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HIV Stigma Policy Implementation is Critical to Attaining UN Zero Stigma Target: The Nigerian Experience

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Abstract

A stigmatizing environment poses service barriers. The enactment of HIV Anti-stigma Law 2014 in Nigeria was aimed at creating an environment without stigma. However, the effect of policy on stigma is unknown. This study was done to determine if policy contributed to HIV stigma decline. I conducted a cross-sectional Stigma Index study in 2021 in collaboration with Network of PLHIVs in 16 States and FCT. A stigma index questionnaire was administered to 1,235 PLHIVs. living with HIV. I also conducted secondary review of two previous Stigma Index surveys (2011 and 2014). Then utilised a one-sample Z-test to test the differences in PLHIV stigma in my study in 2021 (after laws) and in the secondary review in 2011 (before laws). The Z test revealed that stigma was significantly higher in 2011 before laws than in 2021 after laws. Similarly, the Z test showed stigma was significantly higher in 2011(without stigma law) than in 2014 (law developed). However, on testing the period 2014 and 2021 where laws were available in both years, the Z-test showed there was no difference in both years for some forms of stigma while for other forms, it was higher in 2014 than 2021. This confirms that after stigma policies in 2014, stigma dropped such that stigma in 2014 and 2021 wasn't significant for some behaviours. Although laws have contributed to stigma reduction the UN's Zero Stigma target is yet unachieved. Zero stigma may not be reached if implementation of laws is not sustained as donor funding dwindles.

Keywords: *Anti-Stigma Law, Discrimination, HIV, Laws, Policy, Stigma.*

Introduction

Problem Statement

HIV stigma refers to irrational or negative attitudes, behaviours, and judgments towards people living with or at risk of HIV [1]. PLHIVs are stigmatized because HIV is associated with unacceptable societal practices and marginalized groups such as sex workers, drug users, homosexuals and transsexuals. Furthermore, PLHIVs are stigmatized because HIV stigma further compounds preexisting stigma [2]. Marginalized populations such as sex workers, men who have sex with men and people who inject drugs are not only stigmatized for their practices but are further stigmatized for having HIV.

When stigma is acted upon, the result is discrimination[1]. Discrimination is unfair treatment towards a person or a group of people based on certain characteristics. Stigma leads to discriminatory actions and discriminatory actions reinforce stigma.

The stigma and discrimination endured by transgender people (including from healthcare providers) is frequently associated with poor mental health, substance abuse, lack of social support, homelessness and unemployment all of which also compromise their access to HIV and other health services [3]. More so, stigma and discrimination among other factors hinder access to health care for migrants living with HIV [3]. Therefore, breaking down HIV

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stigma is a critical part of ending the HIV epidemic.

Stigma and discrimination violate the human rights of Persons living with HIV (PLHIVs) and this violation is a key factor driving the prevalence of HIV [4, 5]. The UN Declaration 2021, states that discrimination on the grounds of one's HIV status is a violation of human rights. Everyone including people living with, vulnerable to or affected by HIV is entitled to the enjoyment of all human rights and to exercise equal participation in civil, political, social, economic and cultural life, without prejudice, stigma or discrimination of any kind.

UNAIDS recommends that to create an environment in which stigma, discrimination and human rights violations are no longer tolerated or practiced, countries need to implement HIV programs that deal with stigma at collective and community levels, develop and implement laws and policies that protect PLHIV from stigma and discrimination [1]. Nigeria laid the framework for an enabling stigma-free environment by enacting the HIV/AIDS Anti-Stigma and Discrimination Act 2014 [6]. which makes it illegal to discriminate against people based on their HIV status. Also, the National HIV/AIDS Stigma Reduction Strategy was developed in the country. The National Plan of Action (NPA) on removing legal & human rights barriers to HIV/AIDS response (2017- 2022) is another significant policy intervention addressing S&D and human rights in Nigeria [4]. The National Agency for the Control of AIDS (NACA) conducted a Legal Environment Assessment for HIV/AIDS Response in Nigeria and it revealed gaps in the justice system. These gaps, however, were not due to a lack of laws, but the fact that the available legal provisions were not well utilized; as PLHIVs or institutions were either unaware of the laws or were oblivious to how to seek redress. In response, a guideline to improve access to justice for PLHIVs was also developed.

Since enacting the Anti-Stigma and Discrimination Act in 2014, the National Agency for the Control of AIDS (NACA) and its partners have taken measures to implement these policies and the provisions in the HIV S&D Act in Nigeria.

Therefore, Nigeria is not lacking in policies as this paper shows that the country is compliant with UNAIDS guidelines on anti-HIV stigma policies and interventions. Also, Nigeria has made significant strides in research, policies, and programs on HIV stigma and discrimination in the past two decades. However, evidence linking trends in stigma over time to policy development and implementation in the country is largely unavailable. Little is known about the impact of policy implementation and programs on HIV stigma. This paper intends to establish the significance the Stigma Act and other stigma policies have had on stigma and discrimination. This study is necessary to demonstrate whether Nigeria's legal framework, policies and implementation are effective in reducing HIV stigma.

Globally, efforts to monitor stigma and discrimination have increased as countries and communities aim to reach the goal of zero HIV discrimination. The People Living with HIV Stigma Index study led by the network of PLHIVs was first launched in 2008 to monitor progress with HIV Stigma and Discrimination. More than 100 countries have conducted PLHIV stigma index studies [14]. Nigeria has conducted two Stigma Index Surveys. As a staff in the survey and surveillance division of the Research, Monitoring and Evaluation Department of NACA, I collaborated with the Network of People Living with HIV/ AIDS in Nigeria (NEPWAN) to conduct the 2021 PLHIV Stigma Index Studies. I led the study team to design the study protocol, review questionnaires and collect data. Moreover, the analysis and findings presented in this paper are entirely my work and the objectives of this paper are only addressed in this paper. I have

triangulated this study with two previous stigma index studies in 2011 and 2014 to determine the effect of stigma laws and policies before they were available i.e. 2011 and after development and implementation (2014 and 2021).

Objective of the Study

The primary objective of this study is to determine if the establishment of the anti-discrimination bill, including the development and implementation of other policies since 2014 has contributed to or affected the stigma and discrimination experiences of PLHIVs.

The secondary objectives of this paper are:

1. To measure the effectiveness of the Stigma Act and policies on the experiences of stigma and discrimination for PLHIV groups before and after the enactment of the Stigma Act in 2014.
2. To establish trends in HIV stigma and discrimination in Nigeria in the last 10 years.
3. To make recommendations that will strengthen HIV-related stigma advocacy in Nigeria.

Research Questions

This stigma index study will attempt to answer the following questions:

1. To what extent have stigma legislation and policies been effective in addressing stigmatizing behaviours towards PLHIVs in Nigeria?
2. What is the status of HIV stigma in the country in the last decade?
3. What measures are needed for Nigeria to attain zero HIV stigma and discrimination?

Literature Review

Intersectoral STIGMA

Most times HIV stigma intersects with other forms of social marginalization [7] (e.g., race, gender identity, sexual orientation, socioeconomic status, country of origin, and health status). Evidence has shown that different forms of stigma do not exist singularly but rather individuals experience multiple forms of stigma [10]. HIV-related stigma does not exist in isolation rather it interacts and intersects with social inequalities and oppression to create layers of stigma which negatively impact those affected [12]. The term intersectionality was by Crenshaw's. Intersectional stigma is a concept commonly used to refer to the convergence of multiple stigmatized identities in a person or group [13].

Intersectional stigma drives health inequities and is a barrier to health care around the world [14]. Previous studies have shown that people living with HIV from multiple stigmatized population groups experience worse HIV treatment and care outcomes than those not belonging to these populations [12, 13].

In most countries around the world, the groups at the highest risk for acquiring HIV are those belonging to multiple socially stigmatized populations, such as marginalized groups with intersecting gender, and sexual minority status. In the United States, HIV incidence is higher among Black, Latino, and multiracial individuals than among White individuals [14]. Also, black women account for more than half of new HIV cases among women overall [14]. In Nigeria, gender disparity in HIV prevalence exists with young girls having 2 times the prevalence of young boys [2]. Also, Key populations (PWID, FSW, MSM) account for about 12% of HIV new infections although they represent less than 2% of the total population of Nigeria [1]. The intersectional relationship between HIV-related stigma and other forms of social marginalization indicates that HIV stigma is not only a public health issue but also a human rights issue [12].

Although the experience of intersectoral stigma is seen at the individual, community and institutional levels, often it is ignored in

targeted interventions [14]. By viewing stigma through an intersectional lens, we gain a more comprehensive view of the impact of HIV/AIDS on PLHIVs and identify overlaps between risk factors that may allow for the development of more impactful and efficient solutions [10]. It has been established that interventions addressing a single health-related stigma, without considering the co-experience of stigmas, marginalization, and resilience associated with other conditions, identities, or behaviors, are likely to be ineffective in reducing health disparities and achieving sustainable improvements in health [13]. In recent years, the impact of intersectional stigma on HIV prevention and treatment has increased in HIV research and interventions [10, 12]. However, in Sub-Saharan Africa, more studies on intersectional stigma and its implications for HIV-related health outcomes are needed as intersectoral stigma studies in this region are limited. Furthermore, Nigeria has made progress in its efforts to reduce intersectional stigma and improve HIV-related outcomes. One-stop shops are primary healthcare delivery structures operated by community-based organizations and Key populations. One-stop-shop model for the delivery of services to key populations is an enabling environment that is stigma-free, conducive, gender-responsive, client-friendly and safe for access. Nigeria has over 118 one-stop shops (OSS providing stigma-free HIV services for key populations.

Given the critical need to investigate the effects of intersectional stigma on HIV-related outcomes, researchers have used diverse approaches to measure HIV-related intersectional stigma and discrimination [10]. However, no consensus exists on the measurement and analysis of intersectional stigma and discrimination [15]. There is also little consensus on how best to characterize and analyze intersectional stigma, or on how to design interventions to address this complex phenomenon [13].

The Practice of Intersectoral HIV Stigma Approaches

The understanding of an intersectoral approach to HIV stigma is growing and this has resulted in the availability of information on the practice of this approach. Firstly, when implementing intersectoral HIV interventions or research, consideration should be given to community engagement [21]. Ensuring community ownership, engagement, and connectedness is critical for successful stigma reduction intervention implementation [14]. Secondly, the perspectives and experiences of service providers and key populations living with HIV are valuable in designing research and effective interventions. Equal participation from communities and healthcare entities, providers, and staff should be emphasized [14]. Thirdly, intersectional dynamics between different social inequalities and identities are contextual and vary for different cultural and geographical settings. Consideration must be made for the contextual realities in which HIV research and interventions are implemented [12].

Internalized Stigma

Enacted stigma or discrimination is described as negative opinions and treatment by society [11]. The acceptance and adoption of negative opinions held in society about PLHIVs and applying these opinions to oneself is referred to as internalized HIV stigma, [16]. The manifestations of self-stigmatization include feelings of shame, feelings of guilt and fear [7].

It is well established that internalized HIV stigma is associated with poor access to HIV treatment and care [22]. A study in the United States showed that a decrease in internalized stigma over time was positively associated with viral suppression, ART adherence, and visit adherence [17]. Also, internalized HIV stigma has been linked with mental health outcomes, such as depression, anxiety, hopelessness, dysfunctional coping styles and

low quality of life, [18]. Studies indicate that PLHIVs experiencing HIV stigma also experience depression and develop poor coping skills [17]. Additionally, research reveals that associations between enacted stigma may be mediated by increased internalized stigma. A study conducted in the Netherlands examined if self-stigma mediates the relationship between enacted stigma to quality-of-life outcomes. The study revealed that self-stigma had a significant effect on quality-of-life outcomes [18]. Also, the effects of enacted stigma on quality-of-life outcomes were mediated by self-stigma [18]. Therefore, interventions aiming to reduce internalized HIV-related stigma are critical, if intended HIV service outcomes are to be achieved.

Determinants of health are complex social structures, norms and practices, as well as economic and political inequalities that limit health. Internalized HIV stigma is driven by determinants of health because individuals are influenced by their external environment, networks, and institutions [19]. Psycho-educational interventions focusing on skill building and social support networks that assist PLHIVs in managing negative feelings, developing stigma coping strategies, and providing information on HIV have been effective in reducing internalized HIV stigma [20]. Similarly, a reduction in internalized HIV stigma was reported across studies with interventions that include both structural and individual-level components than with only individual-level interventions. All these studies suggest that interventions with multi-components (e.g. psychosocial support, health education, structural factors, and economic empowerment) are needed to reduce internalized HIV stigma [20]. In line with this, the combination prevention approach, known as Minimum Prevention Package Intervention (MPPI) has been implemented in Nigeria since 2014 and consists of behavioural, structural and biomedical interventions [29].

Furthermore, intersectional approaches have been applied to expand the understanding of internalized stigma. The fact that the experience of living with HIV never occurs in a vacuum agrees with intersectional theory. Internalized stigma operates within overlapping relationships with other marginalized social status based on sex, age, gender, race, sexual orientation etc [19]. As such the integration of social, structural and intersectional approaches to tackling and researching internalized stigma is recommended [25]. The establishing and implementing of laws and policies are aimed at affecting social, structural and environmental systems. It is essential to determine whether the Stigma Act and other policies have achieved this result in Nigeria.

Structural Stigma

Structural approaches are activities that improve structural factors that influence the stigmatization process, such as laws that criminalize HIV, hospital or workplace policies that institutionalize discrimination of PLHIV such as mandatory HIV testing before employment, or unavailability of universal precaution materials needed by healthcare workers [9]. Structural approaches can also include efforts to ensure that legal aid is available for PLHIV to seek justice if discriminated against.

Strengthening community systems and PLHIV peer leadership is recognized as another impactful structural response to HIV stigma [21]. Peer-led response arises when organizations established and managed by PLHIVs are addressing their concerns. Multilevel interventions need to strengthen these community systems to effectively reduce stigma [21]. Supporting PLHIVs and enabling them to be at the forefront of the HIV response is a critical approach to tackling structural stigma.

In the global response to HIV, priorities have shifted to combination interventions

targeting multi-levels of HIV stigma and discrimination. The identification and integration of effective multilevel interventions for reducing stigma into national responses is crucial to the success of the global AIDS response [9]. According to the National HIV prevention guidelines for Nigeria, HIV interventions need to address the biological, behavioural and structural risk factors that increase the risk for HIV infection in addition to interventions that target the wider population connected to PLHIVs, Key populations and their clients. This brings to the fore that advances or setbacks in HIV stigma in Nigeria identified in this study are a collective outcome of programmatic and policy efforts. Therefore, policy and laws are only contributing to this outcome.

HIV STIGMA and the SDGS

The Sustainable Development Goals (SDGs) are the blueprint to address the global challenges we face in our world to achieve a better and more sustainable future for all. The SDGs are based on human rights principles of equality and non-discrimination to ensure the inclusion of marginalized groups and that no one is left behind.

According to UNAIDS, adopting a human rights-based approach is necessary for ending AIDS. A review paper showed that although evidence pointed to the need for human rights and gender in HIV policies and interventions, this was still lacking in many interventions and research [22]. This paper intends to shed some light on Nigeria's progress in achieving the zero-discrimination target.

The financial resources available for HIV programming are decreasing, especially for countries in Africa where HIV funding from domestic sources has not increased yet funding from global donors has been declining [23]. A study on sustaining HIV response in Nigeria revealed some financing issues such as the unpredictable and untimely release of government budgeted funds for HIV, the slow integration of HIV treatment services into social health insurance schemes and ineffective coordination of the procurement of HIV commodities [24]. The study also mentioned opportunities for domestic resourcing of the HIV response through the HIV Trust Fund led by the private sector [24]. The sustainability framework for HIV has critical implications for achieving zero HIV stigma in Nigeria.

Laws Criminalizing Plhiv and Key Population

According to global AIDS update from UNAIDS, out of 151 reporting countries, 92 continue to criminalize HIV exposure, transmission and nondisclosure [3]. A significant number of countries, have enacted legislation that restrict the rights of HIV-affected individuals and groups. These actions include:

1. the compulsory screening and testing of groups and individuals;
2. the prohibition of people living with HIV from certain occupations and types of employment;
3. isolation, detention and compulsory medical examination, treatment of infected persons; and
4. limitations on international travel and migration including mandatory HIV testing.

In Nigeria, these are some of the laws and policies that criminalize PLHIVs and hinder the enjoyment of human rights: Same-Sex Marriage Prohibition Law, 2014 (Law on Same-Sex Marriage in Nigeria): This law has made so many PLHIV who are members of the men who have sex with men community go into hiding which has prevented them from accessing HIV services. The Abuja Environmental Protection Board Law, 1997 (Law on Female Sex Work): Although this law is for ensuring a safe and clean Abuja city it is used by the police to arrest female sex workers (FSWs) in a bid to keep the city safe. The

implication is that sex workers go underground and they cannot be reached with services that they need or require for HIV prevention and other interventions. The Age of Consent policy protects against violation of human rights: The permitted age of consent for access to Sexual and Reproductive Health (SRH) services including HIV treatment is 18 years which hinders adolescents below age 18 living with HIV from independently accessing essential HIV/SRH services.

Laws And Policies Protecting Plhiv And Key Population

According to Global AIDS Update, in dozens of countries there are policy provisions and services in place to protect the health, safety and security of PLHIVs. However, the degree to which policies and legislation are implemented and enforced including their coverage and quality varied widely [3].

In Nigeria, a mapping was conducted to identify laws and policies on gender-based violence and its intersections with HIV.

HIV and AIDS (Anti-Discrimination) Act

Purpose and Content of the Law

The establishment of the HIV and AIDS (Anti-Discrimination) Act was an important step towards implementing recommendations from UNAIDS that countries needed to develop and implement laws and policies that protect PLHIV from stigma and discrimination [2].

The main objective of the HIV and AIDS (Anti-Discrimination) Act, 2014 is to protect the rights and dignity of PLHIV by eliminating all forms of discrimination based on HIV status. The anti-discrimination act specified the rights of PLHIVs and their responsibilities. It also specified the obligations of institutions to PLHIVs and penalties for violation of Act.

Following the establishment of the anti-discrimination act, the AIDS Healthcare Foundation in collaboration with the National Agency for the Control of AIDS (NACA) developed a simplified version of the act to educate PLHIV and the public [12].

Other positive laws are the Violence Against Persons Prohibition (VAPP) Act, and the Administration of Criminal Justice Act (ACJA). In addition to the positive laws, Gender and Human Rights Technical Committee (GHRTC) was established at the national level and in 5 states and FCT. However, some studies have indicated that although Nigeria signed the Anti-Discrimination Acts into law, lack of implementation is a severe challenge and this is why HIV stigma continued to develop in Nigeria over the years [8].

In addition to the positive laws, the following guidelines and plans are available in Nigeria to address stigma such as National Plan of Action (2017-2022) on removing legal and human rights barriers to HIV and AIDS response in Nigeria [5]. and the National HIV and AIDS Stigma reduction strategy.

The GAP

The negative effect of HIV stigma and discrimination on human rights, other rights, and access to prevention, treatment and care services of PLHIVs globally and in Nigeria is established. Studies on HIV stigma in health facilities, workplaces, specific ethnic contexts, and its relationship with GBV in Nigeria exist. Also, laws, guidelines, policies, and programs on HIV stigma and discrimination have been developed and implemented in response to stigmatization. However, there isn't available information on how all these efforts have impacted or influenced change in stigma over time. This paper intends to establish the extent to which policies and their implementation since the passing of the bill in 2014 have contributed to eliminating discrimination based on HIV status in Nigeria.

Materials and Methods

In conducting this Stigma Index Study, a cross-sectional design was implemented

among PLHIVs in 16 states and the FCT of Nigeria. The study involved the use of the structured and standardized Stigma Index Survey 2.0 tool to interview PLHIV from among the General and Key Population groups in the 16 States + FCT.

Also, a secondary review of previous Stigma Index surveys (2011 and 2014) was conducted and triangulated with data from this study.

Study Setting

The study was conducted in 16 States, plus the Federal Capital Territory (FCT) in Nigeria. These states were selected based on the following criteria:

1. Burden of HIV in the general population. (HIV Prevalence NAIIS) [3].
2. States classified as high-burden Key Population (KP) States based on KP size estimate 2018.
3. Geographical spread (all 6 geopolitical zones (administrative divisions of Nigeria) were represented).

Sampling

The study population was drawn from persons living with HIV, including women, men, young persons and KP (MSM, FSW, PWID and Transgender people). Twenty-five percent (25%) of the overall sample size was allocated to KPLHIV.

Inclusion criteria:

1. Aged 18 years or older.
2. Self-reported as living with HIV, and aware of their status for at least 12 months.
3. Gave informed consent to participate in the study.
4. He/she understands the predominant Nigerian Languages (English or Pidgin English).

The sampling frame consisted of all people living with HIV, including the Key Populations Living with HIV (KPLHIV: FSW, MSM, PWUD, Transgender).

GNP+ guidelines recommend that the fear or avoidance of seeking health care because of anticipated stigma is considered when determining sample size. Therefore, from the previous Stigma Index Survey 2011 and 2014, it was revealed that 34.6% and 11.9% of PLHIV respectively avoided seeking care at a clinic respectively, due to anticipated stigma related to their HIV status. The average of these two numbers (24%) was used to calculate the sample size. Sample size was further adjusted for non-response at 10%.

$$n0 = z2 * p * (1 - p)/d2$$

Where

z = 1.96 (z statistic for a confidence level at 95%).

p = Anticipated % reporting avoidance of a healthcare facility.

d = Degree of precision.

The final sample size was calculated as N = 1235. The study sample size was allocated across the 16 + 1 study states based on the estimated number of PLHIV living in each State.

Recruitment of Participants

Two strategies were used to recruit participants:

1. Venue-Based sampling (also referred to as "Time Location Sampling") and
2. Limited Chain Referral.

This two-tiered strategy ensured the inclusion of PLHIV across all population groups. Before participants' recruitment, formative key informant interviews (KII) were conducted to determine and validate the sites for recruiting study participants.

Secondary Data Review

I reviewed data from 2 main sources: Stigma Index Survey – 2011 and 2014. The findings from the review were triangulated with this study.

Results and Discussion

Demographics

1249 PLHIVs (805 females and 440 males) were enrolled in the study. The study participants either belonged to the key population or the general population group described in Table 2.

Table 1. The Distribution of the PLHIV Respondents by Key and General Population

Typology	**Frequency (%)**
FSW	26(2.1)
General Population	1181(94.5)
MSM	25(2.0)
PWUD	12(1.0)
Transgender	5(0.4)
Total	**1249**

The highest number of PLHIV participants were from the South-South region while the lowest number of participants were from the North East region of Nigeria. The study participants consisted mainly of adults with young person's making up less than 10% of the participants.

Table 2. The Distribution of PLHIV Respondents by Geographical Region

Region	Male (%)	Female (%)	(%)
North East	42.2	57.8	5.2
South East	29.1	70.9	18.6
South West	36.4	63.6	13.1
South South	36.8	63.2	34.4
North West	52.1	47.9	7.9
North Central	29.7	70.3	20.9
			100%

Table 3. The Distribution of PLHIV Respondents by Age

Age	Male (%)	Female (%)	(%)
18- 24	11.4	5.9	7.8
25 – 34	34.7	27.9	30.3

35 -44	17.4	41.9	33.2
45 – 54	23.1	20.8	21.6
55	13.5	3.5	7.0

Table 4. The Distribution of Stigma Experience by Gender (Exclusion by others)

Excluded from social gatherings or activities because of your HIV status				
Gender	**No**	**Yes, but not within the last 12 months**	**Yes, within the last 12 months**	**Total**
Female	678(89.6%)	54(7.1%)	25(3.3%)	757
Male	371(89.8%)	30(7.3%)	12(2.9%)	413
Total	**1049(89.7%)**	**84(7.2%)**	**37(3.1%)**	**1170**
Excluded from religious activities or places of worship because of your HIV status				
Female	702(93.1)	30(4.0)	22(2.9)	754
Male	390(95.1)	12(2.9)	8(2.0)	410
Total	**1092(93.8)**	**42(3.6)**	**30(2.6)**	**1164**
Excluded from family activities because of your HIV status				
Female	677(89.7)	52(6.9)	26(3.4)	755
Male	374(91.7)	20(4.9)	14(3.4)	408
Total	**1051(90.4)**	**72(6.2)**	**40(3.4)**	**1163**

Stigmatizing Behaviors Towards Plhivs: Current Status And Trends

Exclusion of PLHIVs by Others

Current Status for Exclusion of PLHIVs

Over *89.7% of PLHIVs* reported that people did not exclude them from social gatherings, religious activities and family events. However, 3.1% of PLHIVs were excluded from social events, 2.6% excluded from religious events and 3.4% from family events in the year.

Of the population of PLHIVs that experienced exclusion, exclusion from social gatherings and family activities was the highest reported in previous years and 2021.

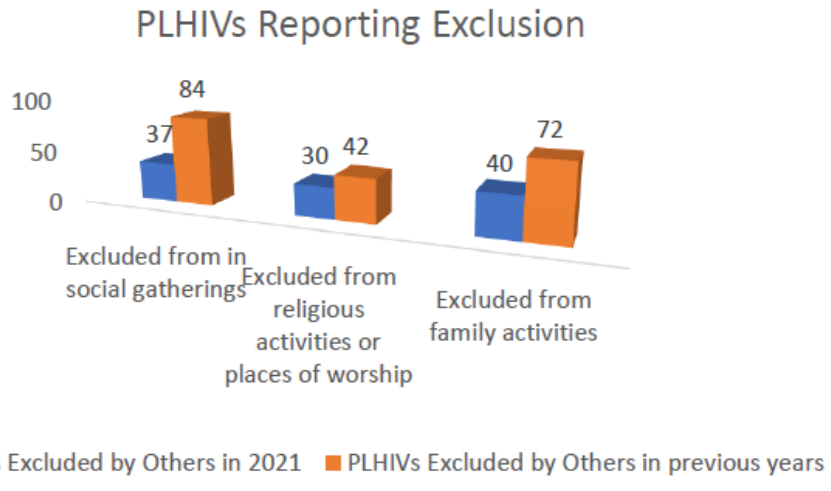

Figure 1: PLHIVs that reported Exclusion by Others

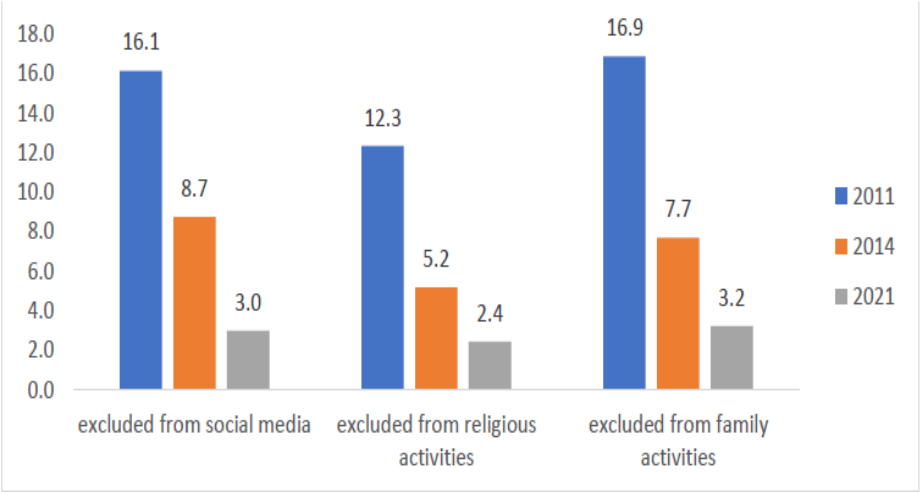

Figure 2: Trends in Exclusion of PLHIVs in the Last 10 years

Trends for Exclusion of PLHIVs by Others

Exclusion of PLHIV from family, religious and social activities was highest in 2011 and improved in 2021.

Denial of PLHIVs' Access to Work and Health

Current Status for Denial of PLHIVs Access to Work and Health

Table 5. PLHIVs Denied Access to Work and Health by Groups

Typology	Refused employment or lost a source of income or job because of HIV status		
	Yes, but not within the last 12 months	**Yes, within the last 12 months**	**Total**
FSW		2(1.9)	2
GP	56(53.3)	42(40.0)	98
MSM	2(1.9)	2(1.9)	4
PWUD	1(1.0)		1
Total	**59(56.2)**	**46(43.8)**	**105**
	Job description or the nature of your job changed or denied a promotion because of HIV status.		
FSW		1(1.7)	1
GP	34(56.7)	22(36.7)	56
MSM		2(3.3)	2
PWUD		1(1.7)	1
Grand Total	**34(56.7)**	**26(43.3)**	**60**

Typology	**Denial of health services because of your HIV status**	
	Yes	**Total**
GP	13	13
Grand Total	**13**	**13**

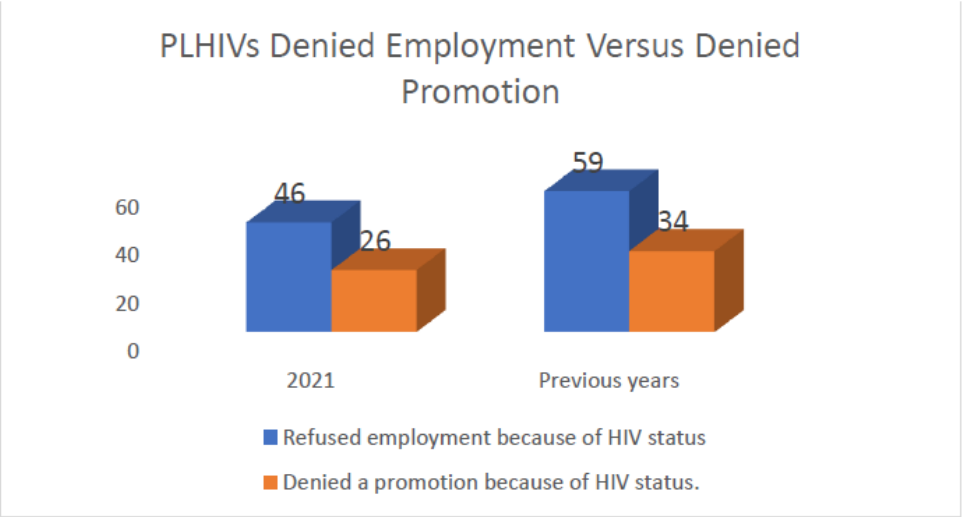

Figure 3. PLHIVs Denied Access to Work

More PLHIVs reported being denied employment than promotion in 2021 and previous years.

Trends in Denial of PLHIV's Access to Work and Health

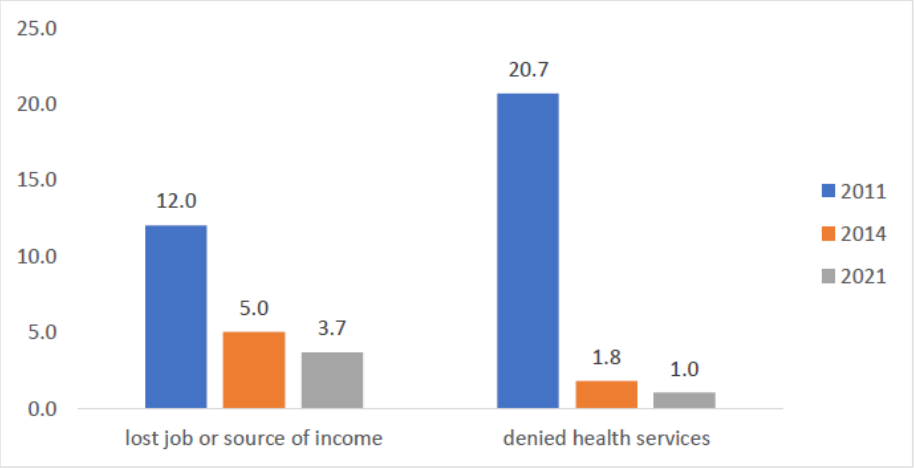

Figure 4: Trends in Denial of Work and Denial of Health Services for PLHIVs

3.7% of PLHIVs were denied access to work and 1.0% were denied access to health services in 2021. This is an improvement from 2011 with 12% of PLHIVs denied access to work and 20.7% denied access to health services.

Violation of PLHIV Rights

Table 6: Violation of PLHIV Right Distributed by Groups

Items	Typology					Total
	FSW	**GP**	**MSM**	**PWUD**	**Transgender**	
Forced to get tested for HIV or disclose my status to obtain a visa or apply for residency/citizenship in a country		17(94.4)			1(5.6)	18
Forced to get tested for HIV or disclose my status to apply for a job or get a pension plan		25(96.2)	1(3.8)			26
Forced to get tested for HIV or disclose my		13(81.3)	1(6.3)	2(12.5)		16

status to attend an educational institution or get a scholarship						
Forced to get tested for HIV or disclose my status to get healthcare services		14(82.4)	2(11.8)		1(5.9)	17
Forced to get tested for HIV or disclose my status to get medical insurance		11(84.6)	1(7.7)		1(7.7)	13
Arrested or taken to court on a charge related to my HIV status		8(100)				8
Detained or quarantined because of my HIV status		9(90)			1(10)	10
Denied a visa or permission to enter another country because of my HIV status		9(100)				9
denied residency or permission to stay in another country because of my HIV status		10(90.9)			1(9.1)	11
Forced to disclose my HIV status publicly, or my status was publicly disclosed without my consent.		22(95.7)		1(4.3)		23
forced to have sex when I did not want to	1(2.6)	36(92.2)		1(2.6)	1(2.6)	39
denied access to a domestic violence shelter		18(100)				18

Forced to have sex, disclosure of HIV status without consent, forced disclosure of HIV status, and forced to get tested were the right violations most reported by PLHIVs. Many respondents (89.1%) from the survey claimed that their rights had never been infringed.

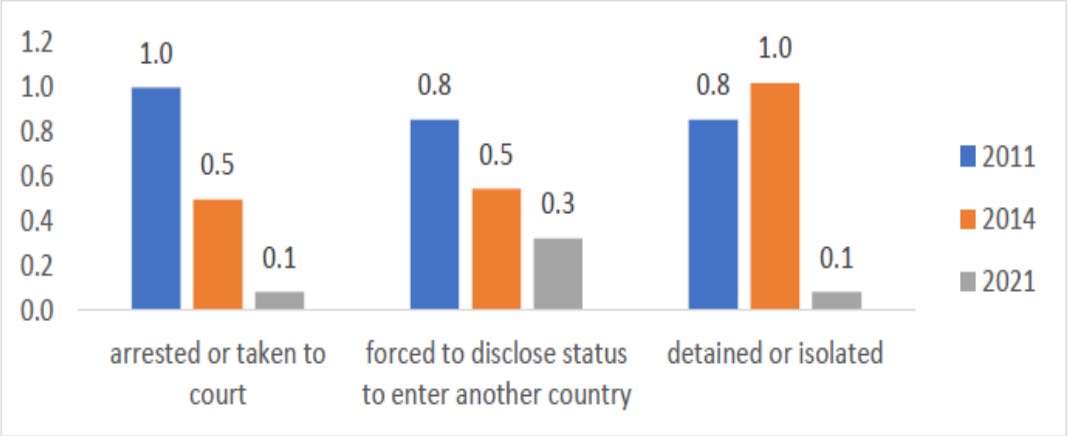

Figure 5: Trends in the Violation of Rights of PLHIVs in the Last 10 Years

Violations of PLHIV rights showed a downward trend from 2011 to 2021.

Internalized Stigma and Fear

Table 7. The Distribution of Internal Stigma and Fear by Gender (Self Exclusion)

I have isolated myself from family and/or friends.			
Gender	**No**	**Yes**	**Total**
Female	697(88.9)	87(11.1)	784
Male	386(89.8)	44(10.2)	430
Total	**1083(89.2)**	**131(10.8)**	**1214**
I have chosen not to attend social gatherings.			

Female	720(90.8)	73(9.2)	793
Male	390(90.1)	43(9.9)	433
Total	**1110(90.5)**	**116(9.5)**	**1226**
I avoided going to a clinic or hospital when I needed to			
Female	742(93.6)	51(6.4)	793
Male	401(92.4)	33(7.6)	434
Total	**1143(93.2)**	**84(6.8)**	**1227**
I have chosen not to apply for a job(s)			
Female	685(91.1)	67(8.9)	752
Male	379(92.4)	31(7.6)	410
Total	**1064(91.6)**	**98(8.4)**	**1162**
I have chosen not to seek social support.			
Female	736(93.9)	48(6.1)	784
Male	400(93.9)	26(6.1)	426
Total	**1136(93.9)**	**74(6.1)**	**1210**
I decided not to have sex.			
Female	667(86.1)	108(13.9)	775
Male	388(90.9)	39(9.1)	427
Grand Total	**1055(87.8)**	**147(12.2)**	**1202**

Although over 87% of PLHIVs reported that they do not experience internalized stigma, at least 12% of PLHIVs still do.

Out of the population of PLHIVs that self-stigmatized, most reported avoiding physical contact with others (i.e. avoiding sex, friends, and social events) while avoiding health facilities was among the least reported.

Trends in Internal Stigma and Fear

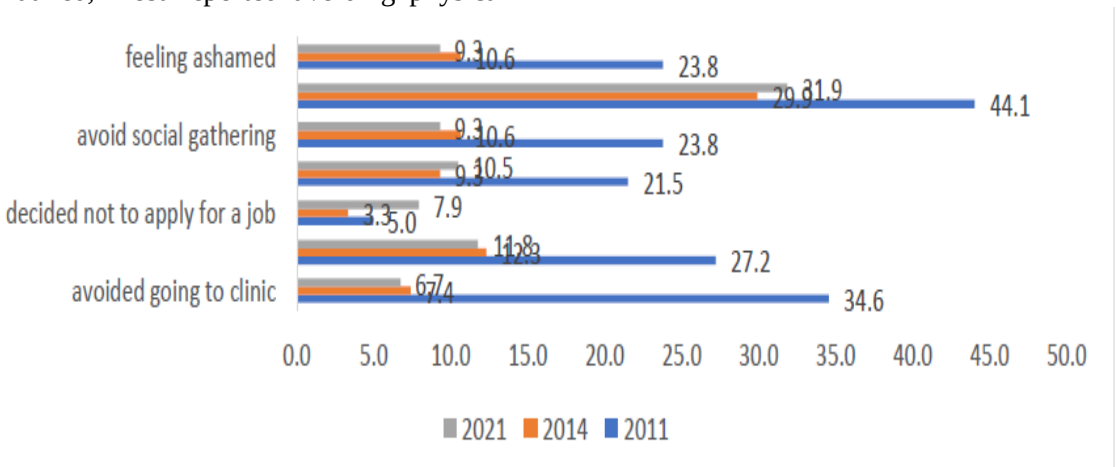

Figure 6: Trends in PLHIV's Experience of Internalized Stigma in the last 10 years

The trends in internalized stigma varied. PLHIV with internal stigma related to avoiding clinic, avoiding sex, avoiding social events and feeling ashamed was highest in 2011 and lowest in 2021. However, PLHIVs that had internal stigma related to job application, avoiding friends and feeling guilty rose in 2021.

Difference In HIV Stigma Before and After Passing The Stigma Act In 2014

Null Hypothesis: The implementation of the HIV anti-stigma bill and other policies has no

significant effect in reducing the level of stigma being experienced by PLHIVs.

The null hypothesis was tested using a one-sample proportion Z test to test the difference in the proportion of stigma experienced by PLHIV before and after passing the Stigma Act in 2014. The results are represented in the table below:

Table 8: The Proportion of Stigma Experienced by PLHIVs Before and After the Stigma Act 2014

	2011 and 2021		**2014 and 2021**		**2011 and 2014**	
Exclusion						
Items	Z value	Pvalue	Z value	Pvalue	Z value	Pvalue
Excluded from social media	-12.663	<0.001	-7.216	<0.001	-13.137	<0.001
Excluded from religious activities	-10.667	<0.001	-4.411	<0.001	-14.184	<0.001
Excluded from family activities	-12.889	<0.001	-5.949	<0.001	-15.95	<0.001
Access to work and health						
Lost job or source of income	-9.075	<0.001	-2.201	0.0278	-13.996	<0.001
Denied health services	-17.137	<0.001	-2.001	0.0454	-30.37	<0.001
Internal stigma and fear						
Feeling ashamed	-22.742	<0.001	-5.724	<0.001	-31.272	<0.001
Feeling guilty	-8.675	<0.001	1.5	0.1337	-18.534	<0.001
Avoided social gathering	-12.041	<0.001	-1.519	0.1289	-20.164	<0.001
Isolated self from family/friends	-9.494	<0.001	1.428	0.1532	-19.355	<0.001
Decided not to apply for a job	4.834	<0.001	8.994	<0.001	-4.828	<0.001
Decided not to have sex	-12.252	<0.001	-0.58	0.562	-21.788	<0.001
Avoided going to the clinic	-20.686	<0.001	-0.916	0.3597	-37.188	<0.001
Rights, laws, and policies						
Arrested or taken to court	-3.251	0.0012	-2.09	0.0366	-3.262	0.0011
Forced to disclose their status to enter another country	-2.039	0.0415	-1.069	0.2852	-2.182	0.0291
Detained or isolated	-2.964	0.003	-3.294	0.001	1.164	0.2445

Test 1: Period of 2011 and 2021 (In 2011 there was no Anti-Stigma Law and in 2021 the Anti-Stigma Law Has Been Implemented For 7 Years)

The result shows that the p-value for each stigmatizing behaviour experienced by PLHIVs except those applying for work between **2011 and 2021** is less than 0.05 (level of significance). The negative signs in the Z statistic values indicate that PLHIV stigma in 2011 was significantly higher than in 2021.

Test 2: Period of 2011 and 2014 (In 2011 there was no Anti-Stigma Law and in 2014 the Anti-Stigma Law was Just Passed)

Similarly, for each form of stigma experienced by PLHIVs between **2011 and 2014,** the p-value is less than 0.05 and Z statistics is negative indicating that stigma was significantly higher in 2011 than in 2014.

Test 3: Period of 2014 and 2021 (In 2014 the Anti-Stigma Law was Just Passed and in 2021 The Anti-Stigma Law has been Implemented for 7 years)

Also, between **2014 and 2021,** some forms of stigma experiences were higher in 2014 than in 2021 while there were forms of stigma with no significant difference in 2014 and 2021.

Discussion

HIV Stigma is a major barrier limiting PLHIVs' access to Prevention, Treatment and Care and has been identified as one of the factors fueling the epidemic [25]. The HIV

trends from this study show a reduction in HIV stigma and discrimination in Nigeria over the last 10 years. According to the results of this study, PLHIVs stigmatized and excluded by their family reduced from 16.9% to 7.7% to 3.2% in 2011, 2014 and 2021 respectively. Also, PLHIVs denied work showed dropped from 12% to 5% to 3.7% in 2011, 2014 and 2021 respectively. As expected, the reduction in stigma improved access to HIV services with just 6.7% of PLHIVs avoiding health facilities in 2021 as against 34.6% of PLHIVs that reported avoiding health facilities in 2011. It is not just enough to know that stigmatizing behaviors towards PLHIVs are changing, it is important to determine what could have led to this reduction in stigma. Aligning with the socio-ecological framework, it is expected that interventions at various levels (individual, interpersonal, organizational, community and policy levels) may have improved stigmatizing behaviours towards PLHIVs in the country [22]. Within the scope of this study, the focus is on measuring if policy efforts have contributed to the observed drop in HIV stigma in the country.

Many studies have identified factors that increase or decrease HIV stigma and discrimination. Misconception is one of the factors identified as fueling stigma. An earlier study in Nigeria reports that populations having less information are more likely to have stigmatizing attitudes towards PLHIVs while those with more information seem to be more compassionate towards PLWHA. Another study linked the gradual decline in HIV-related stigma in the country to the increased awareness of the causes of HIV infection and its transmission which clarified misconceptions about HIV transmission [28, 29]. More so, PLHIVs are living longer due to Antiretroviral Therapy and this has also reduced HIV stigma because it addressed the fear of reduced longevity earlier associated with HIV [6]. Similarly, policy and legal reforms are also other factors that influence stigma. Unlike misconception which increases stigma, policy and legal reforms are aimed at creating a stigma and discrimination-free environment for PLHIVs. Although studies have shown that there are instances where this result may not be attained. In a study among healthcare providers in Bangladesh, the presence of protective policy and legislation did little to reduce enacted stigma and discrimination because protective policy and legislation were rarely enforced and had minimal cultural credibility [27].

Nigeria like many other countries has policy provisions, laws and services in place that address and protect PLHIV from stigma and discrimination. The anti-discrimination Act [6], HIV/AIDS Stigma Reduction Strategy, National Plan of Action (2017-2022) on removing legal and human rights barriers to HIV and AIDS response in Nigeria [5]. and 2020 National HIV/AIDS Access to Justice Guidelines and Capacity Building Manual etc. Despite the availability of PLHIV's friendly laws and policies, in a review paper it was recommended that there was a need to assess the level of awareness, compliance and impact of the HIV anti-stigma law in Nigeria [30]. As such this study aimed to determine if the development and implementation of these stigma legislation and policies has affected stigma and discrimination of PLHIVs in the country.

According to UNAIDS, HIV-related discrimination is a human rights violation and adopting a human rights-based approach is necessary for ending AIDS. The results from this survey showed that for many PLHIVs (89.1%) their rights were not violated. However, for PLHIVs whose rights were infringed, the violations most reported were that they were forced to have sex or disclose their HIV status without consent or forced to get tested. In cases of disclosure without consent 8% occurred among married couples and friends and 11% among family members. This study confirms that stigmatization

frequently occurs in contexts and settings not regulated by legislation, such as within families and everyday social encounters and urgent action is needed in these environments to combat its occurrence. Furthermore, most PLHIVs whose rights were violated did not seek redress and the main reason reported by 40.8% of PLHIV for not seeking redress was that they were unaware of where to seek redress. Therefore, it seems like though the 2020 National HIV/AIDS Access to Justice Guidelines and Capacity Building Manual aimed at providing information on the justice process exists, access to information on justice for PLHIVs is still limited. Diversifying platforms for the dissemination of information on access to justice for PLHIVs is critical.

A one-sample Z-test was done to test the level of significance of the differences in PLHIV stigma in 2011 before laws and policies were developed and in 2021 after the development and implementation of laws and policies. The Z test revealed that the difference in HIV stigma in 2011 and 2021 is significant. HIV stigma was significantly higher in 2011 when laws and policies were lacking than in 2021 after the implementation of laws and policies. Also, the Z test of 2011 (without an anti-stigma law) compared with 2014 when the HIV anti-stigma law passed showed stigma was significantly higher in 2011 than in 2014. However, the anti-stigma law was passed in 2014 and from then till 2021 stigma policies were developed and implemented. On testing the period 2014 and 2021 where laws were available in both years, the Z-test showed that for some forms of PLHIV stigma, there was no significant difference in 2014 and 2021 while for other forms of HIV stigma, it was slightly higher in 2014 and reduced in 2021. This result confirms that following the availability and implementation of stigma policies in 2014 there was a significant drop in HIV stigma as against 2011 when policies were lacking. Also, once the laws were working the stigma level was so low that on comparing 2014 and 2021 the HIV stigma wasn't significant for some behaviours. Therefore, this confirms that HIV stigma laws and policies contributed to the lower levels of stigma being experienced by PLHIVs currently. The null hypothesis is therefore rejected and the alternate hypothesis accepted that the anti-stigma bill and other policies had a significant effect in reducing the level of stigma being experienced by PLHIVs.

Anti-stigma law and other policies were important for changing broader social values and so contributed to the reduction of stigmatization and discrimination in community and institutional settings in Nigeria. Targeted HIV interventions for key populations have been rolled out and scaled up in Nigeria with over 118 one-stop shops (OSS) across the country providing stigma-free HIV services for key populations. Programmatic and policy approaches implemented in the country are interdependent and mutually reinforcing. As a tool for tackling stigma and discrimination, legal and policy reforms would have had limited impact unless supported by the values and expectations of communities and society as a whole. Also, applying the intersectoral stigma lens, advances in HIV stigma reduction in Nigeria identified in this study are therefore a collective outcome of programmatic sector and policy sector efforts. As such, implementing policy and laws only contributed to the observed decline in HIV stigma.

Since implementing stigma policies and laws contributed to reducing HIV stigma then these gains can be eroded if the government and relevant institutions do not sustain the implementation of HIV stigma laws and policies. Nigeria like many other countries is faced with the present reality of dwindling donor funds for HIV [41] so there is a need to prioritize measures to sustain the prevention and enforcement of HIV stigma policies and laws despite the decline in HIV funding.

Furthermore, this study showed that currently there is a rise in PLHIVs deciding

not to apply for work due to internalized stigma 5.0%, 3.3%, and 7.9% in 2011, 2014 and 2021 respectively. A previous ILO study showed that 75.2% of people in Nigeria were not willing to work directly with PLHIVs because of the risk of getting infected with HIV. This indicates that HIV stigma and discrimination still exist in the workplace. It is also indicative that the degree to which HIV stigma policies and legislation were implemented and enforced in the workplace may be weak. It is therefore necessary to intensify programs addressing HIV stigma in the workplace in Nigeria.

Self-stigma can affect an individual's or community's sense of pride and worth and may manifest in feelings of shame, self-blame, and worthlessness, which, can lead to depression, self-imposed withdrawal and even suicidal feelings [43]. The results of internal HIV stigma in this study improved for some indicators and declined for other indicators. The results showed improvement in PLHIV's participation in social events with fewer PLHIVs avoiding social events in 2021 compared to previous years. At the same time, PLHIVs avoiding friends and feeling guilty increased in 2021. These results are indicative that self-stigma is still an issue. Although the feelings generated by internalized stigma are personally felt by a PLHIV, these feelings do not occur in a vacuum but arise as PLHIVs interact with others [19]. Therefore, multi-level / sector interventions in response to stigma cannot be over-emphasised.

It is also important to point out that although there has been significant improvement in reducing HIV stigma in Nigeria, the UN's target of Zero Stigma by 2023 has not been achieved for any of the stigmatizing attitudes. This again points to the need to sustain the prevention and enforcement of HIV stigma policies to achieve zero stigma in the country.

Conclusion

In conclusion, a stigmatizing environment is non-supportive and poses barriers to HIV prevention, treatment and care [1]. The enacting of HIV Anti-stigma law 2014 and other policies in Nigeria was aimed at affecting broader social values and creating an environment in which stigma, discrimination and human rights violations are no longer tolerated or practiced. However, evidence demonstrating the effect of policy development and implementation in the country on the stigma experiences of PLHIVs was largely unavailable. Currently, evidence from this study reveal that the legislative and policy frame work in the country has been effective in improving the stigma and discrimination situation for PLHIVs in Nigeria. It has also contributed significantly to the reduction of HIV stigma. As a note of caution, although HIV stigma and discrimination has declined, it hasn't been eradicated and so the UNAIDS zero stigma target has not been achieved in Nigeria.

Furthermore, advances in HIV stigma reduction in Nigeria identified in this study are a collective outcome of programmatic and policy efforts. Therefore providing and sustaining multi-level & multi -sector interventions in response to stigma is critical for achieving zero stigma.

Similarly, Nigeria like many other countries is faced with the present reality of dwindling donor funds for HIV [41] so there is a need to prioritize measures to sustain the prevention and enforcement of HIV stigma policies and laws despite the decline in HIV funding.

Conflict of Interest Statement

Manuscript Title : HIV Stigma Policy Implementation is Critical to Attaining UN Zero Stigma Target: The Nigerian Experience

I the author, Idoteyin Ezirim do certify that they have NO affiliations with or involvement in any organization or entity with a financial

interest in this manuscript's subject matter or materials.

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