policy brief | Volume 1, Issue 6

ENACTMENT OF ANTI-STIGMA LAW: A PRIORITY FOR HIV/AIDS MITIGATION IN OGUN STATE

EXECUTIVE SUMMARY

The increased rate of new HIV infections amongst low and high risk groups in Ogun State has been linked to the high prevalence of HIV/AIDS stigma and discrimination.[1] Many people within the group considered as low-risk have consistently refused to voluntarily test for HIV or disclose their status even where it is known.

They do this because of the climate of ostracisation created in the society by widespread stigma. As such, partners continue to get infected, mothers continue to pass it on to their children, and the vicious circle continues. The scenario is worsened when the role of healthcare providers and community members is examined in the escalation of HIV/AIDS stigma and discrimination. Health care providers in many instances are the first to treat PLWHA in ways that discriminate against them and perpetuate stigma. The impact of continued rise in new infections portends grave danger for the state as a whole. The strategies deployed by Ogun State government through its relevant agencies to combat the epidemic is applauded, but in the light of new incidence reports, there is a need to device new strategies to address stigma and discrimination beyond sensitisation that has so far been the focus.

The thrust of this policy brief is to propose the enactment of an anti-stigma law as an urgent intervention methodology to mitigate the impact of new infections in the State. This law will basically prescribe sanctions for perpetuating and perpetrating stigma and discrimination, encourage compliance, and protect PLWHA.

CONTEXT AND IMPORTANCE OF THE PROBLEM

The first case of AIDS was reported in Nigeria in 1986 and in Ogun State in 1990. Since then, the epidemic has grown from a concentrated epidemic experienced by high-risk groups to a generalised epidemic experienced by both high and low risk groups. From 1991, the country has undertaken regular sero-prevalence surveys amongst women attending antenatal clinics, from which the national HIV prevalence rate has been estimated. The HIV prevalence in Ogun State increased to 0.1% in 1995, 3.6% in 2003, and decreased to 1.7% in 2008 (ANC survey). However, the general population-based survey (2008) reported a HIV prevalence rate of 8.6% among the adult population (15 - 49 year) in Ogun State. Interestingly, the HIV prevalence has consistently

been higher in rural than in urban areas.

The HIV Modes of Transmission (MoT) and Prevention Response Analysis (PRA) report for Ogun State (2010) shows that about 40% of new infections are occurring amongst couples who at the time would be considered to be engaging in low-risk sex. Also, Intravenous Drug Users (IDUs), Men having Sex with Men (MSM) and their partners respectively contribute about 3.6% of the annual new infections. Unfortunately, there is very limited knowledge of the dynamics of infection transmission amongst these groups in the state due to the considerable focus on heterosexual transmission. There is obviously a need to determine the extent and distribution of high-risk practices in the state because targeted interventions at these groups could have a considerable effect in mitigating new infections. Among all these groups a major factor contributing to increasing rate of infections is the prevalence of stigma and discriminatory practices and attitudes in the wider society.

In rural Ogun State, families and communities are deeply intertwined such that the beliefs and perceptions within one affect the other. Therefore, it is believed that the high incidence of HIV infections amongst low-risk groups including married couples is not unconnected to the stigma associated with HIV status disclosure. By inhibiting open and honest communication, stigma makes disclosure within the family (amongst couples) difficult and without disclosure, prevention and care is almost impossible.

The implications of stigma and discrimination of persons living with HIV and AIDS are not far-fetched. At the individual level, it has been shown to lead to low self-esteem and lack of interest in containing HIV and AIDS. Fear of stigma and discrimination limits the efficacy of HIV-testing programmes because it prevents individuals from taking an HIV test while it also leads to lack of motivation to practice prevention.

At the community level, the fear of stigma has caused pregnant women to avoid voluntary counselling and testing, which is the first step in reducing mother-to-child transmission. In actual fact, anti-natal clinics in the state have recorded many cases of clients not voluntarily taking the HIV test or disclosing their status even when they are aware of it. Health care providers have had to treat the issue of non-disclosure by clients as non-verbal acceptance of HIV status and therefore treated as such. Stigma may also force mothers to expose babies to HIV infection because using alternative feeding methods, other than breast feeding, especially in the rural communities, would arouse suspicion of their HIV status.

Stigma against PLWHA has also been seen in the termination of appointments, hostility, denial of gainful employment, forced resignation or retirement. The stigma experienced within the health sector represents one of the most inimical forms of institutional stigma. Common discriminative acts observed among healthcare workers in the State include denial of treatment, testing of clients without consent, the delivery of poor quality treatment and counselling services, early discharge of PLWHA from hospital, segregation of hospital wards, isolation, the marking or labelling of patients beds, files and ward, and consistent breach of confidentiality.

Various studies[2], including the MoT, have shown the role of perceived stigma both at individual and community level which has resulted in reducing the willingness and readiness to participate in HIV testing. Invariably, non-stigmatisation promotes the self-esteem of people living with HIV and AIDS (PLWHA), and enables them adopt responsible behaviour that reduces the risk of transmission to their loved ones and the community as a whole.

PRESENT EFFORTS & RESPONSES

In Ogun State, no legislations, policies or guidelines on HIV and AIDS have been documented and implemented at the State Level, even though some national guidelines including monitoring and coordination instruments have been adopted to ensure appropriate implementation of HIV/AIDS, prevention of mother-to-child transmission (PMTCT), voluntary counselling and testing (VCT), anti-retroviral therapy (ART) and sexually transmitted infections (STIs) programmes. There are equally no policies on issues of discrimination, care and support that have emanated from local government councils. Existing law on female genital mutilation (FGM) and the child rights law (CRL) do not directly address issues relating to HIV and AIDS in the State. The National HIV/AIDS workplace policy has been adopted in the state but as is with its National counterpart, there is little or no mechanism for its enforcement. As a result, stigma and discrimination still occur and is widespread in the work place, health care facilities, religious circles, community and the private sector.

Reports have shown that a lot is being done by the various agencies assigned with HIV/AIDS mitigation responsibilities in the state. The State Action Committee on AIDS (OGSACA) along with line Ministries of Health, Education, and Women Affairs have designed systems and programmes that address the socio-economic and health impact of the epidemic. Prevention work has focused on coordinating various networks, civil society groups and local agencies to sensitise the populace on modes of HIV prevention as well as the need to support those that are already living with the virus.

However, in spite of the multitude of programmes and funds made available in the state for HIV prevention, the current MoT shows the alarming rate of growing infections among low-risk groups in particular and all groups in general. In other words, the average married couple and youth in school, who were hitherto considered to be low-risk, should now become focus of attention for prevention work. The need to adopt new strategies have become inevitable and this was reinforced by the report of an assessment that observed that governance and leadership of co-coordinating agencies would have to be strengthened, to ensure proper policy directions and mutuality amongst stakeholders.

As a result of the foregoing and in addition to strengthening enforcement and implementation of existing laws and policies, there is an urgent need for a comprehensive law with strong enforcement procedures considering that HIV/AIDS related stigma and the resulting discriminatory attitudes and practices create an environment that fuels the epidemic.

The National HIV and AIDS and Reproductive Health Study (NARHS - 2007) found reluctance on the part of many Nigerians to relate with PLHIV. Only 24% of respondents were willing to share meals with infected persons and only 16% were willing to buy food from a shopkeeper known to be HIV infected. Just about two-fifths were willing to work with an infected colleague, allow an infected student in school, and allow an infected female teacher in school. Obviously the absence of explicit laws leaves PLWHA extremely vulnerable to the violation of their rights as available evidence demonstrates.

In addition, the National HIV/AIDS Strategic plan (2010- 2015) agrees that without the backing of the law, government policy documents can only be inspirational in wishing for an effective national HIV/AIDS response that respects the rights of PLWHA and People Affected by AIDS (PABA). Thus, although PLWHA have human rights to be respected and protected, it is the tendency of the society to have pervasive prejudices and to visibly and secretly stigmatise and discriminate against them.

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CONCLUSION

The need for an anti-stigma law in Ogun State is a pressing one particularly in the light of recent findings that 40% of new infections are amongst low risk groups. Stigma and discrimination is at the root of non-disclosure both for the low and high-risk groups such that many are not seeking to know their HIV/AIDS status and as such keep infecting their partners. All hands must be on deck to mitigate the impact increased infection poses to the socio-economic life of the state.

All Ogun State indigenes and residents, with no exception, have now become subject to a high risk of HIV infection; there is an urgent need to take action now and enact a law to address HIV/AIDS stigma and discrimination as a decisive way of ensuring HIV/AIDS mitigation and prevention in the state.

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