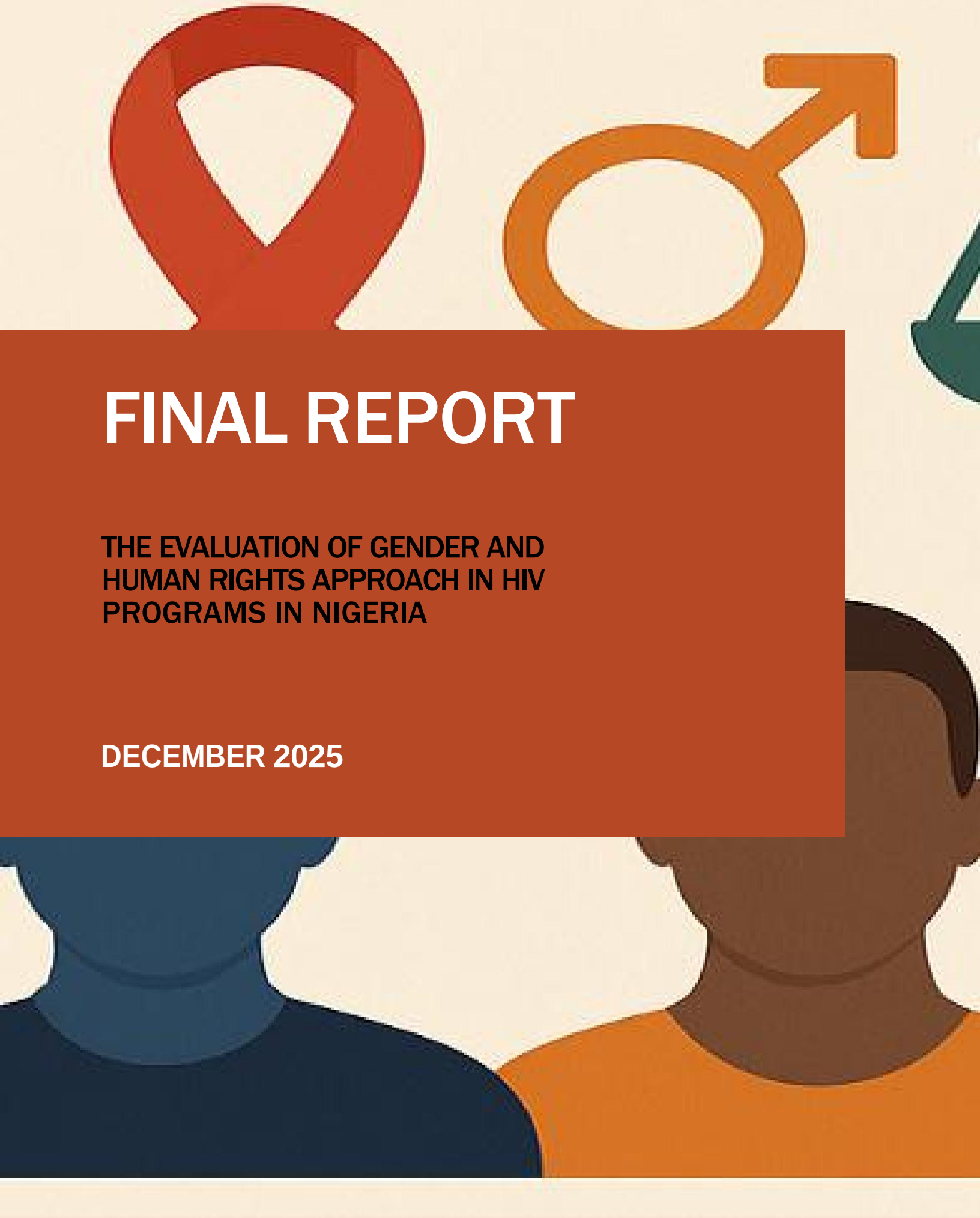

FINAL REPORT

THE EVALUATION OF GENDER AND HUMAN RIGHTS APPROACH IN HIV PROGRAMS IN NIGERIA

DECEMBER 2025

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretrovirals
CBO	Community-Based Organizations
DHS	Demographic and Health Survey
FGD	Focus Group Discussion
FMoH&SW	Federal Ministry of Health and Social Welfare
FSW	Female Sex Workers
GBV	Gender-Based Violence
GF	Global Fund
GoN	Government of Nigeria
HIV	Human Immunodeficiency Virus
HCW	Health Care Worker
IMR	Infant Mortality Rate
IIT	Interruption in Treatment
IDI	In-depth Interviews
IP	Implementing Partner
KII	Key Informant Interview
KP	Key Populations
LGA	Local Government Areas
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MSM	Men who have Sex with Men

NACA	National Agency for the Control of AIDS
NASCP	National AIDS, Viral Hepatitis and STIs Control Program
NEPWHAN	Network of People Living with HIV/AIDS in Nigeria
NGO	Non-Governmental Organizations
NHREC	National Health Research Ethics Committee
ODK	Open Data Kit
OR	Operations Research
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PP	Priority Population
PWID	People Who Inject Drugs
RSSH	Resilient and Sustainable Systems for Health
SACA	State Agency for the Control of AIDS
SASCP	State AIDS and STI Control Program
SPSS	Statistical Package for the Social Sciences
TG	Transgender
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organization

FOREWORD

The evaluation of gender and human rights approach in HIV program in Nigeria is a comprehensive assessment of our efforts in achieving gender equality in the HIV response. This report showcases our progress in promoting gender equality in HIV service uptake and protecting the human rights of persons living with HIV (PLHIV).

The evaluation details how gender considerations and human rights have been integrated into Nigeria's HIV response strategies over the past years. It highlights the strides made and the challenges that persist, offering valuable insight that will guide future initiatives. It reflects our commitment to upholding the principles of justice, dignity, and fairness for everyone, aligning with national and international standards. The insights this study provides offer a roadmap for scaling up and strengthening our interventions to achieve better outcomes

I commend the dedicated efforts of the Research Monitoring and Evaluation (RM&E) department of the agency, partners, ASHWAN, NEPWHAN, Key population and all stakeholders whose tireless work and commitment have been instrumental in the conduct of this evaluation. I also commend all stakeholders driving progress in our gender and human rights initiatives in the country. Your expertise and passion have significantly contributed to the successes highlighted in this report.

As we move forward, applying the findings of this evaluation, we expect to achieve an HIV response that is more gender and human rights transformative in its policies and practices, and more inclusive and equitable for all. We also expect to see continued progress in the elimination of gender-based violence, and increase in HIV service uptake, and care for PLHIVS

I acknowledge with gratitude the Global Fund (GFATM), whose financial support has made a significant impact in conducting this evaluation. Their dedication to advancing gender and human rights is inspiring, and we look to continued collaboration.

DR. TEMITOPE ILORI

Director General

National Agency for the Control of AIDS

EXECUTIVE SUMMARY

Nigeria has made significant progress in integrating gender and human rights considerations into its national HIV response over the past decade. This evaluation, conducted across 12 states and at the federal level, provides a comprehensive assessment of how well gender equality, rights protection, and inclusive service delivery have been incorporated into HIV programming. Using a triangulated methodology that combined quantitative data from 187 respondents, qualitative evidence from 182 Key Informant Interviews (KIIs), and 30 Focus Group Discussions (FGDs), along with insights from a desk review of 34 national and global documents, the study offers an in-depth view of the current landscape, highlighting areas of progress, ongoing gaps, and priority actions needed to advance Nigeria's HIV response.

Access to HIV services across all states was reported to be high, with 97.3 percent of respondents indicating they could obtain prevention, treatment, care, and support services. However, the depth and quality of access varied greatly among men, women, and key populations (KPs). Women continued to show the highest levels of service uptake, reflecting years of targeted investments in PMTCT, community outreach, and gender-sensitive programming. Quantitative data showed significant improvements in women's access. Meanwhile, desk review evidence from sources such as the NDHS and HIV Health Sector Annual Reports confirmed that women outperform men in the HIV testing and treatment cascade. Despite these advances, women still face structural and cultural barriers, including gender-based violence, economic dependency, unequal decision-making power, and harmful sociocultural expectations that increase their vulnerability to HIV and limit their autonomy in accessing care.

Men showed increased engagement in HIV services, with many respondents recognizing greater male participation in testing, counseling, and treatment over the years. These improvements were attributed to intensified community awareness efforts, the Differentiated Service Delivery (DSD) Model, the creation of male champion models, and the involvement of religious and traditional leaders. However, the evaluation revealed that deeply rooted gender norms, such as perceptions of invulnerability, fear of stigma, and expectations of masculine stoicism, still limit men's health-seeking behaviors. These patterns lead to lower diagnosis rates and later entry into care for men compared to women, consistent with findings in national data and academic research.

For key populations including sex workers, MSM, transgender persons, and people who inject drugs, access to HIV services has improved through one-stop shops, peer-led initiatives, and community-based ART delivery models. However, significant disparities persist. Many KPs reported experiences of police harassment, extortion, arrest, and violations related to the enforcement of the Same-Sex Marriage (Prohibition) Act and other punitive legal frameworks. Although the evaluation indicated some reduction in overt stigma within communities and health facilities, structural discrimination remains a significant obstacle. Limited access to PrEP and PEP, ongoing stock-outs of essential commodities, and mistrust of formal institutions continue to obstruct KP-focused service delivery, despite these groups carrying some of the highest HIV burdens in the country.

Across all population groups, structural and economic barriers emerged as significant obstacles to equitable access to services. High transportation costs, long distances to health facilities, and frequent stock-outs of essential commodities were identified as the most critical challenges. Respondents from peri-urban and rural areas described spending hours traveling to get ART refills, while others reported repeatedly encountering shortages of condoms, test kits, PrEP, and PEP. These findings align with desk review evidence, which highlights ongoing weaknesses in supply chain systems and inequities in the geographic distribution of services. Unfriendly provider attitudes, limited confidentiality in some facilities, and lingering community stigma were also common issues, especially among women and key populations.

The evaluation also looked at changes in societal norms, behaviors, and gender roles that affect HIV vulnerability. Across different states, respondents observed gradual shifts in attitudes, such as less stigma, more acceptance of HIV as a manageable condition, and greater male participation in care. However, deeply entrenched patriarchal norms remain highly influential, especially in rural and conservative areas. Women explained ongoing expectations of sexual silence, obedience, and deference, while men discussed pressures to display dominance and avoid behaviors seen as "weak" or feminine. These patterns continue to promote risk-taking, hinder open communication, and reduce the chances of timely testing and treatment, indicating that Nigeria's progress so far reflects gender-neutral programs rather than fully gender-transformative efforts.

Participation in HIV-related decision-making processes also remains inconsistent. While many respondents observed an increase in women's involvement in community consultations and program discussions, qualitative findings indicated that such participation is often symbolic rather than meaningful. Women rarely influence key policy or budget decisions, and key populations are mostly absent from strategic platforms that shape service design and resource allocation. Stakeholders

consistently emphasized the difference between merely being present at a meeting and having the ability to influence outcomes effectively.

Gender-based violence and human rights violations continue to pose serious challenges to effective HIV programs. Women still experience intimate partner violence, coercion, and stigma, which can delay testing, reduce treatment adherence, and heighten HIV risk. Men, although less likely to report violence, share experiences of emotional abuse and discrimination related to HIV disclosure. Key populations face the highest rates of violations, often citing police brutality, extortion, sexual violence, and mistreatment by healthcare workers. While partnerships with legal aid organizations have improved access to justice and psychological support for survivors, systemic gaps in enforcement within the justice sector still hinder consistent protection of rights.

The desk review showed that Nigeria has solid policy frameworks supporting the integration of gender and human rights, including the Gender Mainstreaming Guidelines, the HIV Anti-Discrimination Act, and the VAPP Act. However, implementation remains uneven across states due to limited institutional funding, weak enforcement mechanisms, inadequate gender-responsive budgeting, and poor coordination between health, justice, and social welfare sectors. Gender and Human Rights Technical Working Groups exist in most states but differ significantly in effectiveness, with better performance seen in states like Nasarawa and Ogun, where multi-sectoral coordination and referral systems are more developed.

Overall, Nigeria has made significant progress toward establishing a fairer, rights-based response to HIV. Community resilience, peer-led advocacy, and expanded service models have improved access and reduced stigma across different population groups. However, deeply embedded socio-cultural norms, economic disparities, punitive legal systems, and weak institutional frameworks still prevent the full realization of gender and human rights commitments. To sustain progress and move toward epidemic control, Nigeria needs to shift from programs that simply recognize gender differences to initiatives that actively challenge harmful norms, address systemic inequalities, and ensure that all population groups can access HIV services without fear, discrimination, or structural barriers.

1.0 INTRODUCTION

1.1 BACKGROUND

Gender and human rights remain key factors that influence health outcomes, determining who becomes infected with HIV, who gets diagnosed, who accesses treatment, and who stays virally suppressed (1). In Nigeria, gender norms, discriminatory laws, harmful practices, and unequal power dynamics continue to impact health-seeking behaviors among men, women, girls, boys, and key population services (2,3). These structural factors intersect with socio-economic inequalities and social vulnerabilities, increasing exposure to HIV and limiting equitable access to prevention, treatment, care, and support services (4).

Nigeria's national HIV response has increasingly acknowledged the importance of tackling these inequalities, aligning with global commitments under the Sustainable Development Goals (SDGs). SDG 3 highlights universal access to health services (Good health and Well-being), SDG 5 aims to eliminate gender inequalities, and SDG 16 promotes justice and strong institutions. Reaching these goals requires integrating gender-sensitive and rights-affirming approaches into all aspects of HIV programming.

The World Health Organization (WHO) defines gender as the socially constructed characteristics, norms, and behavior associated with men, women, girls, and boys (5). The Universal Declaration of

Human Rights also states that "all human beings are born free and equal in dignity and rights", and this affirms fundamental rights to life, liberty, security, and well-being (6). The inclusion of gender and human rights considerations into health programs are important for achieving equitable health outcomes and safeguarding the rights of all individuals—including girls, women, boys, men, and key and vulnerable groups (e.g., sex workers, people who inject drugs, Men who have sex with Men, transgender people living with disabilities ,people in closed settings, survivors of gender-based violence and vulnerable children)(7) (4).

Globally, an estimated 33 million people are living with HIV. In Nigeria, the most recent data indicates that HIV prevalence among adults aged 15–49 years was approximately 1.4% as of 2021 (2,8). While there were marginal differences in AIDS-related deaths in 2020; 15,000 men compared to 13,000 women, HIV&AIDS remains the fifth leading cause of death for both genders in Nigeria. However, women demonstrate better outcomes across the testing and treatment cascade with over 98% of

women being aware of their HIV status compared to 79% of men, and more than 98% of women being on treatment compared to 73% of men. Also, 85% of women achieved viral suppression compared to 61% of men (2). These figures suggest that men may have lower rates of access to treatment or retention compared to women.

Over the past decade, NACA has worked to integrate gender and human rights into national and state HIV policies, strategies, and service delivery systems (8,9). This includes creating national guidelines, building capacity, establishing Gender and Human Rights Technical Working Groups (TWGs), and forming partnerships with government ministries, civil society organizations, and development partners. These efforts aim to ensure that women and girls, men and boys, and key and vulnerable groups, including sex workers, MSM, transgender persons, people who inject drugs, adolescents and young people, GBV survivors, persons with disabilities, and individuals in closed settings, can access HIV services without facing discrimination or violence. Gender mainstreaming, an internationally recognized strategy (ECOSOC, 1997), involves assessing and addressing the implications of planned actions on boys, girls, women and men throughout all stages of project development, implementation, monitoring, and evaluation. This approach helps prevent the perpetuation of gender inequalities and promotes more equitable and effective HIV&AIDS responses in Nigeria.

These interventions aim to reduce gender inequalities, address harmful norms, and uphold human rights, all of which are essential for improving health outcomes and achieving epidemic control (10). Some of these programs include the implementation of several strategic interventions to address gender-based violence and human rights violations among PLHIV. Key among these is the scaling up of the Prevention of Mother-to-Child Transmission (PMTCT) programme, with accelerated efforts at both primary healthcare and community levels, particularly targeting young girls, women, key population and vulnerable groups.

Despite these efforts, gender inequality, stigma, harmful social norms, and rights violations remain deeply rooted. Women still face gender-based violence, economic dependence, and limited decision-making power. Men continue to underuse testing and treatment services because masculinity norms discourage seeking health care. Key populations encounter the greatest structural and legal barriers, including criminalization, police harassment, discrimination in healthcare, and social exclusion. These ongoing inequities highlight the urgent need to assess how well gender and human rights principles are integrated into the

national HIV response (7)(11).

To ensure effectiveness, strategic partnerships have been mobilized through collaborations with faith-based organizations, women-focused NGOs, traditional rulers, and both public and private sectors, often coordinated through the offices of the First Lady and the wives of governors and local government chairmen. Additionally, reproductive health and HIV services have been integrated to holistically address gender inequality, including interventions that examine the socialization of boys and girls. Moreso, the government also promotes the involvement of gender-focused networks, including women and girls with disabilities (8). Furthermore, the ongoing institutionalization of a Gender Management System is designed to ensure a gender-responsive framework at both national and sub-national levels, supported by gender-responsive budgeting in HIV&AIDS programming.

This evaluation marks an important step in understanding the progress achieved, the remaining gaps, and the opportunities to improve Nigeria's HIV response through gender-responsive, rights-affirming strategies.

1.2 PROBLEM STATEMENT

Although HIV services have expanded and new models of differentiated care have improved access, gender inequalities and human rights violations still impede Nigeria's progress toward epidemic control. Women and girls remain disproportionately vulnerable due to harmful practices intimate partner violence, early and forced marriage, economic dependence, and limited control over sexual and reproductive health decisions. Men face gender norms that normalize risk-taking, discourage testing, and reduce health-seeking behavior. (10,12)

Despite ongoing efforts, gender and human rights issues remain significant barriers to an effective HIV response in Nigeria. Girls and Women are especially vulnerable due to gender-based violence, early marriage, harmful cultural practices, and limited decision-making power, which hinder their access to HIV services and increase their risk of infection (10,12)

Key populations face even greater vulnerabilities due to criminalization, widespread stigma, police brutality, extortion, and discrimination in healthcare settings. These issues prevent access to essential services and foster distrust of institutions. Existing laws, including the Anti-Discrimination law and the

VAPP law offer protections but are often poorly enforced (13,14).

Although gender and rights principles have been incorporated into national HIV policies since 2013, their implementation in programs and services remains inconsistent. Many state-level mechanisms lack adequate funding, capacity, and coordination. As a result, the actual experiences of men, women, and key populations still expose gaps in protection, voice, agency, and equitable access to HIV services.

Therefore, it is urgent to evaluate how well the national HIV response incorporates gender and human rights principles in practice, how these approaches affect service uptake and outcomes, and which structural barriers still hinder progress (15).

1.3 JUSTIFICATION

Nigeria's HIV epidemic cannot be effectively addressed without confronting gender inequality and human rights abuses. These issues contribute to new infections, delay diagnosis, impede adherence to treatment, and lead to loss to follow-up. A gender-sensitive, rights-based HIV approach is essential to ensure that no population group is left behind. Although Nigeria has implemented several policies and guidelines to promote gender equality and human rights within the HIV response, their application varies across states. Many interventions remain gender-accommodating rather than gender-transformative. Limited funding for gender and human rights units, weak coordination mechanisms, and a lack of accountability structures obstruct progress (16).

A gender and human rights approach recognize the specific vulnerabilities, social norms, and systemic inequalities that affect different groups' ability to access HIV prevention, treatment, and care services. It emphasizes not only biomedical interventions but also social justice, dignity, and rights protection, crucial components for effective and sustainable HIV responses (15)

Evaluating how well gender and human-rights approaches are incorporated into policies, institutional frameworks, and service delivery is essential for guiding strategic planning and enhancing Nigeria's HIV response. This evaluation also helps NACA and partners align with global best practices and national development goals while pinpointing actions to accelerate progress toward controlling the epidemic.

1.4 OBJECTIVES

The primary goal of this evaluation is to assess how effectively Nigeria's HIV policies and programs incorporate gender and human rights principles, and how well these strategies address the needs of all population groups. This evaluation seeks to monitor progress, identify gaps, and recommend actions to enhance gender equality and rights-based HIV efforts at both national and local levels.

1.4.1 SPECIFIC OBJECTIVES

EFFECTIVENESS

Objective 1: To evaluate the current access to HIV prevention, treatment, care & support among target population in the HIV response over the years.

1.1 Identify gender-specific barriers to access HIV services among target populations.

1.2 Assessment of service outcomes amongst different target groups (infection rates, treatment adherence, viral load suppression).

1.3 Assess the provision of services in support groups (PLHIV support groups, OTZ, mother -to-mother support groups).

NB: Population groups in the HIV response (PLHIV, KPs, AYPs, Pregnant women, People in custodian and closed settings (inmates & IDPs), and survivors of GBV)

Objective 2: Evaluate changes in societal norms, behaviours, and gender roles that drive HIV transmission.

2.1 Identify societal norms, behaviours, and gender roles that drive risky behaviour

2:2 Assess community perception changes in norms, behaviours, and gender roles that drive HIV transmission.

RELEVANCE

Objective 3: Determine participation of the target groups in HIV-related decision-making processes at the household, sub-national and national levels.

3.1 Document gender representation in decision-making forums.

3.2 Explore perceived inclusiveness.

3.3 Compare PLHIV and other target populations input into guidelines/program outcomes.

Objective 4: Identify contextual factors influencing HIV services, GBV response, societal norms, and PLHIV involvement over the years.

Objective 5: Measure cases of GBV and human rights violations among population groups.

5.1 Document reported GBV cases and human rights violations among PLHIV, KPs, and other population groups.

5.2 Evaluate available services for GBV cases and human rights violations

5.3 Map and assess referral networks.

Objective 6: Analyze integration of gender and human rights into HIV guidelines/policies, strategies, plans, programs, and assess progress toward gender and human rights responsiveness.

6.1 Review policy frameworks for gender & Human Rights responsiveness.

6.2 Measure gender & human rights policy, strategy, and plans implementation status.

6.3 Identify gaps and opportunities in the integration of gender & human rights programming.

SUSTAINABILITY

Objective 7: Evaluate gender & human rights co-ordination platforms in HIV programs and their role in promoting gender equality over the years.

7.1 Map gender & Human rights co-ordination platforms/structures.

7.2 Measure stakeholder perceptions of impact.

Objective 8: Identify lessons learned and provide recommendations for enhancing gender equity and human rights in HIV responses.

8.1 Identify successes, best practices, and challenges.

8.2 Develop actionable recommendations.

2.0 METHODOLOGY

2.1 DESK REVIEW

This included reviews of published and grey literature on Gender and human rights approach programs in HIV. The thirty-two (32) materials identified and reviewed included scholarly publications, namely, journal articles. Also, reports, guidelines, policies, and policy briefs on GHR provided by NACA and stakeholders were used.

The desk review covered existing guidelines/ policy documents, programme reports, and published or unpublished research provided for or sourced relevant to G&HR in the context of HIV. This includes reports from National Demographic and Health Surveys (NDHS), the Stigma Index, eNNRIMS, DHIS, NDARS, NDR, National GBV Dashboard, GAM and NOMIS, etc., and the report of a formative assessment on the relationship between forced migration, HIV transmission, and other related public health issues. Additional sources included case management records, legal, and human rights documentation. The review synthesized evidence to highlight contextual factors, emerging patterns, and intervention outcomes.

This process was guided by a structured proforma to identify relevant information and to ensure comprehensive coverage of indicators related to gender and human rights (G&HR) violations, service provision, and programmatic responses. These sources provided quantitative and administrative evidence on service delivery, case trends, and the operational context of HIV interventions.

The aim was to identify trends, gaps, and policy implications, with particular attention to the needs and vulnerabilities of children, women, adolescents, and young people (AYP), and internally displaced persons (IDPs). Insights from this phase informed the design, targeting, and strengthening of interventions to address G&HR violations in HIV programming.

2.2 STUDY DESIGN

2.3 STUDY LOCATION & TARGET POPULATION

A purposive sampling approach was applied to select participants and sites across twelve (12) states in Nigeria. This approach is appropriate for the evaluation's focus on understanding how gender equality and human rights principles are integrated within the HIV response, and on capturing the experiences of populations most affected by gender-based barriers and rights violations.

The twelve states were purposively selected to ensure geographical and programmatic diversity, reflecting variations in HIV prevalence, gender norms, human rights contexts, and implementation capacity. This allowed the evaluation to capture a broad range of gender and human rights dynamics across different socio-cultural and epidemiological settings. Within each selected state, participants were purposively identified from key stakeholder categories central to the HIV response. The evaluation employed two (2) approaches to purposive sampling, which are maximum variation sampling to ensure inclusion of diverse perspectives and criterion sampling to target individuals directly involved in gender and human rights programming within the HIV response.

The evaluation employed a mixed-methods approach to strengthen triangulation and ensure a comprehensive understanding of gender and human rights integration within the HIV response.

Both quantitative and qualitative data were collected concurrently.

- Quantitative Component: Structured questionnaires were administered to PLHIV and KPs to gather measurable information on the inclusion of gender and human rights in HIV policies, programs, and service delivery. Quantitative data provided descriptive statistics on coverage, policy implementation, and resource allocation.
- Qualitative Component: Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) were conducted with key populations, PLHIV networks, community leaders, and gender/human rights advocates. These methods explored perceptions, lived experiences, and barriers related to gender equality, stigma, discrimination, and human rights in access to HIV prevention, treatment, and care services.

Integration of both data types allowed the evaluation to compare perceptions (qualitative) with documented evidence and program data (quantitative), leading to richer insights and actionable recommendations.

The evaluation for the study was carried out in twelve (12) states in Nigeria (Adamawa, Nasarawa, Gombe, Akwa-Ibom, Oyo, Delta, Sokoto, Niger, Kano, Ogun, Ebonyi, Anambra), two from each geopolitical zone. This takes into consideration the geographical spread across the country.

- North-East: Adamawa, Gombe
- North-Central: Nasarawa, Niger
- North-West: Sokoto, Kano
- South-South: Akwa Ibom, Delta
- South-East: Ebonyi, Anambra
- South-West: Ogun, Oyo

2.3.1 State Selection

The selected states offer a mix of urban, semi-urban, and rural environments, with varying levels of HIV prevalence, service availability, and sociocultural factors. They encompass conflict-affected areas with significant humanitarian challenges and displacement, culturally and religiously conservative settings, high-burden states with concentrated epidemics among key and vulnerable populations, and economically advanced hubs with innovative service models. This diversity allowed the study to:

- Compare program responsiveness in various contexts.
- Identify challenges and best practices unique to the region.
- Develop context-specific recommendations to enhance the integration of gender and human rights in Nigeria's HIV response.

2.3.2 Participants

The study participants were drawn from both national and state levels to ensure perspectives are captured across the policy, programmatic, and implementation spectrum. Participants included individuals directly affected by HIV interventions, service providers, and institutional stakeholders whose roles influence the integration of gender and human rights into Nigeria's HIV response.

A. National-Level Participants

1. Government Agencies
   - National Agency for the Control of AIDS; (Chair-Person-Gender and Human right TWG.
   - National AIDS and STDs Control Programme (NASCP)
   - Ministry of Women Affairs
   - National Human Rights Commission
   - Ministry of Justice
2. Development Partners
   - UN agencies: UNAIDS, UNODC, UNDP, WHO, UN-WOMEN
   - US government entities: CDC, PEPFAR
   - Global Fund: Country Coordinating Mechanism (CCM), IHVN,
   - Implementing partners:
3. Civil Society Organizations (CSOs)

- National networks of PLHIV (e.g., NEPWHAN, ASHWAN)
- KP Secretariat
- Association of Positive Youth Living with HIV/AIDS in Nigeria

4. Traditional/Religious Leaders and Community Gatekeepers (NINERELA+)

B. State-Level Participants

1. Primary Beneficiaries
   - People Living with HIV (PLHIV): Women, men, and adolescents living with HIV, including state-level members of NEPWHAN, APYIN, and ASHWAN.
   - Key Populations: Men who have sex with men (MSM), transgender individuals (TG), sex workers (SW), people who inject drugs (PWID)
2. Service Providers

   Healthcare Workers/GBV Responders and Social Workers: Doctors, nurses, counselors, and community health workers.
3. Law Enforcement Agencies: Nigeria Police Force
4. State Government Agencies
   - State Agencies for the Control of AIDS (Chair State Gender and Human Rights TWG)
   - State AIDS and STI Control Programmes (SASCP)
   - State Ministry of Women Affairs
   - State Ministry of Justice.
   - State offices of the National Human Rights Commission.

2.4.1 INCLUSION CRITERIA

- Eligibility to participate in the assessment was defined as follows:
- People living with HIV (PLHIV) and key populations (KPs).
- Age 18 years and above for primary data collection
- Service providers in HIV&AIDS, gender, and human rights programme implementation
- Provided informed consent to participate in the assessment.
- Are mentally sound and capable of providing consent to participate
- Must understand the predominant Nigerian Languages (English and Pidgin English).

2.4 INCLUSION & EXCLUSION CRITERIA

2.4.2 EXCLUSION CRITERIA

- Individuals who declined to participate in the study

- Persons who were newly diagnosed at the time of the study (1-6months)

2.4.3 CRITERIA FOR INTERVIEWERS

- The interviewer should be fluent in the local language.

Quantitative

To generate both regionally and nationally representative data for the quantitative component, the sample size was calculated

2.5 SAMPLE SIZE DETERMINATION

using the Leslie Kish formula to recruit PLHIV and KP.

The Leslie Kish formula for calculating sample size in cross-sectional studies is given by:

$$n = \frac{Z^2 p q}{d^2}$$

Where:

n = minimum required sample size

Z = standard normal deviate 1.96 corresponding to the desired confidence level of 95%

p = Prevalence of desired outcome – 0.54% (54%), which is the proportion of clients (PLHIV and KP) reporting respondents who had opposed, challenged, and educated someone who was stigmatizing or/discriminating against them (Lannap et al., 2023).

q = 1- p

d = desired level of precision (2.5%)

$$n = \frac{1.96^2 \times 0.54 \times (1- 0.54)}{0.025^2}$$

$$n = \frac{3.842 \times 0.54 \times 0.46}{0.000625}$$

n=1,526.96

We assumed an acceptable difference and non-response rate of 5% and 10% respectively.

n/ (1-0.05) and n/ (1-0.1) = 1,607-1697

This gave us a minimum sample size of 134 - 141participants per 12 states.

Assumptions:

1. The precision (d) was adjusted to 2.5% to ensure the study is adequately powered.
2. We also assumed equal proportions of participants to be selected across the states across all states.

Sample size of 134 was distributed per 12 states. However, Questionnaires were administered to a total number of 187 participants across the 12 States.

Quantitative data were collected from PLHIV and KPs using structured, pre-tested questionnaires. These instruments capture information on physical, sexual, and emotional violence; incidence of human rights violations; and relevant socio-demographic and programmatic variables. Sampling aimed at statistical representativeness within each target group, ensuring adequate coverage across geographic locations. Data was collected through face-to-face interviews administered by trained enumerators to ensure quality, consistency, and sensitivity when addressing potentially traumatic topics. The questionnaire was administered to 15 respondents, covering the PLHIV and KPs respondents in each state. For the 12 states, a total of 180 respondents were targeted for the interview, which was exceeded

Quantitative sampling matrix (Per State)	
Respondents	***No of Respondents***
NEPWHAN	**5**
Key Population	**5**
ASHWAN	**5**
Total	**15**

Qualitative

The qualitative component employed purposely selected Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs).

Interviews with key informants (KIIs): Key Informant Interviews (KIIs)were conducted during the data collection phase by both the consultants (nationally) and data collectors (in states) to gather evidence on existing interventions, achieved results, interacting factors, and challenges encountered. These interviews engaged a diverse range of stakeholders to explore systemic, programmatic, and socio-cultural drivers of gender-based and human rights (GHR) violations. A structured interview guide was used to ensure consistency, enabling the collection of detailed insights from stakeholders on gender and human rights issues within the HIV programme context.

Focus Group Discussions (FGDs): FGDs were conducted with PLHIV in each state, comprising two sessions.

- One with NEPWHAN members
- One with ASWHAN members
- One Key Population members

Each FGD consisted of a homogeneous group of five participants selected based on shared characteristics or roles within the PLHIV community, fostering relatability and open dialogue. Discussions explored lived experiences, coping mechanisms, and

perceptions of the responsiveness of HIV services to gender and human rights (GHR) issues. Facilitators used semi-structured guides to maintain consistency across sessions while allowing flexibility to probe emerging themes. Participant selection was guided by principles of gender sensitivity and equity to ensure inclusive and representative perspectives.

Qualitative Data collection	
Focus Group Discussions (FGDs)	
State level FGD participants (Per State)	*No of FGDs*
NEPWHAN	1
ASHWAN	1
KEY POPULATION	1
Total	3
Key Informant Interviews (KIIs)	
State level participants	*No to interviewed*
SACA	1
SASCP	1
NEPWHAN	2
Key Population Secretariat	1
ASHWAN	1
Health and Gender service providers	1
Gender and Human Rights State Response Teams	1
State Ministry of Women's Affairs	1
State Ministry of Justice	1
PACA – Police Action Committee on AIDS, gender unit representatives	1
State offices of Human Rights Commission	1
Association of Positive Youth in Nigeria (APYIN)	2
Key Population (2 FSW, 1 MSM, 1 PWID, 1 TG)	5
Total	19

National level participants	
UN – UNAIDS, UN Women, WHO, UNDP, UNODC	5
USG- CDC, PEPFAR	2
GF – CCM, IHVN	2
NACA	2
NASCP	1
Ministry of Justice	1
Heartland Alliance	1
Legal Aid Counsel	1
Other implementing partners	1
Human Rights Commission	1
Member of Gender and Human Right Technical Working Groups	1
Total	18
Grand Total	37 per state

Table showing number of states covered for the NACA's quantitative data collection

	State	KII	FGD
1	FCT	9	-
2	Oyo	19	3
3	Akwa-Ibom	6	1
4	Gombe	19	3
5	Kano	18	3
6	Delta	12	3
7	Ogun	18	3
8	Niger	3	-
9	Nasarawa	21	3
10	Sokoto	9	2
11	Anambra	18	2
12	Ebonyi	9	2
13	Adamawa	21	5
		Total: 182	Total:30

2.6 DATA TOOL & VARIABLES

Mixed methods were deployed using a questionnaire for quantitative data collection, key informant interviews and focus group discussion guides for qualitative data collection.

2.6.1 QUANTITATIVE

Quantitative data was collected through structured questionnaires administered by trained data collectors. Participants' responses were recorded using Open Data Kit (ODK) forms, which support both online and offline data entry. All completed forms were uploaded and retrieved by the data officer at the data management center for cleaning and analysis. The questionnaire was administered to PLHIVs and KP who are 18 years above, who access and use various HIV services.

The questionnaire had the following eight sections:

- Section 1 – Sociodemographic characteristics and general information.
- Section 2 – Level of Access to HIV Prevention, Treatment, Care & support services
- Section 3 – Influence of Societal Norms and Attitudes
- Section 4 – Decision-Making Participation
- Section 5 – Gender-Based Violence and Human Rights Violations
- ● Section 6 – Lessons Learned and Recommendations

2.6.2 QUALITATIVE

The key informant interview (KII) and Focus-group discussion (FGD) guides were developed through the review of literature. The FGD was used to interview PLHIVs and KPs while the KII was used to interview relevant stakeholders as outlined in the table above. The guides included questions on Access, Participation & Societal Norms, Decision-Making & Contextual Factors, Violence, Human Rights & Program Effectiveness, Policy & Programming.

Qualitative data was collected through interviews conducted by an interviewer (Consultants and other data collectors), accompanied by a note-taker. With participants' consent, discussions were audio-recorded. Recordings were uploaded to a password-protected external hard drive, and a secure, password-protected online backup was created for the study. Access was restricted to the principal investigator and the Co-Investigator.

2.7 VARIABLES (QUANTITATIVE & QUALITATIVE)

2.7.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS

This includes age, gender, educational status, employment, how long you have been receiving HIV services, duration of diagnosis/treatment (PLHIV and KP).

2.7.2 OTHER VARIABLE

These include:

Level of Access to HIV Prevention, Treatment, Care & support services, Influence of Societal Norms and Attitudes, Decision-Making Participation, Gender-Based Violence and Human Rights Violations, Lessons Learned and Recommendations.

2.8 PRE-TESTING

The pretest assessed the wording of the translated questions, the comprehension of the questions, identifying any ambiguity, and the overall flow of the questionnaire.

Pre-testing was conducted during the training of data collectors. After the pre-testing, ambiguities were corrected, and the flow of questions was re-arranged based on the results of the nominal group session. After finalizing the study instruments, the instruments were validated by stakeholders/ NACA/ IPs/ funding organizations and reviewed for suggested additions, edits, and comments. The finalized instruments were used for data collection from the respective states.

2.9 RECRUITMENT & TRAINING OF DATA COLLECTORS

Data collectors and field workers were recruited by the staff of NACA. Data collectors were trained for two days on the purpose of the study, methodology, obtaining consent as applicable, study population, sampling techniques, sample size, filling consent forms, data collection tools, data entry, and using the checklist that summarizes their fieldwork daily. They were also trained on obtaining informed consent and the basic ethics required in research. Below is the training agenda.

Training agenda

- Purpose of the evaluation
- Study protocol

- Ethics: Confidentiality, Engaging key vulnerable groups e.g. key population groups (KPs)
- Scheduling survey administration
- Sampling technique and selection of participants
- Materials needed for survey administration
- Checklists for fieldwork
- Questions and Answer
- Data instrument: Role plays/ Simulations

The data collectors had a minimum of secondary education, were able to communicate in English and the major local language in the state where they worked, had a functional mobile phone or tablet, and had participated in a data (quantitative and qualitative) collection exercise prior to this project.

2.10 DATA COLLECTION

Data was collected quantitatively and qualitatively.

2.10.1 QUANTITATIVE DATA COLLECTION

I. The data collector administered the questionnaire and recorded the participant's response on the ODK form with online and offline synchronization.

II. The interviewer captured the geographical coordinates of the location on the ODK form.

III. The data entered was retrieved at the backend in the data management centre by the data officer.

2.10.2 QUALITATIVE DATA COLLECTION

i. This comprised the interviewer who conducted the interview and recorded the discussion after obtaining consent, and the note taker.

ii. The interview was conducted in a quiet environment where auditory and visual confidentiality was ensured (that is, where they were not seen or heard by other individuals)

iii. Data from the recording device was uploaded to a password-protected external hard drive and a password-protected online backup server created for this research. These backups were only accessible to the Principal Investigator and Co-Investigator. The recordings were deleted from the recording devices once they had been successfully uploaded to the online backup server and external hard drive.

2.11 DATA MANAGEMENT & ANALYSIS

2.11.1 DATA VERIFICATION AND VALIDATION

The consultant and the research team ensured that the entire data collection and management process aligned with the study protocol and best ethical practice and were responsible for data safety and monitoring. All data were timely, complete, accurate, and aligned with the study protocol.

Data from the ODK server was downloaded and exported to IBM SPSS Statistics for cleaning. The dataset examined for missingness, outliers, double entries, and irrelevant observations. Double entries and irrelevant observations were removed from the dataset. Missing data evaluation/analysis was conducted to examine missingness. However, significant missingness was not expected due to the rigorous process of verification that was at every level. Therefore, the method used for dealing with data missing completely at random was list-wise deletion of missing cases, employed depending on the pattern of missingness.

2.11.2 DATA SAFETY AND TRANSFER

The Consultants ensured data security by restricting access to it. In line with the Nigeria Data Protection Act (2023), the project observed the following.

- **The soft data was encrypted and saved on external drives, kept safely by the investigator and the institution, based on the data safety policy of NACA.**
- **A copy was stored on a solid-state disk in a small Faraday bag under lock and key.**
- **Data access was restricted to authorized personnel only.**
- **Participants' data was held in sacred trust and exchanged only for the project and not for any other purpose whatsoever.**
- **All investigators and research assistants completed and passed the Nigerian National Code for Health Research Ethics online course.**
- **To transfer de-identified data, a data use agreement was required to ensure the protection of participants' data and privacy.**

2.11.3 DATA ANALYSIS

The quantitative study data were used to compute sample statistics, to have an idea about the precision of the study, and to generalize our findings to the target population. IBM Stata

version 26 was used for quantitative data analysis. The data is presented as follows: