

EXPANDING DELIVERY OF AND ACCESS TO EVIDENCE-BASED COMPREHENSIVE HIV/SRH SERVICES AMONG MEN WHO HAVE SEX WITH MEN (MSM) AND TRANSGENDER PERSONS IN NIGERIA



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PROJECT OVERVIEW

Men who have sex with men (MSM) remain vulnerable to HIV in Nigeria due to stigma and discrimination fueling increasing prevalence rates and resulting in many not knowing their status. Between 2007 and 2020, HIV prevalence amongst this population increased from 13.5% to 25% (FMoH). In 2020, the Elton John AIDS Foundation awarded a grant of \$997,400.00 to Population Council to expand delivery of and access to evidence-based comprehensive HIV/SRH services among MSM and Transgender people in Nigeria.

The goals of this project were to: (1) increase HIV service delivery to MSM, transgender women (TGW), and their sexual partners; (2) build capacity of a local NGO to function as a one-stop-shop for HIV and STI services; (3) generate evidence related to service delivery, access and stigma reduction among MSM and transgender populations and (4) sensitize health care providers in spoke facilities on the needs of key populations and reduce stigma and discrimination.

Delivery of and access to HIV/SRH services: It is likely that the project increased the reach of HIV services in Lagos, testing 9,245 MSM, 510 transgender women, and 375 female sex workers during its life cycle. Of those tested, 1,013 tested positive and 811 were linked to and retained on treatment (80%).

Almost 1,000 people were initiated on PrEP, the majority of whom were supported through spokes, that is, public health care facilities trained to provide key population- friendly services.

10,130

**MEN WHO HAVE SEX WITH MEN,
TRANSGENDER WOMEN AND FEMALE
SEX WORKERS WERE TESTED FOR HIV.**

80%

**OF THOSE WHO
TESTED POSITIVE
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AND RETAINED ON
TREATMENT**

Building local organizational capacity:

It is likely that the project strengthened the organizational capacity of The Initiative for Equal Rights (TIERS), a local NGO, to deliver these types of interventions. Capacity strengthening activities trained staff on monitoring and evaluation, sexually transmitted infections (STI) and syndromic management services, laboratory biosafety, and other medical services (cervical cancer and breast cancer services). The training and facility restructuring expedited the registration process with the state authorizing agency, HEFEMAA (Health Facility Monitoring and Accreditation Agency).

Evidence Generation: The project completed three evidence generation activities – an evaluation of the hub and spokes model, a transgender sexual healthcare assessment, and an evaluation of a pilot stigma reduction intervention that addressed internalized and intersecting stigmas.

The hub and spokes evaluation found that there were no significant differences in client satisfaction between receiving services in hubs or spokes, indicating that successful KP-friendly interventions can be carried out in public health facilities.

The transgender healthcare assessment highlighted several considerations for health delivery to transgender populations in this context.

The stigma reduction intervention was highly relevant, and qualitative interviews with program participants suggested that there were some positive effects of the program, despite the RCT being unable to isolate any statistically significant differences in key outcomes between participants in treatment and control.

CONCLUSION

The project was highly relevant to target groups and Population Council demonstrated a commitment to learning and the use of evidence throughout implementation.

There is some evidence that the project contributed to its key outcomes. However, without a rigorous evaluation of overall project impact, changes observed in key outcomes may not be attributable to project activities. Future implementation of such programs would benefit from an evaluation which accounts for what would have happened in the absence of intervention, and for alternative explanations of observed changes. The project would have additionally benefited from approaches to measure changes in capacity of trained health workers, changes in the capacity of TIERS, and changes in the capacity of other staff in public facilities.

Several lessons were surfaced through the report, including on the importance of addressing internalized stigma for HIV/STI prevention and treatment, the importance of securing buy-in from national/regional bodies, the role of focal points in spoke facilities, and the need for further training on gender-affirming care. Lessons learned and sustainability considerations are further detailed in the report.



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Expanding delivery of and access to evidence-based comprehensive HIV/SRH services among Men who have Sex with Men (MSM) and Transgender persons in Nigeria

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SUMMARY

The goals of this project were to: i) increase comprehensive HIV service delivery among MSM, transgender women, and their sexual partners, ii) build the capacity of a local NGO to function as a one-stop-shop for HIV and STI services, and iii) build evidence around the “hub and spokes” service delivery model, how to best reach transgender populations, and to pilot an intervention intended to promote mental health and reduce intersectional, internalized stigma experienced by sexual and gender minorities (both living with HIV and at risk of HIV acquisition). The project implemented a “hub and spokes” model of service provision of comprehensive HIV, sexual and reproductive health and support services to MSM and transgender women in Lagos. Key opinion leaders were essential in creating demand among their large social networks for services at the hub (a one-stop-shop facility) and public health facilities (spokes) that were trained to be a key-population friendly facility. Public health facilities can be capacitated to provide key population friendly services. The project also piloted a mental health promotion and stigma reduction intervention for MSM and transgender women, that addressed the multiple stigmas experienced by sexual and gender minorities (i.e. intersectional stigma). The intervention determined that there is great need for and interest in such a stigma reduction intervention. The project also highlighted the need for more transgender-inclusive programming given the multiple levels of stigma that the community experiences. To reach more key populations, the hub and spokes model of service delivery should be expanded to other regions.

Keywords: HIV/AIDS, SRH, Stigma, Key Populations, Nigeria

PROJECT OVERVIEW

Men who have sex with men (MSM) remain vulnerable to HIV in Nigeria with increasing prevalence rates (from 13.5% in 2007 to 25% in 2020 (FMOH, 2007, 2020)) with many not knowing their status. Same-gender sexual activity is stigmatized and criminalized in Nigeria leading to human rights violations against sexual and gender minorities (SGM) (Human Rights Watch 2016; The Guardian 2019; FMOH 2020). Consequently, MSM and

other SGM have limited access to public health services, including HIV and sexual health services (Giwa et al., 2020).

From 2016-18, the Elton John AIDS Foundation (EJAF) (combined with additional funding from the USG Department of Defence (DoD)) engaged Population Council to implement a “hub and spokes” peer-led model of service provision of comprehensive HIV, sexual and reproductive health and support services to MSM in Lagos. With the hub and spokes model, the Centre for Population Health Initiatives (CPHI) – a local

organization founded by Population Council -- operated its community health centre as the “hub”, while 15 public health facilities (PHFs) across 14 local governments in Lagos State operated as “spokes.”¹ The hub is a safe space community health centre providing comprehensive HIV prevention, treatment, and psychosocial support services to key populations (KP). In addition, the hub has a dedicated clinical team and network of peer educators creating demand for clinical services in a culturally sensitive manner. “Spokes” are public health care facilities providing comprehensive HIV treatment and trained by hub staff to provide key population- friendly services.

Riding on the success of the model, EJAF funded a second phase of the project to: (1) increase HIV service delivery to MSM, transgender women (TGW), and their sexual partners; (2) sensitize health care providers on key population in spokes facilities to reduce stigma and discrimination among providers; (3) build capacity of a local NGO to function as a one-stop-shop for HIV and STI services; and (4) generate evidence related to service delivery and access among MSM and transgender populations (specifically, the implementation of the hub and spokes model, the development and pilot of a stigma reduction intervention for MSM and TGW that addressed both intersectional and internalized stigma, and a qualitative assessment of the role of stigma in access to sexual health services among transgender men and women);.

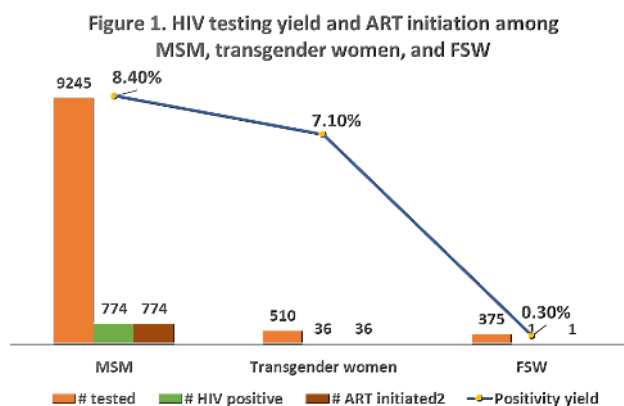
WHAT EVIDENCE IS THERE THAT THE PROJECT ACHIEVED ITS OBJECTIVES?

INCREASE REACH OF HIV SERVICES (TESTING, TREATMENT, AND LINKAGE TO CARE) TO MSM AND TRANSGENDER WOMEN

The EJAF project aimed to expand access to HIV testing services, intentionally reach new transgender women clients (in addition to MSM clients), identify and enrol HIV positive clients on antiretroviral (ARV) drugs and HIV negative clients on pre-Exposure prophylaxis (PrEP), and sensitize health providers on key population sexual health services and programming, including stigma reduction.

Over the life of the second phase of the project (May 2020 to December 2022), a total of 10,130 (9,245 MSM, 510 transgender women, and 375 female sex workers (FSW)) were provided HIV testing services. The

positivity yield was 8.4% (MSM), 7.1% (TGW), and 0.3% (FSWs). (A target of 10% positivity rate was established with EJAF based upon the rates from previous years.) The positivity rates for MSM and TGW were higher than the positivity rate for all populations through Nigeria’s Enhanced Community Case-Finding Package in Lagos (5.4%) (Jahun et al. 2021); however, they are lower than the positivity rates among MSM (19.7%) and transgender persons (27.8%) in Lagos from the 2020 Integrated Bio-Behavioural Surveillance Survey (IBBSS 2020). Of all the 811 persons who tested positive (774 MSM, 36 TGW and an FSW) were placed and retained² on ART (Antiretroviral Therapy) treatment. (Figure 1) Intensive follow-up strategies with both key opinion leaders (KOLs) from the MSM and TG community and community health workers (CHEWs) were drawn upon to stay in contact with any participants missing their scheduled appointments. A total of 629 (77.55%) viral load samples of clients on treatment were collected; of those, 548 (87.1%) were virally suppressed. A total of 977 (960 MSM and 17 TGW) high-risk HIV negative clients who requested PrEP were placed on PrEP.



SENSITIZATION OF HEALTHCARE PROVIDERS ON REDUCTION OF STIGMA AND DISCRIMINATION AMONG KPS

Improving access to HIV treatment and prevention services was possible through the sensitization of 532 healthcare providers from 15 public health facilities (spokes) in Lagos State on stigma and discrimination, and strategies to build a key population-friendly healthcare environment. The engagement of the spokes augmented ARV and PrEP linkage because of the proximity between the location of the community outreaches and the healthcare facilities. Additionally, 20 KOLs served as trusted peer educators and promoted

¹ The project initially worked with 15 PHFs; however, 8 remained by the end of the project. The 7 facilities were discontinued due to low attendance for several reasons: long distances to facilities, proximity to the hub facility, and discomfort of clients with attending the police and military hospitals.

² A person is considered lost to follow-up when they have not been successfully reached through the intensive tracking system after three months.

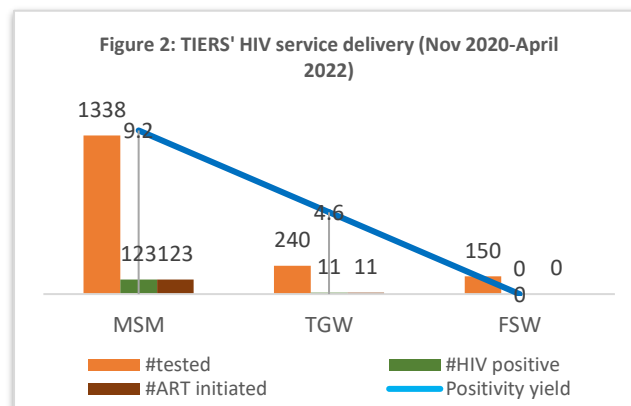
HIV services within their large social networks. Provider sensitization, strategic location of spokes within the community, and demand promotion by KOLs bolstered the successful referral for HIV services to these spokes facilities.

- In Year 1 of the project, only 59 clients initiated PrEP. As sensitization training for and engagement with the public health facilities increased in Year 2, the number of clients initiating PrEP increased to 918 clients. Of these clients, 747 (76.5%) initiated PrEP at the spokes facilities. The high PrEP initiation through the spokes facilities is likely due to the community outreach activities by the facilities and the close collaboration between the EJAF team and the spokes facilities. The EJAF team worked with the spokes mobile outreach team during outreach activities conducted by the spokes facilities to enroll clients for PrEP (initiations in the community with follow-up in the facilities).
- A similar effect was seen in ART enrolment and linkage services at the spoke facilities. A total of 268 positive clients were enrolled and retained on ART in Year 1. In Year 2, 543 clients were enrolled and retained on ART. Among those who initiated ART, 470 (58.0%) received ART from one of the spokes facilities.

CAPACITY BUILDING OF A LOCAL NGO

A local NGO (The Initiative for Equal Rights [TIERS]), that is MSM- and transgender -inclusive was identified and trained to function as a one-stop-shop (OSS) for comprehensive sexual health services. In collaboration with CPHI, which functions as a leading health service organization for key populations, the project provided mentorship and training to enable TIERS to become a key population -inclusive OSS. The team conducted capacity assessments to determine programmatic and structural needs to enable TIERS to function as an OSS in the state. The identified gaps included inadequate human resources, lack of a clinical documentation and service monitoring system, and lack of a functional pharmacy unit. The capacity strengthening activities focused on training staff on monitoring and evaluation, sexually transmitted infections (STI) and syndromic management services such as cryotherapy, laboratory biosafety, and other medical services (cervical cancer and breast cancer services). We also supported and oversaw the provision of a functional pharmacy unit and engagement of qualified personnel on the clinic team. Additionally, a subaward grant was provided for TIERS to augment their operational activities (i.e., establishing a functional pharmacy, recruitment of

additional staff, and engagement of key opinion leaders). Hence, through the trainings, mentorship, and supervision, TIERS was able to increase their outreach for HIV prevention and treatment services both in the facility and community. The training and facility restructuring expedited their registration process with the state authorizing agency, HEFEMAA (Health Facility Monitoring and Accreditation Agency).



GENERATING EVIDENCE TO IMPROVE SERVICES FOR MSM AND TRANSGENDER POPULATIONS.

The project completed three evidence generation activities, outlined below. The results of these activities are discussed in the next section on *Lessons Learned*.

Hub and spokes model evaluation – We conducted exit interviews with 207 clients at the hub (CPHI Community Centre) and seven spokes facilities in March 2022 to assess client satisfaction with services. Only clients who were recruited through the EJAF project outreach activities and were seeking HIV/sexual health services at these facilities were recruited to participate. We also conducted a desk review of progress reports to extract lessons learned.

Transgender sexual healthcare needs assessment: The project conducted a qualitative study to characterize and understand the sexual health needs of transgender men and women. The study involved 13 transgender men (TGM) and 25 transgender women (TGW), 10 representatives of civil society organizations (CSOs) working with SGM, and 8 healthcare providers (HCPs) who had provided health services to TGM and TGW at selected healthcare facilities.

Development and evaluation of a stigma reduction intervention to address internalized and intersecting stigmas: A cognitive behavioural therapy-based curriculum was developed to reduce internalized stigma related to HIV and/or being a sexual or gender minority.

The intervention consisted of four 2-hour group workshop sessions facilitated by trained Community Health Extension Workers (CHEWs). The sessions addressed stigma related to different identities, the development of individual and shared resiliency and coping strategies, and the promotion of social support networks. To determine the preliminary effectiveness of the intervention, a randomized controlled trial was conducted with 120 MSM and 120 TGW (120 positive and 120 negative) participants. Participants were randomised into two groups (the immediate intervention and a delayed group). A behavioural survey was conducted at multiple time points - before the intervention, immediately after the intervention, and 3 months after the intervention. The delayed group received two rounds of the survey before their intervention to serve as a comparison. Qualitative interviews with a subsample of both intervention groups, group session facilitators, and program managers were also conducted post intervention.

Limitation of each of these studies are described in Annex I.

WHAT LESSONS WERE LEARNED FROM IMPLEMENTING THIS PROJECT?

LESSONS FROM IMPLEMENTATION OF THE HUB AND SPOKES MODEL:

- Public health facilities can be capacitated to serve MSM and transgender populations.** Despite the prevailing homophobic environment, a high proportion of clients accessed HIV services at the *spoke* facilities (58.0% for ART services and 76.5% for PrEP services). Based on exit interviews, over 90% of the clients at both the hub and spoke's facilities felt the staff were respectful and knowledgeable, were satisfied with the privacy of the services, and were overall satisfied with the services. There was no difference in experiences between MSM and transgender persons. The high level of client satisfaction at the spokes (that is equal to that of the hub) likely points to the success of the sensitization training.
- Key opinion leaders are a critical bridge between the MSM and TG communities and public health facilities.** KOLs served as trusted peer educators. They were able to map and identify high-risk hotspots (physical and virtual), and to conduct counselling and HIV testing, and peer navigation for PrEP and ART enrolment, including escorting clients to the facilities, particularly the spoke facilities. Both clients and KOLs themselves indicated that because KOLs were from the MSM and TG communities, clients trusted their advice and counsel to seek services at the hub and spokes. Going forward, a select group of KOLs who are more experienced / skilled can be provided with more in-depth counseling training (e.g., cognitive behavioral counseling skills, internalized stigma).
- Sensitization and training of public health facilities must include step-down training to include non-clinical staff.** Based on project reports and feedback from project staff and clients, we learned that while clinical staff need to be trained in patient-centered KP-friendly services, all staff who would interact with or even see KP clients need to be trained, including receptionists, security personnel, and cleaning staff because stigma and discrimination can start as soon as a client enters the facility.
- Spoke facilities must be strategically selected.** For example, based on feedback from PHFs and program staff, spoke facilities that were in relative proximity to a hub facility were less likely to be accessed by KP clients. While KP clients do access spoke facilities, they still prefer the patient-centered care and shorter wait times at the hub facilities. Therefore, spoke facilities that are close to a hub facility will likely be accessed less. Further, some clients shared that they were not comfortable accessing services at police and military hospitals due to fears of being turned into the authorities.
- Securing buy-in and necessary approval from national/regional approval bodies is time- and resource- intensive.** Obtaining approval from the Health Service Commission for the team to work in the public health facilities required months of advocacy, complicated by the existing criminalization of the LGBTQ community. While some Commission representatives were supportive of HIV services tailored for populations such as MSM and other sexual and gender minorities, changes in leadership are common, and hence regular re-sensitization was necessary. When replicating a hub and spokes model in other sites, it will be necessary to build in time and resources for advocacy with key stakeholders.
- HIV self-tests can reach a high number of first-time testers.** A total of 1,500 HIV oral self-test kits were disseminated (1174 MSM, 102 TGW and 224 FSWs) through physical hotspots and by reaching the population via social media (WhatsApp), followed by in-person distribution. HIV positivity differed by outreach method (physical hotspots: 2.7%; social media reach: 5.9%). Strategies are needed to improve ways of reaching target populations through social media, especially as social networking sites are

increasingly becoming viable recruitment platforms and as the homophobic climate compels many MSM and TG persons to abandon physical hotspots.

Stigma influences hiv services for transgender men and women.

- **Transgender identity disclosure triggers anticipated stigma experience among transgender persons due to fear of legal repercussions:**

Theoretically, it is believed that disclosure of transgender identity could contribute to promoting more HIV prevention services. However, we discovered that Nigeria's punitive law, which promotes stigma, inhibits gender disclosure, and thus prevents trans-persons from accessing sexual health services in public health clinics. Participants also disclosed legal repercussions, such as being turned in to authorities as a major reason for not disclosing their identity to healthcare providers. Despite the sensitization of public health providers, some providers reported difficulties in eliciting information about clients' gender identity. It was reported that some providers felt uncomfortable about the topic in general.

- **Conflation of gender and sexual identities limits the effectiveness of sexual health services:**

Transgender persons disclosed that both sensitized and non-sensitized providers confused TGM with lesbian women and TGW with being gay. Also, we discovered that this misunderstanding contributed to the generalized assumption that transgender persons and their co-mingled counterparts have similar health needs. Further studies highlighted how this can limit access to and the effectiveness of HIV preventions services and other unique needs acknowledged by the different transgender identities. Sensitization trainings are a useful means to explicitly address this issue.

- **Offering HIV services without tailoring to transgender community needs can reinforce stigma:**

TGM, TGW, CSO representatives and providers reported that HIV providers from mainstream public health facilities in general (not specifically those in the project supported by EJAF) exhibit stigmatizing attitudes and refusal to attend to transgender clients. Also, we learned that stigmatizing attitudes and gender insensitivity made transgender clients feel

uncomfortable about receiving physical examinations from providers, particularly in mainstream health facilities. These findings showed that stigma acts as a barrier to HIV testing, and consequently, transgender people do not have the opportunity to access the HIV care continuum. Future interventions should include competency training on gender-affirming services for HIV and STI unit providers in mainstream facilities (Tun et al., 2022).

Stigma reduction intervention to address both intersectional and internalized stigma was highly acceptable

- Participants reported very high satisfaction³ with the intervention. There was near-universal participant retention at all study timepoints (>99%) and in all intervention sessions (>89%), suggesting high feasibility of and participant interest in the intervention and related research.
- We found marked improvements in most psychosocial outcomes (internalized stigma related to SGM and HIV⁴, depression, anxiety, resilience, and coping⁵) among both respondents who had received, and not yet received, the intervention. Additionally, at subsequent timepoints, there were further improvements in many outcomes, including depression, anxiety, resilience, and coping. Qualitative data indicated that the delayed intervention/ control group already were contemplating the importance of stigma reduction due to the two surveys themselves and developing rapport with the data collectors, and that delayed intervention participants discussed the intervention with intervention participants prior to engaging with the program, so this likely explains the positive shifts experienced by delayed intervention participants as well.
- Qualitative data collected post intervention from a subset of participants provide additional insights, and support for the positive effects of the intervention. Program participants reported increased self-confidence about their sexual and gender identity and for some, it facilitated disclosure. Participants also reported experiencing a reduced sense of isolation, improved resiliency and coping mechanisms, improved communication skills, and increased health-seeking behaviors (e.g., psychological support, ART and PrEP services).

³ Participants were asked about their satisfaction using a 4-point scale with 10 aspects of the intervention related to content, comfort, usefulness of content, and general satisfaction.

⁴ Internalized stigma (IS) was assessed by parallel sets of items related to MSM, TGW, and HIV status, asked of each respective group of participants. These scales were adapted from several validated scales, particularly Kalichman et al.'s Internalized AIDS-Related Stigma Scale.

⁵ Depression was assessed using the Patient Health Questionnaire-9 (PHQ-9) (Kroenke 2001), removing the final item about suicidal ideation which the study team believed to be too sensitive for the highly vulnerable study population, leaving eight final items. Anxiety was assessed using the General Anxiety Disorder-7 (GAD-7) (Spitzer 2006). Coping was measured using the Brief Coping Scale, which includes four items (Sinclair 2004).

WHAT ROLE DID RESEARCH PLAY IN THE PROJECT'S DELIVERY?

The study focused on assessing needs of the transgender community strengthened partnership among transgender-led organisations: The study was highly participatory, and we engaged several transgender-led organizations as partners in the study. This was one of the few studies in Nigeria that recognized the vulnerabilities and health needs of sexual and gender minority populations. This fostered a pathway for collaboration with transgender-focused organizations in Lagos state, and improved referrals and accessibility of comprehensive services at CPHI's community clinic and spokes facilities among transgender persons.

Strengthened psychological support related to internalized stigma and ART and PrEP services: The study piloting a stigma reduction intervention increased awareness among clients and providers of the extent to which many of the MSM and transgender clients experience internalized stigma related to multiple identities. The intervention also had a positive effect on clients' access to PrEP services; clients learned what PrEP was, and about the importance of PrEP in staying healthy (based on both the qualitative and quantitative data from the study). Some participants reported increased PrEP use: *"When I came for the workshop and I was like, wow, it won't look well for me to keep someone in your dark and we are in a relationship. So, the best thing I did was I had to ...take him to a clinic for PrEP. So, he was placed on PrEP, and I had to tell him."* [MSM]

WHAT ACHIEVEMENTS ARE LIKELY TO BE SUSTAINED AND WHAT ADDITIONAL SUPPORT NEEDS TO BE PROVIDED TO SUPPORT SUSTAINABILITY?

Expanding stigma intervention access to the MSM and transgender community: The capacity of the CHEWs that were trained to facilitate the stigma reduction workshops using cognitive behavioural therapy will be sustained beyond the life of the project. Feedback from the CHEWs after the intervention indicated that they gained counselling skills around internalized stigma and resiliency in the face of stigma that would help them with their interactions with clients. Because CHEWs are involved with direct client service for HIV prevention and treatment in both clinic and

community settings, they are now able to provide psychosocial support to other clients experiencing internalized stigma. Therefore, the skills garnered from the training will enable them to support and reduce the level of stigma both for people living with HIV, sexual and gender minorities, and other key populations.

Stakeholders partnership facilitated support and solutions to challenges: The established relationships with stakeholders within the state government who served on the project's Community Advisory Committee (CAC), will enable and sustain future programming for the MSM and transgender community in Lagos state. The CAC board consisted of key stakeholders such as representatives from the ministries, HIV/AIDS agencies, PHFs and members of the MSM and TG communities. The CAC board members played a vital role in the success of the project as they provided the team with technical support, as well as insights on how to better reach the target population. Most likely, the effect of the training on creating a key population-friendly environment will continue based on results from the evaluation of the hub and spoke model, which showed greater acceptance of SGM among providers at public health facilities. However, additional research is needed to reinforce the lessons from this project as well as assess future sustainability, effectiveness, and actionable plans.

Sustainability of peer supporters: The engagement of 20 KOLs to reach the MSM and transgender community with HIV testing and treatment services was also a sustainable strategy. These identified KOLs are respected and influential members of the community (MSM and TG), and they are a cadre of qualified educators who will be available in the future to contribute towards promoting HIV education and positive sexual health among the MSM and TG communities. As the project was ending, the project team discussed with focal persons at the spoke facilities the possibility of continuing to work with the KOLs to reach clients after the completion of the project. The model of working with KOLs to reach key population members has also been adopted by other NGOs.

Additional support needed for internalized stigma: The stigma reduction intervention gave participants the opportunity to explore many deep feelings and reflect on traumatic experiences related to their sexual and gender identity and in some cases, their HIV status. As a result, some participants would likely benefit from additional psychological support beyond the intervention period, with ongoing support groups or from support staff such as community health workers and psychologists.

Stigma reduction among public healthcare providers expands access to HIV treatment and prevention services for MSM and TGW: Given the positive results of the training on stigma reduction provided to health care providers in the spokes, additional step-down trainings at various facilities would be beneficial. Based on feedback from participants, stepdown trainings should occur for different cadre of spoke staff, including but not limited to care providers. The high level of satisfaction with services at the public health facilities by participants is indication that the hub and spokes model is feasible and acceptable and can increase accessibility to HIV prevention and treatment services among key populations. Thus, there is a need to expand further stigma reduction trainings to ensure that all spoke staff cadre are reached.

CONCLUSIONS & RECOMMENDATIONS

The project highlights the propelling effect of stigma and discrimination and the need to intensify and develop innovative approaches to identify and reduce the incidence of HIV among the MSM and transgender communities. Evidence from this project calls for the need to incorporate advocacy to key stakeholders (program and policy makers) to sensitize them on the impact of same-sex and HIV stigma among MSM, TGs and other KPs and implement tailored interventions for them to enable healthcare access.

Results from the studies also identify social media as an avenue to disseminate information to key populations about HIV self-test kits and key opinion leaders as important focal persons to reach and navigate access to HIV services to the MSM and transgender community.

Recommendations

1. Securing buy-in and necessary approval from national/regional approval bodies is a critical step before project implementation
2. Sensitization/Training at public health facilities should include step-down training to include non-clinical staff (security, data clerk, cleaners, etc)
3. Spokes facilities need more services that meet the needs of KPs (e.g., mental health services, cryotherapy)
4. Focal persons based at spoke facilities should assist key population clients to navigate linkage to services and appointments – helps to create a safe, enabling environment
5. Structure future interventions to include framework and competency training for HIV/STI practitioners on gender-affirming services
6. Increase distribution of HIVST kits to KPs to help increase the number of first-time testers.
7. Consider having public health facility staff undergo competency training in gender-affirming care (HIV/STI units)
8. National HIV/STI service delivery guidelines need to include specific language around gender-affirming services

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ANNEX 1: LIMITATIONS

- 1. Client exit interviews at hub and spokes:** The main limitation of this assessment is that participants may over-report satisfaction due to social desirability bias. However, this bias may be minimal given that the exit survey was

completed in private on a computer tablet and no names were attached to the survey.

- 2. Transgender study:** One of the main limitations of this study was that we did not differentiate between public health facilities (PHF) that were part of the EJAF project and those that were not in the interview guide. Therefore, participants were referring to the broader realm of PHFs, as opposed to specifically the EJAF project PHFs. It is likely that providers at the EJAF project PHFs were less likely to hold stigmatizing attitudes compared to providers at the non-EJAF PHFs since the EJAF PHFs had received sensitization training. Additionally, since the qualitative data were obtained from TGM and TGW who are connected to transgender inclusive CSOs, the views of those not connected to such CSOs may not be represented. Nevertheless, the findings are consistent with those reported in other settings but more importantly highlight the specific ways in which stigma creates gaps in the provision of and access to services for transgender people in Nigeria.
- 3. Internalized stigma reduction study:** First, there may have been contamination from the immediate intervention group to the delayed intervention group. It is possible that those in the immediate group may have share lessons from the group workshops with friends in the delayed group. This would have reduced the measurement of intervention effect. However, we assessed for contamination during the complementary qualitative interviews post intervention, and it does not seem like a major factor. Those in the delayed group who indicated they received some information about the intervention before they participated in the group sessions received information such as - it was good and they should participate - as opposed to detailed content about the sessions. A second limitation is that respondents may have provided more positive responses in follow-up rounds post-intervention knowing that the intervention is supposed to improve internalized stigma and other related outcomes. This would reduce the measurement of pre-post intervention effect, however, this bias is likely to be similar between the immediate and delayed groups.



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