Technical Brief 1

Improving Government Stewardship of the Legal, Policy and Funding environment in the HIV & AIDS Sector

Experiences and Learning from the Enhancing Nigeria's Response to HIV&AIDS (ENR) Programme Jan 2009–Dec 2014

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Contents

Acronyms

AIDS	**Acquired Immune Deficiency Syndrome**
ANC	Antenatal Care
ART	**Antiretroviral therapy**
BBC-MA	BBC Media Action
CSO	**Civil Society Organisation**
DFID	Department for International Development
DHIS	**District Health Information System**
ENR	Enhancing Nigeria's Response to HIV&AIDS Programme
ERPS	**Epidemiology and Response Policy Synthesis**
FLHE	Family Life Health Education
GoN	**Government of Nigeria**
HAF	HIV&AIDS Fund
HCT	**HIV Counselling and Testing**
HIV	Human Immunodeficiency Virus
HPDP	**HIV&AIDS Project Development Programme**
HRC	Human Right Commission
IEC	**Information Education and Communication**
IPC	Interpersonal Communication conductor (Agent)
IPs	**Implementing Partners**
JFA	Joint Financing Arrangement
LACA	**Local Action Committee for HIV and AIDS**
IBBSS	Integrated Bio-Behavioural Surveillance Survey
FIDA	**International Federation of Female Lawyers**
JAR	Joint Annual Review
LOP	**Life of Project**
LGA	Local Government Area
LF	**Log Frame**
MAP	Measuring Access and Performance
MARPS	**Most At Risk Population**
MDA	Ministry Departments and Agencies
MoE	**Ministry of Education**
MoH	Ministry of Health
MoLG	**Ministry of Local Government**
MoWA	Ministries of Women's Affairs
MOT	**Mode of Transmission**
M& E	Monitoring and Evaluation
MTSS	**Medium term Sector strategy**
NACA	National Agency for the Control of AIDS
NHOCAT	**National Harmonised Organisational Capacity Assessment Tool**

Acronyms

NARHS	**National HIV&AIDS and Reproductive Health Survey**
NHRC	National HIV&AIDS Resource Centre
NNRIMS	**National Nigeria Response Information System**
NSP	National Strategic Plan
NEPWHAN	**Network of Persons Living with HIV&AIDS in Nigeria**
OCAT	Organisation Capacity Assessment Tool
PADEF	**Partnership Assessment and Development Framework**
PLHIV	Person Living with HIV
PCRP	**Presidential Comprehensive Response Plan**
PMTCT	Prevention of Mother To Child Transmission
PHC	**Primary Health Care**
PLACE	Priority for Local AIDS Control Efforts
PSRHH	**Promoting Sexual Reproductive Health and HIV**
STI	Sexually Transmitted Disease
STTA	**Short Term Technical Assistance**
SFH	Society for Family Health
STAR	**Society Tackling AIDs through Right**
SOP	**Standard Operating Procedure**
SACA	**State Agency for The Control of Aids**
SASCP	State AIDS and STI Control Programme
SASA	**State AIDS Spending Assessment**
SHARHS	State HIV&AIDS and Reproductive Health Survey
SMOH	**State Ministry of Education**
SMoA	State Ministry of Health
SSP	**State Strategic Plan**
SUOP	State Unified Operation Plan
SNR	**Strengthening Nigeria's Programme**
TOC	Theory of Change
TWG	**Technical Working Group**
TOR	Term of Reference
UNAIDS	**United Nations Joint programme on HIV&AIDS**
UNICEF	United Nations Children 's Fund
USAIDS	**United States Agency For International Development**
UAFC	**Universal Access to Female Condoms**
VFM	**Value for Money**
WB	**World Bank**

1. Overview of the Technical Brief series

This technical brief series presents select learning and reflection from implementing the Enhancing Nigeria's Response to HIV & AIDS (ENR) programme between January 2009 and December 2014. There are four volumes in the series, each volume uses two case studies to highlight an aspect of the programme. These volumes are:

- **Technical Brief 1** – focused on highlighting lessons learnt from working with the Government of Nigeria (GoN) at the national level and in eight states to improve their stewardship oversight of Nigeria's HIV & AIDS operating environment. The two selected case studies (1) Enacting HIV & AIDS Anti-Stigma and Discrimination Law at state level and financing the HIV & AIDS Response to community level talks to the importance of improving legal/policy and financing elements of government stewardship.

- **Technical Brief 2** – Strengthening state and non-state institutional capacity for effective HIV & AIDS intervention uses two case studies, the NHOCAT System for tracking Public Institution and Partnership System for Mass Media capacity strengthening to highlight the ENR programme approach to capacity building.

- **Technical Brief 3** – on HIV and Health communication at the community level presents design and implementation experiences of HIV interpersonal communication (HIPC) and its subsequent integration into existing state government system for sustainability and modified House to House health communication campaign with its powerful impact on increasing recipient knowledge of subject matter and reaching the hard to reach.

- **Technical Brief 4** – covers the unique system, mechanisms and structural arrangements used by ENR's 8-member consortium for internal management; how it worked, reduced friction, increased efficiency and etc. in the delivery of programme results.

These briefs combine elements of a "how - to" guide with those of a lessons learnt series. Each case study can be used on its own, or each volume together depending on the reader's particular area of interest. It is envisaged that the user will find these guides useful when designing or reviewing similar elements of work. The series would also be valuable in a non-HIV setting considering that the issues they focus on also apply to other health areas. They reflect, to a large extent, the unique operational theatre that the three tiers of government represent in the design and deployment of developmental interventions in Nigeria.

Finally, a number of resource materials that complement and actually support implementation of some of the interventions mentioned in these briefs are available at the National HIV & AIDS Resource Centre. The centre has both a physical library and an online portal. Readers are encouraged to avail to these resources.

2. The ENR Programme

Enhancing Nigeria's Response to HIV&AIDS (ENR) an innovative six year, integrated HIV prevention and institutional strengthening programme was implemented nationally (with commodity social marketing), at the federal level and across eight states. Designed in 2007/2008, the programme, which started in January 2009, builds on two previous United Kingdom's Department for International Development (DFID) programmes - Promoting Sexual Reproductive Health and HIV Reduction (PSRHH) and Strengthening Nigeria's Response to HIV&AIDS (SNR) programmes.

The goal of the programme, which ended in December 2014, was to contribute to Nigeria's achievement of Millennium Development Goal 6 by reducing the spread of the HIV epidemic and mitigating the impact of AIDS. The expected outcome of the programme was to improve access to effective HIV&AIDS prevention, treatment, care and support information and service for those most vulnerable to infection.

To achieve this outcome, the programme delivered three outputs at the federal level (working with the National Agency for Control of AIDS (NACA), three Federal Line Ministries (health, education and women's affairs) and Civil Society Networks) and with State Agencies for Control of AIDS (SACAs), three Line State Ministries (Health, Education, Agriculture, Women Affairs and Youth & Sports) and civil society networks and organisations in eight states representing more than 25% of the Nigerian population; The three outputs were:

1. Strengthening stewardship for sustainable and effective multi-sectoral and evidence-informed HIV prevention response by federal and state government;
2. Improving the institutional and technical capacity of civil society to engage in HIV&AIDS prevention, care and support interventions;
3. Improving knowledge, changing attitudes and availability of commodities conducive for safer practices for effective HIV&AIDS prevention.

ENR was implemented by a consortium comprising Society for Family Health (SFH) as Managing Agent; ActionAid Nigeria, BBC WST, Population Services International (PSI), Options Consultancy Services, Benguela Health Pty, Population Council and Crown Agents.

The programme contributed to Nigeria's AIDS control efforts in the last six years, increasing vulnerable persons' access to HIV prevention treatment and care interventions by achieving the outcome targets for life of project and improving service delivery to Nigerians. The programme made significant impact across the following strategic themes: Institutional capacity of government for planning, coordination, reporting, resource mobilisation and using evidence to track the epidemic as well as in programmatic and allocative decision making. Other strategic themes where the programme made significant impact include strengthening civil society organisations as service providers and as advocates, HIV&AIDS and health promotion and ensuring expanded access to services across HIV counselling and testing, PMTCT and condom supply.

Select achievements at the end of programme include:

1. Comprehensive HIV knowledge increased from 35% for male and 23% for females in ENR states as at 2007 to 45% for males and 38% for females in 2014. This translates to a 28% point increase for men and 64% for women over the life of the programme.

2. The proportion of people who received HIV counselling and testing and received results in ENR States increased from 13% (f) and 15% (m) in 2007 to 50% (f) and 44% (m) in 2014 far exceeding the 2014 target of 18% (f) and 20% (m) respectively.

3. The programme distributed 1.23 billion male and 4.0 million female condoms between 2009 and 2014. Access to condoms in rural areas also increased from 50% in 2007 to 90% as at end of 2014. Condom use also increased where 69% of men and 56% of women used a condom in their last risk sex in ENR states in 2014 compared with 56% for male and 40% for female in 2007.

4. Distributed condoms, associated health promotion and increased use have prevented an estimated 109,364 new HIV infections, provided 8,400,000 couple years of contraceptive protection, and averted 2,500,000 unintended pregnancies, preventing 10,000 maternal deaths and generating 10 million disability adjusted life years (DALYs).

5. The passage of the anti-stigma and discrimination law in Benue and Ogun states in 2014 with ENR, means that at the end of ENR in Dec 2014 all 7 states with anti-stigma and discrimination laws in Nigeria were all ENR states. Quality of available data, particularly state level data and its use in decision making increased significantly during the programme.

3. Government Mandate and Stewardship of the National HIV&AIDS Response

In Nigeria, the National Agency for the Control of AIDS (NACA) and the State Agency for the Control of AIDS are responsible for coordinating and providing overall stewardship of the National HIV&AIDS response at federal and state levels respectively. Stewardship and oversight in the HIV&AIDS sector, like other sectors, is triggered and managed through the Instrumentality of improving the (1) legal/policy environment, (2) Financing including resource mobilisation, (3) leading planning and coordination, (4) reporting and accountability and (5) a commitment to use the best available evidence in both programmatic and allocative decision making.

The ENR programme worked across these five pillars of stewardship supporting both technical and governance reform-focused gaps in the six years of programme implementation. Broader capacity strengthening at the institutional level was defined and tracked by NHOCAT; while technical capacity was built to overcome the legacy of poor planning, weak coordination and limited use of evidence to inform decision making. Tactical support was pursued across the programme's theory of change scale to achieve legal and policy reform; this created an enabling operating environment for technical inputs to achieve results.

In this technical brief – Improving Government Stewardship of the Legal, Policy and Funding environment for HIV&AIDS, we use two case studies: experiences and learning from the anti-stigma law processes and lessons from channelling funds to local government level interventions for a better enabled environment.

4. Case study 1- Enacting HIV&AIDS Anti-Stigma and Discrimination Law: Experiences and Learning from the ENR Programme

4.1. Introduction

Stigma and discrimination are among key drivers of the HIV&AIDS epidemic in Nigeria and they remain critical issues in HIV prevention interventions. HIV related discrimination occurs when people are treated unfairly because they are infected with or affected by HIV and AIDS. Stigma and discrimination threaten the effectiveness of HIV prevention, treatment and care programmes by discouraging individuals from coming forward to access testing and treatment services where available, and from seeking information on how to protect themselves and others. The fear of stigma and discrimination, and the fear of violence and abandonment, especially in the case of women also prevents people living with HIV (PLHIV) from disclosing their status. Stigma and discrimination is expressed in various settings including the home, workplace, places of worship, hospitals and the community as a whole. This often results in the violation of fundamental human rights and thus discourages people from seeking treatment, care and support services. Rights violation has contributed to the long silence surrounding HIV and thus to the further spread of HIV&AIDS.

Percentage of people with non-stigmatising attitudes toward PLWHIV across the ENR states (NARHS 2007 and 2012)

	2007	2012
Akwa-Ibom	19.5%	29.1%
Benue	21.2%	56.1%
Cross River	27.1%	55.6%
Enugu	49.8%	44.8%
Kaduna	34.2%	56.4%
Lagos	29.5%	35.2%
Nasarawa	33.5%	53.1%
Ogun	7.7%	23.5%

From the NARHS 2012 the percentage of people with non-stigmatising attitudes to PLWHIV in Nigeria is 37.8%. This is an improvement from 2007 when only 30.7% of people have accepting attitudes to PLWHIV.

Discrimination against people living with or those presumed to be living with or affected by HIV and AIDS violates fundamental human rights and the government has an important role to play in providing a legal framework for individuals to assert their rights. The government has the responsibility of instituting, invoking and enforcing anti-discrimination laws and regulations through the courts, human rights tribunals and professional regulatory bodies. Previously amongst the legislature and executive, there had been limited knowledge of the negative effects of stigma on the HIV response. This contributed to the slow processes in getting appropriate legislature passed.

Composite questions used to measure Stigma

- Would you be willing to care for a male or female relative with HIV and AIDS?
- Would you allow a healthy HIV positive teacher to teach your child?
- Would you buy food from a HIV infected person?

4.2. Why the Anti-Stigma Law

Many times PLWHIV are helpless and feel dejected when their rights are violated as a result of their real or perceived HIV status. When PLWHIV face stigma and discrimination, they have nowhere to report such acts and so they withdraw from the society leading to possible adverse effects on the HIV response as a whole.

There was no legal framework to protect them from rights violation. In the past, lawyers were not eager to dabble with cases that involve stigmatisation of people living with HIV. It was often seen as a Herculean task for lawyers to grabble from the Human Rights angle and this often caused problems.

A law that prohibits HIV related stigma and discrimination would provide the legal framework to protect the rights of people living with HIV and AIDS. This will boost their courage to report issues of discrimination and also provide lawyers with a tool to work with.

Forms of stigma and discrimination faced by PLWHIV

- Mandatory HIV testing before job employment, admission to school. The results then used to determine success.
- Disclosure of HIV test results to other people.
- Tenants sent packing by landlords or co-tenants.
- Loss of job because of perceived or real HIV status.
- Women forced out of marriages where they also loose all property including their children.
- Denial of any leadership position in the traditional or religious council.
- Isolation within families and communities.
- Use of separate eating utensils, toilets, beds and etc.
- Compulsory testing before marriage; a positive result is announced openly and this can lead to cancellation of the wedding by religious authorities.

Beyond using the law to prosecute cases of rights violation for PLWHIV, the law is available to serve as a deterrent. The law ensures that people refrain from stigmatising people living with and affected by HIV. When people are aware that reasonable penalties exist, the average citizen refrains from engaging in disobeying/breaking the law. This will have a huge positive impact on the HIV response as a whole.

4.3. The Law Development Process: Our Experience

Nigeria operates a presidential system of government with three distinct but complimentary arms namely the executive, legislature and judiciary. This structure is found at both the federal and state level. Amongst its other functions, the legislature has the mandate to make and review laws at state and federal level.

In 2009, when ENR commenced operations, only Lagos and Enugu states have a law prohibiting stigma and discrimination against people living with and affected by HIV&AIDS. ENR began the process of supporting the other six states (Cross River, Kaduna, Benue, Nasarawa, Akwa-Ibom, Ogun) to enact the HIV and AIDS anti-stigma and discrimination law.

The aim was to help create a legal framework for protecting rights of people living with and affected by HIV. It was expected that the existence of these laws would contribute to reducing stigma and create an enabling environment for effective implementation of HIV prevention, treatment and care services in supported states. By December 2014, ENR had supported 5 other states to have HIV&AIDS anti-stigma and discrimination legislation. This was aimed to provide support that led to protecting the rights of people living with and affected by HIV&AIDS in these states.

4.3.1. The Law Process: Step by Step

For a law to be enacted in any state in Nigeria, a legislative process - a structured step-by-step process, must be followed in all the states. ENR worked with the state network of people living with HIV and AIDS (NEPWHAN), State Agency for the Control of AIDS (SACA) and various stakeholders following each step to ensure passage of the laws. It is however important to note that the legislative process does not work on its own. To get the laws in place, stakeholder teams carried out several interventions with technical support from ENR. The period of time between initiating a bill and its passage into law varies from state to state. In our experience it ranged from 10 months e.g. in Nasarawa State, to up to 3 years in Kaduna State. State context and peculiarities have to be kept in mind and the existing structures within the state have to be identified and carried along.

At the state level, the State House of Assembly (SHOA) is responsible for making laws. Before an item of legislation becomes a law, it exists as a bill proposed to the SHOA. A bill is a proposal for a new law, or a proposal to change an existing law. The bill can be proposed by any member of the house, as a private member bill or can be introduced by the governor as an executive bill. In four (Cross River, Kaduna, Benue and Ogun) out of the five ENR states where bills were passed into law, the bills were presented as executive bills. Only Nasarawa state was presented as a private member bill. The following process is administered for a bill to become a law:

Bill Initiation: The first stage involves identifying the need for a bill; this can also be called the proposal stage or the bill initiation stage. The issue identified as requiring a law should be one that benefits a large population. The bill can be initiated either by the executive or legislators, or the idea sold to them by external groups.

First Reading: After initiation, the bill is drafted and presented to the House. This is the first reading. At this stage, only the title of the bill will be read on the floor of the House without debate. The bill is given a reference number and a date for second reading is agreed upon. Some bills die at this stage and will not receive an opportunity to be presented for a second reading. In such cases, the bill is termed "dead on arrival".

Second Reading: At this stage, the bill is read in details. The purpose of the bill is explained, and there is a general debate on the bill by the House. The bill is then referred to a committee to review and work on the issues raised.

Committee Stage: After the second reading, a Committee of the House meets for a detailed examination and debate on the bill, after which amendments are made.

All amendments made are done in line with, and with relevance to the principle and subject matter of the bill as agreed on at the second reading stage. The bill then proceeds for the third and final reading.

Public Hearing: The purpose of a legislative public hearing is to obtain public input on legislative decisions on matters of policy that have generated public interest. In Nigeria not all bills pass through a public hearing. At the public hearing, members of the public and any public officials have an opportunity to testify in support of, or opposition to a particular bill being heard on a given day. If a person intends to speak at a public hearing about a particular bill, there is need to plan ahead by reading the bill and preparing a position to be presented. All inputs to the bill will be collated by the house committee and harmonised.

Third reading: The committee puts together all the inputs to the bill in a clean document. The House committee then presents the bill on the floor of the house, where it is read a third time. At this stage there is no debate on major issues but general language modification – "dotting the "i's" and crossing the "t's"."

Bill Passed: When all the corrections are agreed on, the House is asked to vote on the bill. A majority vote passes the bill. With the bill passed by the House, a clean printed copy of it containing the various amendments is signed by the Clerk and endorsed by the Speaker. The copy is made available to the Governor for his assent.

Governor's Assent: For the bill to become a law, the governor has to assent on it by signing the bill. The governor has 30 days to sign the bill otherwise the SHOA can override his assent and pass the bill as law. However our experience in all the states showed that the after the bill was passed by the SHOA it took a minimum of 4 months and up to a year to receive the governor's assent.

4.3.2. Our Inputs

Training on Policy Influencing and Advocacy:

From the assessments carried out by ENR on state response, a gap in skills on policy and advocacy at CSOs and their networks, SACA and community in general was observed. To address this gap, capacity building on policy influencing and advocacy was carried out. The participants cut across the SACA, members of the policy and advocacy TWG, CSOs, CSO networks, media representatives, NEPWHAN, and etc. A key outcome of the training in all the states was the identification of policy gaps and the development of a state advocacy plan to address the gaps identified. A significant policy gap was the absence of anti-stigma legislation in six out of the eight ENR states (Cross River, Benue, Akwa-Ibom, Ogun, Nasarawa, Kaduna). In the two states where the law existed, Lagos and Enugu, awareness of its existence and provision of the law were very limited and rights' violation of PLWHIV was very common.

Formation of Stakeholder Group:

To facilitate the process of enacting the anti-stigma law, ENR supported the formation of state-level stakeholder groups consisting of SACA, NEPWHAN, ENR, civil society organisations, civil society networks, the Judiciary, representatives of the Nigeria Bar Association, technical working groups members (prevention, policy and advocacy, gender TWG), other implementing partners, and the media. This group was responsible for developing and implementing the state advocacy plan for enacting the state HIV&AIDS anti-stigma and discrimination law. Each member of this group had a key role to play based on their expertise.

Drafting and Review of Bill:

ENR provided members of the state stakeholder groups with technical support for drafting the bill. Members of each state's group drafted the bill taking into consideration the context and peculiarities of the state. After the stakeholder group drafted the bill, it was referred to the Ministry of Justice for review of language and finalisation.

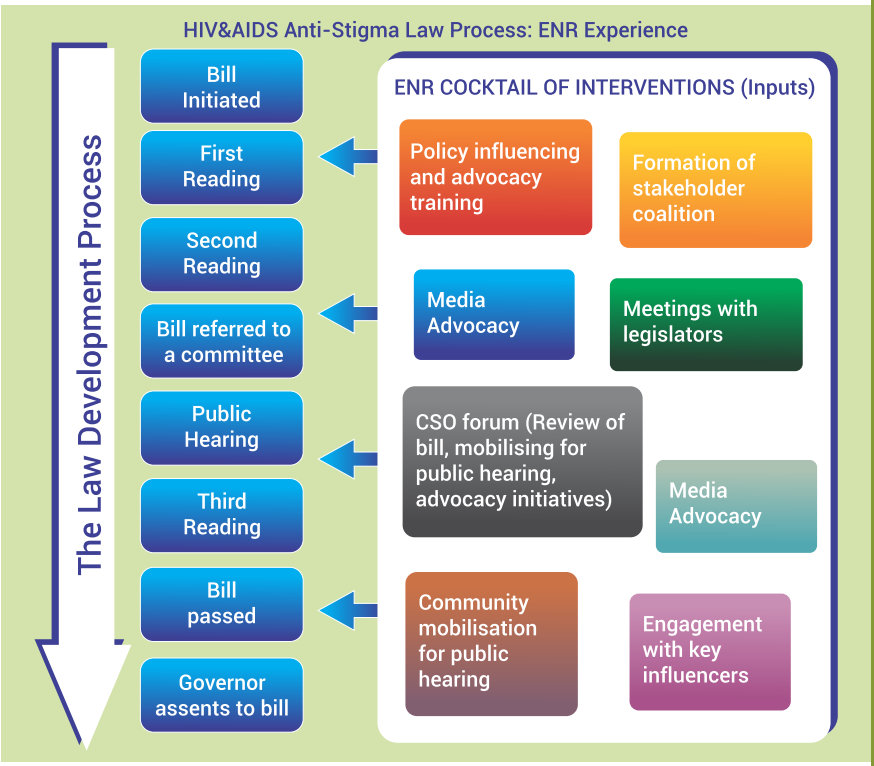
Stakeholder	Role
SACA, Ministry of Health	Coordination and provide a guide on government processes
NEPWHAN	Takes a lead. Provide information on the experience of stigma and ensure all areas are covered
Nigerian Bar Association/ Judiciary	Give legal technical input
CSO, Implementing Partners, CSO Network, TWG	Provide technical data and input on HIV interventions

Having government agencies as part of the stakeholder group made it easy to sell the idea of the bill to the governor. The bill was presented in the state executive meeting by the commissioner of health in Ogun and the attorney general in Benue. Thus the bills in these two states were presented to the SHOA as executive bills. In Nasarawa state however, there was limited support to the bill at the executive level. Therefore, advocacy was paid to various members of the state assembly to sell the idea and eventually a member of the State House of Assembly, Hon. Abdulkareem Ombamas, the Chairman House Committee on Health, adopted the bill as a private member bill.

In Cross River and Kaduna state, a draft bill already existed when ENR commenced work in the state, however it had been stuck in the SHOA and was not receiving the required attention. The stakeholder group was also formed in these states with the mandate to retrieve the bill, review it, and garner support for it with the state executive and legislators. Series of advocacy initiatives were carried out and both bills were presented as executive bills.

Meetings with Legislators:

The members of the SHOA have the responsibility of making laws in the state. However they have limited knowledge on general HIV issues especially the effects of stigma and discrimination on the HIV response. Meetings with House of Assembly members were held individually and in their committees. The meetings gave the opportunity to share facts about HIV and AIDS and the negative effects of stigma on the response with legislators. It also provided a platform to discuss the importance of the HIV anti-discrimination law, harmonise thoughts on the bill and reach a consensus on facilitating the passage of the bill. Working with the stakeholder group, the legislators were followed up with periodic advocacy visits and text messages on the importance of having the HIV and AIDS anti-stigma and discrimination law.



Participation in Public Hearing:

ENR worked with the stakeholder groups to follow-up the bill from the time it was submitted till it went for the first, second and third readings. Advocacy initiatives to the clerk of the state house of assembly in different states made it possible to receive first hand information on the bill's progress and ensure that the bill was on the order paper of the house when due. ENR participated in and mobilised state-level stakeholders to participate in the public hearing of the bill by the House of Assembly. A good strategy that has worked well in different states is having a stakeholder meeting before the public hearing to further review the bill and produce a common voice on issues to be raised on the bill at the public hearing.

Media Advocacy:

The media played a critical role in developments leading to the passage of the anti-stigma law. They were part of the state-level stakeholder group and helped stimulate public discourse on the law. Free airtime on radio and television channels through talk shows and phone-in programmes were provided; these helped raise public awareness of the anti-stigma law. ENR, SACA and CSO network members made several public appearances on radio and television stations to educate the public on the new law. ENR trained media practitioners on stigma and discrimination and the law to help them understand the issues and participate meaningfully in the discussions. In Nasarawa for instance, NTA organised a free programme on the importance of having the bill passed into law a day before the third and final reading of the bill in the state house of assembly. This contributed to creating awareness on the need and importance of having a HIV&AIDS anti-discrimination law.

Disseminating the Laws:

Once the laws were passed, ENR supported its dissemination. ENR did this deviating a bit from the usual approach, which is to simply convey top relevant statesmen to a launch event. ENR also included a strategy to break the law down to simple, understandable language, devoid of technical legal terms yet maintaining legal integrity.

An information leaflet was created which broke down the contents of the law, making it easy to understand with images and colourful graphics instead of bland legal pages of complicated jargon. In this leaflet, space was allocated to the various contacts that can assist an individual in case they face issues with stigmatisation. These leaflets are available in many of the major languages of the different states. More than 5000 copies of this simplified law have been printed and distributed in each of these states with support from ENR.

After this, different groups of people were gathered according to what their roles were in implementing the law. For example, traditional leaders convened with religious leaders. The police with security agencies, the lawyers and judges separately and finally, the support groups of the people living with HIV&AIDS. Different disseminations were done for different groups; this ensured focused presentations on the law's provisions and elicited better understanding of the law and their specific roles in implementing it.

Through dissemination activities more than 500 major stakeholders per state became aware of the passage of the law and its implications. The forums provided an opportunity to analyse confidentiality and discrimination concerns and to enlist support for protecting the rights of PLWHIV. Beyond this, more than 20% of the adult population in the communities have also been made aware through communal level activities including communal dialogue activities in focal ENR communities and interpersonal communication activities in 2014 alone.

In some states, radio programmes and TV slots are aired on creating awareness and protecting people with HIV&AIDS. ENR tried to reach as many people as possible and with every event or programme, there was great emphasis on using the opportunity to mention the anti-stigma law, how it can be used and where to go to for help.

4.4. Results so Far

Seven of the ENR-supported states (Cross River, Kaduna, Ogun, Lagos, Nasarawa, Benue and Enugu) have passed an anti-discrimination legislation and the outstanding state (Akwa-Ibom) has carried out quite a number of necessary steps including a public hearing to get the bill passed. Presently these 7 states are the only states that have passed anti-stigma legislation out of the 36 states in Nigeria and FCT Abuja.

The HIV anti-stigma law helped increase political will and commitment to support HIV programmes. It made it easy for government to sign off on the HIV&AIDS Fund thus providing funds for running SACA. Government has ensured that HIV is mainstreamed in the activities of all MDAs and line ministries. With funding from the World Bank, MDAs now have their own HIV programmes, including HIV work plans. The law has also increased visibility for HIV&AIDS issues in both the public and private sectors and has increased partnership and collaboration among stakeholders in the states.

This has repositioned SACA strategically to carry out its mandate of protecting the interest of PLWHIV and people affected with AIDS in the states.

In Cross River State, for instance, a family court that operates in the 18 local government areas has been established to facilitate application of the law. This has improved collective action against stigma and discrimination at the community level. Although arbitrations at the community level are hindering direct engagement of the court, the court intervenes accordingly whenever cases get to them.

The anti-stigma law has encouraged status disclosure by PLWHIV in the states with such laws; where some PLWHIV who were once afraid can now openly declare their status. These people are also now collaborating to strengthen support group activities at the facility and community levels.

Furthermore, disputes bordering on HIV related stigma are being resolved. Many cases seem to be settled at the traditional level, that is, the community level. Sometimes these cases are taken to the local Chief who is already aware and understands how to handle cases on that level. Some local laws also come in play as decided by the traditional leaders or Chief. They can sometimes decide to penalise individuals for stigmatising against PLWHIV in the community. These penalties can range from payment in yams or other types of crops or animals.

4.5. The Impact of the Laws

While it seems logical that states with anti-stigma laws should have better accepting attitudes towards PLWHIV, this had not been confirmed in Nigeria. A comparative analysis of the changes in level of accepting attitudes in four states with anti-stigma legislation and four control states, revealed a significant difference in the level of accepting attitudes between 2007 and 2012. The study was part of an attribution study to measure the effect of various interventions carried out by ENR during the programme. It examined the effectiveness of such laws in reducing stigma directed at PLWHIVs.

Four states in Nigeria that have anti-stigma laws passed (ASLS) were compared with contiguous states that had no laws (non-ASLS). Data from the National HIV&AIDS Survey (NARHS) 2007 and 2012 was used. Stigma was determined using the 4 question composite index. In 2007 there was no significant difference between the level of stigmatising attitude between ASLS and the non-ASLS. In 2012, there was a significant difference in the levels of accepting attitudes between ASLS and the non-ASLS.

In 2012, persons from states with anti-stigma legislation were 2.6 times more likely to have an accepting attitude towards PLWHIV than persons from non-ASLS (95%CI: 2.3-2.8). Logistic regression of data for the 2012 NARHS showed that respondents were more likely to have a stigmatising attitude if the persons were from ASLS (AOR):0.385;95%CI:0.347-0.487); or persons were of a higher educational status (AOR):0.501;95%CI:0.448-0.560).

At community level, issues have also been solved by mere knowledge of the anti-stigma law and the penalties involved. Another example in Nasarawa is of a woman who had her children taken away from her when the community found out that she was HIV positive.

This is another case where an issue was quickly solved through the use of the law and the woman was reunited with her children, even though she no longer lived with her husband.

Finally, not forgetting the frequently headlined Lagos case of Georgina Ahamefule, an auxiliary nurse who became infected on the job and was fired for being HIV positive. This case was won after 12 years becoming the first stigmatisation case in Nigeria where the plaintiff received compensation. The anti-stigma law in Lagos has been in existence even though people were not aware of it. Since Lagos was an ENR State that already had an anti-stigma law, ENR approached different stakeholders to enforce the law.

The anti-stigma legislation's use in Kaduna, Nigeria

A female HIV positive tenant had been cohabiting with a house full of other tenants who were unaware of her status. By some unknown means, some of the tenants found out that she had HIV&AIDS. Upon this revelation, the other tenants approached the landlord urging him to evict the woman, as they were not comfortable having her around, sharing a bathroom and sharing kitchen utensils. To which the landlord responded in their favour.

The woman took the case to her support group, which forwarded it to SACA, the Ministry of Justice, the Human Rights Commission and the police. When the police presented this anti-stigma law to the landlord, he was strongly cautioned, being a first time offender. Since this was the first case since the enactment of that law in Kaduna, he got off with only a warning. The landlord and the other tenants showed remorse after being confronted with this law and the HIV positive woman has continued to live as a tenant with no further problems.

The Nigerian Bar Association was approached to address the matter of sensitising people of the State on the essence of the law. At that time, many of the lawyers present were not aware of the anti-stigma law's existence so ENR raised the issue.

The response was tremendously positive. One was quoted saying, "I would never touch a case concerning HIV&AIDS because there was nothing to hold onto but now that I know that there is a law out there to protect people with HIV, I will gladly work with them." Some lawyers went on to say that with their new knowledge of the law's existence, they would offer pro bono services.
ENR does not claim to be the reason behind the victory behind the Georgina Ahamefule case but we believe that the awareness created, contributed to its successful resolution.

[1]Fajemisin O, Oginni A, Idogho O, et al. Effect of anti-stigma legislation on the level of stigma directed towards persons living with HIV in Nigeria. AIDS 2014. Melbourne, Australia. July 20-25, 2014. TUAD0103.
Abstract: http://pag.aids2014.org/Abstracts.aspx?SID=1117&AID=4347

4.6. Conclusion

HIV stigma and discrimination are violations of human rights and they pose additional obstacles to efforts that tackle the HIV&AIDS epidemic. Stigma and discrimination are often associated with low uptake of HIV services and non-participation in counselling and sensitisation activities at the community level.

Efforts in Nigeria have been focused mainly on awareness creation, sensitisation, and education about HIV&AIDS but these have been insufficient in addressing stigma and discrimination. ENR's support for the enactment of the anti-stigma law as an innovation highlights the importance of legal aid as an entry point for reducing stigma and discrimination. The strategy was initiated in recognition of the fact that stigma exists not simply within individual actions, but within broad social and cultural contexts that need to be addressed through comprehensive stigma reduction programmes.

The HIV anti-stigma law is very important as a country- or state-level response to stigma and discrimination. It is a valuable tool for protecting the rights and dignity of people living with and affected by HIV&AIDS. It can help reduce susceptibility and vulnerability, which in turn could halt or slow the reinforcing cycle of stigma and discrimination. Having a comprehensive law with strong enforcement procedures can help create an environment for reducing stigma and discrimination at all levels of the response. When combined with efforts that challenge social norms, promoting a legal environment can help support the rights of people living with and affected by HIV&AIDS.

The HIV anti-stigma law is an important tool for defending the rights of PLWHIV, and its enactment makes it possible to hold those who abuse the rights of PLWHIV and their family members criminally responsible. It provides a legal framework for defining violations and for talking about and monitoring the violation of the rights of PLHIV.

Lessons from the ENR experience should be applied in other states towards enacting the national HIV anti-stigma law.

5. Case Study 2 - Resourcing the AIDS Response to Community level: Reflections from the ENR programme

5.1. Financing as a key Stewardship Instrument

In the continuum of policy-planning-financing and programme implementation, as typifies the government stewardship framework for delivering development dividends to citizens, financing moderated in budgetary allocations and release represents one of the strongest measures of a government's commitment to a particular issue or programme. It can be agreed that Nigeria's HIV&AIDS response has not enjoyed the required level of government commitment. A review of the National AIDS Assessment (NASA) reports between 2007 and 2012 suggests that only an average of between 13% and 30% of funding expended in the national AIDS response comes from the Government of Nigeria. This raises significant issues on the medium and longer-term sustainability of the country AIDS Response.

Against this background, the ENR programme sought to explore mechanisms to increase resource mobilisation from the GoN, particularly at state government level, and increase financial flows to local community health promotion efforts. In this way the programme ensured a direct link between technical capacity strengthening of government and service delivery including working directly with communities to promote health seeking behaviours and uptake of services/products such as condoms, HCT and PMTCT. This case study explores the 3 models used by the programme; examines results achieved and makes some recommendation for readers who may want to try out some of the learning and experiences.

5.2. HIV&AIDS financing at the State and Local level

Local government areas (LGAs) provide primary level support to Nigeria's healthcare delivery system. LGAs experience the developmental impact of HIV because they are in direct contact with local communities through primary healthcare centres (PHCs). They are therefore best placed to design and deliver appropriate HIV interventions including promoting access to HIV services and products. Funding HIV and AIDS interventions at the LGA level is however a very big challenge in Nigeria.

The Local Action Committees on AIDS (LACAs) have huge responsibilities in HIV prevention at the grassroots level. LACAs are responsible for coordinating partner activities at the LGA level, including the meetings of stakeholders. They oversee peer education, home-based care, support group activities, community awareness, training of volunteer community workers, HIV counselling and testing activities, as well as monitoring of activities. LACAs are usually unable to carry out these functions because of a lack of funds from their local councils. Considering the growing need to provide funding for HIV and AIDS interventions at the local level, ENR began an initiative in four states – Cross River, Lagos, Nasarawa, Benue – to develop a local sustainable financing model free of encumbrances encountered at the LGA level. This initiative was made to ease the difficulty of monetary allocation to LACAs from the LGA purse. The aim was to strengthen the role of LACAs in contributing to effective local level HIV and AIDS responses.

5.3. The Three Intervention Model

The three focal states - Cross River, Kaduna and Benue have high HIV prevalence and an epidemic that is relatively rural in nature; state funding was generally epileptic with the bulk of interventions driven by donors and the World Bank HPDP 2. Even where budgetary commitments were made, these often do not materialise to physical cash for purposes earmarked. The local government area (LGA) response was completely un-funded and the LACAs, which bear the responsibility of coordinating the response at the LGA level were generally non functional. Limited activities in select locations were entirely donor dependent. If service uptake was to become optimal and new infection controlled, it was imperative that community based actions received support both in terms of increasing knowledge levels, reducing stigma and expanding service uptake.

Three models were developed and tested. Model 1 "physical centrally ring fenced" model was used in Benue and Cross River states. The SACAs working in partnership with the MoLGA, and the LGAs, created a funding system where resources were deducted at source and deposited in a dedicated bank account with BENSACA oversight. Each LACA received a direct transfer from this account triggered by a work plan and quarterly reporting. Accountability to the LGA chairperson and council was shared between SACA and the LACAs. N200,000 was deducted per month for each LGA to make a total of N2.4 million per LGAs. This translated to N55m in Benue and N43m in Cross River states per year channelled directly to community level interventions.

Model 2, an "LGA parallel cash flow" model mirrored the existing mechanism for funding National Immunisation Days (NID) and was implemented in Kaduna state. At the State Governor's approval, N500,000 was deducted at source by the MoLGA and channelled directly to each LGA, albeit separate from the mechanism of the routine LGA allocation. Operationally the Director of Primary Health Care oversees the "parallel" local HIV fund and the Chairperson supervises wider budgetary release to the LGAs. Disbursement was triggered by the LACA work plan and while the LACA and Director PHC are accountable for results, KADSACA had a rigorous system for supporting on ground utilisation of resources and tracking performance of each LGA.

Model 3, the "LGA centric model", implemented in Lagos builds on the existing system of funding where the LGA executives were made to fund LACAs. On a month-to-month basis, LGA executives made allocative decisions often shaped by a complex interplay of factors.

The three models had their strengths and weaknesses. While the third model was the most aligned with existing structure and systems for funding at the LGA level, it was unfortunately the least predictable and therefore did not achieve as much result as was desired. One outcome from this model was a better appreciation by LGA political leaders of the issue of HIV&AIDS as compared to the other models. This however did not translate to increased action.

Model 1 and 2 worked very well in terms of pooling and application of resources to the LACA's developed work plans.

However model 1 needed continuous advocacy, as without on-going high-level pressure from the "user group" at the LGA level; it appeared that the pooling process at MoLGA halted by the second and third year of the process. Model 2 partly driven by the Directors of PHC seemed to enjoy a life of its own requiring no further input to maintain operation. On the downside, using select HIV knowledge and stigma indicators as measure, it seemed that Model 1 led to better outcome level results with the stronger SACA oversight and ability to coordinate cross –LGA type activities and learning.

The three models each have unique functionalities thus selection should be shaped by the prevailing operating circumstances, including capacity at LGA levels and the SACAs' ability or lack-of to implement effective direct or indirect oversight as the case may be. In model 2 for example, it is important to develop an effective supportive supervisory system across the various levels of interventions. It is also important to manage the SACA level to prevent interlocutors both LGA and frontline community volunteers from becoming negligent or laidback in terms of tangible service delivery even when the resources are available.

5.4. The results

It is important that the focus remains on improving service delivery in all interventions aimed at increasing resource flow, as this is what will impact on the epidemic. Improving service delivery will also provide credibility for its acceptance and substance. ENR was particularly interested in ensuring expanded action especially in rural settings to increase HIV knowledge and promote service uptake. Thus ENR worked extensively to support LGAs' to develop implementable work plans, incorporating interventions in HIV knowledge, stigma reduction knowledge and service/health promotion working through interpersonal communication agents, HCT promotion and community testing, condom promotion and distribution, to outline a few. LACA management costs for coordination and other planning meetings were kept to a minimum.

> "...with these resources, Benue community level response which is the bedrock of the state approach to scaling back new HIV infections is on a sustainable footing..."
>
> **Mrs. Grace Ashi Wende - Executive Secretary - BENSACA**

Impressive results were recorded across the various states irrespective of the model, some more than others. In Benue and Kaduna states for example, LACA trained and is supporting 460 and 534 IPC agents across all the LGAs in the states. The total of 1377 IPC agents working across all 8 focal states successfully made a total of 8.5 million interpersonal contacts over six years of the programme. Their interactions focused on increasing comprehensive knowledge of HIV, stigma reduction information, promoting uptake of services including condom use, HCT and PMTCT.

Service uptake also increased in the states with HCT uptake literally doubling at 208,000 counselled and tested across the states in the first half of 2014 compared to 172,000 for a similar period in 2013. Condom uptake increased and rural access particularly improved.

Specific examples include Biase LGA of Cross River state where nearly 8000 individuals were counselled, tested and given their results and nearly 7000 women enrolled for prevention of mother-to-child transmission of HIV (PMTCT) services between January 2011 and June 2013 with support from LACA. In Calabar Municipal Area Council, LACA supported distribution of more than 10,000 pieces of condom between 2010 and 2012. LACA in Odukpani LGA conducted 10 outreaches between 2012 and mid 2013. In Lagos State, LGA chairmen conducted training on STAR and there was a roll out of activities with funding from the LGAs.

LACAs in the states now have office space and office equipment including computers, to facilitate their activities. They now hold LGA level coordination meetings regularly and this has improved data reporting and information sharing. Programme planning at the LGA level has improved, resulting in better coordination and impact. The LACAs have helped in developing an inventory of support groups in the states with detailed information about their activities. These are valuable information that has helped in building partnership and coalition for programme support at the LGA level. Trust between civil society organisations (CSOs) and LACAs has increased. For example, in Ogoja LGA, CSOs drive the HIV&AIDS activities with LACA.

The support provided has helped build confidence in the ability of LACAs to perform their functions at the local level and this has translated to increased funding and support for community-driven activities.

5.5. Critical Success factors

Across the three models, certain factors and inputs were critical in securing the success recorded. ENR used advocacy as a key strategy to secure the commitment of major stakeholders to provide funding for HIV and AIDS activities at the local government level. ENR discussed issues with the State Agency for the Control of AIDS (SACA) and worked with them to develop a systematic advocacy plan. This plan used a skillful blend of HIV and other health epidemiological data, particularly evidence from the State AIDS Spending Assessment (SASA) report, coupled with strong civil society and citizen mobilisation with policy makers and influencers. Identifying these critical influencers is critical. In Kaduna, for example, the Governor's wife was a powerful mobiliser who the programme relied on for success while in Benue the Commissioner for LGA affairs played this role.

Advocacy was conducted to key stakeholders including local government chairmen, the Ministry of Local Government and Chieftaincy Affairs and the state governors. ENR and partners in the states held meetings with these stakeholders and followed up with letters and memos providing information on the necessity of local funding for HIV and AIDS activities at the LGA level. This led to high-level discussions and the decision to provide additional funds for HIV&AIDS activities at the LGA level. ENR provided technical and operational support for developing various policy briefs used in these engagements. The policy briefs targeted at various groups, helped build the groundswell of support. The management of these engagements was also very important, as an open adaptable mind-set was useful in assuaging the issue of lack of trust in such multi-sector activities.

5.6. Tips for replicating the models

Each and every Nigerian state is different with its unique people and balance between the forces for change and status quo. As in any other governance reform programme, the reader may wish to adapt the following tips when using elements of this case study to increase resources from the public purse to any public health Intervention.

- Conduct a political economy analysis of the operating environment to understand what shapes resource allocation and release. Explore the interest of the various key stakeholders in the state and those with powerful voices and influence. Engagement with civil society and other development partners is critical to build a full picture.

- As the political economic analysis occurs, carry out an analysis of the problem area including the local epidemiological picture of the area of interest, complete with a comparative analysis of nearby and or other "competitor states". While there is on-going debate on level of involvement of the government "interlocutor" agency during the political economic analysis, there is a consensus that they should be at the heart of epidemiological and response analysis of the problem area.

- Work with the relevant beneficiary government agency to translate information into policy briefs and meeting guidance notes targeted at various stakeholders.

Tips for working in a government multi-agency environment

- Conduct a power analysis and work out which one can impede or block desired targets the most and which can deliver the most goals.

- Articulate a shared agenda with the different levels talking to each agency. In Kaduna for example the interest of KADSACA for strong supervisory oversight and that of the Directors of PHC were reflected in the final operational guidance note.

- Engage positive influencers and other stakeholders including civil society and select political leaders. Based on results from these preliminary engagements, work with government counterparts to see which of the models will work in that context. Models can be phased in and out such that the state can start with one and then evolve to others.

- Further refine advocacy materials and policy briefs along the desired model and commence full advocacy engagement processes.

- Once agreements are reached, ensure these are documented, with clear roles and responsibilities and the intended results with a defined timeframe.

- Support some of the initial tracking of delivery against an agreed results framework to further deepen longer-term commitment to the agreements.

- Finally ensure skills transfer happens along all these steps to the government counterpart as they will need it for continuing advocacy for budget and cash release processes.

5.7. Conclusion

As donors continue to meet about 70% of the funding for HIV&AIDS interventions in the country, strategies aimed at improving internal public sector resource mobilisation and targeting such resources to what works will be crucial. Internal resource mobilisation is crucial; particularly as donor response evolves from emergency relief to longer-term public health issues. Community based service delivery is needed through better and well-resourced Primary Health Care and community systems. It is hoped that some of the results achieved and lessons documented here by the ENR programme will inspire others to continue this critical element of the work.

Formal National presentation of NHOCAT by Prof Idoko - DG NACA and Dr Omokhudu Idogho ENR Programme Director

Advocacy visit to Akwa Ibom Goodswill Akpabio by Dr Omokhudu Idogho, ENR programme Director and UNAIDS Country Coordinator

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