmitted infections, including HIV infection, reproductive tract infections, cervical cancer, and other gynaecological morbidities; promotion of sexual health, including sexuality counselling; and prevention and management of gender-based violence.

Sexual Orientation: Refers to each person's profound emotional and sexual attraction to, and intimate and sexual relations with, individuals of a different, the same, or both sexes.

Stigma: Stigma can be described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others. Within particular cultures or settings, certain attributes are seized upon and defined by others as discreditable or unworthy. When stigma is acted upon, the result is discrimination that may take the form of actions or omissions.

Transgender: A transgender person has a gender identity that is different from his or her sex at birth. Transgender people may be male to female (female appearance) or female to male(male appearance). It is preferable to describe them as 'he' or 'she' according to their gender identity, i.e. the gender that they are presenting, not their sex at birth.

Vulnerability: Refers to unequal opportunities, social exclusion, unemployment, or precarious employment and other social, cultural, political, and economic factors that make a person more susceptible to HIV infection and to developing AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV risk and may be outside the control of individuals. These factors may include: lack of the knowledge and skills required to protect oneself and others; accessibility, quality, and coverage of services; and societal factors such as human rights violations or social and cultural norms. These norms can include practices, beliefs, and laws that stigmatize and disempower certain populations, limiting their ability to access or use HIV prevention, treatment, care, and support services and commodities. These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV. 4

EXECUTIVE SUMMARY

HIV/AIDS and Gender Intersect

> *Mainstreaming of gender into all policy-related and programming activities and related structures to ensure that all interventions and programmes are gender-sensitive and gender-responsive, appropriately meeting the separate as well as related needs of females and males.*[3]

The guiding principle statement above is a clear indication of the due recognition of the place of gender equality in the national HIV response. There is however a clear gap between rhetoric and reality. Available data continues to point to the fact that women, girls, men and boys are disproportionately affected. Women and girls vulnerability to HIV is deeply rooted in their biological make up and this is exacerbated by a complex mix of societal norms and value systems which not only affect women and girls but also men and boys. The benefits of addressing gender inequality as a central goal of a national HIV response in order to halt the spread are noted. However, gender inequality is grounded in systems and will therefore require systemic approaches that will challenge the status quo. Nigeria as a nation is a patriarchal nation and sexual behaviour is intricately linked with societal constructs of femininity and masculinity. Acceptance of gender equality requires a shift in the long standing social, cultural and religious beliefs about men and women and sexual orientation of individuals. This change therefore requires specific interventions backed by resources if the response is to be truly gender transformative.

Rationale for Assessment

Though gender mainstreaming is celebrated and advocated for in International and National settings and is often incorporated into policies and plans, more often than not, national strategic planning processes often lack essential information on the epidemic, context and response from a gender perspective. This in a way accounts for why budgeting processes have not been gender sensitive. In view of the overarching importance of engendering strategic plans, it has become a factor in accessing funds from the Global Fund to fight AIDS, Tuberculosis and Malaria. A gender assessment of this nature using the Gender Assessment Tool enables a review of the HIV epidemic, context and response from a gender perspective. Findings from the assessment is expected to bring to fore the extent to which the national response recognises and acts on gender inequality as a critical enabler of the HIV response as well as position gender equality in the "strategic investment" discussion.

Methodology

The gender assessment process was led by the National Agency for the Control of AIDS (NACA) representing the Federal Government of Nigeria (FGN) with support from UNAIDS Country Office (UCO) in Nigeria and the Joint UN Team on AIDS. A Gender Assessment Team (GAT) was however put in place to facilitate the whole process. The team comprised 13 members including representatives from Government, UN system, development partners and civil society networks with special inclusion of women living with HIV and two consultants (national and international).

The assessment methodology applied the Gender Assessment Tool developed by UNAIDS. The tool is a planned, systematic and deliberate set of steps and processes which examine and question the status of the HIV response in terms of plans and actions undertaken

[3] National Agency for the Control of AIDS (2009). *National Policy on HIV/AIDS.*

by the government to address HIV with specific reference to its gender dimensions. A two-fold approach to compiling relevant information to populate the tool was adopted. The first step was an in-depth desk review of HIV and gender national documents and relevant literature by the national consultant in order to populate the tool. The second step was the presentation of the preliminary findings at a national stakeholders' data collection workshop to verify the authenticity of the information as well as receive further insight, clarifications and recommendations towards a gender transformative response.

The selection of the participants at the national stakeholders' workshop done by the GAT was representative as state and non-state actors were included. State actors were drawn from both the health and non-health sectors including States Agency for the Control of AIDS (SACA), Line Ministries such as Education, Planning, Justice, and Information while non-state actors included civil society organizations such as Civil Society on HIV & AIDS in Nigeria (CISHAN), Association of Women Living with HIV/ AIDS (ASWHAN) and human and women rights bodies such as International Federation of Women Lawyers (FIDA). The United Nations, the United State Government (USG) and the Department for International Development (DfID) and other development partners were also involved. The international consultant assisted by other facilitators and the national consultant gave direction to the workshop. Sixty- six (66) participants attended the workshop.

Summary of Findings

Knowing Your Epidemic

The analysis of the epidemic in Nigeria was done through available prevalence, incidence and behavioural data as well as contextual issues such as socio-economic and legal factors. An in-depth desk review of national gender and HIV related documents as well as a 4-day national stakeholder's data collection workshop provided additional information. Data from 2012 NARHS was preferably used in this report considering the fact that it presents opportunity for comparison between males and females unlike the Sentinel Survey which is based on pregnant women who attend ante natal clinics.

A population based survey, 2012 NARHS reported that the HIV prevalence in Nigeria is 3.4%. This compares favourably with 2007 NARHS which reported a national HIV prevalence of 3.6%. This indicates a slight decline in the HIV prevalence in Nigeria. The analysis of the prevalence trend indicates that in the general population there is still a feminization of the epidemic. While the prevalence for females dropped from 4.0% to 3.5%, there was a slight increase for men from 3.2% to 3.3%. HIV prevalence was also higher for females than male across all age groups except 35-39years and 40-44 years age group in 2012. Notably too, in both urban and rural, HIV prevalence was consistently higher among females when compared to males. In 2007, it was 4.6% and 3.6% respectively for female while it was 3.0% and 3.3% for male with rural being higher than urban. Also in the same year, prevalence was higher for females in all geopolitical zones except the North West. In 2012, it was higher for females in four zones except the North West and South-South. There is however a survey data gap for the 0-14 age bracket, information for which cannot be inferred from other age groups especially their HIV prevalence.

Among key populations inclusive of most at risks population, prevalence is highest among Female Sex Workers (FSW) followed by Men who have Sex with Men (MSM). It is disproportionately higher among female Injecting Drug Users (IDUs) than their male counterparts. New infections in females continue to surpass that in males, contributing to about 52.4% of sero-conversions that occurred in 2012. MOT study revealed that 62% of new

infections occur among persons perceived as practising "low risk sex" in the general population including married sexual partners. The rest of the new infections (38%) are attributable to IDUs, FSWs, MSM and their partners.

In the general population especially among the youth, males seem to have a more correct knowledge of prevention methods across the age groups compared to their female counterparts. For the key populations, knowledge surveys demonstrate that female sex workers are more aware of how to prevent HIV than all other key population groups as at 2010 with road transport workers being the least. The percentage of women and men aged 15-49 who had more than one partner in the past 12 months, who used a condom during their last sexual intercourse is higher for the men than the women while the lowest reported users were found to be amongst the 15 to 19 age group. This indicates that there is a growing youth population becoming infected and displaying behavioural patterns that place them at risk of HIV infection.

Contextual factors contributing to the epidemic comprised of poverty, child marriage, gender-based violence, masculinity and femininity norms, disabilities, harmful traditional rites as well as human right, legal and political factors. Perhaps this accounts for the data gap for transgender populations.

Knowing Your Response

Legal framework for the national response is nested in national and international frameworks including the 1999 constitution of the Federal Republic of Nigeria. The national HIV response transited from an emergency response managed by the Health sector to a multi-sectoral one involving non-health sector players with NACA as the coordinating Agency. The National Policy on HIV and the National Strategic Plan (2010-2015) elucidate the strong commitment of the response to promoting gender equality.

Within the ambits of the policies and legal frameworks, participation and involvement of women, girls, men, boys and the marginalized and key populations is encouraged. The federal nature of the country also allows each State to enact its own laws and develop its own policies. Gaps however exist both in implementation and provision of some of the laws that mitigate its efficiency. Punitive laws may reverse the gains in the HIV prevention achieved over the years especially among Most At Risk Populations (MARPS). Efforts are however being scaled up to make gender equality in the response a reality, such efforts include the development of a 5-year Strategic Plan on Women, Girls, Gender Equality and HIV &AIDS; the creation of gender desk in NACA; the institutionalization of the Gender Technical Committee (GTC) and the continuous technical efforts of the GTC in gender mainstreaming of the national HIV/AIDS response. Other gender focus efforts of the national HIV response includes the input of NACA in the ongoing review of the National Gender Policy; the inclusion of gender expert in the mid-term review of the NSP and the commissioning of the gender assessment of the response being presented in this report.

Nigeria has made significant achievements towards Universal Access to HIV prevention, treatment, care and support. The prevention efforts towards provision of more HIV/AIDS Counselling and Testing (HCT) sites and scaling up of Prevention of Mother to Child Transmission(PMTCT) are note-worthy; there is however room for improvement in order to ensure a gender transformative HIV response.

Key Recommendations

Nine key recommendations are presented here. Other targeted activities to actualize these recommendations are in the action plan that will dovetail into the national plan. Other recommendations made at the National Data Collection Workshop are in the annex.

Systemic approach to deconstructing issues of masculinity and femininity

The critical role of gender inequality and male dominance to the vulnerability of women and girls needsto be brought to the fore. There is a need for comprehensive programmes that address gender inequality in a holistic way and cross examine the socialization of boys and girls at home and school. Some of the norms and values, beliefs and myths, gender roles and stereotypes constitute gender gaps that limit maximum participation of boys and men, girls and women and others with different sexual orientation and so need to be deconstructed through gender sensitive models.

Strengthen coordination and meaningful participation in the national response

More involvement of male and female/gender focused networks involved in gender related HIV response is needed. Participation of such groups is critical in technical working groups and in the design, implementation, monitoring and evaluation of gender responsive HIV programmes and policies. Meaningful participation would mean involving all relevant key populations including people with disabilities (PWDs). PWDs especially women and girls are also being marginalized and need to come on board. The Mid Term Review (MTR) of the ten targets shows that the country is not on track to reduce transmission of HIV among PWDs and eliminate gender inequalities; gender based abuse and violence; and increase the capacity of women and girls to protect themselves (Targets 2&7). Institutionalization of their meaningful participation is crucial to a gender transformative response.

Review of laws towards ensuring human rights and gender equality in the response

The review of laws reveals that Nigerian laws need to be revisited and reviewed with gender lens. Of immediate importance is the passage of the Anti-Stigma Bill, Violence against Persons Prohibition Bill and other bills to create an enabling environment for HIV prevention, treatment care and support. Policy and legal framework to address human rights and gender equality should be expanded in order to make room for increased access to justice through nationally standardized programmes for law enforcement agents on the right of all citizens.

Legal and social transformative interventions regarding Gender Based Violence (GBV)

One of the most serious manifestations of unequal gendered relations is gender-based violence which can increase vulnerability to HIV. It happens in many contexts be it home, school, workplace, health care settings and public places. The current national response has no mechanism to track GBV. **The involvement of men is very crucial to the change in gender based norms and should therefore be involved in** ending gender-based violence. To ensure a comprehensive response to GBV within the HIV setting, it is therefore recommended that GBV plan/guidelines be developed to guide the response. Indicators should also be developed to capture various forms of violence across different age groups.

Resource allocation/budgetary provision to specific gender sensitive interventions

Development of a gender specific costed work-plan detailing specific strategies and interventions is critical for provision of gender sensitive interventions. NACA and other partners should ensure specific allocation and budgetary provisions in all treatment, care and support programmes and initiatives. Allocation for gender activities including budgets where need be should be incorporated into all thematic areas. Resources and expenditure should

also be tracked in order to ensure that gender specific interventions have budget lines and are executed appropriately.

Provision of Integrated Health Services for all including people with disabilities

Health services to women, girls, men and boys can be improved by broadening the sexual and reproductive rights and health frameworks. Gender-sensitive integrated prevention, care and support approaches are required. Some of such approaches among others include encouraging national and State routine HCT consented to by household members and scaling up of the availability of HIV services including prevention messages, treatment, care, and support services are adapted to meet the needs of people with disabilities.

Institutionalization of Gender Management System (GMS)

NACA as the apex body is on the track of institutionalising GMS through the development of a 5-year Strategic Plan on Women, Girls and HIV/AIDS among others. However, there is a need to ensure the functionality of the system at national and sub-national levels. Enhancing National Response (ENR) has blazed the trail in this regard by commencing the process of institutionalizing GMS in its seven focal States. The MTR of the NSP identified some indicators that are not tracked. They include *proportion of partners' reports reflecting gender sensitive programming*, *proportion of key NACA, SACA, LACA, key partners staff trained in gender and HIV/AIDS programming, proportion of HIV/AIDS Budget addressing gender gaps.* Strategies and activities must be put in place at all levels so that policies, resources, capacities are built towards identifying and tracking gender indicators and setting benchmarks.

- ***Monitoring, Evaluation and Research***

There is a need for strong monitoring and evaluation mechanism that will measure changes and impact over time of the gender sensitive strategies. Though tools are available to capture sex-disaggregated data, the MTR and JAR shows that not all partners pay attention to disaggregation. Another finding from the MTR is that interpretation of disaggregated data and use of findings for decision making is inadequate.

There is also a need to build an evidence base on what works in gender-related programming in Nigeria. Data through survey is needed on the link between GBV and HIV; correlation between sex education and delay in sex debut; tracking violations of the rights of MARPs; evidence on growing Intimate Partner Violence(IPV) and effects on education in reconstruction of social norms on boys and girls.

- ***Addressing stigma and discrimination of PLHIV and other marginalized group***

The National HIV response through awareness campaign has been able to reduce stigma and discrimination of PLHIV as revealed in the Stigma Index report. However, gap still exists and a lot still need to be done. Clear strategies to address stigma and discrimination against PLHIV, MARPS and people with disabilities especially at the community level should be put in place. Introduction of the human rights element is needed to ensure that the rights of these people regardless of their status are ensured.

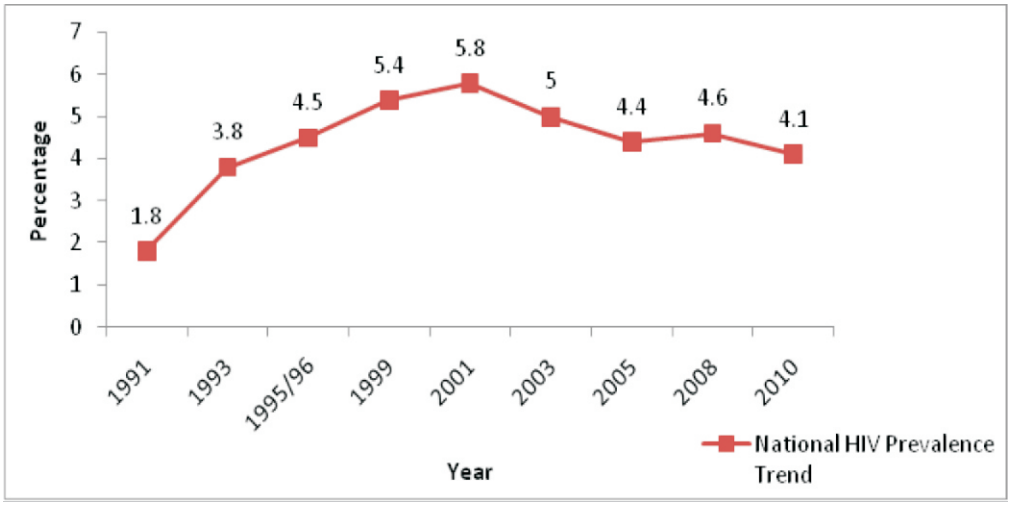
1.0 INTRODUCTION

1.1 Background

The HIV/AIDS epidemic is a global phenomenon that has continued to constitute serious health, socio economic and developmental challenges. As at 2011, statistics revealed annual AIDS death of 1.8 million while about 33million people are living with HIV and 2.6 million new HIV infections occur annually across the globe.[4] Also worthy of note is the fact that global efforts and advocacy have placed HIV/AIDS on the priority agenda of many nations as many governments commit to halting the spread of the virus through the signing of treaties.

In Nigeria, the emerging picture in the pattern, trend and level of HIV infection over the years show a great diversity and can be described as complex. The pattern shifted from being only a concentrated epidemic restricted to some populations in some States to a more generalized one. The adult HIV prevalence as monitored through antenatal HIV Sentinel Surveillance among pregnant women increased from 1.8% in 1999 and peaked at 5.8% in 2001 and then dropped to 5.0% in 2003. It however stabilized within the range of 4.6% -4.1% between 2005 and 2010. (Figure 1)

Figure : National HIV Prevalence Trend[5]



There are also geographic dissimilarities in the dynamics of the epidemic as the prevalence of HIV/AIDS vary from one state to another including rural and urban populations. States like Benue, AkwaIbom, Bayelsa, Anambra and the FCT have prevalence of between 8.6% and 12.7% while Kebbi, Ekiti and Jigawa States have prevalence of between 1.0% and 1.5%.[6] Benue State has been described as the epicentre of the infection. While some States have more of an urban epidemic, others a rural epidemic, some others seem to have pockets of high prevalence found among high risk groups that could easily infiltrate into the general population through bridge populations.[7]

Of interest, however, is the social dynamic of the infection. Of the 3.1 million people living with HIV, 1.72 million are females indicating that females are worst hit by the epidemic. It was observed that in 2007, prevalence was higher amongst females in all the geo-political zones except in the North West where prevalence is 3.6% for males and 2.3% for females.[8] In the same year, the HIV prevalence was consistently higher for females than males in both

[4]National Agency for the Control of AIDS (2011). Brief on the HIV Response in Nigeria. Factsheet.
[5]Ibid.
[6]Ibid.

urban and rural (F: (U: 4.7%; R: 3.6%)) and (M: (U: 3.0%; R: 3.3%)). Females in the reproductive age bracket have the highest prevalence. Among young people aged 20-24, the infection rate of females (4.5%) is more than double that of their male counterparts (1.9%).[9]

An understanding of the various dynamics and dimensions of the HIV infection has over the years also informed the national response as various policies and action plans were developed. The immediate response of the government to the epidemic was the development of the HIV/AIDS Emergency Action Plan (HEAP) which spanned a period of four years from 2001-2004.This was replaced by the National HIV/AIDS Strategic Framework (NSF 2005-2009),and more recently by the NSF 2010-2015 and National HIV/AIDS Strategic Plan (NSP 2010-2015). Although the HEAP was designed to address the concerns of both men and women, it was however discovered to be gender blind and this informed the series of activities that led to the mainstreaming of gender into the NSF 2005-2009, NSP 2010-2015 and current initiative – the Presidential Comprehensive Response Plan for HIV/AIDS (PCRP) in Nigeria.

Although the commitment to gender equality in HIV is increasingly visible and states are recognizing the need for an epidemic-tailored response that can adequately address the needs of women and girls as seen in the mainstreaming of gender in HIV policies and plans as well as the formation of women bodies such as the Gender Technical Committee (GTC) and National Women Coalition on AIDS (NAWOCA) among others. However, there are still some gaps between policy and implementation.

A gender assessment of the national response is therefore necessary in order to provide a framework for an improved accelerated response and coordination of gender issues within the national response. It will enable stakeholders/implementers to mainstream gender dimensions in the designs, plans, structures and processes of policies, financing mechanisms, programmes, monitoring, evaluation and research frameworks of the national response.

1.2 Goal of the Assessment

Nigeria commits to gender equality in the National HIV/AIDS response as reflected in various policies, plans and guidelines but there is an urgent need to move beyond commitments to practical action as the issue of gender inequality in the response still exists. To effectively do this, planning and action need to be evidence informed.

The goal of the gender assessment is therefore to determine empirically the status of the epidemic and the National response from a gender perspective with a view to coming up with interventions that will make the national response to be more gender transformative.

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[7] National Agency for Control of AIDS (2008). The National HIV/AIDS Behaviour Change Communication Strategy (2009-2014).
[8] Federal Ministry of Health Nigeria (2008). National HIV/AIDS and Reproductive Health Survey , 2007 (NARHS PLUS).
[9] Ibid.

1.3 Objectives of the Assessment

The objectives of the assessment are to:

1. Identify strategic investment areas that will enable gender mainstreaming in the national HIV response;
2. Identify the strategic planning and budget processes that havecogent information about the HIV epidemic, its context and the national response from a gender perspective;
3. Facilitate learning about the extent to which the national HIV response recognizes, acts and addresses gender inequality as a critical factor that can fuel the occurrence of new HIV infection;
4. Have a benchmark for monitoring and evaluation of Gender Management System (GMS) in the national HIV response; and
5. Understand the challenges and opportunities that could be useful in ensuring effective gender mainstreaming at the state and community levels in the HIV response.

1.4 Guiding Principles

The gender assessment is guided by the principles stated below in terms of the constitution of the Gender Assessment Team (GAT), data collection processes, analysis and plan for use of the assessment report.

The guiding principles are:

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

1.5 Gender Assessment Team (GAT)

The GAT selection was based on the involvement of the various organizations and their effortsat mainstreaming gender in the national HIV response. The selection also ensured the involvement of network bodies of people living with HIV/AIDS. Membership was voluntary and non-remunerated. The GAT members are also expected to report to the Gender Technical Committee (GTC). The members are:

1. NACA (Programme Coordination Department – Coordinator/Convener)
2. NACA (Strategic Knowledge Management Department.)
3. NACA (Policy and Strategic Planning Department.)
4. FMWASD
5. UNAIDS
6. UNDP
7. USG

8. SFH
9. ENR
10. ASWHAN
11. CISHAN
12. FIDA
13. Consultants(International and National)

The GAT was tasked with the following functions:

- Closely familiarize itself with the gender assessment tool and related materials;
- Develop a gender assessment framework;
- Agree on the final goal of the gender assessment;
- Decide on its guiding principles and ways of monitoring the application of the principles;
- Collect, collate and store relevant documents and data;
- Answer the questions outlined in the Gender Assessment tool;
- Analyse and use the findings of the gender assessment to identify gaps and opportunities and develop evidence based interventions;
- Prepare a report summarizing the analysis of the HIV epidemic, data on the context, of current HIV response, prevention programmes and initiatives, HIV treatment, care and support from a gender perspective;
- Convene a workshop to analyse and use the findings as part of the gender assessment process;
- Develop a communication and advocacy plan; and
- Develop a resource mobilization plan for gender mainstreaming in the national HIV response

1.6 Expected Results

The findings from the assessment are expected to be used in:

- Strengthening of the gender management system in the National Strategic Plan. Measures will be taken to address gender specific issues in the NSP and the President's Comprehensive Response Plan (PCRP).
- Providing key opportunity for strengthening gender and reference including indicators and measurement to the High Level Meeting (HLM) 2011 political declaration goal and in the GFATM New Funding Model.
- Helping to document best practices on what works for women and girls.
- Supporting to achieve United Nations Development Assistance Framework (UNDAF) targets especially on gender equality and women's advancement in Nigeria by providing (baseline) information on (globally) required indicators

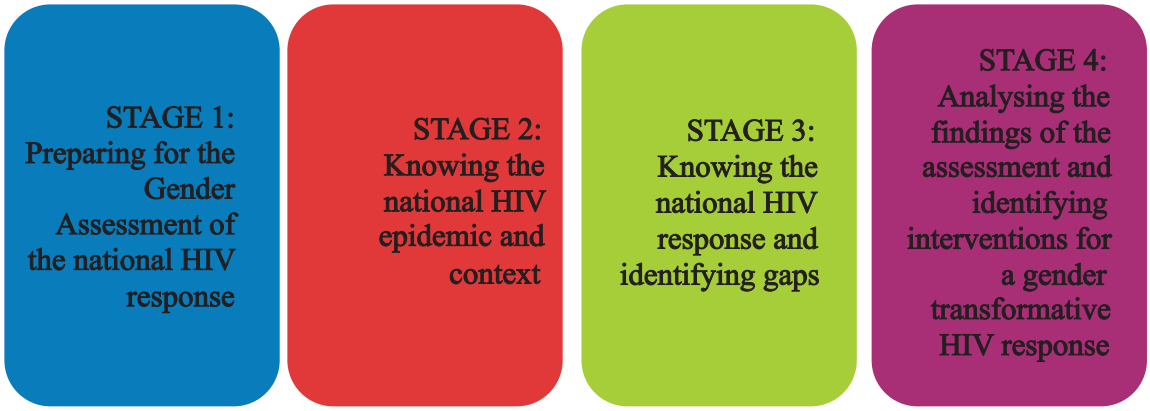
2.0 METHODOLOGY

2.1 Assessment Framework

The Gender Assessment Tool for HIV Responses which was developed by UNAIDS Secretariat, in close collaboration with co-sponsors, government, civil society, and development partners serves as the generic analytical framework for this assessment. The tool which has been piloted in five countries and is being used in more than ten countries applies a modular approach. It uses questions to clarify already available information at different stages and identify gaps especially in the areas of knowledge and response to the epidemic with regards to gender.

The tool is a planned, systematic and deliberate set of steps and processes which examine and question the status of the HIV and its gender dimension response in terms of plans and actions undertaken by the government. The tool comprises of four stages and the framework is given below:

Figure 2: Framework for Nigeria Gender Assessment (Adaptation of the UNAIDS tool)



The four stages are described below:

1. ***Preparing for the Gender Assessment of the National HIV Response***

This stage comprises of six steps. Two consultants (National and International) were contracted to support the process. Consequent steps include the constitution and the inauguration of the GAT with clear Terms of Reference (ToR) by Director General of National Agency for the Control of AIDS (NACA) on the 3rd of October, 2013 thus indicating a buy-in of government and ownership. Relevant documents were also collected and collated and these were used by the National consultant to populate the tool. The selection of participants for the National Stakeholders data collection workshop was also done by the GAT using agreed criteria.

2. ***Knowing the National HIV Epidemic and Context***

This second stage consists basically of three steps with questions woven around knowing the HIV epidemic and context in the country. Step one posed questions to elicit data on HIV prevalence and incidence in the country while step two deals with questions on social, cultural and economic factors and context of the epidemic. The third step is on legal and political aspects. The tool was populated as much as feasible from the desk review with a preliminary analysis of the information carried out. Gaps in information were taken to the stakeholders' data collection workshop for further data gathering; however, data on transgender still poses a challenge.

3. Knowing the National HIV Response and Identifying Gaps

This is the third stage and it equally consists of three steps. The first step centres around questions on gender equality in HIV, policies and programmes while the second step focuses on questions on Comprehensive HIV response and the last step was on gender considerations per community. This was equally populated with information from the desk review

4. Analysing the Findings of the Assessment and Identifying Interventions for a Gender Transformative HIV Response

This final stage entails triangulation and analysis of findings. Key prioritized interventions were proposed in the report for consideration in the second workshop where the report would be validated and consequent communication and advocacy as well as resource plans would be developed.

2.2 Assessment Process

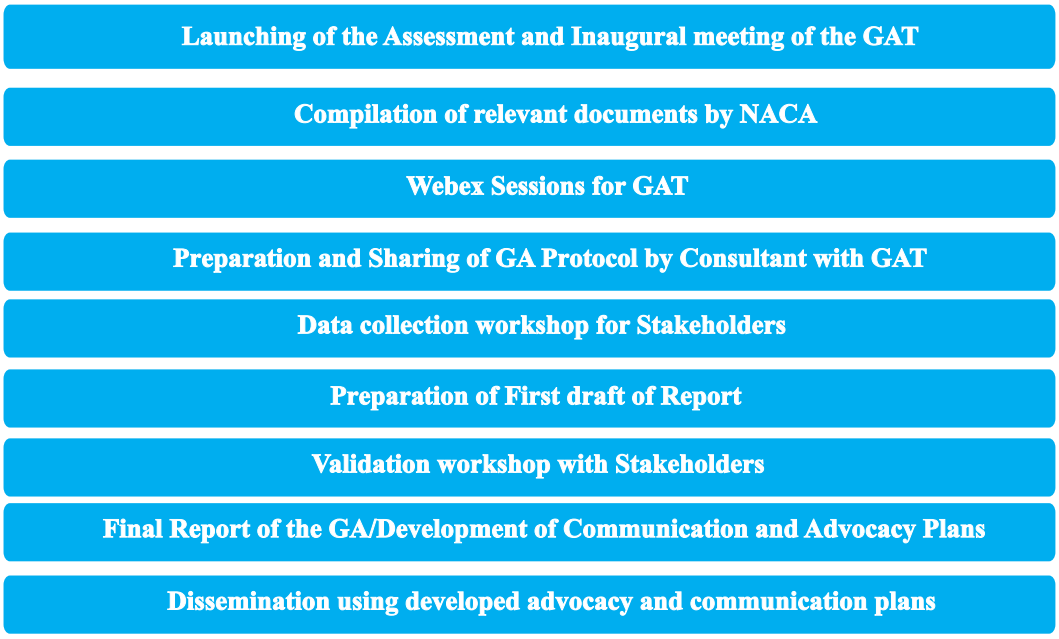
The process was led by the NACA representing the Federal Government of Nigeria (FGN) with support from UNAIDS Country Office (UCO) in Nigeria and the Joint UN Team on AIDS. The Gender Assessment Team (GAT) comprising of 13 members included representatives from Government, the UN system, other Development Partners, Civil Society networks with special inclusion of women living with HIV and two consultants (National and International consultants). The GAT with a clear ToR provided oversight functions as well as facilitated sessions at the National stakeholders Data Collection workshop. A webex session was organized by UNAIDS on the 10th of October 2013 for the GAT after their inauguration to take the GAT through the UNAIDS tool. The protocol for the assessment was drafted by the National consultant. This was reviewed and approved by GAT after which the National Consultant was mandated to populate the tool and carry out preliminary analysis for presentation at a 4-day National stakeholders' data collection workshop.

The GAT adopted a multi stage sampling technique that employs both stratified and purposive methods to select the participants for the National Stakeholders data collection workshop. Participants for the workshop were drawn from 18 States and FCT. At least two States were selected from each of the six geopolitical zones while care was taken to include urban and rural settings to ensure adequate coverage and representativeness. The sampling procedure, apart from considering high prevalence which has been taken care of in the 12+1 States, also took into consideration States with low prevalence rates as well as a socio cultural mix of the States. The sampling also ensured representativeness of all stakeholders including State and non-State actors. State actors were drawn from both the health and non-health sectors including the SACA, line Ministries such as Education, Justice and Information while non-State actors included Civil Society organizations such as Civil Society on HIV & AIDS in Nigeria (CISHAN), Association of Women Living with AIDS (ASWHAN); and human and women rights bodies like International Federation of Women Lawyers (FIDA). The United Nations, the United State Government (USG) and the Department for International Development (DfID) and other development partners were also involved. In all, sixty five (65) participants attended the workshop.

A four-day workshop was held in Abuja in November, 2013. The National and International consultants assisted by other facilitators gave direction to the workshop. Presentations were made by partners and consultants after which breakaway sessions took place. This provided an opportunity to deliberate on specific aspects of the assessment and make recommendations (Annex). Next steps were also agreed on; including the production of a first draft report for consideration at the Report Finalization Workshop scheduled for December, 2013. Other expected deliverables were resources mobilization; communication and advocacy plan as well as a resource plan.

2.3 Flow Chart of the Process

Figure 3: Flow Chart of the Gender Assessment Process



2.4 Sources of Information

2.4.1 Desk Review

In depth review of HIV and gender related documents was done by the consultants. The desk review provided the background and on the context of the situation of the epidemic and the national response so far from the perspective of gender equality. Over one hundred documents were reviewed. Relevant materials for the desk review included:

- The UNAIDS Gender Assessment Tool for National HIV Response;
- Laws and regulations related to HIV, gender and human rights issues;
- Policies, strategies and guidelines including international, country and state-specific documents from State and non-State actors;
- Other documents and reports, including situation analyses on gender topics; country and state-specific reports from international donors and NGOs on specific topics related to gender and HIV;
- Websites providing relevant information.

2.4.2 Data Collection Workshop for National Stakeholders

It was a four-day workshop (12th -15th November, 2013) organized for stakeholders to review the preliminary analysis of stages 2 and 3 of the tool, complete the data by filling out and correcting information as well as generating recommendations. The consultants and the CAT had a pre-workshop meeting. Consultants presented the available data guided by the tool on knowing your epidemic and knowing your response on the first day. Other days were devoted to group discussions on the following themes: Law/Policy/Guidelines; Gender Equality and Power Relations; Socio-cultural and Religious Issues and HIV intersect; Gender Equality and Power Relations - Public and Social sector; and Economic Empowerment and HIV. A 30-minute presentation was done by members of the GAT daily before the take-off of each session on definitions, framework and country direction. The international consultant drafted the questions that guided the group discussions. Groups presented their deliberations and recommendations in plenary sessions. Timelines for the next steps after the workshop were also agreed on.

2.4.3 Report Finalization Workshop

A two-day report finalization workshop was held in December 2013. The workshop provided a forum for deliberation on the first draft report produced by the consultants. The comments at the workshop produced the final report.

3.0 FINDINGS

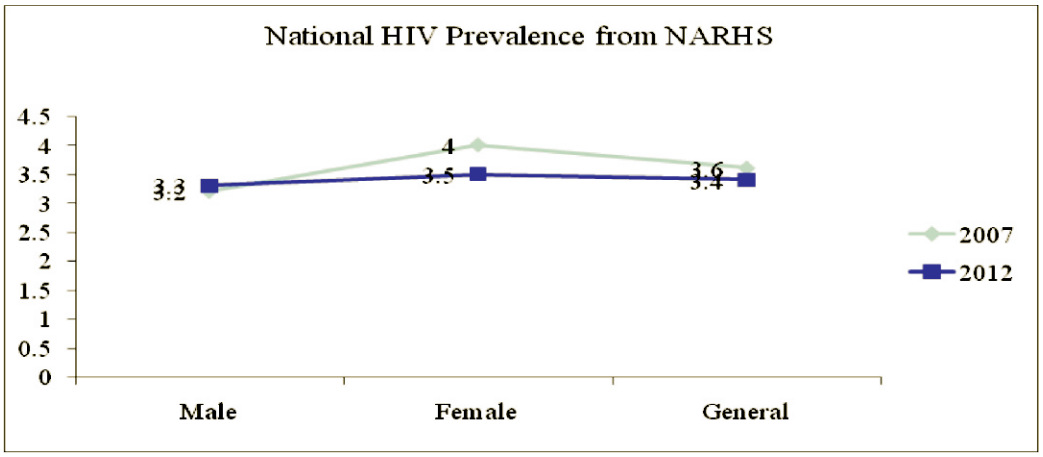
3.1 Knowing Your Epidemic

3.1.1 HIV Prevalence, Incidence and Behavioural Information

3.1.1.1 Prevalence and Incidence

Prevalence and Incidence in the General Population

Figure 4: National HIV Prevalence from NARHS



NARHS (2012) reported that the HIV prevalence in Nigeria is 3.4%. This represents a slight drop from 3.6% reported in 2007 NARHS. While the prevalence for females dropped from 4.0% to 3.5%, there was a slight increase for men from 3.2% to 3.3%.

The disaggregation of HIV data by sex and age indicates that in the general population there is a feminization of the epidemic. For the adult age group of 20 to 39, the female prevalence rates are higher than those of the males, with females 30 to 34 having the highest rate HIV prevalence at 4.2%. For the age group 35 to 44, the male prevalence rates are higher than those of females with the highest rate at5.3% being found amongst males 35 to 39. Above 49 years old, the female rates are again higher, and for the youth 15 to 19, males and females have an equal prevalence rate at 2.9%. See Table 1 below for prevalence rates in the general population.

Table 1: HIV Prevalence in Nigeria by Age and Sex[10]

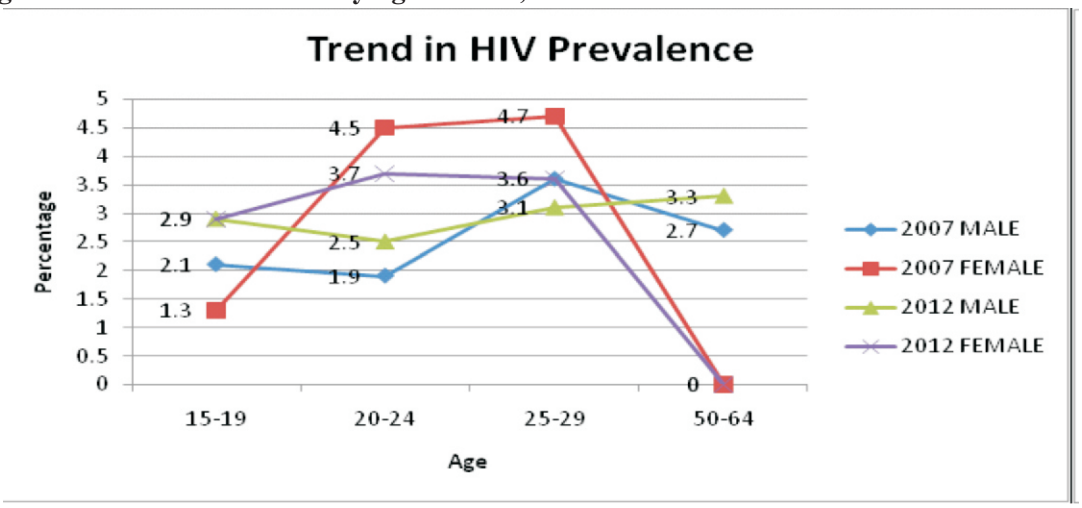
Age	Total Population	Male	Female
0-14	N/A	N/A	N/A
15-19	2.9	2.9	2.9
20-24	3.1	2.5	3.7
25-29	3.4	3.1	3.6
30-34	4.0	3.7	**4.2**
35-39	4.4	**5.3**	3.5
40-44	2.9	3.1	2.7
45-49	3.7	3.5	3.9
50-64	3.3	3.3	N/A
TOTAL		3.3	3.5

NA= Not Available

[10]Federal Ministry of Health Nigeria (2013). National HIV/AIDS and Reproductive Health Survey , 2012 (NARHS PLUS).

Using the NARHS survey of 2007 as a benchmark, the trend over time in prevalence data shows a decrease in infection rates amongst females aged 20 to 39. For men of the same age group the picture is mixed with increasing prevalence rates being observed for the 20 to 24 grouping but decreasing for the 25- to 29-year olds. Six years ago prevalence was highest across board for those in the age bracket 30 to 39 regardless of sex, with both men and women registering figures above 5%. Today, it remains the same with this group but found at lower figures for women. The trend amongst youth aged 15 to 19 is tending towards an increase for both sexes, with both rising above the 2.5 threshold. Data on transgender persons as well as age brackets 0-14years were not available. See the graph below for a comparison of prevalence rates by age and sex between 2007 and 2012.

Figure 5: Trend in Prevalence by Age and Sex, 2007 and 2012[11][12]



The latest national HIV incidence findings disaggregated by sex and age can be found in the Table below for the general population.

Table 2: HIV Incidence, 2012[13]

Population	2011
Total	310,322
Adults>15	243,430
Children< 15	67,190
Female	170,431
Male	140,169

Incidence data is not clearly disaggregated into age groups and sex; thus making comparison between male and female within age brackets difficult. However, females recorded a higher incidence (54.9%) compared to the males (45.1%). New infections in females continue to surpass that in males, contributing to about 52.4% of sero-conversions that occurred in 2012 as revealed by the Spectrum Modelling done in 2012.

Prevalence and Incidence among Key Population

Population size estimations for key populations has been done as recommended/outlined in the National Strategic Plan. The appraisal was limited to only 8 States of Nigeria and the Armed Forces, Police and Transport Workers were excluded.

[11] Federal Ministry of Health Nigeria (2008.) National HIV/AIDS and Reproductive Health Survey, 2007 (NARHS PLUS).
[12] Federal Ministry of Health Nigeria (2013). National HIV/AIDS and Reproductive Health Survey, 2012 (NARHS PLUS).
[13] National Agency for Control of AIDS (2012). Global AIDS Response Progress Report (GARPR, 2012).

Table 3: Key Populations Size Estimates[14]

Key Populations Estimate, 2013	
Key Population	**Size Estimation**
BBFSW	459,887
NBBFSW	
MSM	25,476
IDU	11,692
ARMED FORCES	N/A
POLICE	N/A
TRANSPORT WORKERS	N/A

N/A = Not available

HIV prevalence amongst key populations indicates that the rates are highest amongst Brothel-Based Female Sex Workers. Similarly, highest rate of HIV prevalence were identified in the groups in these groups in 2007 and 2012. In terms of age, age group 25 to 49 has higher HIV prevalence rates than the age 20 to 24 for all seven key populations listed inTable 4:

Table 4: HIV Prevalence among Key Populations by Age & Sex, 2007 & 2010[15][16]

			BY SEX		**BY AGE**	
Key Population	**Overall 2007**	**Overall 2010**	**Male (2010)**	**Female (2010)**	**20-24 (2010)**	**25-49 (2010)**
BBFSW	37.4	27.4	*N/A	27.4	20.3	30.8
NBBFSW	30.2	21.1	*N/A	21.1	18.0	24.8
MSM	13.5	17.2	17.2	*NA	16.2	20.0
IDU	5.6	4.2	3.1	21	4.0	4.3
ARMED FORCES	3.1	2.5	N/A	N/A	0.3	2.6
POLICE	3.5	2.6	2.0	4.5	0.9	2.7
Transport Workers	3.7	2.4	2.4	N/A	0	2.6

*NA= Not Applicable. N/A= Not Available

The trend over time in prevalence data is difficult to determine as it has not been consistently disaggregated by sex and age. However, the IDU and Police data for 2010 was disaggregated by sex and it shows that females have higher HIV prevalence rates than males. In the case of PWIDs, this is almost seven times higher. The reason for the disproportionate high rate among female PWIDS is unclear. In 2007, police data in 6 states was disaggregated by sex and showed that female police officers have a higher HIV prevalence rate than their male counterparts.[17]

Mode of Transmission

The result of the Mode of Transmission (MoT) analysis in Nigeria, in 2008, showed that about 62 percent of new infections occur among persons perceived as practising "low risk sex" in the general population including married sexual partners. The rest of the new infections (38 percent) are attributed to People Who Inject Drugs (PWIDs), female sex workers (FSWs), MSM and their partners who constitute about 3.5 percent of the adult population.[18] Few States that received funding from ENR however carried out their own state specific MoT using the spectrum modeling method for projections and estimates. The box below however contains indication that the mode of transmission remains mainly by heterosexual sex and vertical transmission.

[14]National Agency for Control of AIDS (2013). Ten Targets of the UN General Assembly 2011 Political Declaration on HIV/AIDS-Mid Term Review.

[15]Federal Ministry of Health (2008). Nigeria Integrated Biological and Behavioural Surveillance Survey, 2007 (NARHS PLUS).

[16]Federal Ministry of Health (2010). Nigeria Integrated Biological and Behavioural Surveillance Survey (IBBSS).

[17]Federal Ministry of Health (2007). Nigeria Integrated Biological and Behavioural Surveillance Survey (IBBSS).

Box 1: Mode of Transmission of HIV in 2011[19]

Recent estimates show that the annual number of new infections in the country has been on a steady decline, decreasing from 340,015 in 2008 to 319,322 in 2010 and 310,620 in 2011. The decline is mainly due to the decline in the number of new infections. The number of new infections among adults in 2008 and 2011 were 271,151 and 243,430 respectively. Furthermore, the number of infections in children increased by 4.0% from 2008 to 2010 before declining in 2011 by about 6.2% most likely because of recent scale up activities to improve PMTCT uptake. New infections in females continue to surpass that in males contributing to about 54.9% of sero-conversions that occurred in 2011.

Rural Versus Urban Prevalence Variations

For the general population, in 2007, prevalence was higher in urban than rural areas (3.8% urban, 3.5% rural). However, this was reversed in 2012 with rural being higher (3.6% rural to 3.2% urban). In general, it shows in 2007, that prevalence was consistently higher among females than males both in urban and rural areas and also higher for females in all geopolitical zones except the North-west. In 2012, the HIV prevalence was higher among females in four zones except the North-West and South-South. Table 5 indicates variations for male and female prevalence rates by region including urban versus rural averages with a comparison between 2007 and 2012.

Table 5: Prevalence Rates by Region and Sex, 2007 and 2012

	URBAN			RURAL			NW			NE			NC			SW			SE			SS		
General Population (NARHS, 2007)	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F
	3.8	3.0	4.7	3.5	3.3	3.6	3.0	3.6	2.3	3.4	2.2	4.8	5.7	5.1	6.5	3.4	3.0	3.9	2.6	1.9	3.4	3.5	3.3	3.8
General Population (NARHS, 2012)	3.2	NA	NA	3.6	NA	NA	3.2	3.6	2.8	3.5	3.4	3.7	3.4	3.0	3.9	2.8	2.7	2.9	1.8	1.0	2.5	5.5	5.6	5.5

Data is available for key populations by States but not by geopolitical zones, which represents a limitation.[20][21]

Knowledge on Prevention-Youth

The proportion of young people aged 15–24 who both correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission is 21% for the ages 15 to 19 and 27% for the ages 20 to 24. See the Table below for the **disaggregation by sex.**

Table 6: Knowledge on Prevention among Young People by Sex and Age, 2007&2012

Young People: Knowledge about HIV and Prevention								
				2005[22]	2007[23]	2012[24]		
Age	Total	Female	Male	Total	Total	Total	Male	Female
15-19	21.8	20.8	22.9					
20-24	27.4	23.9	32.1	22.5	24.2	24.4	27.0	22.3

Amongst the youth, males seem to have amore correct knowledge across the age groups compared to the females. Within the grouping, the males have a higher knowledge in the 20-24 than the 15-19 age brackets. In 2007, disaggregation in the general population was done by sex for rural and urban areas.

[18] National Agency for the Control of AIDS (2009). National Policy on HIV and AIDS.
[19] National Agency for Control of AIDS (2012). Global AIDS Response Progress Report (GARPR, 2012).

Knowledge on Prevention – Key Population

For the key populations, 2007 and 2010 knowledge surveys demonstrate that Female Sex Workers are more aware of how to prevent HIV than all other key population groups as at 2010. Three years before that, the Armed forces scored the highest in terms of knowledge, followed by MSM. This shift may be based on a recent HIV programming focus on female sex workers and the fact that the Armed Forces, police and transport workers were excluded from the 2013 MARPS estimates done. **Correct knowledge of HIV prevention is least amongst Transport Workers.** Though these latter groups are categorised as key populations, they were not considered as MARPs because of their prevalence rates which were lower than the National prevalence average. It will be useful to have an estimate of these population groups. Table 7 below provides a comparison of knowledge levels between 2007 and 2010 among identified key population groups.

Table 7: Knowledge about HIV and Prevention by Key Population Group, 2007 & 2010 [25] [26]

Key Population group	2007	2010
BBFSW	25.3	21.6
NBBFSW	38.9	19.2
MSM	44	19.5
IDU	33.9	4.2
Armed Forces	50.6	2.4
Police	34.9	2.6
Transport Workers	21.1	2.3

Knowledge of Condom Use

The proportion of young women and men that have knowledge of whether a person can reduce the risk of getting HIV by using a condom every time they have sex is higher amongst males than females. At the data collection workshop, this skew in knowledge was attributed to under-reporting by females caused by socio-cultural factors which expect that "good" women/girls should not know much about sex and should also be shy to speak about sex. However, there was no immediate way to verify this argument

The age groups 20 to 39 are the most knowledgeable across board. Table 8 below presents knowledge about HIV by age and sex in 2007 and 2012.

***Table 8: Knowledge about HIV and prevention by way of consistent condom use by Age and* Sex, 2007 and 2012**

Age Disaggregation			Sex Disaggregation			
Age	2007	2012	NARHS 2007		NARHS 2012	
15-19	77.7%	55.7%				
20-24	87.0%	64.0%	Male	Female	Male	Female
			63.1%	44.9%	65.9%	54.7%
25-29	87.0%	64.3%				
30-39	87.3%	62.6%				
40-49	84.2%	56.0%				
50-64	86.6%	57.6%				
Total	84.6%	60.3%				

[20] Federal Ministry of Health (2007). Nigeria Integrated Biological and Behavioural Surveillance Survey (IBBSS).

[21] Federal Ministry of Health (2010). Nigeria Integrated Biological and Behavioural Surveillance Survey (IBBSS).

[22] National Agency for Control of AIDS (2012). Global AIDS Response Progress Report (GARPR, 2012).

[23] Federal Ministry of Health Nigeria (2008). National HIV/AIDS and Reproductive Health Survey, 2007 (NARHS PLUS).

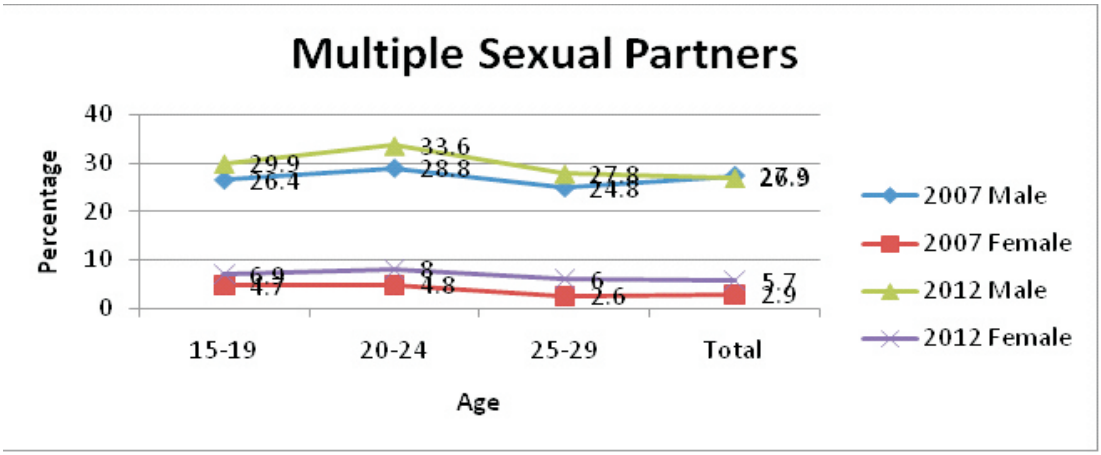
[24] Federal Ministry of Health Nigeria (2013). National HIV/AIDS and Reproductive Health Survey, 2012 (NARHS PLUS).

3.1.1.2 Behavioural Information

Multiple Partnerships

The percentage of women and men aged 15-49 with multiple sexual partners is higher amongst males than females, with more than 30% men ages 20 to 24 reporting multiple sex partners in 2012, an increase over the 2007 figure. Figure 5 shows the comparison of multiple sexual partnerships between 2007 and 2012.

Figure 6: Multiple Sexual Partnerships by Age and Sex, 2007 and 2012[27][28]



Condom Use with Multiple Partners

The proportion of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse was higher for the men than the women, while the lowest reported condom users were found to be amongst the 15 to 19 age group. Some gains have been made since 2007 in this age group, with higher condom use being noted in 2012. Table 9 shows condom usage by age and sex.

Table 9: Condom Use with Multiple Partners by Age and Sex, 2007 and 2012[29][30]

Age	2007		2012	
	Male	Female	Male	Female
15-19	47.8	28.7	56.4	39.4
20-24	54.2	38.7	64.8	48.5
25-29	62.2	47.5	67.6	48.8
30-39	54.1	24.5		
40-49	43.5	15.8		
50-64	-	NA	37.3	NA
Total	54.2	35.3	61.2	43.0

There is some resistance amongst men regarding using the male condom due to the perception that it reduces sexual pleasure during the act of intercourse. It was gathered during the data collection workshop that women's low negotiating power attributed to their low condom use figures. It was noted that poor negotiating power is due mainly to the low social status of women and cross generational relationships between older men and young girls. Married women may likewise face a challenge negotiating condom use with their husbands for fear of being perceived as being promiscuous which has in some instances led to intimate partner violence.

[25]Federal Ministry of Health (2007). Nigeria Integrated Biological and Behavioural Surveillance Survey (IBBSS)

[26]Federal Ministry of Health (2010). Nigeria Integrated Biological and Behavioural Surveillance Survey (IBBSS)

Data Collection on Unwanted Pregnancies

Nigeria has carried out studies and research on unplanned pregnancies among unmarried adolescents but has no national survey data.

In a study titled 'Unwanted Pregnancy and Induced Abortion in Nigeria - Causes and Consequences' by Oye-Adeniran*et. al.* (2005), funded by the David and Lucile Packard Foundation and The John D. and Catherine T. MacArthur Foundation, the following findings were documented:

Nearly one-third (28%) of women of reproductive age have had an unwanted pregnancy at some point in their lives.

An estimated one in five pregnancies in Nigeria are unplanned.

Many factors contribute to unwanted pregnancy among which are low levels of contraceptive use, growing urbanization, the increasing participation of women in the paid labor force and the diminishing ability of families to support many children (partly because of the costs of educating them).

More than one-quarter (27%) of all Nigerian women aged 15–49 need effective contraception – that is, they are able to become pregnant, are sexually active, do not want a child soon or ever, but are not using any method of contraception. (22%) are using traditional methods (5%), which have high failure rates.

Six in 10 women (61%) who have had abortion were not using any method of family planning when they conceived, 33% were using a modern method, and 6% a traditional one.

Forty-three percent (43%) of women who sought an abortion did so because they were not married, were too young or were still in school

At the time of the survey, 27% of all respondents were at risk of an unwanted pregnancy.

It was equally reported in the Nigeria Demographic Health Survey that 4% of children born were unwanted while 7 percent were wanted later, that is, mistimed.[31] Sexual intercourse reportedly takes place among adolescents mainly without the use of contraception.[32] Consequently, incidence of unwanted pregnancy, unsafe abortions, HIV and other STIs are high among adolescents. Overall, 17% of women aged 15-19 years have an unmet need for effective contraception. The country policies and programmes do not make a direct link between prevention of unwanted pregnancies and HIV prevention, but rather indirectly through condom programming and communication related messages.

Intimate Partner Violence

Nigeria collects data on violence against women including intimate partner violence. According to the 2008 NDHS, the 20-24 and 18-19 age groups experience sexual violence more than any other age group. Among ever-married women who have experienced sexual violence, the proportion reporting that their current husband or partner committed sexual violence against them increased to 50 percent. Among never married women, strangers are the most commonly reported perpetrators of sexual violence (23 %), followed by a friend or acquaintance (18 %) and current or former boyfriend (17 %).[33]

[27]Federal Ministry of Health Nigeria (2008). National HIV/AIDS and Reproductive Health Survey, 2007 (NARHS PLUS).
[28]Federal Ministry of Health Nigeria (2013). National HIV/AIDS and Reproductive Health Survey, 2012 (NARHS PLUS).
[29]Federal Ministry of Health Nigeria (2008).National HIV/AIDS and Reproductive Health Survey, 2007 (NARHS PLUS).
[30]Federal Ministry of Health Nigeria (2013). National HIV/AIDS and Reproductive Health Survey, 2012 (NARHS PLUS).
[31]National Population Commission (2009). Nigeria Demographic and Health Survey 2008.

Nationally the proportions of females and males respectively that felt that a husband is variably justified to beat his wife and the reasons accepted are as follows: If the man feels the woman is unfaithful (58.0% and 55.4%); If she neglects the children (56% and 54%); If the woman goes out without telling the man (54% and 52%); if she refuses him sex (48% and 46%); if the food is not ready on time (48% and 45%); and if she argues with him (48% by both female and male respondents).[34] The analysis on the reasons behind the acceptance of violence is offered later in this report.

Stigma and Discrimination

1. Data on stigma and discrimination toward Persons Living with HIV (PLHIV) has been collected in Nigeria using the Stigma Index. See Table10 below for the results.

Table 10: Stigma and Discrimination due to HIV Status by Sex[35]

S/N	Parameters	Male (%)	Female (%)
1.	Exclusion from social gathering/Activities	56	43.2
2.	Exclusion from Religious activities	42.4	32.3
3.	Exclusion from family activities	50	49
4.	Forced to change place of residence	37.5	51.2
5.	Lost job or another source of income	50	42.7

Exclusion from social activities was the most common form of discrimination experienced by male PLHIV with 56% of the men surveyed reporting this experience, 51% of women surveyed were being forced to change residence as a result of discrimination.. The issue of a place of residence is the only stigma parameter for which women experience more difficulties than men. Given the societal expectation that men either host or provide lodging for their

wives, daughters or female relatives, challenges in this area signify a breakdown of the social protection usually enjoyed by women.

In terms of health, male PLHIV consistently experience more denial of health services than female PLHIV. In general, however, there exists a basic level of tolerance in the health care setting as 68% of men and 74% of women surveyed reported never having experienced any denial of health service due to their HIV status. See Table 11 below.

Table 11: Denial of Health Services due to HIV Status by Sex, 2010[36]

Stigma Index Q uestion: In the past 12 months, have you been denied health services, including dental care, because of your HIV status?			
Responses	**Male**	**Female**	**Total**
Never	171 (68.40%)	338 (74.10%)	509 (72.10%)
Once	19 (7.60%)	32 (7.00%)	51 (7.20%)
A few times	28 (11.20%)	38 (8.30%)	66 (9.30%)
Often	15 (6.00%)	14 (3.10%)	29 (4.10%)
Not applicable	17 (6.80%)	34 (7.50%)	51 (7.20%)
Total	250	456	706

[32]Federal Ministry of Health Nigeria (2013). National HIV/AIDS and Reproductive Health Survey, 2012 - reported study by Alan Guttmacher Institute, 2004.
[33]National Population Commission (2009). Nigeria Demographic and Health Survey 2008.
[34]Federal Ministry of Health Nigeria (2013). National HIV/AIDS and Reproductive Health Survey, 2012 (NARHS PLUS).
[35]Network of People Living with HIV and AIDS in Nigeria (2010). The People Living with HIV Stigma Index.

Box 2: Key Gender Differences, Gaps and Observations

HIV PREVALENCE , INCIDENCE AND BEHAVIOURAL INFORMATION

Key observations

There is a generalised feminisation of the HIV epidemic with a growing number of women being infected.

There is a growing youth population becoming infected and displaying behavioural patterns that place them at risk of HIV infection.

There is a survey data gap for the 0 -14 age group, information for which cannot be inferred from other age groups especially their HIV prevalence
There is a research and survey data gap for transgender populations.

Women and girls are disproportionately affected and women's vulnerability to HIV is exacerbated by a variety of factors as discussed.

3.1.2 Social, Cultural, and Economic Factors

The socio-cultural and economic norms and practices in Nigeria that may contribute to increasing the risk of HIV transmission among women and girls, men and boys, and transgender persons, as identified by desk research and confirmed during the data collection workshop are outlined below. They are divided into fivecategories:

1. Child marriage
2. Gender-based violence
3. Masculinity and Femininity norms
4. Disabilities
5. Harmful traditional rites

3.1.2.1 Child Marriage

About a third of adolescent girls (15-19 years) were already married in 2003, and out of this 16% were actually married by age 15.[37] Children of young age are married off to older men who likely have other wives and sexual partners. The girl's vulnerability is high because the HIV status of the prospective husband is not usually verified before marriage. Child marriage is not by choice, and normally the girls do not have decision making power over their sexuality and health, which implies their inability to negotiate safe sex.

The practice of child marriage is sometimes based on the religious/cultural belief that it curbs promiscuity because it reduces the exposure of young girls to multiple sexual partners before marriage.

It is also economically-motivated in other cases where baby girls even before they are born are betrothed to older men as a means of debt settlement. This is known as 'money woman' and is a common practice in Obanliku, Cross River state.

To tackle the practice and the effects of child marriage there are ongoing awareness creation programmes within the government MDAs (Ministries, Departments and Agencies), as well as sensitization of the media on the need to create awareness on HIV/AIDS and gender equality issues. At the community level, there are increasing number of opportunities made

[37] National Population Commission (2004). Nigeria Demographic and Health Survey 2003.

for the public to come together to talk about HIV/AIDS and related issues such as child marriage. At the individual and household levels, individuals are taking steps to resist early marriage of their daughters; families have begun appreciating the need to educate girls and boys alike, and also educating the children about dangers of child marriage.

3.1.2.2 Gender-Based Violence

There exists the belief that women are typically weaker, powerless and more dependent. This makes females more susceptible to violence, including intimate partner violence (IPV).
See Table 12 below for data available on IPV, including sexual violence.

Table 12: Percentage of Women age 15-49 who have experienced different forms of Violence by Age[38]

Age	Physical Violence only	Sexual Violence only	Physical & Sexual Violence	Physical or Sexual Violence
15-19	21.9	1.8	4.8	28.5
15-17	21.2	1.7	4.4	27.3
18-19	22.8	2.0	5.3	30.2
20-24	22.0	2.5	6.2	30.7
25-29	23.8	1.6	6.2	31.7
30-39	22.6	1.5	4.8	29.0
40-49	21.5	1.5	4.4	27.4
Total	22.4	1.8	5.3	29.5

Rape and sexual assault initiated by one or more persons against female makes them vulnerable to HIV. Types of sexual assault generally identified by the participatory evaluation process included wife battering with rape, “curative rape” of lesbians (using rape as a corrective measure for their sexual orientation) and employer's rape of female domestic workers who are often trafficked persons. These acts often receive no redress due to the unequal power relations involved, and also because victims are dissuaded by relatives not to speak up due to the societal shame that may surround the family of a rape victim, perceived loss of value and/or marriage prospects of the woman/ girl.

In terms of myths, there is a cultural belief that having intercourse with a virgin removes curses from a person or family. This makes virgin girls, including daughters, susceptible to rape and HIV infection, leading to unwanted pregnancies and unsafe abortions, which can lead to death. Another myth that may place women and girls at risk of rape and HIV infection is that of “indecent dressing” which encourages sexual abuse. This myth encourages rape, blaming the victim for the act and thereby effectively discouraging victims from reporting sexual abuse and rape.

The participatory evaluation acknowledged a general culture of silence around violence against women for a variety of reasons, including the fear of loss of financial support on the part of the victims, the fear of being victimized further by the perpetrator if the crime is reported and the fear of loss of family bonds when third parties are involved especially in the case of incest.

In the case of married partners, it is difficult to report and get redress in any legal system because of the belief that marital rape is a paradox as the wife's body should belong to the husband. It was noted that victims of rape were normally assumed to be females and so combined with the culture of silence, boys and men are expected to be strong and never seen

[38]National Population Commission (2009). Nigeria Demographic and Health Survey 2008.

as possible victims. Therefore, it would be a challenge for a male to report and follow through with legal procedures if he was raped. These factors combined may contribute to an under reporting of violence experienced.

3.1.2.3 Masculinity and Femininity Norms

Masculinity norms stipulate that men engage in multiple sexual partnerships as a show of manhood. This, coupled with the commonly held view that condoms reduce sexual pleasure, translates to unsafe sex with more than one partner. Table 13 below provides data on high risk sexual intercourse (multiple/concurrent partners) and the use of condom during that period.

Table 13: High Risk Sexual Intercourse disaggregated by Sex and Age[39]

Women			**Men**		
Age	**% of those involved**	**% of those who use a condom**	**Age**	**% of those involved**	**% of those who use a condom**
15-24	28.8	35.5	15-24	79.2	49.4
15-19	33.3	28.6	15-19	94.5	36.3
20-24	26.3	40.5	20-24	74.1	55.1
25-29	11.9	38.4	25-29	46.7	60.7
30-39	4.7	25.7	30-39	20.5	58.5
40-49	3.5	4.5	40-49	8.8	46.5
Total	13.1	33.4	Total	29.5	53.8

Men (29.5%) are more involved in higher risk sexual intercourse than women (13.1%). The lower figures may be due to the fact that virginity at marriage is highly valued across the various cultures and religions of Nigeria and that it is culturally not acceptable for women to have extramarital affairs, with repercussions for those found guilty in some areas of *Akwa-Ibom, Edo, Benue, Delta, Imo, Ebonyi, and Enugu* states. Young men aged 15-19 are more involved in the practice of having multiple sexual partnerships (94.5%) and only 36.3% use condom during the act, exposing them to HIV infection.

Both men and women are shown to perceive low levels of risk connected with not using a condom as shown in Table 14 below:

Table 14: Low Risk Perception among respondents[40]

	Risk Perception			**Ever used condom**
	High	Low	No risk at all	
Male	1.8	44.6	47.7	44.5
Female	1.3	42.0	46.0	30.2
Total	1.6	43.3	46.6	38

For men who are financially stable, there is a phenomenon of having affairs with younger women, sometimes 10 or more years younger. The lure for girls and young women is often financial security.

Young women may also become unwillingly initiated into this type of relationship. It is a practice for mothers in some parts of the country to encourage their girl-child into prostitution for economic benefits. In addition, it is believed that some banks purposefully employ young attractive girls to market their packages and threaten them with loss of their jobs if sales targets are not met. This predisposes employees to sexual advances from prospective bank clients.

Table 15 shows data on age disparate sexual relationships between older men and younger women.

Table 15: Percentage of Women age 15-19 who had Higher-riskSexual intercourse with a Man 10+years older[41]

AGE	PERCENTAGE
15-17	12.9
15-19	10.5
18-19	8.6

As mentioned above in relation to violence, the evaluation participants highlighted the fact that men felt supported by the general culture and they are indeed supported by law to physically "correct" their wives in a bid to demonstrate their leadership of the home in line with accepted masculine stereotypes. This perspective had also been accepted by many women victims of violence. It was, however, noted that if a woman attempted to physically abuse her husband, it would be frowned upon.

While girls are expected to keep their virginity until marriage, masculinity norms stipulate early sexual debut for boys. The issue of value of virginity is often discussed in favour of girls by default. The participatory evaluation noted that there was not much space available for discussion of boys' virginity, which works against efforts being made for abstinence to curb HIV spread.

There are some socio-cultural femininity norms that increase women's vulnerability to HIV infection. In addition to those already mentioned, these include:

An expectation that a woman should be respectful and submissive to her husband. This does not allow them to bargain for safe sex or the use of female condom – as it puts them in an initiator role – for fear of being tagged promiscuous.

Some also believe that having unprotected sex will help gain the trust of their partners.

The belief that women should be seen as being taken care of financially, religiously, physically and intellectually by a man makes for women to miss out or pass up opportunities that can improve their lives in favour of more balanced gender relations.

The fact that delivering babies at home is used to deem the woman a hero makes it more popular to use Traditional Birth Attendant (TBA) services rather than go to a health facility, thus precluding the protocol of HIV tests and initiation of PMTCT services. These TBA services sometimes do not meet standards of handling of blood and blood products. Knowing that caesareans could be recommended by doctors in health facilities, some pregnant women prefer to stay at home and retain the services of these TBAs because of the stigma attached to caesarean sections.

A mistrust of western medicine among women has led to increase in demand for traditional cures for HIV, STD and OI related illnesses.

An Islamic tradition designed to appreciate new mothers stipulates that their husbands should get involved in chores and pay them for breast feeding. This may have the unintended consequence of ostracism against women who choose not to breastfeed, even though their reason may be related to their PMTCT options, being HIV positive themselves.

In the Hausa/Fulani culture, girls are expected to hawk in the neighborhood with the underlying motive to make them visible to potential suitors; however, this may also expose them to potential sexual abuse.

[40]Federal Ministry of Health Nigeria (2013). National HIV/AIDS and Reproductive Health Survey, 2012 (NARHS PLUS).
[41]National Population Commission (2009). Nigeria Demographic and Health Survey 2008.

Within the Hausa/Fulani culture, girls are denied access to education on the premise that it exposes them to sexual promiscuity.

The religious promotion of abstinence can be harnessed for promoting a delay in debut of sexual relations on the part of young girls and also young boys, both Christianity and Islam have large followership.

The fact that daughters and other girls in a family may be given out as housemaids in some parts of the country makes girls vulnerable and exposes them to sexual violence and HIV infection.

Wives of men who are impotent have cultural license in some parts of the country to have extra marital affairs in a bid to end a state of childlessness, which is related to the high value placed on a marriage that yields children. This makes the wife and consequently the couple vulnerable to HIV infection.

3.1.2.4 Disabilities

In terms of socio cultural factors, existing studies highlight the belief that when men have sexual relations with a physically disabled female or one that is mentally unwell, they will get protection and wealth. This fuels much of the rape, unwanted pregnancies and HIV infection experienced by women with disabilities. This belief is wide spread across communities in Nigeria.

Underlying the practice is the cultural perception that disabled persons are not entitled emotionally or sexually, or even capable of engaging in a relationship that involves sexual attraction. The latter assumption, combined with poor understanding of the needs of the disabled and low social acceptance, has led to them not being targeted for HIV prevention and gender equality interventions. For example, blind women in particular are not considered fit as wives and may therefore be seen in a degrading manner, making them vulnerable to sexual assault while at the same time being excluded for HIV programmes.

In terms of girls and boys, parents have sometimes tended to send physically challenged children to either hawk merchandise or to beg, which exposes them to abuse that may sometimes be sexual.

3.1.2.5 Harmful Traditional Rites

Nigeria has many social and cultural practices, some widespread but most of them being specific to certain ethnic groups. In this section, practices that render men, women, boys and girls vulnerable to HIV infection will be outlined.

Female Genital Mutilation (FGM) is practised by a few ethnic groups and is often taken as a rite of passage for girls to prevent them from being promiscuous. Harmful effects may include Vesico Vaginal Fistula (VVF), which presents itself by way of continuous leakage of urine. If the person is HIV positive, there would be implication for particular handling of bodily fluids. Other effects are compromise of the reproductive organs, and if a shared unsterilized object is used for cutting, then vulnerability to HIV infection by the procedure itself.

In some parts of the country, when a husband dies, the widow is restricted from moving around and is expected to mourn, but when a wife dies, the widower is kept away from the ceremony and provided with a young woman to keep him company. This is done for the widower without regard to his HIV status or the status of the young woman. Also, in some States, widows are not allowed to remarry but they are allowed to continue having children, so

that they would be allowed to keep property of the former marriage. If she remarries, however, she will be disinherited. The consequence is that widows may seek out multiple sexual liaisons in a bid to have children, but particularly to have boys who would be counted culturally as the sons of the deceased husband. In the process, she becomes exposed to HIV infection.

Some States also prohibit widows from remarrying and are disinherited from property at the same time. This exposes widows and their children who don't have alternate means to survive to commercial sex, and exposure to HIV infection.

Wife inheritance is practiced by many cultures of Nigeria. This involves a widow being handed over to the brother of her deceased husband, normally without regard to her HIV status, or the brother's. The brother is to be her provider and guardian over the children and she is to join his household as a wife and not expected to have sexual relationships with other men. This arrangement is akin to a forced marriage and exposes the woman to marital rape, and HIV infection for them both if either is HIV positive, as well as the existing wife or wives of the brother, and their babies if they become pregnant.

In certain States, cultural festivals that involve unsafe sex are regularly held. An example is *Salejeje,* which is observed in some Yoruba communities as the day of the concubine**.** Participants at such festivals are exposed to HIV infection through unsafe sex.

The tradition of carrying out male circumcision by age or peer groups is often carried out using a single cutting instrument. Those undergoing circumcision will be exposed to HIV unless the material is sterilized. The religious belief that PLHIV became infected because they sinned can prevent persons from seeking care and treatment for fear of being ostracized.

3.1.3 Human Rights, Legal and Political Factors

There is legal provision as well as policy guidelines for the protection of human rights of Nigerians. These are contained in the following laws, bills and policies:

National Policy on HIV/AIDS; NSF2010-2015; NSP 2010-2015
National Gender Policy
Child's Rights Act
1999 Constitution
National HIV Prevention Plan
OVC NPA
Anti-Stigma and Discriminatory Bill

However, there exists stigma and discrimination against sex workers and MSM which impedes these groups from actually accessing HIV prevention, care, and treatment and support services at their disposal. The gender dimension becomes visible in terms of gender identity in the case of MSMs, the fact that women experience more residence-based discrimination than men (as outlined in the stigma index report) and the incidences of rape and other acts of gender based violence committed against both lesbians and female sex workers with impunity because the victims are women.

The stakeholders of the data collection workshop pointed to cultural and religious beliefs about same sex relationships being behind service providers not providing health services to people who engage in same sex relationships, which in turn acted as a deterrent to homosexuals from accessing services for fear of discrimination. It was likewise noted that

the assertion that homosexuality/intersex/transgender were not part of the Nigerian culture fuelled underground unprotected sexual activities.

The GARPR of 2012 thus commented on redress of human rights violations of specific groups in Nigeria in connection with the legal HIV context:

> "In spite of the numerous policies, minimal progress has been made in addressing the human rights and legal issues surrounding HIV/AIDS. This is mainly due to the fact that, in Nigeria, official policy documents do not constitute law and cannot be enforced in the courts of law. They constitute merely administrative tools and guidelines that provide direction for governmental action. However, these policy documents can and may elaborate and specify the goals, values, and standards to which existing laws aspire and may be useful in interpreting the latter as well as guiding programmatic interventions by the government. The problem is that, at the moment, there are no HIV/AIDS specific laws in the statutes. Due to the delay in the progress of legal reforms and the absence of the backing of the law, government policy documents can only serve to inspire an effective national HIV/AIDS response that respects the rights of PLHIV and PABA."

There remains an absence of non-discrimination laws specifically for MARPs and in fact the Same Sex Prohibition Bill mainly intended to outlaw gay marriage in Nigeria also makes operation or registration of gay organizations a criminal offense. This latter aspect in effect will impede mobilizing MSMs and lesbians, in particular amongst the MARPS, towards organizing themselves officially around HIV prevention, treatment, care and support. More legal and political issues including the approach to policy are further dealt with in the following section on knowing the country's response to the epidemic.

3.2 Knowing Your Response

3.2.1 Gender Equality in the Conceptual Framework and Design

The National HIV Policy (2009), the National Strategic Framework and the National Strategic Plan on HIV/AIDS (2010-2015) are developed within the context of the following national and international frameworks that promote fundamental human rights and gender equality:

> The 1999 Constitution of the Federal Republic of Nigeria affirms the national philosophy of social justice and guarantees the fundamental right of every citizen to life and freedom from discrimination.
>
> The NACA Act empowers NACA to facilitate engagement with all tiers of government and all sectors on issues of HIV/AIDS prevention, care, and support, advocate for mainstreaming HIV / AIDS in all sectors of society, and formulate policies and guidelines for HIV/AIDs;
>
> The President's Comprehensive Response Plan (PCRP) 2013-2015;
>
> The President's 7-Point Agenda on cross-cutting issues including gender and HIV/AIDS;
>
> National Gender Policy (2006) (under review);
>
> Universal Declaration of Human Rights (1948);
>
> The Convention on Economic, Social and Cultural Rights (1976);
>
> The Convention on the Elimination of All Forms of Discrimination against Women (1979)(CEDAW);
>
> Convention on the Rights of the Child (1989); and
>
> The African Charter on Human and People's Rights (July, 2003).

Rights of vulnerable groups, enhanced focus on MARPs and addressing gender factors that increase female vulnerability to HIV are some of the guiding principles and commitments of the NSP. Asides these two documents that elucidate the role of gender equality in 'fighting AIDS to finish', the 5-Year Strategic Plan and Programme Implementation Framework for Women, Girls, Gender Equality and HIV (2011) was developed to further address gender inequality. The Federal nature of Nigeria however permits each State to have its own laws according to need based on guidelines provided by Federal laws. Table 16 presents an overview of laws, policies and guidelines at State, Federal and International Levels as it relates to gender equality and fundamental human rights. It is by no means exhaustive.

Table 16: List of Laws, Conventions, Policies, Plans and Guidelines[42]

LEVEL OF LEGISLATION	NAME OF LEGISLATION
NATIONAL LEVEL	The Constitution of the Federal Republic of Nigeria, 1999
	Criminal Code CAP C38 Penal Code Law, cap 89, Laws of the Federation of Nigeria (LFN), 1963. Child's Rights Act, 2003 The Trafficking in Persons (Prohibition) Act, 2003 establishing the National Agency for the Prohibition of Trafficking in Persons (NAPTIP) The Trafficking in Persons (Prohibition) Law Enforcement and Administration (Amendment) Act, 2005 African Charter on Human and People's Rights (Ratification and Enforcement) Act, Cap A9, 2004 Laws of the Federation Lagos State Administration of Criminal Justice Law, 2011 Prevention of HIV Discrimination and to Protect the Human Rights and Dignity of People Living with HIV and Affected by AIDS and Other Related Matters, Bill. Violence Against Persons Prohibition B ill
STATE LEVEL	Anambra State Gender and Equal Opportunities Commission Law, 2007. Anambra StateMalpractices against Widows and Widowers (Prohibition) Law No. 2005 Bauchi State Withdrawal of Girls from Schools for Marriage (Prohibition Law No 17 of 1985) Child Rights Laws of 24 States of the Federation out of 36 Ebonyi State Domestic Violence and Related Matters Law, Law No 003 of 2005 Edo State Female Circumcision and Genital Mutilation (Prohibition) Law No.4 of 1999 Enugu State Prohibition of Infringem ent of a Widow's and Widower's Fundamental Rights Law No. 3 of 2001 Imo State Gender and Equal Opportunities Law No 7 of 2007 Imo State Widows (Protection) Law 2003 Street Hawking (Prohibition) Law of Lagos State Street Trading Law of Anambra State Child's Rights Law of Lagos State, 2007 Lagos State Protection Against Domestic Violence Law 2007 Lagos State Protection of People Living with HIV and Affected by AIDS Law 2007 A Law to Provide Rules on Criminal Conduct, Regulate Public Order and for Connected Purposes, 2011, Lagos State Lagos State Same Sex (Prohibition) Law 2007; A law to Prohibit Girl -Child Marriages and Female Genital Circumcision or Genital Mutilation in Cross River State, 2000 The Female Genital (Prohibition) Law, Bayelsa State, 2000 A Law for Monitoring of Maternal Mortality in Edo State and Other Matters Connected Thereto, 2001 River State Reproductive Health Service Law No. 3 of 2003 River State Schools Rights (Parents, Children and Teachers) Law No.2, 2005 Women's Reproductive Rights, An ambra State, 2005 Enugu State HIV/AIDS Anti -Discrimination and Protection Law, 2007 Ekiti State Gender-Based Violence (Prohibition) Law, 2011 AkwaIbom State Law on Widowhood Rites

[42]UNDP (2013). 'Mapping of Laws, Policies, and Services on GBV and its intersections with HIV (2013) + National Stakeholder Data Collection Workshop'

INTERNATIONAL CONVENTIONS/ DECLARATIONS	UN Declaration on HIV/AIDS Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), 1979 International Covenant on Economic and Socio Cultural Rights (ECOSOC) International Covenant on Civil and Political Rights (ICCPR) Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment The UN Convention o n the Rights of Persons with Disabilities, 2008
REGIONAL CONVENTIONS	The African Charter on Human and Peoples' Rights in Africa, 1986 Protocol to the African Charter on Human and Peoples' Ri ghts on the Rights of Women in Africa (2005) The African Charter on the Rights and Welfare of the Child, (1990)
POLICIES	National Policy on HIV/AIDS, 2009 National Workplace Policy on HIV/AIDS, April 2005 National Gender Policy, 2006 National Priority Plan for OVC (in draft form) National Policy on HIV/AIDS -Federal Ministry of Health, (2003) National Reproductive Health Policy and Strategy – Federal Ministry of Health, (2001) National Policy and Plan of Action on Elimination of Female Genital Mutilation in Nigeria (2002). National Child Health Policy Primary Health Care Policy National Policy on HCT National Policy on Maternal and Child Health – Federal Ministry of Health, (1994) Gender policy for the National Police Force - Nigeria police Force, Septemb er 2012 (awaiting Strategic Framework for Implementation, Monitoring and Evaluation) Jigawa State Gender Policy, A Holistic Approach Towards Women Development, May 2013 Ekiti State Gender Policy, 2011 Kaduna State Workplace Policy School Feeding Policy in some states like Kano and Osun
PLANS AND GUIDELINES	National HIV/AIDS Strategic Framework 2010 – 2015 Integrated Maternal New Born and Child Health Strategy (2007) National HIV/AIDS Strategic Plan 2010-2015 National Prevention Plan 2010-2012 (under review) National Guideline for implementation of HIV prevention programmes for FSWs (2012) State Strategic Plans National Strategic Framework on the Health and Development of Adolescent and Young People in Nigeria –Federal Ministry of Health (2007-2011) National Health Strategic Plan 2010 – 2015 National Gender Policy Strategic Implementation Framework and Plan National Guidelines and Intervention Strategies on Gender Based Violence in Nigeria (2008) Annual State Strategic Plans of State Agencies for the Control of AIDS Jigawa State Gender Policy Action Plan
CONSENSUS DOCUMENT	International Conference on Population and Development (ICPD), 1994 Beijing Platform of Action, 1995 Millennium Development Goals, 2000

A few barriers were however identified in the way of implementation of these laws. The obstacles ranged from contradictions in the submissions of the laws to sheer ignorance and reluctance on the part of the citizenry to seek redress due to economic and socio-cultural norms.
On why laws are not being implemented, the following are the submissions from the stakeholders' workshop:

Box 3: Submissions on Lack of Implementation of Laws

'Not being implemented because of lack of political willpower and cultural beliefs and different cultural settings. Nigeria is filled with many different cultures, so it makes it difficult to completely go through and adhere to Federal Laws, because States are different and cultures are different'-Group 2

'The question we should be asking is, are the laws in place being implemented? Some States have selected parts of the Child Rights Act but not completely. Some are implementing it wholly, some are extracting from it, and some are not using it at all. Federal Laws should be implemented nationally, not just in FCT. In Kano, they are still contemplating using the Child Rights Act because it uses the age 18, but in Kano, they do not believe in the late marriage. In Osun, Child Rights Act has not been passed, it has only been enacted. It is only the FCT that we are sure of it being completely implemented without modification. In Cross Rivers, the law is modified to age 21'- Group 2

Other obstacles identified at the workshop are:

Lack of popularization and ownership of documents, policies and laws.
The stakeholders involved in the formulation, ownership and development of the policies are not all inclusive or representative of the true population.
The constitution is in itself contradictory as it states that the government shall provide and at the same time the government can't be held responsible for not providing. That is why the government can't be held responsible for the non-implementation of laws.
The level of sensitization is low and political commitment is still low to address anomalies in our laws.
Litigation and its processes are quite long and expensive. Justice is hard to access.
Some states are lagging behind due to political, religious and cultural factors, which impede the fight against gender inequality and other developmental issues.
Skills gap on the part of implementers and ignorance on the part of law enforcement officers.
System failure: most institutions have weak administrative structures, but have strong individuals who are not able to solely carry the implementation of such policies and laws. Policies are sometimes not backed by implementation frameworks.
Lack of budgetary allocations.

A review of some of the laws and policies enacted to achieve gender equality reveal some contradictions in their provisions as shown in Box 4 below

Box 4: Review of Provisions of some Laws Relating to Gender and HIV

1999 Constitution:

Provisions

Section 1(1) states that 'the Constitution is supreme and its provisions shall have binding force on the authorities and persons throughout the country'.

Sub section (3) states that 'If any other law is inconsistent with the provisions of this Constitution, this Constitution shall prevail, and that other law shall, to the extent of the inconsistency, be void'

Sections 15(2) and 42 prohibit discrimination on grounds origin, sex, religion, status, ethnic or linguistic association or and affirm a legally enforceable right to equality of all persons.

Section 17 provides that the state social order is founded on the ideals of freedom, equality and justice

Section 29, Sub-section 4(b) proclaims that every woman who is married shall be regarded as an adult.

Section 21 of the Constitution enjoins States to protect, preserve and promote Nigerian cultures that "enhance human dignity and are consistent with the fundamental objectives as provided..."

Irregularities and Implications

Any provision in the law that is not gender -friendly subsists and cannot be challenged even if other amenable laws have been passed because of the supremacy of the constitution except amended. An e xample is the issue of child marriage with the attendant HIV related issues such as VVF. CRA defines a child as under 17years but unfortunately some state laws peak it at 14years and once a child is married at any age before 18, she is regarded as an adult by the constitution but by CRA, it is child abuse. Literature is replete with how child or early marriage predisposes women and girls to HIV infection.

'Culture that enhances human dignity' is subject to various interpretations and so FGM may not be seen as harmful and predisposing women and girls to HIV infection but rather as preparing the women for the husband's sexual enjoyment and preventing promiscuity in some cultures.

The Same Sex Bill being proposed may affect and reverse gains made in reaching so me key populations and also negates provisions of the constitution

Penal Code

Provisions

Section 55 of the penal code allows wife beating as long as it does not amount to grievous hurt.

Section 241 of the penal code defines "grievous hurt" to include emasc ulation, permanent loss of sight, ability to hear or speak, facial disfigurement, deprivation of joint, bone fracture or tooth dislocation.

Section 182 also provides that "sexual intercourse by a man with his own wife is not rape if she has attained puberty.

Implications

Intimate Partner Violence (IPV) has been reported to lower women's ability to negotiate safer sex.

Criminal Code

Provisions

Section 383 makes an indecent assault on males punishable by 3 years imprisonment. Section 360 makes an indecent assault on females punishable by 2 years imprisonment as it is treated as mere misdemeanor.

Violence Against Persons Prohibition Bill (VAPP)

Provisions

In lieu of heightened reported rape cases in Nigeria, the issue of rape was defined broadly and placed as f irst offence in the bill which is presently before the senate but unfortunately marital rape was deliberately left out despite available

Some successes on implementation of laws and policies towards gender equality in the National response were achieved. These are highlighted below:

Anti-Stigma Bill passed in some states has helped to reduce discrimination amongst people living with HIV and AIDS.

Good political will driving the formulation of the PCRP and gradual increase in investment

Implementation of DHIS 2.0 M&E tool for HIV interventions.

Human Trafficking on the Federal Laws (NATIP works extensively to make sure that girls who were being taken abroad and used as sex-slaves are returned, rehabilitated, and connected to their families).

Some police officers have been trained to take care of rape cases but the trainings are not similar in all the police stations.

Due to the fact that children in Kano were not as motivated about going to school as the children in other states, the State Government created a policy in collaboration with Ministry of Education and Ministry of Agriculture for free feeding of the students in schools and the enrolment levels have increased in primary and secondary schools. Girl-Child Initiative, which empowers women who would have been prostituting and otherwise vulnerable, has borne transportation, uniforms and feeding of the girl-child. It has reduced the prices of foods and given jobs to women – National Stakeholders Workshop

In CrossRiver State, widowhood inheritance laws as well as laws against Female Genital Mutilation have been enforced. (In Boki, there was a high level of widowhood inheritance), NGOs, CBOs and CSOs have been empowered by the State (Ministry of Women Affairs) to enforce implementation of these laws which have led to the reduction of FGM, domestic violence, Child Rights infringement and widowhood inheritance issues. These organizations have also empowered and sensitized community leaders, religious leaders, and local government.

Before the policy (PHC and HCT) there was an HCT testing gap at the community level, however, following this policy the capacity of service providers has been built to provide HCT services at PHCs. With the existence of these policies, People Living with HIV/AIDS are currently being empowered within various communities to receive treatment. Now at the community level, HCT services are available and affordable —National Stakeholders (please clarify if this is a statement by National stakeholders or an output form the National stakeholders workshop)

Government has engaged in a wide-ranging set of consultations in preparing the national strategy on HIV/AIDS, including with s. NGOs and civil society organizations participated in the consultations on the national strategy. They have been heavily involved in the on-going project, both as Board members at the federal and states levels and as beneficiaries of project funds under the HAF. NACA and the SACAs have staff who are community development specialists and who focus on interactions with civil society and NGOs. – *PAD, 2009*

3.2.2 Meaningful Participation and Coordination of Various Sectors

Networks and organizations focused on People living with HIV, women's rights, gender equality, youth, and other key populations have been constituted into Constituency Coordinating Entities (CCEs) as an integral component of the national partnership. They are involved in decision-making at different stages, levels, and sectors of the national HIV response, including design and implementation of the response where necessary. The CCEs are:

1. Civil Society for HIV/AIDS in Nigeria (CISHAN)
2. Network of People Living with HIV/AIDS in Nigeria (NEPWHAN)
3. Society for Women Against AIDS in Nigeria (SWAAN)
4. Nigeria Youth Network on HIV/AIDS
5. National Faith-Based Advisory Council on AIDS (NFACA)
6. Media, Arts and Entertainment
7. National AIDS Research Network
8. Nigeria Diversity Network – representing groups with high risk of infection
9. National Women Coalition on AIDS (NAWOCA)
10. Association of Women Living with AIDS in Nigeria (ASWHAN)

> Targeting these groups (MARPS and MSM in particular) will be significantly beneficial to reversing the spread of the epidemic in Nigeria but notwithstanding the clarity of this need, there still remain enormous hurdles to mounting an effective response targeted at slowing down the transmission of HIV through these groups. These include the presence of policy and regulatory barriers that prevent engagement and recognition of these groups, increasing stigma and discrimination and threatening all efforts made at providing effective prevention, treatment, care and support for them.

NACA facilitated the formation, funding, and capacity building of CSOs into constituent coordinating entities. These CSOs have had active involvement in the development of the multi-sectoral strategy: the review of the national HIV/AIDS Policy; participation in the NSP development; work with the House Committee on HIV/AIDS; and participation in the review of the NSF II. They have also been actively involved in the planning and budgeting process for the NSP on HIV both at the state and national levels. Furthermore, NACA created a platform for CSO interaction and partnerships with donors. CSO networks and constituent[43] Coordinating Entities, whose development NACA has facilitated, have become viable platforms for programme activities. These networks have become recognized as critical players in the national response. For example, CiSHAN has a membership of over 3000 affiliate CSOs with six large constituencies.

As earlier discussed however, though policies are available to support the operations of these entities, policies are at best statements of intentions and are not justiciable. As at present, the problem is that there is slow and delayed legal reforms which could give backing to the meaningful and effective participation of some of these entities. A case in point is the Anti Stigma Bill still waiting to be passed into law. In the absence of these laws, policy documents will not be effective in driving a national HIV/AIDS response that respects the rights of PLHIV and PABA.

For some other key populations such as MSM, PWID and FSW, their meaningful participation may be compromised as there are no clear non-discrimination laws to protect

[43] National Agency for Control of AIDS (2012). Global AIDS Response Progress Report (GARPR, 2012).

them. The Nigerian Senate, has passed a bill to prohibit same sex marriage. Tagged Same-Sex Prohibition Bill, the bill proposes up to 14 years imprisonment each for gay couples who decide to solemnize their union, while witnesses to the marriage or anyone who assists the couples to marry could be sentenced to 10 years imprisonment. This bill, originally designed to outlaw gay marriage in Nigeria, could criminalize gay groups and organizations and promote the discrimination and persecution of persons on the basis of their sexual orientation and gender identity if passed. Lagos state has a similar law. Same-sex sexual activity in Nigeria is a felony according to Chapter 21, Articles 214 and 217 of the Nigerian Criminal Code and is punishable by imprisonment of up to 14 years throughout the country.

3.2.3 Review of Expenditure Allocation in Relation to Gender in the HIV Response

The biennial National AIDS Spending Assessment (NASA) is a comprehensive and systematic resource tracking method that describes the level and flow of resources and expenditures of the HIV and AIDS response in Nigeria. The general picture of HIV funding is revealed in Table 17.

Table 17: HIV Funding in Nigeria[44]

Financing Sources	USD, 2009	%	USD, 2010	%
Public Sources	97,790,519.00	23.55	125,139,587.00	25.18
Private Funds	278,303.00	0.07	850,547.00	0.17
International Funds	317,218,608.00	76.39	370,927,337.00	74.65
Total	**415,287,430**	**100.01**	**496,917471.00**	**100**

A further exploration of the funding process revealed that gender was treated as a cross cutting issue with no direct line budget to address gender equality interventions but rather budgets are lumped in thematic areas where programme data is disaggregated by gender either for general or key populations as we have in Table 18. In the breakdown of budget by population beneficiaries in Table 18, budget for gender under general population is at most **1.00%** of the total expenditure. For key populations, the total budget allocation for 2009 is **0.09%** and **0.11%** in 2010. In NASA, gender issues related to the various thematic areas are addressed under the specific thematic activities as well as in the indicators. While the NSP identifies specific actions to address the needs and rights of women and girls, it does not include a speci? c budget to address its gender related activities

Table 18: Breakdown of HIV Funding in Nigeria[45]

Beneficiary Population	2009		2010	
	AMOUNT (USD)	%	AMOUNT (USD)	%
A. People living with HIV	**207,110,810.00**	**49.87**	**187,424,838.00**	**37.72**
1.-Adult and young men (aged 15 and over) living with HIV	0	0.00	1,754.00	0.0004
2.-Adult and young women (aged 15 and over) living with HIV	338,718.00	0.08	2,577.00	0.001
3.Adult and young people (aged 15 and over) living with HIV not broken down bygender	107,414,321.00	25.87	57,681,481.00	11.61
4.Girls (under 15 years) living with HIV	0	0.00	9.00	0.000002
5.Children (under 15 years) living with HIV not broken down by gender	4,744,410.00	1.14	6,764,949.00	1.36
6. People living with HIV not broken down by age or gender	97,613,361.00	22.78	122,974,068.00	24.75
B. Most-at-risk populations	**378,255.00**	**0.09**	**557,700.00**	**0.11**
1.Injecting drug users (IDU) and their sexual partners	2,251.00	0.001	1,731.00	0.0003
2.Female sex workers and their clients	373,114.00	0.09	478,658.00	0.10
3.Male transvestite sex workers (and their clients)	2,890.00	0.001	1,034.00	0.0002
4.Most at-risk populations not broken down by type	0	0.00	76,277.00	0.02
C. Other key populations	**20,332,659.00**	**4.90**	**22,744,908.00**	**4.58**
1.Orphans and vulnerable children (OVC)	9,112,493.00	2.19	7,118,795.00	1.43
2.Children born or to be born of women living with HIV	9,909,322.00	2.39	13,958,961.00	2.81
3.Prisoners and other institutionalized Persons	2,251.00	0.001	11,251.00	0.002
4.Truck drivers/transport workers and commercial drivers	380,800.00	0.009	857,453.00	0.17
5.Children and youth out of the school	647,450.00	0.16	734,435.00	0.15
6.Recipients of blood or blood products	276,557.00	0.07	56,795.00	0.01
7.Other key populationsnot broken down by type	863.00	0.0002	1,034.00	0.0002
8.Other key populations	2,923.00	0.0001	6,220.00	0.001
D. Specific accessible population	**1, 130,254.00**	**0.27**	**3,118,459.00**	**0.63**
1.Junior high/high school students	386,506.00	0.09	2,363,759.00	0.48
2. University students	0	0.00	10,475.00	0.002
3.Health Care Workers	273,156.00	0.07	60,877.00	0.01
4.Police and other uniformed services (other than the military)	350,345.00	0.08	501,304.00	0.10
5. Factory employees (i.e. for workplace interventions)	28,006.00	0.01	178,733.00	0.04
6. Specific"accessible " populations not broken down by type	88,930.00	0.02	0	0.00
7.Accessible populations not elsewhere classified (n.e.c.)	3,311.00	0.00	3,311.00	0.00
E. General population	**23,452,982.00**	**5.65**	**62,125,892.00**	**12.50**
1.Male adult population	341,477.00	0.08	0.00	0.00
2.Female adult population	5,502.00	0.00	421,475.00	**0.08**
3.Girls	71,509,.00	0.02	50,192.00	**0.01**
4.Children (under 15 years) not broken down by gender	0	0.00	142,996.00	**0.03**
5.Young females	374,766.00	0.09	0	0.00
6.Youth (aged 15 to 24) not broken down by gender	121,523.00	0.03	255,941.00	0.05
7.General population not broken down by age or gender	22,538,205.00	5.43	61,255,288.00	12.33
F. Non-targeted interventions	**162,882,470.00**	**39.22**	**220,787,650.00**	**44.43**
G. Specific targeted population n.e.c.	**0**	**0.00**	**158,024.00**	**0.03**
Total	**415,287,430.00**	**100**	**496,917,471.00**	**100**

[45]National Agency for Control of AIDS (2010). National AIDS Spending Assessment.
[46]National Agency for Control of AIDS (2010). National AIDS Spending Assessment.

3.2.4 Comprehensive HIV Response

There are however indications of pockets of funding to promote gender equality interventions such as the GFATM funds for gender equality interventions under Round 8 with provisions made for CISHAN, PPFN and SFH to scale up gender sensitive HIV prevention treatment and care for different groups and in different areas.[46] There still remains a dearth of funding specifically targeting gender issues in the national response.

Inadequate resource allocation and over reliance on international funds though gradually changing is a major funding issue. Public funds account for 25.2% of total funds while international funding is about 74.7% ($371 million in 2010). This is not a sustainable approach for addressing a chronic major public health issue. It is noteworthy however that overall, the public funding for HIV response in Nigeria has increased and this is in line with the expected national contribution of 50% by 2015 as set by the Partnership Framework Agreement.

3.2.4.1 Prevention

Prevention and supportive services available can be broadly classified as HIV Counselling and Testing (HCT); Prevention of Mother-to-Child Transmission (PMTCT) of HIV; Prevention of Biomedical Transmission of HIV; Early Detection, Treatment and Control of Sexually Transmitted Infections (STIs); Condom Promotion; Communication Interventions (both to the general population and MARPs) and Integration of Sexual and Reproductive Health (SRH) and HIV Services.

FGN, in recognition of the role of HCT as the entry point forHIV/AIDS prevention, treatment, care and support services, commits to the provision of a network of HCT services that will provide universal access to quality and affordable testing. To this end, the importance of strict observance of confidentiality, including pre- and post-test counselling with the informed consent of the client before testing was documented.[47] In a bid to achieve universal access to HCT services, the number of sites providing HCT increased from 1,064 in 2010 to 1,357 in 2011 and 2,624 in 2012 though the number still falls below the expected 23,640 sites required for adequate service provision.[48]

Other approaches to increasing HCT uptake include the conduct of community outreaches and door to door sensitization by public health facilities in collaboration with WHDC members in the community; and provision of mobile HCT services and testing campaigns to rural communities and other hard to reach areas and populations. By so doing, the likelihood of reaching the poor in rural locations, especially women is increased. HCT is also conducted in family planning clinics, STI clinics, TB clinics, and ANC clinics respectively at the PHC and SHC facilities. There were significant efforts at conducting media campaign and promotion of the Heart-to-Heart logo as a means of facilitating easily recognizable HCT-supportive facilities by community members.[49]

All of these efforts contributed to exceeding the target of 2012 fixed at 23% to 26.3% among persons aged 15-49 years. Despite this modest achievement, there are still unmet needs with regard to uptake of HCT services. Specifically, records show that more females access HCT

[46]Report of the Evaluation of the Global Fund Supported Interventions to HIV and AIDS Response in Nigeria, 2013.

[47]Federal Ministry of Health (2011). National Guidelines on HIV Counselling and Testing.

[48]National Agency for Control of AIDS (2013). Ten Targets of the UN General Assembly 2011 Political Declaration on HIV/AIDS-Mid Term Review.

[49]National Agency for Control of AIDS (2013). Report of MTR of the Implementation of NSP 2010-2015.

than males and that there is reluctance on the part of men to access HCT. HCT uptake is low in rural areas and among people of low educational background. It is also low among MSM. A few reasons adduced for this low uptake is tied to the socio-cultural environment in which men in a patriarchal society must show that they are 'men' in all its ramifications and so admittance of need for help becomes an issue.

Another important aspect of prevention is the prevention of vertical transmission. In Nigeria, MTCT accounts for about 10% of new infections. In 2012, the estimated number of children newly infected with HIV through mother- to -child transmission is 56,681. It is in realization of the importance of PMTCT that a scale up plan was developed in 2012 to accelerate PMTCT programming starting with 12+1 States which bear 70% of the national burden of the epidemic. The 2012 achievement of 20.2% is far below the set target of 50% pregnant positive women receiving ARV to reduce the risk of transmission to the child. By 2015, the country should have about 14,480 sites[50] providing comprehensive PMTCT services in Nigeria; it is hoped that the scale up will lead to achieving the 80% target of 2015.

A novel idea is the encouragement of partners to follow their wives to ante natal clinic and some states are said to do this through gifts of towels or giving the woman whose husband follows her to the health facility priority attention. It is hoped that through this medium, the man may also be encouraged to access HCT services. Prevention services cannot however be said to be non-discriminatory in practice in some circumstances especially with regards to respecting, promoting and protecting the rights of women, girls, men, boys and key populations independent of marital status, profession and age. Some of the reasons adduced for this set back in accessing prevention services include:

Stigma and discrimination of PLHIV

Patriarchal nature of the society that encourages certain norms regarding masculinity and femininity. A boy must show prowess by having sex and probably without condom because it is not satisfactory. A girl may be seen as being promiscuous if she talks about sexuality issues.

Harmful socio-cultural practices that encourage unprotected sexual practices during festivals.

Gender based violence and unfavourable laws that prevent victims from seeking redress.

Poverty which affects women more and makes it difficult to access health services.

Criminalization of persons with different sexual orientation such as MSM and transgendered men and women may prevent uptake of prevention services.

Abortion is allowed strictly for saving lives yet so many young girls when they are raped or get pregnant in any other way seek abortion services with quacks in order not to bring shame to their families.

Scarcity of female condoms.

Sexual minorities may not want to access public health service due to societal issues.

Access to justice may still be a far cry because the laws themselves are not friendly and cultural beliefs that prohibit families and communities from seeking redress in law courts still subsist.

[50]National Agency for Control of AIDS (2013). Ten Targets of the UN General Assembly 2011 Political Declaration on HIV/AIDS-Mid Term Review.

3.2.4.2 Treatment

As discussed under prevention, the entry point for treatment is also in knowing one's status through HCT. The rate of uptake of ART services is therefore dependent on the rate of uptake of HCT. Table 19 illustrates the percentage of individuals targeted versus those reached on provision of treatment services.

Table 19: Treatment Services -Target versus Reached

Percentage of eligible adults currently receiving antiretroviral therapy (2010 Guideline)	53.0% (2012 Target)	35.3% (2012 Achieved)	80.0% (2015 Target)
Percentage of el igible children currently receiving antiretroviral therapy (2010 guideline)	53.0% (2012 Target)	12.1% (2012 Achieved)	80.0% (2015 Target)

From the Table, there are indications that the target is still far from being met, especially for children. A total of 459,456 adults were receiving antiretroviral therapy in 2012. Of those on ART, 471,024 patients were on first-line therapy, 19,962 patients were on second-line therapy and 35 patients were on salvage therapy. In 2012 alone, 103,173 patients were newly enrolled on ART. In 2011, 73.4% of patients were on treatment 12 months after initiation of antiretroviral therapy, and in 2012 estimates place this figure at 75%-78%.[51] The data was not disaggregated by sex though revised facility data collection tools that disaggregate by age and gender have been introduced.

-Commitment to promote and protect rights and reduce vulnerability of women, children, young people and marginalised groups to HIV infection.

-Determination to address social, economic and cultural fac tors responsible for disproportional vulnerability of women and girls to HIV infection.

- National Policy on HIV, 2009 (Guiding Principles)

One of the major efforts aimed at increasing access to ART is the decentralization of ART service delivery and the utilization of task shifting and task sharing. This programme utilizes PHCs as ART refill centres with integration of this service delivery by healthcare workers already employed at the PHCs. Nurses and Community Health workers at these PHCs do not initiate patients on ART but perform rapid HIV screening and provide supportive services for those already initiated on ART. Point-of-care HIV treatment monitoring[52] tools have only been introduced on a very small scale; however sample transfer from the spokes to the hubs is utilized to ensure treatment monitoring.Again in principle and on point of policy, treatment services are supposed to be equally accessible for women, men and key populations but they are not so in practice due to some of the reasons mentioned under prevention.

3.2.4.3 Care and Support

The Hub and Spoke Network Model tagged the cluster system has been adopted by the country for the provision of a continuum of care and support to PLHIV and PABA in the communities. The model consists of a network of one treatment centre, two HCT centres and two support groups of PLHIV providing treatment adherence, stigma reduction and generating uptake for HCT services, five CBOs providing HBC services, and one CBO providing OVC services.

[51]National Agency for Control of AIDS (2013). Ten Targets of the UN General Assembly 2011 Political Declaration on HIV/AIDS-Mid Term Review.

[52]National Agency for Control of AIDS (2013). Report of MTR of the Implementation of NSP 2010-2015.

Within the communities and outside of the cluster model, there are other CSOs, trained HBC officers, PHC officers, youth groups and PLHIV support groups that help to mobilize PLHIV to receive care. Members of CiSHAN and NEPWHAN worked with their members to implement Community Home Based Care (CHBC) service delivery. Also, community leaders are mobilized to support the CHBC programme through the nomination of volunteers who can give their time to support the programme. These volunteers were drawn from health facilities, the community and from support groups of people living with HIV. They undertook a six-day intensive training to equip them with knowledge and skills to provide Home Based Care services to PLHIV, conduct community sensitization programmes and campaigns for HIV & AIDS prevention/stigma reduction, and follow up clients who missed their appointments. Usually, the health care providers from the facility serve as a link to register sick clients who wish to be visited at home. They also provide technical assistance on health related issues to the volunteers.[53] Other services provided address the needs of orphans and vulnerable children (OVC). Caregivers and older OVC are linked with Income Generating Activities (IGA).

In the continuum of events however, women and girls bear the burden of care giving functions. Women are more involved in providing care as revealed by various studies. Male child preference in the society leads to the girl child being pulled out of school for care giving functions. The issue of child and female headed households abound in OVC programming and this calls for addressing the burden of care on women and girls and beyond facilitating access to IGA.

3.2.4.4 Gender-Based Violence

The National response is committed to the elimination of gender inequalities and gender-based violence (GBV) and to that end priority is given to efforts that promote increasing the capacity of women and girls. The NSP has multiple indicators that measure gender sensitivity in programme planning and implementation. In addition, national HIV related data is disaggregated by sex to enable analyses of gender patterns and trends in the national response.Various policies and laws are also in place to ensure equity and equality among the sexes and promote legal rights and protection of women and girls impacted by HIV.

The review of the laws under gender equality in the conceptual framework and design in this report however revealed that some of the laws need to be revised in order to make them useful tools in the hands of implementers. The needs and rights of transgender people are also not addressed.

An important fact emerging from the MTR of the NSP is the fact that more human right activists are involved in the crusade against GBV or VAW than actors in the HIV field which obscures the intersection between HIV and GBV.[54] Also revealed is the fact that there is no national mechanism to track GBV despite the fact that the NDHS captured data on women who have experienced physical or sexual violence from a male intimate partner[55]. Unfortunately too is the fact that in spite of the laudableguiding principles in the NSP that applauds gender equality, no budget or programme to curb GBV is in place! Table 20 gives a clear picture.

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[53]Ibid.
[54]National Agency for Control of AIDS (2013). Report of MTR of the Implementation of NSP 2010-2015.
[55]National Agency for Control of AIDS (2013). Ten Targets of the UN General Assembly 2011 Political Declaration on

Table 20: Indicators on Elimination of Gender Inequalities (Target 7)[56]

Target 7: Eliminate gender inequalities and gender -based abuse and violence and increase the capacity of women and girls to protect themselves from HIV				
	2010 Baseline	**2012 Target**	**2012 Achievement**	**2015 Target**
Proportion of ever -married or partnered women aged 15 -49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	17.5%	NAT	No data	NAT
Specific budget for HIV -related programmes for women and girls	NAT	NAT	NAT	NAT
Programmes in place to engage men and boys in efforts to eliminate gender -based violence	NAT	NAT	NAT	NAT

NAT – Not a target identified in the National Strategic Plan

GBV is posited to increase HIV risk through three mechanisms:

1. Violence constrains women's and girls' ability to negotiate safer sex;
2. Sexual abuse during childhood or adolescence increases the likelihood of engaging in risky sexual behaviours; and
3. Rape increases the biological likelihood of HIV transmission, particularly where there might be lacerations as a result of the use of force.

It is in realization of the linkage between GBV and HIV that UNDP commissioned a study in Nigeria to map the laws, policies and services related to GBV and its intersection with HIV. The findings are also expected to shed more light on how gender is addressed in the national response.

4.2.4.5 Sexual and Reproductive Health & Rights

There is a National Reproductive Health Policy and Strategy in place. The components of RH as adopted by Nigeria include:

Safe motherhood comprising prenatal care, safe delivery, essential obstetric care, post-partum care, neonatal care, and breastfeeding;

Family planning information and services;

Prevention and management of infertility and sexual dysfunction in both men and women;

Prevention and management of complications of abortion;

Prevention and management of reproductive tract infections, especially sexually transmitted infections (STIs), including HIV.

> AIDS feeds on systems of injustice that existed long before HIV had considerable impact on human society. Ending the epidemic both exposes these systems and presents to a historic opportunity for real change. It will involve a revolution in long-held cultural beliefs and intensely held personal norms for both men and women.

Promotion of healthy sexual maturation from pre-adolescence, responsible and safe sex throughout life and gender equality;

Elimination of harmful practices, such as female genital mutilation (FGM), child marriage, domestic violence against women;

Management of non-infectious conditions of the reproductive system, such as genital fistula, cervical cancer, complications of FGM and reproductive health problems associated with menopause.[57]

HIV/AIDS-Mid Term Review.

[56] Ibid.

SRH is integrated with HIV at the primary health care level. The integration process had however increased the burden of care for many health care providers as staff numbers in most of the facilities have not increased commensurately with the growing responsibilities. It is therefore suggested that training and capacity building of health care workers to learn new skills to facilitate integration be undertaken as the curriculum of health care providers does not include integrated health care management approach.[58]

3.2.4.6 Other Gender Considerations

A gender assessment of this nature needs to touch on basic issues of what gender and gender equality actually are as they differ in concept from sex in terms of women, girls, men, boys, and transgender. The inequalities between men and women that are created and reinforced by gender roles affect men and women in different ways though the latter are disproportionately disadvantaged. Even more disadvantaged are the transgenders who by virtue of their sexual orientation are regarded as more or less 'outcasts' in many societies.

Women and Girls

"…..in no society do women enjoy the same opportunities as men."
- (1995 Human Development Report)

This statement emphasizes the fact that must be addressed comprehensively if the HIV national response is to achieve its goals. Women are placed at higher risk of infection biologically, socially, economically, politically and culturally. We often talk about feminization of HIV and poverty and develop policies and laws to address these issues but consistently, researches have shown that there is a strong correlation between all the factors mentioned above and the spread of HIV.

In Nigeria, women are under-represented in all political decision making bodies and their representation has not significantly increased since the inception of democratic rule. In the upper chamber of the National assembly, female membership increased from 1 to 7 out of 109 (6.4%) seats, while the LGA which is close to the community has no female member either as chairman or councillors. These all have implications for legal reforms and community towards fighting AIDS to finish.

Again, a high percentage of women's employment is restricted to low income-generating activities concentrated within the unregulated, informal labour market which are not adequately represented in the National Accounting Systems. In the Federal Civil Service, which is the largest single-entity employer in Nigeria, 76% of civil servants are men whereas 24% are women and women hold less than 14% of total management level positions. The feminization of poverty means that women and girls increasingly have to exchange sex for money, food, shelter or other needs, and are also vulnerable to being trafficked into sexual slavery. The cultural expectation that women will be the prime or only care-givers to their infected family members creates disproportionate social and economic burdens on them and also girls who due to the same cultural preference cause girls to be pulled out of school for care giving functions.

[57]Federal Ministry of Health Nigeria (2013). National HIV/AIDS and Reproductive Health Survey, 2012 (NARHS PLUS).
[58]National Agency for Control of AIDS (2013). Ten Targets of the UN General Assembly 2011 Political Declaration on HIV/AIDS-Mid Term Review.

All these exacerbate women's vulnerability to HIV. A meaningful gender transformative response will need to address all these issues in a systemic and consistent way with accountability structure in place. The present response seems to be lacking in strategies that will really address women and girls with funds allocated to drive such strategies.

Men and Masculinities

From the analysis of the epidemic in this report, men's action or inaction inadvertently fuels the spread of HIV. They are culpable in terms of multiple sexual partnerships, transactional sex without condom and much more. However these masculinity norms make men vulnerable too. The archetypal image of the strong, virile, aggressive male makes men and boys not to access prevention, treatment and care services when needed but that will run contrary to a man's nature who is supposed to know much about sexual issues and boast in his sexual prowess even when in danger.

Of importance too is the fact that the patriarchal nature of the society gives room for men to have more control over decisions regarding sex and so interventions that will enlist men to take responsibilities for their actions and inactions as it affects them and the rest of the household become crucial. The submission on the review of the ten targets of the UNGA 2011 political declaration by NACA and UNAIDS is that the national response '*partially includes activities to engage men and boys.*'

Key Populations

Key populations consist of MARPS, the mobile population and the marginalized and confined persons namely FSW (BBFSW&NBBFSW), MSM, PWID, Uniformed Service Men, PLHA, OVC, ISY, OSY, Prisoners and physically challenged.[61] Efforts need to be intensified between these group especially the MARPS. Living in denial will not help the situation as the high prevalence witnessed among these groups call for special interventions especially when there is interaction between them and the general population who see themselves at low risk. More advocacy needs to be made to government to protect the right of individuals regardless of their sexual orientation.

[59]DFID (2012). Gender in Nigeria Report: Improving the lives of girls and women in Nigeria.
[60]CIDA Nig. GSAA 2006.
[61]National Agency for the Control of AIDS (2009. National Policy on HIV and AIDS.

4.0 KEY RECOMMENDATIONS

To address the major gaps that exist and thus limiting the effectiveness of the national response to gender inequalities, nine broad recommendations are given here. Other specific recommendations suggested during the data collection workshops are presented in the annex.'

Systemic approach to deconstructing issues of Masculinity and Femininity

The critical role of gender inequality and male dominance to the vulnerability of women and girls need to be brought to the fore. There is a need for comprehensive programmes that challenge gender inequality in a holistic way and cross examine the socialization of boys and girls at home and school. Two ways to do this are:

Mass Media Campaign

When AIDS was first detected in Nigeria in 1986, the aggressiveness with which it was tackled through the media was amazing and the results are feasible today. Though awareness may not translate to action, there is hardly any Nigerian that has not heard about HIV/AIDS. In Addition there has been significant reduction in the number of people who still have misconceptions around HIV/AIDS. Culture is dynamic and as such appropriate communication strategies are needed to make gender a public issue using the positive aspect of the culture as an entry point (Some positive cultural practices identified at the data collection workshop are in the annex). There is a need for a comprehensive, consistent and sustained reorientation of the society and the political will to do this must be backed by adequate resource allocations. In addition there must be significant male involvement across all levels in the response.

There are pockets of interventions here and there by CBOs but gender issues in HIV programming has enough critical mass to command its own political and fiscal space. A few of the interventions are:

Project Alert has a programme called the "Male Involvement Programme", where men are deployed to speak with their fellow men on changing their attitude towards women and taking on positive gender role interpretations and to express positive masculinities. A "Men's summit with the theme 'Eliminating Violence Against women: the role of Nigerian Men' held in 2010 in Lagos and had men speaking out against all forms of violence and abuse on women.[62]

The **Ebonyi Men's Resource Centre** (EB-MRC) which is hosted by Daughters of Virtue and Empowerment Initiative (DOVENET) has a network of men, allied with women, acting as role models in violence prevention and positive masculinity. The vision of the network is to cultivate a group of gender sensitive men who will join in stopping violence against women and children and be prepared to work for a better community. A workshop on "Partnering with Men to end Violence Against Women" was carried out and more than 30 EB-MRC members and supporters participated in the training workshop.[63]

Findings from more than 10 studies in Asia, Africa and Latin America conducted from 1997 through 2007 found a positive impact when programmes used appropriate mass media messages and effectively engage men.[64]

[62]UNDP (2013).'Mapping of Laws, Policies and Services on GBV and its intersections with HIV (2013).

[63]Ibid.

[64]Citations and descriptions of the studies and interventions can be found at www.whatworksforwomen.org, Gay, J., Croce-Galis, M., Hardee, K., 2012. What Works for Women and Girls: Evidence for HIV/AIDS Interventions. 2nd edition. Washington DC: Futures Group. Health Policy Project.

Public message campaigns tailored to youth, targeting both girls and boys, to address misperceptions about HIV prevention. A study of girls in Senegal found that they engaged in anal, oral and manual sex to remain technically virgins for their wedding night, yet provide pleasure both for themselves and their boyfriends (van Eerdewijk, 2009). Anal sex can increase the risk of HIV transmission (Powers *et. al.,* 2008), "yet anal sex continues not to be targeted nor even specifically mentioned in most prevention campaigns..." (Halperin*et. al.,* 2009b: S57).

School Based Curriculum- Re-examination of FLHE

Education is a potent weapon of change and this must be employed from primary to secondary level to re orientate boys and girls and make them champion the cause of gender equality. It must be built into the school system consciously. Below is an excerpt from Teacher Education in Sub Sahara Africa (TESSA) resource guide on teaching gender using reverse role play:

> **Mr Auta** is busy cleaning the house. He is carrying the baby on his back because she will not stop crying. Annie, the five-year-old, is pulling at his legs because she wants something. Mr Auta is obviously tired, but dinner is cooking on the small fire. He shouts at some older children outside to go and fetch more wood for the fire. He talks about his problems as he works. He is worried that there may not be enough food when his wife comes home from work at the council.
>
> **Mrs Auta** arrives home from office late. She is a little drunk and she is angry that the dinner is not ready and the house is not clean. She shouts at **Mr Auta** and they have an argument, then **Mrs Auta** hits **Mr Auta** and storms out of the house saying she is going to get her dinner somewhere else.

For adolescents in school, School-based comprehensive sex education programmes have been adjudged to work. Available evidence indicates that sex education can delay sexual debut (rather than encourage young people to have sex), and can increase condom or contraceptive use by sexually active adolescents (UNESCO, 2009a; Mavedzenge*et. al*., 2010a; Kirby, 2001; Coyle *et. al.,* 1999; Hubbard *et. al.,* 1998, cited in Satcher, 2001; Grunseit, 1997).[65]

If school-based sexuality education is to have maximum impact, however, it must be taught by trained teachers (UNESCO, 2009a):"Train teachers to conduct age-appropriate participatory sexuality education to improve students' knowledge and skills" (UNESCO, 2009b; James-Traore*et. al.,* 2004; Arcand&Wouabe 2010). Also, programmes that help parents to talk to children about sex have been known to effect a delay in sexual debut amongst children. This effect has occurred in Kenya when parents had received information to educate their children about sex (Poulsen*et. al.,* 2010).[66]

The recommendation in the MTR of the NISP implementationis to update the content of the FLHE curriculum for in-school and out-of-school young people and the PCRP seeks to promote behaviour change by expanding school-based FLHE and HIV programme for National Youth Service Corps.It is a welcome development and gender experts need to be part of the review so as to incorporate comprehensive sexuality education in schools with a focus on gender equality and human rights as it relates to HIV.

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[65]Citations and descriptions of the studies and interventions can be found at www.whatworksforwomen.org, Gay, J., Croce-Galis, M., Hardee, K., (2012). What Works for Women and Girls: Evidence for HIV/AIDS Interventions. 2nd edition. Washington DC: Futures Group. Health Policy Project.

[66]Ibid.

Strengthen Coordination and Meaningful Participation in the National Response

NACA is the coordinating body in the national response and multi sectoral setting. The multi sectoral approach is not without its own issues. Evidence points to the fact that there is a gap coordinating the national response of line ministries, CSOs and development partners. The MTR of the NSP equally points to the fact that a lot is being done to strengthen the gender desk of NACA. These should not be limited to NACA but extended to other actors in the field.

More involvement of networks involved in gender related HIV response is needed especially their participation in technical working groups and in the design, implementation, monitoring and evaluation of HIV programmes and policies to ensure gender responsive response. Meaningful participation would mean involving them and not just planning for them. The meaningful participation of other key populations, such as FSW, MSM and PWID as well as CSOs working with them in the HIV response should also be ensured. People with disability especially women and girls are also being marginalized and need to come on board. The MTR review of the ten targets shows that the country is not on track to reduce transmission of HIV among PWID and eliminate gender inequalities and gender based abuse and violence and increase the capacity of women and girls to protect themselves (Targets 2&7). Institutionalization of their meaningful participation is crucial to a gender transformative response.

We need to move away from token participation that fails to actually incorporate women. The engagement of young people, especially young women, girls, and young people living with HIV, in the planning, design, and implementation of interventions as well as their involvement in the development of campaigns to reducecross-generational and transactional sex among others should be strengthened

Review of Laws towards Ensuring Human Rights and Gender Equality in the Response

Nigeria ranks 118 of 134 countries in the Gender Equality index.[67] This has implications for the national response. An earlier review of laws in this report reveals that our laws need to be revisited and reviewed with gender lens. Of immediate importance is the passage of the Anti-Stigma Bill, Violence Against Persons Prohibition Bill and other bills that relate to disability. The reversal of gains made in prevention, treatment and care of the general population cannot be overemphasized if the President gives his assent to the same sex marriage prohibitions bill. Efforts should therefore be made to strategically make representations through pressure groups for its reversal. Human rights activists and health practitioners should team up to mount pressure on government. NACA and development partners should create dialogue with key national institutions and persons to review and evaluate the impact of passing the bill on the national response.

Equally important is the formulation of clear policies to consciously engage men and boys strategically in order to end inequality and begin to reverse trends of HIV. The policy and legal framework should also be expanded in order to make room for increased access to justice through national standardized programmes for law enforcement agents on the right of citizens regardless of their sexual orientation.

Legal and Social Transformative Interventions Regarding Gender Based Violence

One of the most serious manifestations of unequal gendered relations is GBV which happens in many contexts be it home, school, workplace, health care settings and public places. Rape is fast becoming common place in Nigeria[68] and care need to be taken to address it promptly hence the need to view GBV as part of the societal inequality between men and women. **The involvement of men is very crucial to the change in gender based norms and should therefore be involved in** ending GBV.

To ensure a comprehensive response to GBV within the HIV setting, it is therefore recommended that GBV plan/guidelines be developed to guide the response. Indicators should also be developed to capture various forms of violence across difference age groups.

Resource Allocation/Budgetary Provision to Specific Strategic Gender Sensitive Interventions

The key recommendations provide information for the development of a work-plan detailing specific interventions and strategies. This work-plan should be costed and resources allocated to them. Allocation for gender activities should not be lumped into other thematic areas but rather specific budget lines should be available for specific strategic interventions. Resources and expenditure should also be tracked in order to ensure that gender specific interventions have budget lines and are executed appropriately.

Integrated Health Services

Health services to women, girls, men and boys can be improved by broadening the sexual and reproductive rights and health frameworks. Gender-sensitive integrated prevention, care and support approaches are needed.

A few sub recommendations are given below:

There is the need to specifically target men and boys with HCT. In addition to taking HCT services to places where men can be reached easily, it is important to promote spousal counselling including in ANC.

National and State routine HCT consented to by household members should be encouraged as this will increase the number of those who know their status which is very critical. Something similar to the routine polio vaccination done from house to house can be encouraged.

Scale-up the availability of HIV services adapted to the needs of people with disabilities and ensure that tools are developed to ensure that all people with disabilities can be reached by HIV prevention messages, and HIV care, treatment and support services.

Integrate awareness and prevention messages about GBV and its intersection with HIV into the broader HIV programme. More often than not, opportunities are lost to identify and treat women suffering violence as an integral aspect of the provision of HIV and other health related services

Scale-up the provision of post-exposure prophylaxis to ensure that all individuals who are victims of sexual violence receive PEP in a timely manner to prevent HIV infection. Ensure that all individuals receive the full PEP package and develop adequate follow-up mechanisms to improve adherence and ensure victims receive the full course of treatment.

[67]DFID (2012). Gender in Nigeria Report: Improving the lives of girls and women in Nigeria.
[68]UNDP (2013). 'Mapping of Laws, Policies, and Services on GBV and its intersections with HIV (2013).
[69]National Agency for Control of AIDS (2013). Report of MTR of the Implementation of NSP 2010-2015.

Training for all involved in integrated approach to service delivery (doctors, nurses, police officers and others).

Link health services with girl education, employment and poverty alleviation programmes for vulnerable population. Increased employment opportunities, micro?nance, or small-scale income-generating activities had been adjudged to reduce behaviour that increases HIV risk, particularly among young people.

Develop programmes for older women to also cater for their health and sexual needs. Research has shown that some grandmothers above 50 are sexually active and some go into sex work due to the care giving function they bear.

Institutionalization of Gender Management System

Gender Management System (GMS) is an integrated web of structures, mechanisms and procedures put in place within a given institutional framework for the purpose of guiding, managing and monitoring the process of gender integration into mainstream culture, policies and programmes in order to bring about gender equality and equity within the context of sustainable development.[70]

NACA as the apex body is on the track of institutionalising GMS through the development of 5-year Strategic Plan on Women, Girls and HIV/AIDS among others but there is a need to establish functional GMS in all states and relevant ministries and bodies. ENR has blazed the trail in this regard by institutionalizing GMS in its seven focal states. There is a need to increase the deployment of gender experts in programme design at all levels as well as more gender sensitive indicators that goes beyond just disaggregation of data by sex.. The MTR of the NSP identified some indicators that are not tracked. They include *proportion of partners' reports reflecting gender sensitive programming*, *proportion of key NACA, SACA, LACA, key partners staff trained in gender and HIV/AIDS programming,proportion of HIV/AIDS budget addressing gender gaps.* All these are pointers to institutionalising GMS so that policies, resources, capacities are built towards identifying and tracking gender indicators and setting benchmarks.

A careful analysis of the indicators needs to be done so as to ensure that data on age brackets 0-14 for both males and females are captured as well as transgender persons

.

Monitoring, Evaluation and Research

There is a need for strong monitoring and evaluation mechanism that will measure changes and impact over time of the gender sensitive strategies. Though tools are available to capturesex-disaggregated data, the MTR and JAR show that not all partners pay attention to disaggregation. Statistics from the treatment and care and support thematic areas were not adequately disaggregated. Another finding from the MTR is that interpretation of disaggregated data and use of findings for decision making is inadequate.

There is also a need to build an evidence base on what works in gender related programming in Nigeria. Data through survey is needed on the link between GBV and HIV; correlation between sex education and delay in sex debut; tracking violations of the rights of FSW, MSM and IDU; evidence on growing IPV and effects of education in reconstruction of social norms on boys and girls.

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[70]Matlin, S., (2011). Gender Management Systems in the Health Sector, Human Resource Development Division, Common wealth Secretariat, London.

Snowball qualitative research technique (also known as chain referral sampling) can be used to access behavioural information on hard-to-reach groups as well as norms and practices amongst all the key populations especially MARPS. Information from some of the study could provide baseline information on critical gender indicators not hitherto captured in the NSP.

Dearth of data on specific gender issues in HIV programming continues to hinder proper planning of interventions and so collaborations between researchers, communities and donors must be strongly encouraged and supported as they work to identify research questions and develop a qualitative research agenda. Research and participatory monitoring among partners on gender mainstreaming in the response should be funded as a matter of national priority. Also, the replication of the gender assessment at the state level will be instructive considering the cultural diversity of Nigeria in order to have specific state tailored response.

Addressing Stigma and Discrimination of PLHIV and other Marginalized Groups

The National HIV response through awareness campaign has been able to reduce stigma and discrimination of PLHIV as revealed in the Stigma Index report but gap still exists and a lot still need to be done. Clear strategies to address stigma and discrimination of PLHIV, FSW, MSM people living with HIV and people with disabilities especially at the community level need to be put in place. Introduction of the human rights element is needed to ensure that the rights of these people regardless of their status and sexual orientation are ensured.

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ANNEX I-PARTICIPANTS AT THE DATA COLLECTION WORKSHOP FOR NATIONAL STAKEHOLDERS

S/N	NAME	ORGANIZATION	DESIGNATION
	IFEOMA MADUEKE		PROG. ANALYST POV& GEN
	ONYEZUE INNOCENT OKECHUKWU	R.W.F	PROGRAMME MANAGER
	GLORIA ASUQUO	ASWHAN	P.R.O
	OKORUKWU AMARACHI	NACA	PROGRAMME OFFICER
	RACHEL TOKURA	CISHRWIN	PROGRAMME OFFICER
	DR. NSEKPONG UDOH	CPD	E.D
	PATIENCE JIBUNOH	DELOITTE (ENCAP)	OD ADVISOR
	BALKISU A.MUSA	KTMDI	PROGRAMME OFFICER
	ANANABA,IHUOMA	ABSACA	PROGRAMME OFFICER
	GLORIA DIDIGWU	NCWS	ADMIN
	MUSAUSO NZIMA	UNAIDS	SERNIOR ST ADVISER
	NDIDI CHRISTIANA	FMARD	ADMIN
	FISHER OLADIPUPO	LSACA	SPO
	OROLAKIN ADETORO	CERBTHSK	PROGRAMME MANAGER
	BELLO SCHOLASTICA (Mrs)	FMARD	ACAO
	AISHATU A LI KADALA	NAWOJ	CHAIRPERSON
	EKAETE UMOH	FACICP	EXECUTIVE DIRECTOR
	ADOO IHYUMAN	BENSACA	GENDER FOCAL PERSON
	HANNATU M. ISMAIL	KADSACA	GFP
	FATIMA ABDU	FOMWAN	GFP
	INYINGI IRIMAGHA	GENDER &DEV. ACTION	PROJECT OFFICER
	ULOMA AJUONU	RURAL WOMEN FOUNDATION	PROGRAMME OFFICER
	BAMIDELE OMOLARA	NYNETHA	PROGRAMME OFFICER
	JAMILA IBRAHIM YAHAYA	SWAAN	GFP
	GABRIEL UNDELIKWO	UNAIDS	CMNA
	EVELYN OTI	CHILD CARE (CCAPI)	PROGRAMME OFFICER
	CHIEME NDUKWE	SFH	DCOP,SHIPS FOR MARP PROJECT
	YEWANDE OGUNNUBI	FHI360	SENIOR GENDER SPECIALIST
	ANTHONIA AINA	US CDC	PROGRAMME SPECIALIST GENDER
	KADIRI AUDU	ICARH	HEAD OF PROGRAMME
	UYEBI SANDRA	FAMILY CENTERED INITIATIVE FOR CHALLENGED PERSONS	PERSONAL ASSISTANCE TO EKAETE
	EDEM, OFFIONO A	CRSACA	GENDER OFFICER
	EGWUONWU. JOY NNENNA	NACA	PO
	ESTHER JAMES	ASWHAN	ADVOCACY OFFICER

NKIRU ODOH	**CWSI**	**GENDER EXPERT**
DR. ANNE OKEM	CWSI	GENDER ASSISTANCE
IYAMU FAVOUR	NACA	PROGRAMME OFFICER
MUSTAPHA H.B	FMWASD	ACSWO
MERCY EGEMBA	NACA	PROGRAMME OFFICER
ESOR FABIAN	NACA	PROGRAMME OFFICER
JIMBA R.F	FME	SEO
OCHANYA IYAYI -PAUL	MSH-PROACT	SNR. CCA
ONUNGBOGBO NIKE	MSH,PLAN HEALTH	M&E OFFICER
ADEOLA ADELANA	MSH,PLAN HEALTH	TO
IJEOMA OBO EFFANGE	MSH	POOD
IFEOLUWA AGBOOLA	NACA	INTERN
LINDA OTI	CCAPI	MEMBER
IFEOMA ANYANWU	FMARD	HEAD,GENDER DESK
DAVID AKINPELU	ENR	IDA
GRACE OBI UKPABI	NPC	GENDER DESK OFFICER
KIBIBI THOMAS MBWAVI	UNAIDS	CONSULTANT
SUSAN AZUKA	NPC	GENDER OFFICER
AMODU DAMIAN	NPC	PLANNING OFFICER
AKANJI MICHAEL	TIERS	DIRECTOR OF PROGRAMMES
OLABOSINDE FUNKE	HEARTLAND ALLIANCE	PROGRAMME OFFFICER
MRS A.O ETTA	FMOH	GENDER FOCAL
NDIDI CHRISTIANA	FMWARD	ADMIN GENDER
UZOMBA CHIAMAKA	NACA	CORP MEMBER
MODUPE ODUWOLE	UNAIDS	STRATEGIC INTERVENTION ADVISER
OKEKEARU IFEANYI	SFH	COP MARPS PROJECT
VICTORIA AGBARA	DELOITTE (ENCAP)	COP
ESTHER OGUNLOWO	POLICE HOSP.	
DR. YINKA FALOLA -ANOEMUAH	NACA	AD
DR BISAYO B. ODETOYINBO	INFLUENCE CONSULTS LTD	CONSULTANT
OSHAGBAMI OLUWASEUN	NACA	POLICY

ANNEX II- RECOMMENDATIONS BY STAKEHOLDERS AT THE DATA COLLECTION WORKSHOP

A. LAWS/POLICIES/GUIDELINES

Recommendations

Women empowerment

Massive awareness on girl child education

Awareness of services and available opportunities

Linkages to services and removal of bottlenecks

Access to free legal aid

Advocacy, holding the government accountable for non-implementation of the laws and play on the conscience to implement policies and guidelines via advocacy and lobbying

Pressure group on accountability in the government structures

Knowing the budget and knowing how it goes (FOI can help) for social mobilization

There should be evidence to show that there is good in the implementation of these laws and policies, getting the communities aware, make it public and engage with duty bearers continuously.

Those in leadership position in Government need to be aware of this issues, capacity building and awareness creation on these issues

Fact sheets to prove to the leaders that these issues are critical and should be addressed, M and E results should be sent to the decision makers. Get consultants to really identify the losses, pros and cons of addressing these issues so they know exactly how these issues affects the work they do as government administrators and how it reflects on the government

Enforcement of laws: Putting a human face to these issues, via documentaries and real life experiences will help create the right kind of impact in the minds of decision makers which will translate into an eventual redress.

Connect the law makers, policy makers and government to the people passing through difficulties from the non-implementation of the laws/policies/guidelines and the realities people face for the non-implementation.

Increase support group centres

Increase access to policy documents

Development of specific state policies for care and support

A. SOCIO CULTURAL AND RELIGIOUS NORMS

What are the socio-cultural and religious norms and practices that negatively and positively impact gender and equality and HIV?

SOCIO-CULTURAL AND RELIGIOUS NORMS	POSTIVE IMPACT	NEGATIVE IMPACT
It is culturally accepted for men to have extramarital affairs.		It predisposes men, their wives and concubines to HIV.
It is culturally, socially and religiously unacceptable for women to negotiate the use of condom before sex.		Increases women's vulnerability to HIV infection Reduces the woman's confidence
Within the Hausa/Fulani culture young girls are denied access to early education due to the belief that education exposes the girl child to sexual promiscuity.		- The lack of early access to education affects their knowledge of sex education and HIV. - It reduces their future economic power which causes economic dependence.
Within the Hausa/Fulani culture the girl -child is exposed to the neighborhood through hawking in order attain prospective suitors.		It exposes their vulnerability to HIV infection, as well as rape, to unprotected sex, violence and early marriage.
It is a common practice for mothers to encourage their girl-child into prostitution for economic benefits. Examples are found in some parts of Itsekiri, Benin, and Kaduna communities.		- Increases vulnerability to HIV infection - Exposes the girls to multiple partners and sexual abuse
Among certain communities in Nigeria, such as in Kaduna, Cross-River, Kogi, Benue, Akwa-Ibom States, it is common for young girls to be given as housemaids.		- Risk of sexual assault - rape - Vulnerability to HIV - They are deprived of education.
Amongst the Guguma group of Rivers State, as well as in Benue State, wives are commonly given to their husbands' guests as a form of entertainment.		- Increases vulnerability to HIV infection. - Reduces confidence and self-esteem
There is a common belief across many communities in Nigeria that men who have sexual relations with disabled persons will become wealthy.		- Increases vulnerability to HIV infection. - Disabled persons become targets of sexual assault - Reduces self-esteem and confidence
Women who are blind are not considered useful as wives in certain areas.		- Increases vulnerability to sexual assault and HIV infection. - Reduces confidence and self-esteem
In the case of childlessness in Ebonyi State, there are culturally motivated		- Increases vulnerability to HIV infection. - Reduces confidence and self-

In the case of childlessness in Ebonyi State, there are culturally motivated permissions for women to have extramarital affairs if the husband is impotent.		- Increases vulnerability to HIV infection. - Reduces confidence and self - esteem
It is culturally not acceptable for women to have extramarital affairs or there will be repercussions e.g. In some areas of Akwa-Ibom, Edo, Benue, Delta, Imo, Ebonyi, Enugu.	- Reduces vulnerability	
More value is placed on the girl-child for the belief that the in-laws spend more during the marriage and they take care of their parents at old age.	More attention is focused on the upbringing of the girl - child.	
Across all communities in Nigeria, it is valued when a girl is a virgin at the time of her marriage	Vulnerability of being HIV infected through intercourse is reduced.	Harsh Punishments/discriminations when women/girls are not virgins at marriage.
It is a common belief and norm that there should be no sex before marriage culturally and religiously.	Vulnerability of being HIV infected through intercourse is reduced.	
Gender Based Violence		FGM: Unsterilized instruments are used. Increases risk of contracting HIV e.g. Ekiti Rape: Sexual assault initiated by one or more persons against another person without that person's consent increases vulnerability to HIV. Wife battering: The belief (predominant in many parts of Nigeria, including Ibadan) that women are typically weaker, powerless and more dependent renders females more susceptible to intimate partner violence including rape by 'partners' and consequently increase their vulnerability to HIV/AIDS infection. 'Money woman': In certain parts of Nigeria, baby girls are betrothed to older men as means of payment of debts even before they are born. This is common practice in Obanliku, Cross River state. Trafficking in persons: Female domestic workers are often violated by their masters.
Masculinity		The tend ency to believe that the

Harmful Traditional rites		Culture of silence: This exists where instances of different forms of violence or assault are not reported because of fear of ostracism or stigmatization. Young girls with unwanted/unplanned pregnancies can be forced to marry the persons responsible for their pregnancy. Again, the HIV status of these persons may not be checked, thereby exposing the girls and their unborn children to the risk of infection. Female to female marriage: In Awkzo, Anambra state, widows who do not have male children can be married off to another woman, where she will be free to have sex with other men. This encourages multiple sexual partnership which increases risk of HIV infection and transmission. TBAs/CBAs: In areas where there is no collaboration with health facilities, the TBA/CBA system will likely prevent pregnant women from attending ANC and if positive, will increase risk of transmitting infection to the unborn child. Widowhoodrites that encourages shaving of women's hair with unsterilized sharp objects exposes them to risk of HIV infection.
Stigma and Discrimination: That HIV and AIDS can be transferred without the contact of bodily fluids (touching nonphysical interaction etc.) Stigma attached to Caesarean operation		Cultural and Religious beliefs about same sex relationships prevent service providers from providing health services to people who engage in same sex relationships. This in turn acts as a deterrent to homosexuals from accessing services, for fear of discrimination. PLHIV -Increases the vulnerability of person's infected with HIV/AIDS to hardship, abandonment, poverty, and encourages migration and more risky behaviour that can spread the virus.
Child marriage: Religious beliefs that it curbs promiscuity -thata girl should see her 2nd	-It reduces the exposure of young girls to multiple sexual partners before marriage	It increases the spread of HIV/AIDS -Girls who marry early are still at the risk of contracting HIV& AIDS

The belief that women should be seen as under the man, being taken care of by the man or lower than the man in all facets be it financially, intellectually, religiously, or physically.		-Women tend to miss out or pass on opportunities that can improve their lives.
The feminine cultural belief of non-acceptance of western medical care in maternal health care.		Rejection of modern SRH services that can increase the rate of infection of HIV/AIDS and increase maternal/infant mortality
Marital rape is not considered as an offence/sex is the right of the man in the marriage and he must have it at his will.		Encourages marital rape, domestic violence and gender based violence in marriage.
AOB - the destitute: They are generally seen as social misfits and totally excluded in all spheres of the society including the family and the government		They are used for several rituals and degrading practices (e,g. rape) - This increase their exposure to HIV/AIDS that can be spread to others who attempt same on them - for the women/girls, pregnancy can occur.

What is currently being done to address challenges?

Individual/household level	Community level	Government level
Girls in the North dress very modestly. Girls are usually not allowed to go out alone at night, they only go out in groups. Sex education is being taught inside the home so they will become more aware of their femininity and their body. Girls are not allowed to be alone with their suitors before the marriage, they are accompanied by their Muharram. Building stronger relationships Bridging communication gaps Increased monitoring of children and sensitivity to GBV Sharing experiences with others Individuals are taking steps to ensure they resist early marriage in their female children having seen the importance of education for males/females alike. People readily access materials from the internet on HIV/AIDS. A few individuals a re speaking up about HIV/AIDS and declaring their status to reduce the stigma and myths surrounding HIV/AIDS IPC programmes Media sensitization	Celebration of virginity. Ukele community in Cross Rivers State has a law through the Chiefs that families are not allowed to give their children out as maids. Sensitizing women through August meetings. Expulsion of mothers from Associations when their children are promiscuous. Reproductive health and Family life education (calling body parts their right names). Sensitization and advocacy by religious groups, community leaders and other key gatekeepers. Child protection committees. Involving men and boys. Mass informal writing in some communities to address issues(Kaduna). Society Taking Action for Rights (STARs) where the excluded population/deprived can come out and speak out. Women are now given position of responsibility e.g in Ward Development Committees Women are now demanding inclusion in governance at community level. CSOs engagement/IPC.	Child Trafficking Prohibition Laws. Health Education at school levels. Government assisted marriages. School-feeding policies. Bills that are in the process of being passed. Creating “enabling” environment. Interpersonal communication and awareness creation within the government MDA’s and agencies. Sensitization of the media by the gove rnment of the need to create awareness on HIV/AIDS and gender equality issues Work place sensitization on HIV/AIDS and gender equality issues (Federal Ministry of Education). Peer education training in schools(step down trainings) (Federal Ministry of Education). Mainstreaming HIV/AIDS topics into the curriculum (9 - year basic curriculum) Training for deaf and dumb on issues of HIV/AIDS in Suleja (Federal Ministry of Education). Budgetary allocation to gender across core MDAs e.g . Women Affairs, NACA, Special Assistant to the President on Gender, Special Assistant to the President on MDA. Post 2015 MDG inclusion of gender equality as a thematic area. Gender desks across all MDAs - 35% affirmation being implemented as stated in the National Gender Policy Policies and laws - VAP Bill, Trafficking in persons, etc. FLHE.

What else can be recommended to address these issues?

Customary Laws and Traditions	Religious-based collaborations	Community-based collaborations	Using the media	Collaboration with educational institutions	Others
To review the customary laws and traditions. To review the practices and beliefs that negatively impact the community. Educating the community through advocacy and sensitization. Using the structure of the chief, community and opinion leaders to influence persons positively within the communities. Sensitize leaders within the community and cause them to become advocates. Increase engagement with judiciary systems, enforcement of laws and review of penalties. Training of unskilled birth attendants, incentives to TBAs for sensitization and referrals. Using the elites in the communities as champions for advocacy for change (walk the talk) Sexual Diversity and expressions	Sensitize and train religious leaders to encourage their members by addressing these issues. Working with religious leaders to utilize parts of their beliefs to tailor messages to their members. Strengthen the internal religious structures.convey Using FBOs to advocate and lobby for gender equality and gender equity. More participation of religious leaders in trainings and meetings that relate to HIV/AIDS .	Community involvement of the males through health education trainings. Setting up a community structure to ensure the welfare, safety and protection of chi ldren in the communication Communities should come up with stricter penalties for offenders. Women should be encouraged to speak out on sexual assault against them. CBO's should be encouraged to embark on sensitisation, advocacy and awareness creation, targeting religious leaders, gatekeepers and key influencers. Programming for condom and condom - compatible lubricants. Up scaling interventions exposing the effects of masculinity norms on the spread of HIV/AIDS.	Advocacy for free slots on the radio to address specific problems. Advocacy for media houses to take responsibility and ownership. Advocacy to the entertainment industry to incorporate gender equality and HIV within television and radio programming. Creating awareness through the media on PEP for rape victims. Involvement of independent media houses on grassroot interventions. Using the local dialects for sensitization. Using towncriers in rural/remote villages. Making use of educative/entertaining short videos on HIV/AIDS/gender equality issues that can be downloadable and popularised through social media.	FLHE should be standardized as a specific subject throughout Nigeria, specifically within private and public schools. Infusion of gender subjects/modules in school curriculum from the primary level. Re-training of teachers on local acceptable terms on sexuality (e.g vagina, penis). More research on sex, gender, sexual diversity and expressions and the need for publicity in local languages.	Providing support for biomedical research e.g. Microbicides for women. Strengthening the capacity of civil societies to engage on issues of sex, gender, sexual diversity and expressions, HIV/AIDS programming based on linkages between HIV/AIDS and human rights

A. GENDER EQUALITY AND POWER RELATIONS

Examples of MDAs and sectoral plans and programmes catering for the HIV-related social protection that promotes gender equality.

	PROGRAMMES
Small and Medium Enterprise Development Agency of Nigeria (SMEDAN)	Start up and support for small and medium scale businesses; Provide training for business management; Provide seed fund and credit facilities for businesses; Entrepreneurship development programme for general population and rural women; Productive weekend for youth; Youth entrepreneurship development programme; Entrepreneurship development programme for youth-corp members.
National Directorate of Employment	Job creation, skill acquisition and vocational training for all; Addressing youth unemployment; Rural agricultural development scheme; Rural handicraft training scheme; Integrated farming training scheme; Economic empowerment programme.
Ministries of Finance, Agriculture, Communication Technology and Women affairs and Social Development	YouWin: Busines s plan competition to support youth entrepreneurs to develop and execute business ideas Support OVC by providing education, child protection, child welfare, women empowerment, orphanages and adoption processes Training of HIV positive individuals on economic empowerment; FADAMA Public Enlightenment on HIV/AIDS, and existing on gender and equality Reinstatement of commercial sex workers in the FCT, providing jobs for them The women's political empowerment project in all the 6 geopolitical zones Skill acquisition for women/girls in all the states.
Federal Ministry of Agriculture and Rural Development	Youth and women in agriculture programme : trains women and youth in agribusiness and entrepreneurship. Youth employment in agriculture programme (YEAP): promote decent income generation and livelihood for youth in rural areas. Training of HIV positive individuals on economic empowerment; FADAMA. Registration of farmers and having their dossiers, providing fertilizers to farmers through their phones. Providing phones for registered farmers.
Ministry of Youth Development	Peer Education for out of School Youths Youth Employment Programme: to provide skills and entrepreneurship training for youth National youth agricultural/vocational skills acquisition and capacity building programme
Bank of Industry, Bank of Agriculture, Cooperative Bank and Aso Savings	Provide capital with little or no interest rate for businesses
Niger Delta Development Commission	Organise training programme for women, men

How empowerment help in reducing:

Gender Based Violence

- Education and economic empowerment enable the woman to be self-assertive, more confident; contribute to the family, increase herself-worth; access justice or some services that she would ordinarily need to take permission from her husband, partner etc.
- Structures put in place by the Federal Government through effective programme monitoring processes and capacity building, and which integrate community ownership create enabling environment for women, youth and key population development.
- Involving programme beneficiaries in planning and implementation processes of initiatives usually ensures a sense of ownership which leads to sustainable outcomes and development.
- Financial independence will increase access to resources and facilitate continuity of business initiatives.
- Building the technical know-how of individuals on financial management, resource mobilization and management, monitoring and evaluation capacities will strengthen ownership.
- When women come together as a cooperative society, this helps to increase access to loans and effective management of resources.
- Male empowerment through enlightenment can reduce GBV.
- Education of couples on prevention of GBV.
- Reduction of incidences of street hawking reduces sexual exploitation vulnerability of girls.
- Increases level of political participation – influence of policies that help in reduction of VAW, also helps to increase assertiveness.
- Empowerment of men will reduce domestic violence.

Child Marriage

- Empowerment will create equal opportunities for education, and thus reduce the likelihood of child labour and early child marriage.
- Enlightening parents to understand the dangers of lack of education for their children/the importance of education.
- Economic empowerment can help parents afford education for their children thereby delaying marriage.
- Enlightening parents in decision-making around child marriage (psychologically and biologically).
- Empower young women/girls to be self-confident and assertive.
- Give young girls access to the right kind of information for them to be aware of other options and opportunities for young girls and women, through schools, religious institution, FBOs, CBOs peer education programme.
- Economically empowering people from low income areas and homes through agricultural loans etc. to address poverty which is a factor that encourages child marriage.
- Enlightenment around the disadvantages of early marriage to the health of a child and also the effect on the family/society at large.
- Putting in place laws to end child marriage in the states/local governments/communities.
- Enforcing laws that discourage parents from withdrawing their daughters from school to be married off; and using school enrolment and drop out records to monitor this.

RECOMMENDATIONS

Encourage exchange and cross-learning programmes.

Interventions should be free of political bias.

Ensure continuity in government initiatives.

Initiatives should be sustainable and community-driven.

Government should strengthen monitoring mechanisms and follow-up activities.

More empowerment programmes for disabled persons.

Increase awareness of government empowerment programme to target population.

Increase active participation of target population within communities at the planning stage of empowerment programmes.

Interventions should be prioritized to address the need of the community.

Social protection policies that will create an enabling environment and encourage women to take positions in which men have previously filled.

The girl-child should be encouraged to attend school.

Create more career awareness for youth, especially the girl-child.

Incorporate higher self-esteem and confidence levels in all empowerment programmes.

Consistent gender audit nationally to identify gaps in gender and proffer solutions.

Institutionalization of social protection programmes/framework at all levels so that the interventions/programmes can be done across all sectors and also target specific vulnerable groups.

Programmes should be targeted at the local government and the communities where the issues are concentrated rather than the urban areas alone.

Pilot cash condition programmes targeted at women should be turned to large scale programmes.