September, 2013

# Integrated MARPs HIV Prevention Program (IMHIPP) Mid-Term Evaluation Report

**By**

Muyiwa Oladosun, PhD
Femi Oladosu
Chika Okeke-Amobi

MiraMonitor Consulting Ltd., Suite 33, Hilltop Plaza, 13 Gwani Street, Off IBB Way, Wuse Zone 4, Abuja FCT., Nigeria
Tel: 08098481237; 08097170566
Email: info@cficnig.com; Website: www.cficnig.com

**ACKNOWLEDGEMENTS**

We take this opportunity to thank the Heartland Alliance Nigeria (HAN) management staff especially the Chief of Party (COP), Bartholomew Ochonye Boniface for providing financial, technical, and administrative muscle for this evaluation. Also many thanks go to Dr. Emmanuel Godwin, Fatiya Askederin, and Winifred Gompil for their unwavering assistance, understanding, and patience. We also thank all the HAN local implementing partners (LIPs) staff in Cross River, Rivers, Lagos, and Kano States, and Federal Capital Territory (FCT) who were very supportive and cooperative in mobilizing the participants, and ensuring that all appointments outside the community centers were promptly accomplished. We are grateful to the participants who voluntarily provided useful and insightful sensitive information. Our many thanks go to the USAID representatives: Abiye Kalaiwo, Duke Ogbokor who were on ground in the fieldwork with us, and Pamela Gado all of whom volunteered invaluable information. Many kudos to staff of MiraMonitor Consulting Limited (MMC) who provided tireless backend support with respect to data entry, and logistics support throughout the period of evaluation.

**ACRONYMS**

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| AGE | Advocate for Grassroots Empowerment |
| ARV | Anti-Retro Viral |
| AJWS | American Jewish World Service |
| CBOs | Community Based Organizations |
| CiSHAN | Civil Society for HIV/AIDS in Nigeria |
| CRSACA | Cross River State Agency for the Control of AIDS |
| DHIS | District Health Information Systems |
| EoI | Expression of Interest |
| ENR | Enhancing Nigeria's Response for HIV/AIDS |
| FBOs | Faith Based Organizations |
| FCT | Federal Capital Territory |
| FACA | FCT Agency for the Control of AIDS |
| FSWs | Female Sex Workers |
| FHI | Family Health International |
| FGDs | Focused Group Discussions |
| GIs | Group Interviews |
| HIV | Human Immunodeficiency Virus |
| HA | Heartland Alliance |
| HAN | Heartland Alliance, Nigeria |
| HCT | HIV Counseling and Testing |
| ICARH | International Center for Advocacy and Rights of Health |
| IMH-I | Improved Male Health Initiative |
| IAH | Initiative for Advancement of Humanity |
| ICT | Information Communication Technology |
| IHVN | Institute of Human Virology, Nigeria |
| IDUs | Intravenous Drugs Users |
| IGA | Income Generating Activities |
| IMHIPP | Integrated MARPs HIV/AIDS Prevention Program |
| KII | Key Informant Interview |
| KASACA | Kano State Agency for the Control of AIDS |
| LASACA | Lagos State Agency for the Control of AIDS |
| LIPs | Local Implementing Partners |
| LGBT | Lesbian, Gay, Bisexual, Transgender |
| MSM | Men who have sex with Men |
| MDAs | Ministry Department and Agency |
| MARPs | Most At Risk Populations |
| MSMLWHA | Men who have Sex with Men Living with HIV/AIDS |
| MSMFSP | Men who have Sex with Men Female Sex Partners |
| M&E | Monitoring and Evaluation |
| MPPI | Minimum Prevention Package Intervention |
| NACA | National Agency for the Control of AIDS |
| NEPWHAN | Network of People Living with HIV/AIDS in Nigeria |

| | |
|---|---|
| NGOs | Non-Governmental Organizations |
| NED | National Endowment for Democracy |
| OSIWA | Open Society Initiative for West Africa |
| OCs | Outreach Coordinators |
| PEs | Peer Educators |
| RIVSACA | River State Agency for the Control of AIDS |
| SACA | State Agency for the Control of AIDS |
| SPSS | Statistical Package for Social Scientist |
| STIs | Sexually Transmitted Infections |
| SFH | Society for Family Health |
| TIER | The Initiative for Equal Rights |
| TAs | Technical Assistance |
| USAID | United State Agency for International Development |
| USIPs | United States Implementing Partners |
| PHDP | Positive Health, Dignity and Prevention |

## CONTENTS

**LIST OF TABLES**

**LIST OF FIGURES**

## EXECUTIVE SUMMARY

This mid-term evaluation was geared to assess how the Integrated MARPs HIV/AIDS Prevention Program (IMHIPP) has been able to support local implementing partners in creating access and enabling environment for high impact HIV prevention services to MARPs (especially MSM sub-group) in Nigeria. It identified gaps and challenges in implementation, best practices and lessons learned and made recommendations for future improvements.

Evaluation employed participatory approach involving stakeholders including participants, program implementers, policy makers, and funding partners in the process. It used both quantitative and qualitative techniques in data collection, and analysis and triangulation of information to enrich findings. For quantitative data, a total of 436 MSM were selected with probability proportion to size and interviewed across Cross River, Rivers, Lagos, and Kano States and Federal Capital Territory (FCT). Purposive sampling was used in the qualitative component to select participants for focused group discussion (FGD) and key informants (KII). In total, 27 FGDs, 46 KIIs, and 8 group interviews (GIs) were conducted across the four states and FCT.

MSM were fairly evenly split between the four states and FCT except in Kano where smaller proportion was recorded in-line with the sample proportions required. Most MSM who participated in this evaluation were urban residents (89%), and were aged 29 or younger (85%). The majority were Protestant Christians (64%), Catholics were 13% and traditional and Muslim and others combined were 23%. Most MSM who participated had at least secondary education (94%), and were mostly from low socioeconomic status (86%).

*Key Findings*

- Evidence showed that capacity and skills of local implementing partners (LIPs) staff have been built in HIV prevention, palliative care programming and project management and administration through intensive knowledge and skills transfer involving co-location of HAN and LIPs staff at their respective offices and frequent formal and informal technical assistance (TA) visits from HAN, Abuja. Future programming need to broaden horizon of LIPs staff by encouraging exchange program to other similar projects within and outside Nigeria.

- Findings showed that most MSM reported that they received information/services on correct condom use which is the main focus of the project. Additional findings showed that small proportion reported that they received information/services on ARV treatment, support services, and nutritional support among others. Most MSM scored high on consistent condom use, while some scored low on knowledge about nine or more ways of preventing HIV. Only a few know the two key differences between HIV and AIDS, and other STIs. Some of the results were statistically significant across selected background characteristics i.e. state, age, residence, level of education, religion, and socioeconomic status. Programming should strengthen knowledge about correct use of condoms and

eliminate gaps in knowledge about HIV, and other STIs while considering highlighted background characteristics as well.

- Results of this evaluation showed that MSM were able to access quality health services through friendly health providers who were committed to helping them. Also, findings showed that about 37% of MSMLWHA who participated in this evaluation were not on any form of HIV treatment. Future programming may need to examine how to institutionalize quality service through friendly health providers at the facilities by eliciting the support of more health providers and the management of the facilities who should be sensitize on peculiar needs of MSM. Also, IMHIPP should examine ways to leverage services from other development partners to ensure that all MSM who need care are able to access. In addition, health professionals need to acquire MSM friendly service provision skills through trainings. This may in the end ensure better access to quality health services at healthcare facilities.

- Evidence from this evaluation established degrees of self-efficacy to use condoms among MSM i.e. would give in to unprotected sex/other responses (11%), would continue to insist on condom use (63%), and would terminate relationship (26%). Programming efforts should be directed to increasing the proportion of MSM who would terminate relationship if their partner insists on sex without condoms. This may ensure maximum effects on reduction in HIV prevalence among MSM. Also, the main positive behavior change reported by most MSM is condom use while there was low response to other aspects of behavior change. In addition to condom use, program intervention need to also increase proportion of MSM who reported behavior change with respect to other ways of contracting HIV.

- Significant progress was made in developing platforms of engagement and collaboration with SACA, FACA, and NACA and with NEPWHAN and CiSHAN over the years through capacity building, staff of HAN serving on various national technical working groups on prevention, retreats, document reviews, and other meetings to develop strategic documents for the national response on HIV prevention. These forms should be sustained and strengthened in the future to ensure more attention and sustainability of MSM programming in the country.

- In order to reduce stigma and discrimination and increase acceptance, it may be necessary to step-up advocacy focusing more on changing negative perception of development partners working on HIV/AIDS, while fine-tuning advocacy to clearly position IMHIPP to focus more on MSM rights to health and the benefits of this to the general population. Also, advocacy that does not align with rights to sexual orientation will be more useful in creating a conducive environment for IMHIPP. Softening the environmental contexts will involve embracing other MARPs sub-groups close to MSM i.e. FSWs, and IDUs which may contribute to reducing misimpression among development partners about HAN goals and objectives.

- In other to attenuate or diffuse the effect of the same-sex marriage prohibition bill, it may be necessary to engage in discussions of its different components for more clarity and the implications for the family, social institutions, and the society as a whole. This may lead to public understanding of the bill and feedback to make it more realistic.

- Other major highlights of findings in this evaluation include need for economic empowerment for the unemployed MSM, and welfare of LIPs staff in the field, need for more HAN autonomy in making decisions at the national office without necessary seeking approval from their headquarters at Chicago, USA, sustainability, more flexibility in funding streams, best practices and lessons learned towards better programming in the future.

## INTRODUCTION

HIV prevalence is considerably high among men who have sex with men (MSM) in Nigeria. Statistics suggest that HIV prevalence among MSM is four times higher than the general population (17.3%, IBBSS, 2010 vs. 4.1%, National HIV and Syphilis Sentinel Survey, 2010). Also, HIV prevalence is considerably high among MSM when compared with prevalence among other most at risk population (MARPs) which is decreasing (IBBSS, 2010).

The Integrated MARPS HIV/AIDS Prevention Program (IMHIPP) implemented by Heartland Alliance Nigeria (HAN), is a five years project uniquely positioned to focus on MSM issues in selected five states across four geopolitical zones in Nigeria. The IMHIPP implementation strategy includes; (1) strengthening institutional and technical capacity of five grassroots MSM organizations in Nigeria, (2) working with members of the MSM community as peer educators (PEs) to reach out to other members of the community with HIV prevention information and community-based palliative care services, (3) working with other stakeholders, including government and non-governmental agencies to make the policy environment for comprehensive MSM and related services more friendly.

### *Program Objectives*

The overall goal of the IMHIPP project is to reduce the incidence of HIV and other STIs among most at risk populations (MARPs) with specific focus on MSM and their male and female partners.

*Program objectives broken down as below:*

- Investing in organizational and technical capacity of grassroots LGBT/MSM organizations to ensure sustainable access to HIV services for MSM and to develop strong local infrastructure for the implementation of MSM-targeted programming beyond the life of this program;

- Reaching MSM and their partners with appropriate prevention messages using a network of trained and supported outreach staff and peer educators;

- Developing service outlets and training outreach workers to provide MSM-sensitive community-based palliative care;

- Creating an enabling policy environment by supporting the capacity of MSM organizations to advocate for MSM-friendly health policy, applying human rights principles to health policy development and training key stakeholders-- Local Agencies for the Control of AIDS (LACAs), State Agencies for the Control of AIDS (SACAs), and the National Agency for the Control of AIDS (NACA) -- and donor/implementing agencies to design and operationalize MSM-targeted service provision in Nigeria.

*Local Implementing Partners (LIPs)*

IMHIPP is implemented in conjunction with five grassroots organization listed chronologically according to when they joined the project.

1. The International center for Advocacy on the Rights to Health (ICARH), in Abuja, the Federal Capital Territory (FCT);
2. The Initiative for Equal Rights (TIERs) in Lagos;
3. Improved Male Health Initiative (IMH-I) in Calabar, Cross River State;
4. Initiative for Advancement of Humanity (IAH) in Port-Harcourt, Rivers State; and
5. Advocate for Grassroots Empowerment (AGE), in Kano State

ICARH and TIERs joined in the first year of the program, IMH-I, and IAH joined in the second year, while AGE joined in the third year.

*Evaluation Objectives*

The main purpose of this evaluation is to:

- Assess the effectiveness, efficiency and quality of the project at supporting local implementing partners systems in creating access and enabling environment for high impact HIV prevention and care services for MARPs in Nigeria;

- Identify gaps and challenges in the IMHIPP implementation process so far;

- Propose key recommendations for further improvement and direction for the remaining project implementation process;

- Document lessons learned and provide recommendations that will factor into future MARPs programming design and directions.

## EVALUATION METHODOLOGY

This evaluation employed participatory approach involving key stakeholders of the IMHIPP right from the planning stage, to fieldwork, and report. It elicited information using both quantitative and qualitative data collection techniques which enriched triangulation of findings.

The evaluation elicited information from program participants, program implementers, policy makers, and representatives of the project funding agency. Program participants were basically members of the MSM community who assumed various roles on the project including MSM and their female partners, MSM living with HIV/AIDS (MSMLWHA), and MSM volunteer caregivers.

Program implementers who participated in the evaluation were categorized as; Heartland Alliance Nigeria (HAN), and Heartland Alliance (HA) USA staff, staff of local implementing organizations (including outreach coordinators, and peer educators PEs), volunteer medical doctors, and staff of other implementing partners such as ENR, NEPWHAN, and CiSHAN. Policy makers were basically Ministry, Department and Agency (MDAs) officials i.e. NACA, SACA, and USAID staff, the funding agency of IMHIPP.

### Quantitative Methods

*Sampling Design*

**Table 1: Showing planned and actual sample distribution of MSM across four states and FCT**

| State | Planned Sample Size | Actual Sample Size | Percent (%) (Planned vs. Actual) |
|---|---|---|---|
| **FCT** | 124 (25%) | 87 (20%) | 70% |
| **Rivers** | 101 (20%) | 91 (21%) | 90% |
| **Cross River** | 115 (23%) | 99 (23%) | 86% |
| **Kano** | 57 (11%) | 56 (13%) | 98% |
| **Lagos** | 103 (21%) | 103 (23%) | 100% |
| **TOTAL** | **500** | **436** | **87%** |

Fieldwork was conducted between December 3rd 2012 and February 8th, 2013 starting from Calabar, Cross River State and ending in Abuja, FCT.

In total, 436 MSM were sampled with probability proportion to size (PPS) and interviewed across Cross River (23%), Rivers (21%), Lagos (23%), and Kano (13%) states, and FCT (20%). Location based sampling technique was employed in selecting and eliciting information from MSM. It is important to note that the security situation in Kano at the time of fieldwork did not adversely affect turnout of the respondents. Each state visited has community centers and "hot spots" which are taken as natural clusters of MSM in the community. The community centers and hot spots are places where MSM usually meet for multiple types of activities. MSM who visited the community centers or were invited by outreach coordinators (OCs) and peer educators (PEs) to the project's community centers during the evaluation were systematically selected and interviewed in a face-to-face fashion.

Selection criteria considered among other things, length of time the MSM joined the community. Fifty-two percent of MSM surveyed, were one year or less old on the project, while 45% represent those who joined over a year ago. MSM who joined the project during the evaluation were not included in the sample.

**Qualitative Methods**

MSM for the qualitative data collection were purposively selected to include those who were knowledgeable and have received services from the project, and are able to provide useful information about the evaluation questions.

*Snowball Sampling:*

OCs and PEs served as "significant others" or gatekeepers in identifying key knowledgeable MSM community members who participated in the qualitative data collection involving mainly FGDs and KII.

**Table 2: Showing the Number of FGDs & KIIs conducted by Participating States Visited**

| State | Focus Group Discussion (FGD) | | Key Informant Interviews (KII) | | Group Interviews (GI) | |
|---|---|---|---|---|---|---|
| | Planned | Actual | Planned | Actual | Planned | Actual |
| **Cross River** | 6 | 5 | 14 | 9 | 1 | 2 |
| **Rivers** | 6 | 5 | 14 | 8 | 1 | 1 |
| **Lagos** | 6 | 5 | 14 | 9 | 1 | 1 |
| **Kano** | 6 | 6 | 14 | 9 | 1 | 1 |
| **FCT** | 6 | 6 | 14 | 3 | 1 | 2 |
| **Other Stakeholders** | - | - | 8 | 8 | - | 1 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **TOTAL** | **30** | **27** | **78** | **46** | **5** | **8** |

Of the 30 FGDs planned in the qualitative data collection, 27 FGDs were conducted and of 78 KIIs planned, 46 were implemented. The difference in the planned and actual FGDs and KIIs was due to: (1) some KIIs were converted to GIs as some respondents preferred to be interviewed together, and (2) KII planned for some program implementers did not take place because there was no one designated to respond to an interview at the time of the evaluation.

*Limitations of the Evaluation*

- The MSM sample that participated in this evaluation may have been skewed by those who were able to come to the community center as the time of the evaluation. The sample may not have adequately represented the population of MSM reached by the IMHIPP project since the "hot-spots" were not visited by the evaluation team, and MSM who were shy or those who did not want to be associated with the community center may have been under-represented.

- Also, MSM in the working class categories and those of high socioeconomic class who participated in the IMHIPP may have been under-represented as well. This is because most of the data collection was done on work days and mostly during working hours (Monday to Friday) which may not have been convenient time to those in these categories. Some information were however, provided on the working class by MSM and LIPs staff who participated in this evaluation.

- Language barrier may have had some influence on the volume and quality of information received from the MSM community members who were not able to express themselves well in English or in Pidgin English. Attempts were made to hire interpreters when necessary to reduce gaps or loss in the data collected.

- In addition, some questions were retrospective in nature and responses may have been affected one way or the other by inability respondents to remember events of the past adequately. Results of initial data analysis did not show that recall lapses had any significant effects on the findings of this evaluation.

- The evaluation team did not have the opportunity to experience many social night parties (called "Gala Nights" in some communities) organized for their members on a monthly bases by the LIPs in the states visited. Many MSM who participated in this evaluation had experience on the night parties which they volunteered to the evaluation team which enriched the qualitative data collected.

## EVALUATION KEY FINDINGS

This section presents key findings starting with background characteristics of the MSM who participated in the evaluation, and evidence on each aspect of the project objectives.

### *Background Characteristics*

**Table 3: Percentage distribution of MSM by selected background characteristics**

| | Percentage (%) |
|---|---|
| **Total (N)** | **436** |
| **State of Residence** | |
| Cross River | 22% |
| FCT | 20% |
| Kano | 13% |
| Lagos | 24% |
| Rivers | 21% |
| **Residence** | |
| Urban | 89% |
| Semi-urban | 4% |
| Rural | 7% |
| **Age group (in years)** | |
| 20 or younger | 21% |
| 21 - 29 | 64% |
| 30 or older | 15% |
| **Religion** | |
| Traditional/Muslim/Other | 23% |
| Catholic | 13% |
| Protestant | 64% |
| **Highest level of schooling** | |
| Primary/Quranic only/None | 6% |
| Secondary | 57% |
| Tertiary | 37% |
| **Marital Status** | |
| **% married to same-sex** | 1% |
| **% married to opposite sex** | 4% |
| **Socio-economic Status** | |
| Low | 86% |
| Medium | 13% |
| High | 1% |
| **Type of economic Activity involved** | |
| **% involved in economic activity** | 50% |
| **Total** | 100% |

Table 3 shows that MSM who participated in the evaluation were evenly distributed across four states where the project was first implemented namely Cross River (22%), FCT (20%), Lagos

(24%), Rivers (21%), and Kano the newest of the four states and FCT had 13%. As expected, the majority of MSM who participated were urban residents (89%), aged 29 or younger (85%), and mostly Protestant Christians (64%). The majority had either secondary (57%) or tertiary education (37%). The majority of MSM who participated in the evaluation were unmarried (over 96%), and only a few (3%) reported being married to the opposite sex, and 1% reported married to same-sex. Also, the majority of MSM reported that they were of low socioeconomic status (86%), and only half (50%) reported that they were involved in an economic activity.

## Sexual Behavior of MSM Partners

This section examines the sexual behavior of MSM with respect to the type of sexual activity that they engage in, the role they play in such activity, and reasons for such sexual behavior.

*Sexual Behavior with Same-Sex*

**Table 4: Percentage distribution of MSM by indicators of sexual and condom use behavior with same-sex**

| | **Percentage (%)** |
|---|---|
| **Total (N)** | **436** |
| **Age started same-sex sex** | |
| 15 or younger | 33% |
| 16-20 | 48% |
| 21-35 | 19% |
| **% involved in anal sex** | 83% |
| **% involved in oral sex** | 83% |
| **Usual role played in sexual activity** | |
| Insertive | 29% |
| Receptive | 18% |
| Versatile | 53% |
| **Last time had sexual activity** | |
| Today/yesterday | 10% |
| Less than a week | 20% |
| A week to a month | 29% |
| Over a month to three months | 29% |
| Over three months | 12% |
| **% used condoms in last same-sex sex** | 89% |
| **% used lubricant in last same-sex sex** | 92% |
| **% reasons involved in same-sex sex-- is for fun** | 65% |
| **% reasons involved in same-sex sex-- introduced by friends** | 28% |
| **% had same-sex sex for money or material gains** | 27% |
| **% ever had drinks containing alcohol** | 55% |
| **% ever had any type of drugs** | 5% |

Table 4 shows that the majority (81%) of MSM started sexual activity at age 20 or younger, were mostly involved in anal and oral sex (both 83%), and over half (53%) reported that they were versatile, and a small proportion were strictly insertive (29%) or receptive (18%). Forty-nine

percent reported that they had sex within a month of the evaluation, 41% reported that they had sex over a month from the time of the evaluation, and 10% reported having sex the day of interview or a day before.

The majority (89%) reported that they used condoms in last same-sex sex, and most (92%) reported that they used lubricant during sex. The majority (65%) said that they were involved in same-sex sex for the fun (pleasure) of it, while small proportions had sex because of friends who introduced them during the course of friendship (28%), and money or material gains (27%).

### *Sexual Behaviour with Opposite Sex*

**Table 5: Percent of MSM by indicators of sexual behavior and condom use with female partner**

| | **Percentage (%)** |
|---|---|
| **Total (N)** | **370** |
| **% ever had sex with female partner** | 81% |
| **% currently having sexual relationship with opposite sex** | 66% |
| **When last had sex with female partner** | |
| Less than a week | 16% |
| A week to a month | 16% |
| Over a month to three months | 26% |
| Over three months | 31% |
| Don't know/no response | 11% |
| **% last sex with female partner used condoms** | 71% |
| **Total** | **100%** |

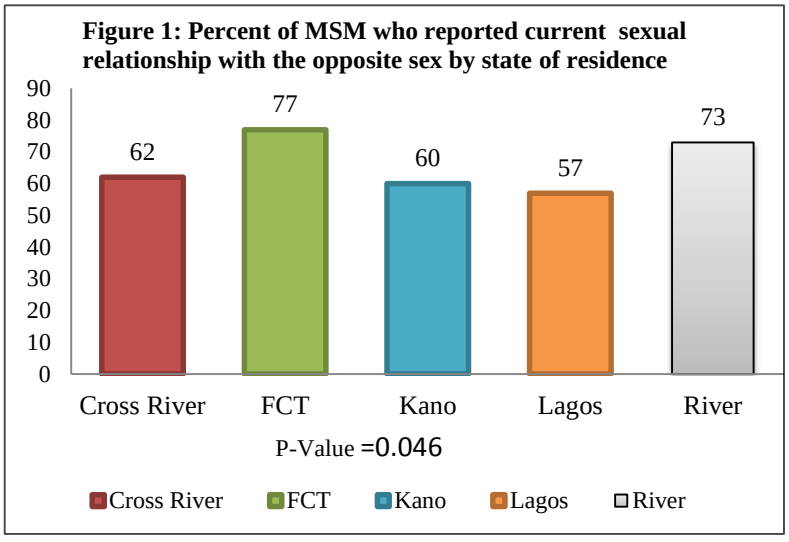
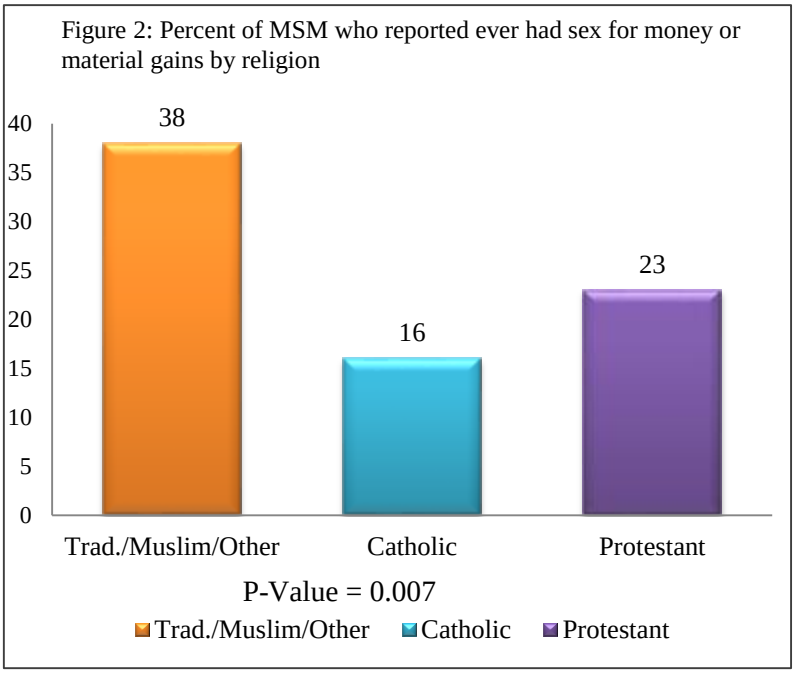



Table 5 shows that the majority of MSM (81%) ever had sex with a female partner, and the majority had an on-going sexual relationship with the opposite sex (66%). Among MSM who

reported sex with a female partner, 57% had sex at least a month before the evaluation, and 32% had sex with female partner within the month of the fieldwork. About 71% of MSM reported that they used condoms in the last sex with their female partner.

Figure 1 above shows that MSM in FCT reported the most bisexual relationship (77%), followed by those in Rivers (73%), Cross River (62%), Kano (60%), and Lagos (57%) (P-value = 0.046).




Also, results showed that only 27% of MSM reported that they ever had sex for money or material gain, and this varied significantly by religion i.e. between traditional/Muslim/other (38%), Catholic (16%), and Protestant (23%) (P-value = 0.007).

*Types of Sexual Practices*

Results from the qualitative data analyzed provided more insights on the sexual activities of MSM. Most MSM revealed during FGD that they are a sexually less restrained community and that "serial monogamy" is common lifestyle for most because the majority of MSM are usually curious to try new things with a new partner or want to find out what a new friend feels like. Findings suggest that a general perception among the MSM community is that they have more sexual libido than other men in the general population. Findings showed that MSM engage in variety of sexual practices including; anal sex, vaginal sex, oral sex, and masturbation. Also, this evaluation showed that while some MSM do not engage in any form of sexual penetration, others are much involved with both anal and vaginal sex.

The qualitative data analyzed also revealed that the majority of MSM reported that they were versatile partners while a few reported that they were strictly insertive. Evidence from qualitative data suggest general consensus that it is more enjoyable to receive (the one penetrated) than to give (the one penetrating) during sexual intercourse. Also, findings suggest that who plays what role among the versatile is determined by two main factors: (1) who is physically more masculine of the two, and (2) who is paying in a transactional sex. The quotes from two FGDs below encapsulate the types of sexual practices of MSM.

*P1. "Anal sex, oral sex, fore play, tie sex. (What kind of fore play?) --is fondling with each other and no penetration. Reaming is licking of the anal hole. We also have vagina sex in this community. How many of us have a girl friend? P1. Some of us have a girlfriend but they don't have sex with them, just for showing that you have a girlfriend. (Which of these sex type is common here top bottom or giver and receiver?) Top bottom is common. P2. versatile. P3. versatile for instance I have money and I meet someone now you fuck me and I fuck you. I go there I see some one that looks like man I allow him to fuck me because I invited him and I go somewhere else I see the one that look like a woman I fuck him. Multiple is common because of poverty, material things unemployment, lack of knowledge and variety"* ***(FGDs with PEs, FCT).***

*P1- "there are many of them, like 1. Blow jobs, it's been done, there is also anal sex, after anal, some do just you know between lapses, they call it grinding (do the also call it laptop?) people believe its grinding, they call it "markade" , sucking it's called "yar sabulu" with hand, we have friction, there is something that they do you will be on your tommy and the other person doing it between the laps not inside the hole, in between the buttocks. Licking of the buttocks they call it ass licking. If we want to call it in Hausa is "lasa birni", vaginal sex. (How many of us do both vaginal and anal sex?) All of us.P2- anal 40% vaginal 60%P3- there is nothing I don't do, am into all. P4-actually I do anal but not all the time you know when it happens I do vaginal but anal is more of 80 and 20 percent. 80 of anal, 20 of vaginal.P5- anal is the sweetest. Is more sweeter. P6- me I have never practice vaginal because I am waiting for the right person but I have the desire. I just want to keep myself maybe to deceive myself that am a virgin. But I have the desire is just that am fooling myself that am waiting for the right person"* ***(OCs, Kano State).***

***Note: P1, P2, P3 etc. are used to identify FGD participants.***

Only a little above half (55%) of MSM interviewed, ever had drinks containing alcohol and very few (5%), reported ever using any types of drugs.

*Perception about Marriage*

This evaluation examined perception of MSM about marriage because this has implications for future sexual practices and HIV prevention when the current mostly youthful population move to adulthood. Findings showed that most MSM were not interested in marriage with the opposite sex although a few were married at the time of the evaluation. The general consensus on marriage to the opposite sex is that this may happen eventually just to reduce family and societal pressure, and the need to have children. Based on the evidence of this evaluation future trend in sexual relationship may be more favorable to bisexual relationships i.e. legal marriage with a woman, while having concubine male friends as well. Excerpts from MSM themselves buttresses the points above.

*P1. "For an MSM the sex drive is 5 times the normal men some people have female alongside the male which is not very common. P2. Naturally if MSM is legalize most men will not want to have women in their houses. (What are your reasons for marriage?) I want to get married because of family and because I love children. P3. I want to get married because of family and I love having children when am of age 45 I will get divorce"* ***(OCs, Lagos).***

*"(What is your perceptions about marriage?) P2: For me I do not have same sex as fiancée for now till its legal. (That means) for now opposite sex marriage. (Why do you like to do that?) Because following the spiritual aspect of it Bible it is written that God make female for man. There is a need for ..... linage. P1: As for me I think of marriage because I just like family. I just want to (have) one by all means anyhow. P3: With the family and the way my people are persuading once I get money I will get marry. P4 What I am putting into consideration is that I do not know whether straight or lesbian. P7: I will go for female marriage because of production of children..... I will say when it is officially link out I can give it a second thought. P8: I will get married because I have to produce. Let me add to it, life without female is lifeless or life without female and God is lifeless P6: I think I buy the idea life without a female is not normal"* ***(MSM, FCT).***

***Note: P1, P2, P3 etc. represents FGD participants.***

## Achievements on Key Program Objective

The achievements of IMHIPP are examined based on the four key objectives explicitly stated in the cooperative agreement. Key objectives examined are preventive service provision, palliative care provision, organizational and institutional capacity building, and policy advocacy.

### *Objective One: Organizational & Technical Capacity of Local MSM/LGBT Organizations*

A key objective of IMHIPP is to strengthen the organizational and technical capacity of grassroots MSM/LGBT organizations to provide HIV/AIDS services to their communities. This evaluation examined this objective from three key areas; (1) training and skills to provide HIV

prevention services, (2) training and skills to provide palliative care services, and (3) infrastructural development of LIPs.

*Training and Skills to Provide HIV Prevention Services*

The results of this evaluation showed that IMHIPP provided numerous trainings and technical assistances (TAs) to the LIPs staff which enabled them to provide HIV and related services to their community members.

Findings from the group interviews conducted suggest that trainings were both informal and formal. LIPs staff reported trainings relevant to HIV prevention on; HIV basic facts, safer sexual practices, PEs and OCs training, minimum prevention package interventions (MPPI), communication skills trainings, and behavior change among other topics. These trainings were reinforced by continuous in-house TAs fostered by HAN staff co-locating with the LIPs staff.

LIPs staff including OCs and PEs reported increased knowledge on HIV which influenced their re-orientation on safer sexual practices, and behavior change communications. Also, LIPs staff reported increased self-esteem and a better sense of responsibility to work and to members of their community. The following from two LIPs group discussions summarizes these points.

*"Well, for me I will say I have been in all of the trainings that have been conducted, well, most of the trainings started in 2010 and we had, may be two trainings in late 2009, when they just started……. But from 2010 we had lots of trainings both leadership management, we had training on behavioral change intervention, we had training on positive behavior when we trained on palliative care … we had training on peer education itself, and CMPPI, then there was a training on, ... palliative care. Then we had training on policy and advocacy, we did (in-house) training on that too. We did training on program implementation and management and we had training (in-house) on that too. And other … trainings (as well). And the training has really helped not just myself, (but) even the community members, that we have been able to reach out to"* ***(LIP staff, Lagos State).***

*P1: "We have capacity building on policy and advocacy, palliative care, capacity building on HIV counseling and testing, PHDP, capacity building for trainers. Under policy and advocacy, capacity training on ethics, it just many, numerous. P4. I have received training in DHIS the one they held in Enugu, and with SACA, NACA. I can do SPSS. I can do the manual driven (of SPSS). We have also done capacity building training in monitoring and evaluation, effective communication skill. (Is like they are numerous?) Too numerous for two years now we have been having training non-stop. Effective administration and leadership training, drug adherence training, technical assistance: P1: Co-location has benefited us so much. Like when we started the project officer was like very green but now he can comfortably talk about programming. Confidently handle program issues, he put up a proposal and perform very well"* ***(LIP Staff, Rivers State)***.

***Note: P1, P2, P3 etc. identify staff who participated in the group interview.***

*Training & Skills of LIPs to Provide Palliative Care Services*

Findings of this evaluation showed that LIPs staff received numerous trainings on how to provide palliative care services to the MSM community that they serve. Staff reported receiving trainings on caregiving and support, palliative care for MSM, FSPs and their dependents, positive health, dignity, and prevention (PHDP), drug adherence, and how to mobilize at the grassroots for HIV counseling and testing. Aside from the HAN case manager resident with the LIPs who continuously reinforced the trainings to improve skills of LIPs staff on the job, field visits from HAN staff in Abuja helped to strengthen the practical aspects of the trainings received.

Below are statements from LIPs staff corroborating the effects of the trainings and TAs received on palliative care services provided to MSM in the communities. Except below from an OC in Cross River state is a clear example of how LIP staff have translated the training and skills received into direct effect on the life of a MSMLWHA.

*"Examples (of an MSM) affected… a friend of mine was sick and could not do anything we went to the client house washed his cloth , bed sheet and provided food for him. This has really helped in building up of our self-esteem and because of the data quality training we had, we don't double count anymore so if u are handling this area people know you are. The project has helped the members of the community to have voice, the trainings has helped along way in filling of forms. The project has really talked about Hiv and Aids and issues concerning it and we can talk about it anywhere. I want to say a very big Thank you to HA for bringing this project to our state. all this data quality and form filling, report writing and writing of concept note .the training we had so far has really improved my skills, my Self-esteem, a good counselor and most of all it has made me to be a good father and it has made me to know how to address so many issues in the community center"* ***(OC, Cross River)***.

*P3: "As for me as a logistic officer, I understudy the case manager that left so I work closely with her she has been able to put me through in the area of counseling, referrals, commodities, taken it in the stores, even when she left I held that position for almost three to five month. Before the new case manager came is like I am virtually.....and the same time OC also. In terms of the logistics did you understudy any body? I do, the logistics manager in HA, we make phone call so if I do not really get to understand something, I call him he will tell me this is how we do it. I have been getting assistance from him both from the state office and the country office. The new case manager we are working together, in terms of meeting client and given them the kind of the necessary counseling they need i.e. sanitation counseling....."* ***(LIP Staff, Kano).***

***Note: P1, P2, P3 etc. identifies staff who participated in the group interview***.

*Organizational Structure & Infrastructural Development*

Organizational structure and infrastructure is the fourth component of development examined in this evaluation. Findings suggest that LIPs moved from being "a group of friends" coming together at the beginning of the project to a full-fledged well-structured organization with an organogram, department or units and positions with functions and responsibilities (including administration, finance, management, M&E, programs, logistics etc.). LIPs staff in all locations visited reported receiving trainings and on-going on-the-site coaching and mentoring in all areas of project management and administration.

The results of this continuous skills transfer (over the last two to three years) are well-established sustainable systems in place with checks and balances, financial, human resources and management policies. Another feature of a well-established structure reported by LIPs staff are functioning boards of directors, effective management staff, and transparency in hiring of human resources and financial management.

Skill development provided to the LIPs staff included proposal writing, grants identification, report writing, abstract and concept papers development etc. Results showed that the old LIPs especially those of FCT and Lagos reported receiving grants for new projects aside IMHIPP which is an important indicator of maturity, and a crucial factor in sustainability.

Simultaneous with the human architecture in place is physical infrastructure that enabled the project implementation as well. LIPs reported receiving assistance with office space, computers, and other office equipment including generator. Also, assistance included providing communication facilities, and salaries of staff. Excerpts from LIPs staff, especially those who had institutional memory of IMHIPP attest to the findings above.

*"initially we were not having technical capacity to implement intervention programs we just do intervention … we just do interventions we don't plan them we just do anything we want to carry out at that particular moment which the capacity building program of Heartland Alliance … being a partner our capacity are being built based on our needs we design deep capacity building together so it makes us like being able to like catch the bull by the horn like we can even build our own capacity internally because technically we are getting stronger by the day, and institutionally you can see that we have all it takes to like collect data, analyze data and share data. Information is like flowing. There is still like challenges here and there but our successes is like increasing by the day which every day we get new things, we are learning new things, we are like from 2011 to date AGE has been registered with the CAC as a non-governmental organization. AGE has team of board of trustees AGE has a structure which didn't come easy like management board the structure of the organization where we manage."* ***LIP Staff, Kano)***.

*"I think (IMHIPP) it has done a great impart, before there (are) some things you just over look, in term of proposal development, may be that is why we have not be able to access funding, but some of the technical support they are giving, really help us, because before so many thing were not there, before we never remove tax from staff salary, we never pay pension, but now the structure is there, all this is through that technical support. (Do you think your system is now financially transparent?) For me I will say yes, because the system has always been transparent, what I can just say is that the documentation style we have now is different from what we had before, now we have different account for different program, that shows transparency, now we have systematic ways of ensuring transparency and accountability, for the donor, even for the auditor and for every other person."* ***(LIP staff, Lagos).***

Another key component of IMHIPP programming focuses on HIV prevention among MSM in the intervention states, and FCT. The HIV prevention program involves HIV messaging and the provision of condoms and lubricants to adult MSM that are sexually active.

Program statistics as of April, 2013 showed that 50,494 MARPs (mostly MSM) were reached by LIPs with individual and/or small group level HIV prevention intervention messaging and other services. Findings from this evaluation (Table 7) provide insights on the types and number of information/services received by MSM through IMHIPP.

*Types of Information about HIV/AIDS*

**Table 6: Percent of MSM who received information/services through the IMHIPP project**

| | Percentage (%) |
|---|---|
| **Total (N)** | **436** |
| **Received information/services about:** | |
| **HIV/AIDS** | 97% |
| **correct use of condoms** | 94% |
| **HIV counseling & testing** | 77% |
| **condoms** | 96% |
| **lubricant** | 94% |
| **ARV treatment** | 37% |
| **laboratory services** | 42% |
| **training on IGA** | 47% |
| **support services** | 41% |
| **nutritional support** | 38% |
| **social support** | 45% |
| **referral** | 47% |
| **Cumulative index of information/services received** | |
| **4 or less** | 19% |
| **5 to 8** | 39% |
| **9 to 12** | 42% |

Most MSM (97%) (Table 6) reported that they received through IMHIPP HIV/AIDS information/services on; correct condom use (94%), HIV counseling and testing (77%), condoms (96%), and lubricant (94%). Other information/services received by MSM who participated in this evaluation are ARV treatment (37%), laboratory services (42%), IGA training (47%), support services (41%), nutritional support (38%), social support (45%), and referral (47%). Excerpts from an FGD conducted with some MSM who participated in the evaluation support these findings.

*P1: "Me, I got to know about HIV/AIDS and I got to know people of my type. I learn so much. Especially information about HIV/AIDS, on how to protect myself or on how to abstain (from sex). And, they do supply us with condoms. P5: Knowledge about using of clipper. P2: HIV test and counseling and referrals. P4: They have been providing mosquito net and commodities. P1: Yes, we have been doing some activities like doing some particular thing and make money out of it. In the field of cooking, sowing and all that … "**(MSM, Cross River)**.*

***Note: P1, P2, etc. represent participants in an FGD.***

Cumulative index of information/services received showed that less than half (42%) of MSM reported that they received 9 to 12 information/services, and smaller percentage (39%) reported 5 to 8 information/services, while 19% reported that they received 4 or less information/services.

However, it is important to note that some of the information/services included in the cumulative index like nutritional and laboratory services, and ARV treatments are provided through referrals and partnerships with other USIPs.

***Access to HIV/AIDS Information/Services by Selected Characteristics***

**Figure 3: Percent of MSM who recieved 9-12 information/services by state of residence**

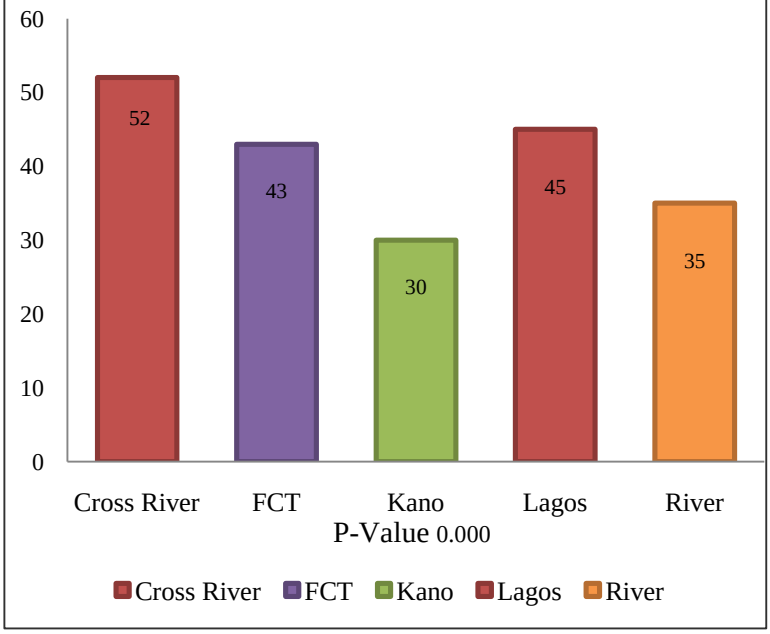
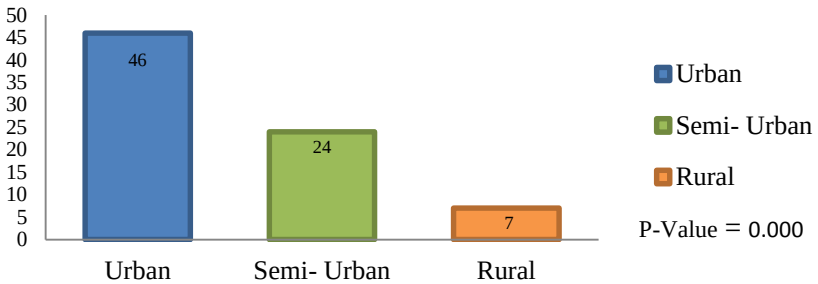
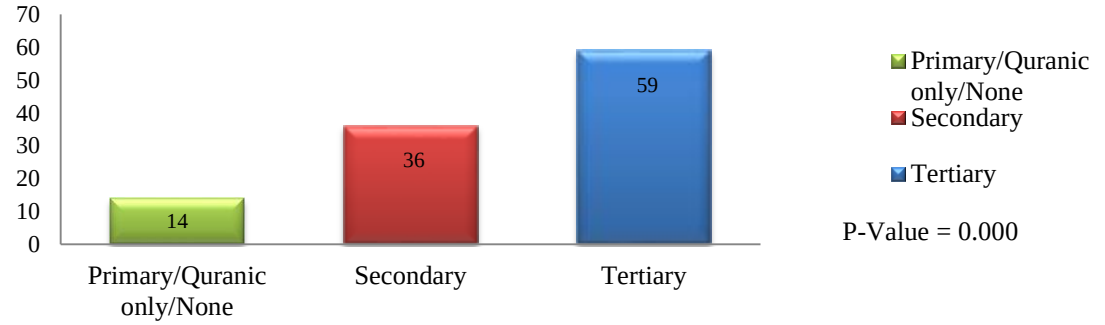



**Figure 4: Percent of MSM who reported 9-12 information/services received by residence**



Results of this evaluation (Figure 3) showed that more MSM in Cross River (52%), than in Lagos (45%), FCT (43%), Rivers (35%), and Kano (30%) reported that they accessed HIV information/services (p-value = 0.000). Also, Figure 4 shows that more urban (46%) than semi-urban (24%), or rural (7%) MSM reported receiving 9 – 12 HIV information/services (p-value = 0.000).

**Figure 5: Percent of MSM who reported receiving 9 - 12 information/services by highest level of schooling**




Also, the number of services received varied significantly by education. Figure 5 shows that more MSM who had tertiary (59%) accessed services than those with a secondary education (36%), or those with a primary/Quranic/no education (14%). As mentioned earlier, other significant indicators of access to HIV/AIDS information/services are religion, socioeconomic status, and types of economic activity (Appendix 1).

*Sources of Information about HIV/AIDS*

This evaluation also examined sources of information about HIV/AIDS among MSM in the communities visited.

**Table 7: Percent of MSM by sources of information about HIV/AIDS**

| | **Percentage (%)** |
|---|---|
| **Total (N)** | **436** |
| **From where heard about HIV/AIDS** | |
| % radio | 98% |
| % TV | 97% |
| % newspapers/magazine/comics | 89% |
| % billboards/posters | 91% |
| % health education program | 89% |
| % community meetings | 87% |
| % friends | 90% |
| % CBOs/FBOs peer educators | 82% |

| Composite index on sources of HIV/AIDS information | |
|---|---|
| 6 or less | 9% |
| 7 to 11 | 45% |
| 12 or more | 45% |

Results from this evaluation (Table 7) showed that the majority of MSM reported accessing HIV/AIDS information through several channels including radio (98%), TV (97%), newspaper/magazine/comics (89%), and billboards/posters (91%). Other sources of HIV/AIDS information reported by MSM are; health education program (89%), community meetings (87%), friends (90%) and through HAN CBOs/FBOs peer educators (82%).

In order to understand the magnitude of exposure, we constructed a cumulative index on sources of information about HIV/AIDS (Table 8). Interestingly, most MSM (90%) had access to at least seven sources of information about HIV/AIDS, and only a small proportion (9%) reported access to six or less sources of HIV/AIDS information.

**Figure 6: Percent of MSM who reported to 12 or more source of information on HIV/AIDS by state of residence**

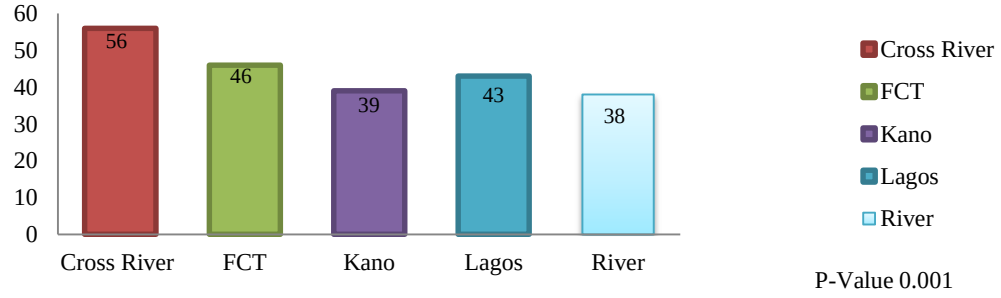
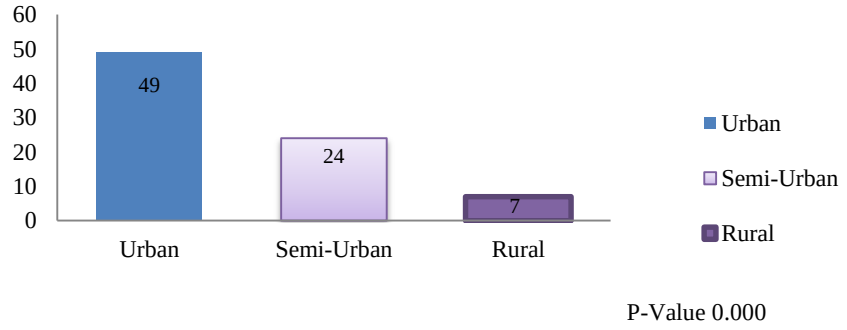



Figure 6 above shows that analysis on sources of information about HIV/AIDS disaggregated by state of residence. Results suggest that MSM in Cross River state had the highest proportion of MSM (56%) who reported at least 12 sources of information about HIV/AIDS compared to FCT (46%), Lagos (43%), and Kano (39%) and Rivers states (38%) reported the least (P-value = 0.001).

Also, there is significant difference in access to 12 or more sources of HIV/AIDS information by residence. Figure 7 below showed that more MSM in urban areas (49%), than those in semi-urban (24%), and rural (7%) accessed 12 or more sources for information about HIV/AIDS (P-value = 0.000). Other significant variations observed included highest level of schooling, socioeconomic status, and type of economic activity.

**Figure 7: Percent of MSM who reported 12 or more sources of information on HIV/AIDS by residence**




### *Knowledge about HIV/AIDS*

This section examines various aspects of knowledge about HIV/AIDS including ways of preventing HIV, the differences between HIV and AIDS, the reasons HIV infected persons may look healthy, and knowledge about other STIs.

*Ways of Preventing HIV*

**Table 8: Percent of MSM by knowledge about ways of preventing HIV**

| | **Percentage (%)** |
|---|---|
| **Total (N)** | **436** |
| **Ways of Preventing HIV** | |
| % correct condom use | **85%** |
| % avoid sterilized needles/sharp objects | **56%** |
| % abstinence from sex | **38%** |
| % one sexual partner | **20%** |
| % avoid casual sex | **14%** |
| % avoid unscreened blood | **11%** |
| % avoid sharing skin piercing objects | **8%** |

Findings in Table 8 above showed that in terms of knowledge about ways of preventing HIV, the most well-known among MSM was correct use of condoms (85%), followed by avoiding unsterilized needles/sharp objects (56%), and abstinence from sex (38%). Other ways of preventing HIV reported by MSM are; maintaining one partner (20%), avoiding casual sex (14%), avoiding unscreened blood (11%), and avoiding sharing skin piercing objects (8%).

This imbalance in knowledge about ways of preventing HIV need to be addressed in future programming geared to have substantial positive influence on the sexual lives of MSM in the states visited.

*Knowledge of the difference between HIV and AIDS*

**Table 9: Percent of MSM according to indicators of key differences between HIV and AIDS**

| | Percentage (%) |
|---|---|
| **Total (N)** | **436** |
| **% who reported that there is difference between HIV and AIDS** | **90%** |
| **% who reported that HIV is a virus, while AIDS is a disease** | **65%** |
| **% who reported that HIV leads to AIDS** | **21%** |
| **Composite index on knowledge of the difference/s between HIV & AIDS** | |
| No knowledge of the difference | **16%** |
| One component of knowledge | **81%** |
| Two components of knowledge | **2%** |

Table 9 shows that 90% of MSM agreed that there is difference between HIV and AIDS, 65% reported that HIV is a virus, while AIDS is a disease. Only 21% of MSM interviewed reported that HIV leads to AIDS.

Also, this assessment examined cumulative knowledge on the differences between HIV and AIDS (Table 9). Results showed that only 2% of MSM know the two key differences between HIV and AIDS, and 81% know one difference, while 16% have no knowledge of the difference between HIV and AIDS. Qualitative data below buttresses this point further. This crucial aspect of knowledge need to be addressed in future programming geared to meet MSM needs.

*P5: Sir, HIV is like any other chronic disease P2: HIV is human immune virus that … if not properly treated or subdued, it (can) develop to AIDS. P4: I will say HIV is a virus being contacted through sexual intercourse. You can also contact it through sharing of sharp objects. P1: The different between HIV and AIDS, HIV is (is that HIV is a) virus that once it enter into you can be control, once you are taking your medicine. If somebody that has HIV and he does not go for test and he allows the virus to destroy his immune system with time it will turn to AIDS. At that time he will (be) having some rashes and other disease will come in and break the person down. P6: HIV is human immune deficiency virus while AIDS (is) acquired immune deficiency syndrome. HIV if not well treated it will lead to AIDS* ***(Participants, Rivers State).***

***Note: P1, P2, P3 etc. are FGD participants)***

**Table 10: Percent of MSM according to reasons HIV infected person may look healthy**

| | Percentage (%) |
|---|---|
| **Total (N)** | **436** |
| **% HIV infected person can look healthy** | **90%** |
| ***Reasons HIV infected person may look healthy*** | |
| % not written on a person's face | **19%** |
| % the disease takes time to manifest | **2%** |
| % may be taking suppressing drugs | **81%** |
| **Composite index on knowledge about physical symptoms of HIV** | |

| | |
|---|---|
| None | **9%** |
| 1 or 2 | **81%** |
| 3 or more | **10%** |

Another area of knowledge on HIV that may lead to positive change is the physical symptoms of HIV. Results in Table 10 shows that most MSM (90%) who participated in the evaluation know that an HIV infected person can look healthy. Reasons provided on why an HIV positive person can look healthy include; (1) the person may be taking suppressing drugs (81%), (2) it is not written on an infected person's face (19%), and (3) the disease takes time to manifest (2%).

Strength of MSM knowledge on physical features of a person living with HIV was examined using a cumulative index. Results suggest that most MSM (81%) know one or two physical features, while a small proportion (10%) knows three or more symptoms, and a few had no knowledge (9%).

**Figure 8: Percent of MSM who reported 3 or more components of knowledge on physical features of a person living with HIV by state of residence**

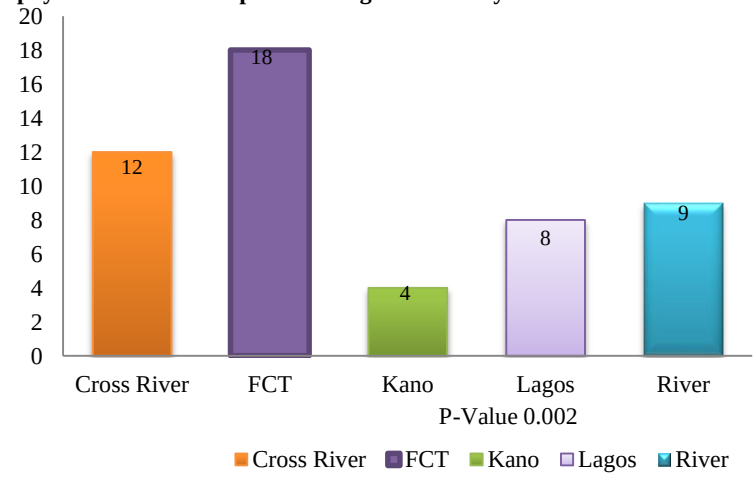



Figure 8 shows that of the MSM who reported knowing three or more symptoms, 18% were from FCT, 12% from Cross River, 9% from Rivers, 8% from Lagos, and 4% from Kano.

*Knowledge about other STIs*

This section examines knowledge of MSM about other types of STIs in general and those common among members of the community.

**Table 11: Percent of MSM according to knowledge about other STIs aside from HIV**

| | **Percentage (%)** |
|---|---|
| **Total (N)** | **436** |
| **Knowledge about other STIs** | |
| **% who reported having knowledge about other STIs aside HIV** | **91%** |
| **% gonorrhea** | **90%** |

| | |
|---|---|
| **% syphilis** | **49%** |
| **% (herpes) staphylococcus** | **25%** |
| **% herpes** | **10%** |
| **% candidiasis** | **9%** |

As Table 11 shows, 91% of MSM reported knowledge about other STIs aside HIV. And specific STIs mentioned include gonorrhea (90%), syphilis (49%), staphylococcus (25%), herpes (10%), and candidiasis (9%).

**Table 12: Percent of MSM according to known common symptoms of STIs in men**

| | **Percentage (%)** |
|---|---|
| **Total (N)** | **436** |
| **Knowledge of common symptoms of STI in men** | |
| % genital discharge | **50%** |
| % burning pains on urination | **48%** |
| % genital ulcers/sores | **9%** |
| % swelling in groin area | **9%** |

On STIs that are common to the MSM community, half (50%) reported genital discharge, close to half (48%) reported burning pains during urination, and a few reported genital ulcers/sores, and swelling in the groin areas (both 9% respectively). Findings from qualitative data collected corroborate qualitative findings. Results showed that anal warts, anal discharge, gonorrhea and syphilis were the most commonly reported in the FGDs and KIIs conducted. Excerpts below from health personnel in two states visited corroborate these findings.

*"A lot of them (MSM) come for condom, STI, more than 90% STI and HIV. Usually I have a chart (that) I gave to Heartland Alliance I do not know whether they give too you. Last year we did a table a statistic this are the number of people referred, these are the number of people we see, the number of people we tested for this, and these are the condition we got. Many of them (have) gonorrhea, syphilis, and candidiasis the women especially ... genital wart. I am not sure I kept a copy (of the statistics submitted to the project staff). I have not done for 2012 because is not end of the year. For 2011 we did that, February to December this year from (the) different conditions they were tested for and treated"* ***(Health Personnel, Cross River).***

*"The most common STI I see amongst them (MSM) is gonorrhea, (and then) herpes, syphilis and genital wart. (Why do you think they come down with this?). Because people with HIV they come down with all types of opportunistic infection and besides that when you go to the hygienic aspect they are not well educated in terms of hygiene some people will use underwear for one week and they don't even care and there is tendencies that all that can happen"* ***(Health Personnel, Kano State)*** .

### *Objective Three: Palliative Care Services for MSM Living with HIV/AIDS*

The third component of the IMHIPP examined in this evaluation is the provision of palliative care services to MSM living with HIV/AIDS (MSMLWHA). Programming include referral linkages to MSM friendly clinical services and health personnel, psychosocial support services and community level counseling and support with healthy living materials like buckets, soaps, mosquito nets, etc.

Statistics showed that the LIPs reached 9,956 MSMLWHA with palliative care services from inception of IMHIPP to date (Cross River = 15%, FCT = 35%, Kano = 5%, Lagos = 31%, and Rivers = 14%). This is a key performance indicator suggesting that LIPs staff now have the requisite capability to provide palliative care services to this sub-group of MSM.

**Table 13: Percent of MSM according to counseling, testing, and HIV status**

| | **Percentage (%)** |
|---|---|
| **Total (N)** | **436** |
| **How can a person know HIV status** | |
| % going for a test | **95%** |
| % going for HIV counseling & testing | **17%** |
| % who reported knowing a place for HIV test | **99%** |
| % ever tested | **90%** |
| **How long been tested for HIV** | |
| % less than 3 months | **49%** |
| % 3 to 6 months | **26%** |
| % over 6 months | **14%** |
| % else | **11%** |
| **HIV status** | |
| % negative | **71%** |
| % positive | **15%** |
| % else | **14%** |
| **HIV treatment status** | |
| % on treatment | **63%** |
| % not on treatment | **37%** |
| **Total** | **100%** |

Table 13 above shows that the majority of MSM (95%) reported that a person can know their HIV status by going for a test, or HCT (17%). Almost all MSM (99%) who participated in this evaluation know a place where an HIV test can be conducted. Most of the MSM involved in IMHIPP reported ever been tested (90%), and have had a test in six months or less (75%).

The majority of MSM (71%) who participated in the evaluation reported that they were HIV negative, 15% reported positive, and 14% did not know their status. Of those who reported positive on HIV test, 63% were on treatment while 37% were not on treatment.

*Quality of Services Received at Health Facilities*

Quality of services at health facilities were assessed based on whether MSMLWHA were discriminated against when they went for treatment, whether they perceived the environment as friendly, and whether they were treated with respect and whether they were able to access the services that they needed.

Results showed that in general, MSM especially MSMLWHA received friendly services from the hospitals and health facilities across the States visited. A key strategy that enabled this result is the identification and working with doctors or hospitals sympathetic to the objectives of the project. Findings suggest that MSM were treated discretely just like other patients who visited the hospitals or health facilities for treatment.

The referral system established credible linkages between IMHIPP and the health facilities as partners working with MSMLWHA who are often given immediate attention at the facilities. Findings also suggest that most health personnel because of their interest and commitment provide other counseling services outside official hours to MSMLWHA.

Findings showed that most private health facilities had their full management support in providing services to MSMLWHA. This was not the same for public health facilities which provided services with the consent of only a few key staff with management support lacking in most cases. Excerpts below corroborate aspects of the quality of service provided by most participating health facilities visited by the evaluation team.

*P1: "For me I have gotten more experience about HIV and also, I got some materials (like) soap, bucket, and net through the (project) support group. P2: Water guard, mosquito net, condom and lubricant, cash transport reimbursement, P3: for myself, my first referral came from this place through their forward referral system. And Heartland Alliance has help me and one of the reason why I said that is, they have been able to carry the burden when I got to know that I am positive. I was able to overcome this through the training which I pass through here. Without those training I do not know how I would have felt. It really helps me to carry my health journey just without much stress. P5: I have received condom. P4: The way he said it that was the way they taught us. Also, ensure that your partner is well educated for easy penetration. P3: they also gave social support. Let's say members of the community who are bedwetting. The coordinator, even support group coordinator, psycho-social support, emotional support, even spiritual support when necessary. Social support you can take the person out more especially, when a patient just discover his status. The person feels depressed. You can just take the person out for a movie."*
***(MSMLWHA, Rivers State).***

***Note: P1, P2, P3 etc. are FGD participants)***

*P2: "When they came in here some of them were looking not healthy they were sick but now they are healthy looking well. There is one that has gone back to school because there is a lot of different in is life and the other one is working. Taking their drug and living a very healthy life style. P1: Is excellent because we are doing a great job here so we took them as our brother we do not discriminate we do not stigmatize even though they have any other problem with other staff we are the one that will stand up and say no, no, no. P3: The same thing assuming you are here to see those one that came today. You would not believe they are MSM. The way they compose them self the way they do things the way they dress. They may get to their gathering and behave funny but whenever they come here they behave well."*
***(Health Personnel, Lagos State)***

***Note: P1, P2, P3 etc. represent FGD participants)***

*Follow-Up Issues*

Although the referral system put in place by the project was functional, it did not guarantee that all MSM referred from the project actually presented at the health facilities to access services. Also, the referral system did not take care of loss to follow-up due to change of residence, inability to pay for services, and issues of identification etc. Also, IMHIPP was not able to leverage on other implementing partners' services in some health facilities as it did in others. Where leveraging on other USIPs services is well in place, it helps defray cost of other services like ARV treatment, STIs, and other opportunistic infections.

*Involvement with Support Group*

Findings showed that support groups specifically for MSMLWHA were on ground and fully functional at the time of this evaluation. All MSMLWHA support groups formed at the states and FCT were registered and well integrated with NEPWHAN, and this is the first of its kind in Nigeria. The support groups offer a safety net for members to address any issues of concern including double stigma and discriminations, drug adherence, how to live positively, personal hygiene and access to project materials such as mosquito nets, soaps, water guard, buckets and other items. The support groups also deal with attitudinal issues including self-denial on the reality of HIV/AIDS.

The statements below surmise the issues addressed at the support groups and the difficulty and challenge of follow-ups with MSMLWHA.

*"To me that is all because there are still things that we have to do … Like adherence to drugs for the reasons of poverty this client do not adhere to their medication they still come back the same or even worst, then secondly they are those even when you tell them, there was a person that tested positive and he said that he did not know what HIV is but he knew but he just didn't want to understand or to accept that he is HIV positive. This is one of the challenges and some of them go into hiding and keep spreading this disease"* ***(Health Personnel, Kano State)***

*"(Do you have issues with drug Adherence?) Yes, we have issues with that but then we are tracking it, some will tell you that they are taking their drugs but you find out that they are not taking it , but with constant information and health talk because we cannot follow them to their houses they will say that they are taking. Then for lost to follow-up most of our clients are not mobile so one thing or the other brought them to Abuja so before you know they have a better job somewhere and they will leave without telling you. So that is really a big issue for us we are losing some of our clients, but now the M&E will tell them that if you are going that you should let us know so we can give you referral and we also know that you are gone. Lost to follow should be 15 to 20 %. [When you joined them what will be the number (of the support group) and now]? When I came here the number was 200 and now is 285."* ***(Health Personnel. FCT).***

## Project Involvement & Behavior Change

A key expected outcomes of the IMHIPP project is positive behavior change among MSM exposed to the program. Positive behavior change may be assessed through the following indicators; (1) ability to say no to unprotected sex, (2) consistent condoms use during sexual acts, (3) reduction in multiple sexual partners, and (4) avoidance of sharing sharp objects. Other positive behavior change include, (5) avoidance of unsterilized needles, (6) avoidance of casual sex, (7) been faithful to one partner, and (8) abstinence.

### *Self-Efficacy to use Condom*

Self-efficacy is an individual ability to use condoms when having sexual intercourse. This is examined using different measures as presented in Table 14 below.

**Table 14: Percent of MSM according to attitude on condoms usage**

| | **Percentage (%)** |
|---|---|
| **Total (N)** | **436** |
| **% who are able to say no to sex without condom** | **83%** |
| ***Partner's threat to stop relationship with sex without condom*** | |
| % who reported will give in to sex | **3%** |
| % who reported will continue to insist on no sex | **63%** |
| % who reported will allow relationship to end | **26%** |
| % else | **8%** |
| **Capable of abstaining from sex** | |
| Strongly agree | **71%** |
| Strongly disagree | **25%** |

The majority of MSM (83%) reported that they are able to say no to sex without condoms. On what they would do if partner threatened to stop the relationship, the majority (63%) reported that they would continue to insist on no sex without condoms. Only 26% percent reported they would allow the relationship to end, and 3% said they would give in to sex without condoms.

Another measure of self-efficacy asked MSM whether they agree to the statement "I am capable of abstaining from sex if I choose to do so," and the majority (71%) reported that they strongly agree, and a small proportion (25%) said they strongly disagree. The following statements from the FGDs corroborate the findings on condom use among MSM.

> *"P4: For me I have them (partners) like four and I will say no condom no sex for both the male and the female P2: For me is the same thing no condom no sex but at times for female, she uses her own condom. P3: For me I prefer using condom regularly I complain to our counselor here most time when I use condom my (penis) this thing will not ejaculate. So when I met with doctor 'Dike' I told him see o. He now said any time I want to have sex I will apply lubricant on my dick before inserting in the condom. It will make it to roll so when I did it, it worked. There are some instances when both parties know our (himself and partner) HIV status. I feel free without using condom, most time if the condom is not there, and the thought might come to you if you miss this opportunity you may not get it again o. Most at times what I do when I was not informed I just go raw but currently I do not do such things, but now no condom, no sex." (**MSM, Rivers)***
>
> ***Note: P1, P2, P3 etc. are FGD participants)***

*Self-Efficacy disaggregated by selected background characteristics*

Figure 9: Percent of MSM reported ability to say no to sex without condom by residence

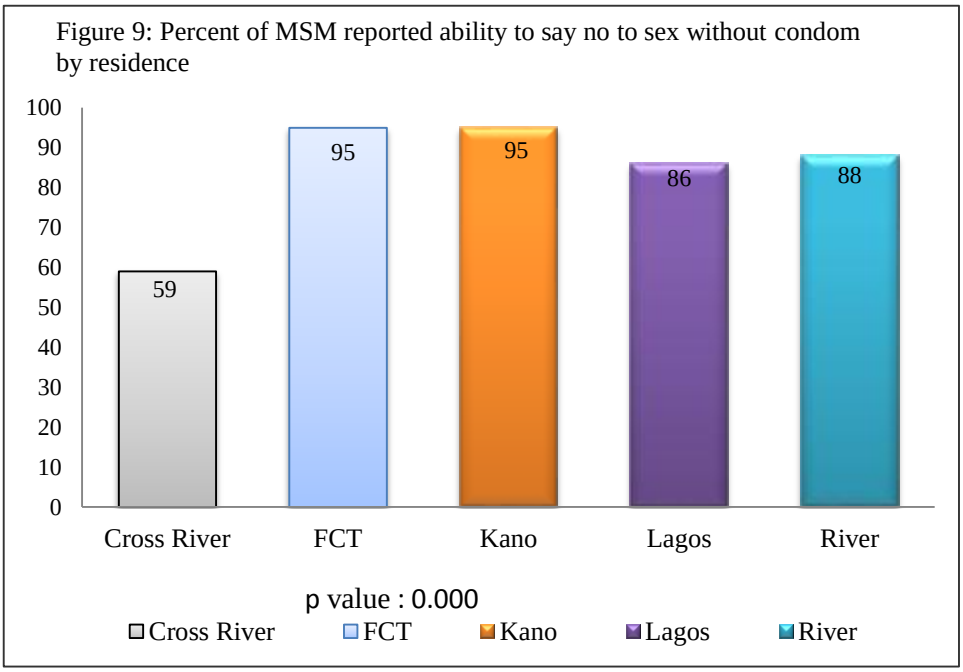
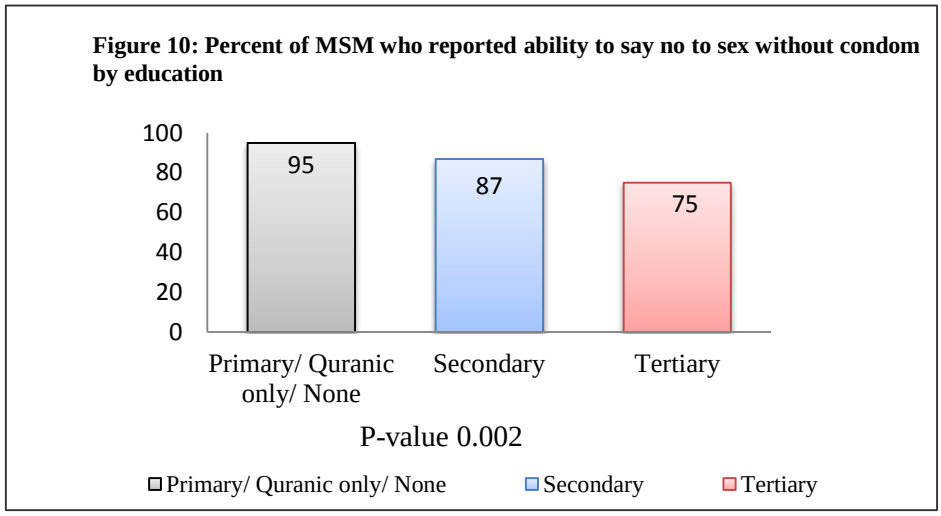


Figure 9 shows responses on the ability to say no to sex without condoms disaggregated by residence. The evidence suggest that more MSM in FCT and Kano (both 95% respectively) compared to those in Rivers (88%), Lagos (86%), and Cross River (59%) reported they would say no to sex without condoms (P-value = 0.000).




Results in Figure 10 suggest that more MSM in the primary/quranic/no education category compared to those in the secondary (87%), and tertiary (75%), reported that they would say no to sex without condoms (P-value = 0.002). This is an interesting finding that needs closer attention and review by program stakeholders.

As expected (Figure 11), more MSM in paid employment (90%), compared to those in petty trading (87%), unemployed (86%), or others (68%) reported that they would be able to say no to sex without condoms (P-value = 0.000).

*Actual Demonstration of Behavior Change*

This section examines MSM use of condoms with same-sex, and with female partners disaggregated by age and group religion.

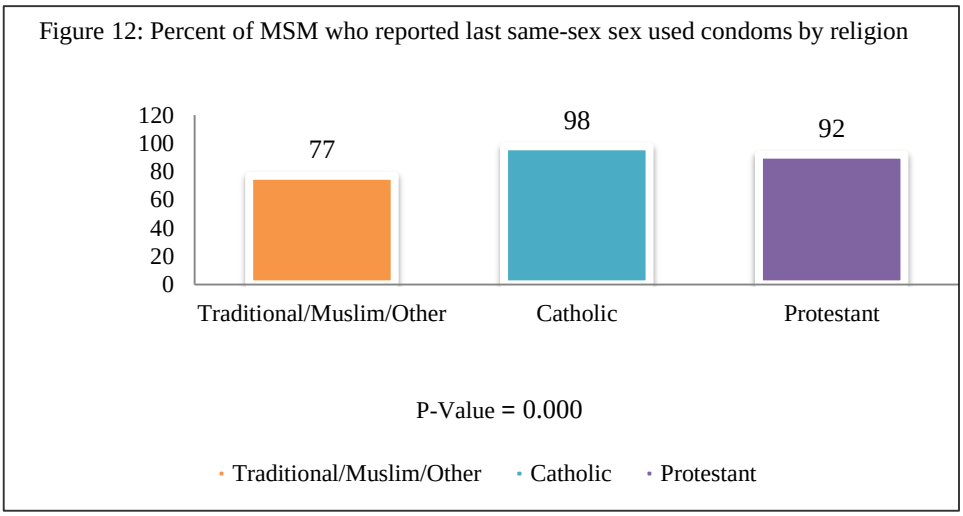
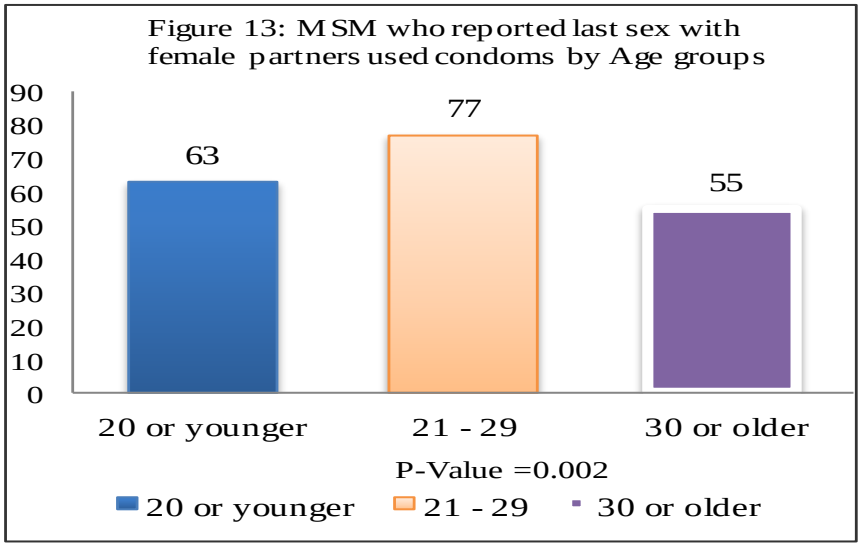
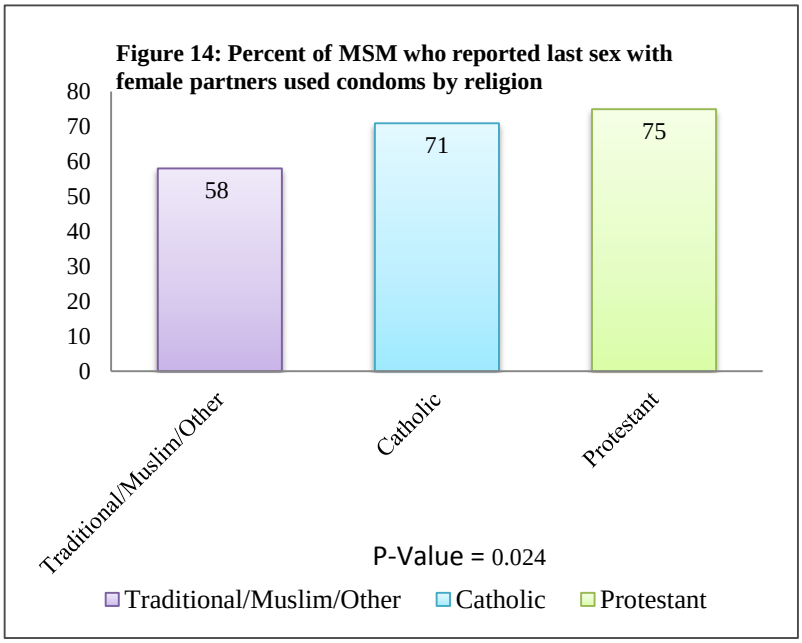



Figure 12 showed that more MSM who were Catholic (98%) compared to those who were protestant (92%) or traditional/Muslim/others (77%) reported condom use in last same-sex sexual encounter.






The results in Figure 14 above suggest that MSM aged 21 to 29 (77%) used condoms in last sex act with female partner compared to those aged 30 or older (55%) or those 20 or younger (P-value = 0.002). Likewise, more MSM who were Protestant (75%) compared to those Catholic (71%) or traditional/Muslim/other (58%) reported condoms use in last sex act with female partners (P-value = 0.024).

**Table 15: Percent of MSM according to project influence on behavior about HIV/AIDS**

| | **Percentage (%)** |
|---|---|
| **Total (N)** | **436** |
| ***Project influence on behavior about safer sex*** | |
| % who reported very much influence | 81% |
| % who reported somewhat or little influence | 16% |
| % no response | 3% |
| *Specific indicators of behavior change* | |
| % abstained from sex | 4% |
| % avoid unscreened blood | 6% |
| % avoid unsterilized needles-sharp objects | 10% |
| % reduced no of sexual partners | 29% |
| % maintain only one sexual partner | 16% |
| % use condoms during sex | 77% |
| % avoid casual sex | 11% |
| % avoid sharing piercing objects | 5% |
| ***Cumulative change of behavior index*** | |
| no change | 3% |
| change one component | 14% |
| change in two components | 39% |

| | |
|---|---|
| change in three components | 39% |
| change in four components | 5% |
| **Total** | **100%** |

Results in Table 15 shows that most MSM (81%) reported that the IMHIPP had very much influence on their behavior about HIV/AIDS. And the main aspect of behavior that most MSM (77%) reported influence is condom use during sex. Other aspect of behavior reported by a smaller fraction of MSM is reduced number of sexual partners (29%), maintaining only one sexual partner (16%), and avoid casual sex (11%). Only small proportion of MSM interviewed reported changes in other aspects of behavior change such as; abstain from sex (4%), avoid unscreened blood (6%), and avoid sharp objects (5%).

On cumulative index on behavior about HIV/AIDS showed that only a fraction (both 39%) of MSM reported two or three components of behavior change, 14% reported one component of behavior change, and 5% four component, while 3% reported no change. Programming may need to examine how more MSM would be able to respond to more components in order to achieve substantial behavior change about HIV/AIDS among them.

Specific areas where MSM experienced change were highlighted in these statements from beneficiaries below.

*P3: "Before I have this mindset that whenever I like to, (I) use condom but now the community has really changed my reasoning towards that. P2: In terms of education I know more about HIV, same sex. I have been educated more than before. P4: HIV enlightenment on how to play safe. P1: They have exposed me; I have been sleeping with girls without condom since I realize this I am using condom regularly".* ***(MSM, Rivers State MSM).***

*P1: "Before they were not using condom but now they are really making use of it because they are aware of what is really battling in the society. Nobody trusts anybody because HIV is not written on the face. P2: I will say like 70/80% of MSM are using condom. P2: One of my friends experienced this last, month he did not use condom now is having Gonorrhea. P1: I have experienced this once with a girl and a boy we wanted to have sex and he said we are going to do it without condom and I say no."* ***(MSM, Cross River State)***

*P1: I have improved my skills. How I improved is that I can protect myself by use of contraceptives during sex. I did not usually use protection but because of the information I got from this organization I now protect myself from sexually transmitted diseases.P2: I benefitted the same thing. P3: now I use condoms to protect myself since I was informed about it because I never used to use condom during sex and lubricant and now I enjoy it.P4: I have benefited from using condom effectively without breaking and also the use of lubricant instead of other liquids and jellies.* ***(MSM, Kano State)***

***Note: P1, P2, P3 etc. represent FGD participants)***

**Figure 15: Percent of MSM who reported 3 aspects of behavior change about HIV/AIDS by state of residence**

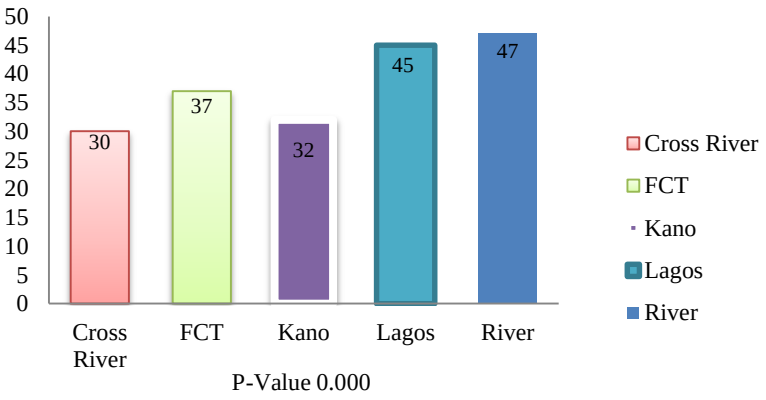
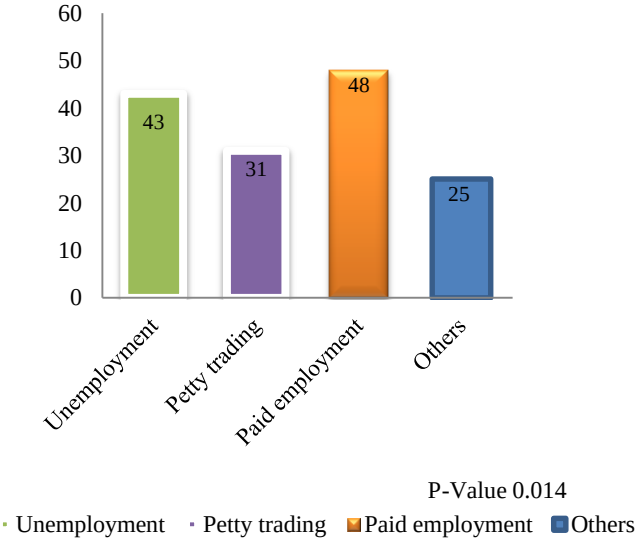
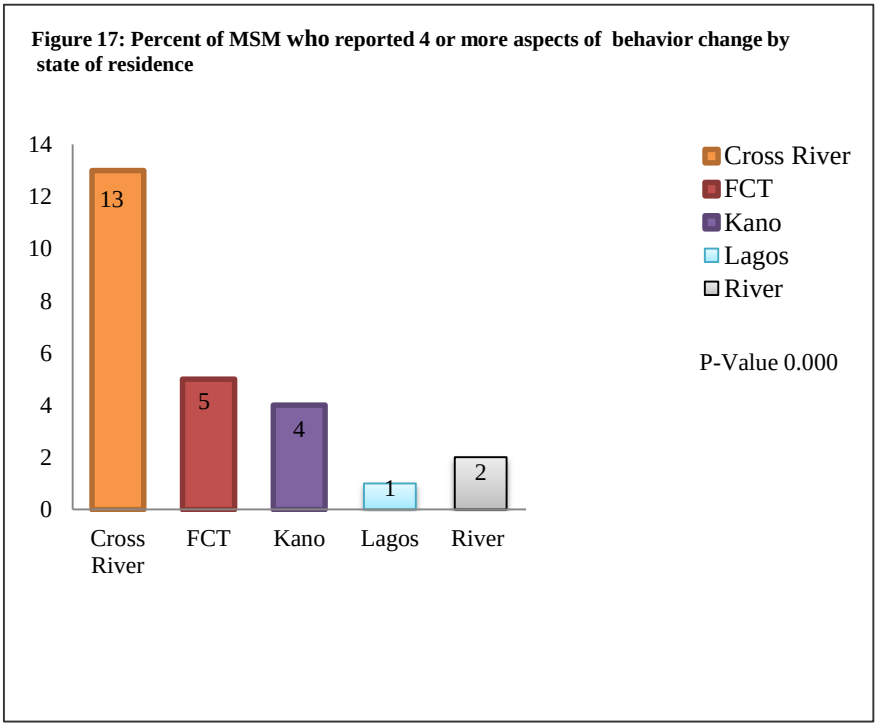



Figure 15 showed proportions of MSM who reported three aspects of behavior change about safer sex by state of residence. Results showed that more MSM in Rivers state (47%) than in Lagos (45%), FCT (37%), Kano (32%) or Cross River (30%), reported three aspects of behavior about HIV/AIDS (P-value = 0.000).

**Figure 16: Percent of MSM who reported 3 aspects of behavior change about HIV/AIDS by the type of economic activity**






Also, Figure 16 showed significant differences among MSM with respects to behavior change about HIV/AIDS by types of economic activity (P-value = 0.014). And Figure 17 showed significant variations in behavior change about HIV/AIDS by state of residence (P-value = 0.000).

### *Project Influence on Other Aspects of Life*

This evaluation also examined effects of IMHIPP on other aspects of MSM's lives including self-respect, confidence, sense of responsibility for own actions, and self as role model among others.

**Table 16: Percent of MSM according to project influence on other aspects of life**

| | **Percentage (%)** |
|---|---|
| **Total (N)** | **436** |
| ***Project influence on other aspects of life*** | |
| % who reported very much influence | 83% |
| % who reported somewhat or little influence | 9% |
| % no response | 8% |
| Project influence on behavior about safer sex | |
| % self confidence | 84% |
| % self respect | 13% |
| % see self as role model | 5% |
| % more responsible for own actions | 18% |
| % more responsible for helping others | 17% |
| ***Cumulative influence on other aspects of life index*** | |

| | |
|---|---|
| no influence | 10% |
| change in one aspect | 52% |
| change in two aspects | 34% |
| change in three to four aspects | 4% |
| **Total** | **100%** |

Findings in Table 16 suggest that the majority of MSM (83%) reported that the project influenced other aspects of their lives very much, and key areas mentioned included; self-confidence (84%), more responsibility for own actions (18%), more responsibility for helping others (17%) and self-respect (13%). Future programming may need to focus on these other aspects of life where fewer MSM reported change to achieve maximum results.

*P1: "Before now I used to have this low esteem but now my peer has enlighten me that I should not allow any body to use my head may be because I am having attractions to women. I have dealt with that part of my esteem that is so low. P2: Personally, I am a kind of person that things do not easily bother. I control my emotions easily before now I have those things in mind and it added to it."* ***(MSMFSP, Cross River).***

*P2: "it helps me to express myself someone like me it has always been a difficult thing for me to go out and talk to a person but after the training I can go out and talk to people. P3: from the training I learnt how to fill the form. P4: it helps me to build confidence and motivate me to educate others. P5 aside from enabling me it has got me thinking and thinking before the training felt I knew everything it has put me through rigorous activities."* ***(PEs, FCT).***

***Note: P1, P2, P3 etc. are FGD participants)***

**Figure 18: Percent of MSM who reported influence on two other spects of their lifes by state of residence**

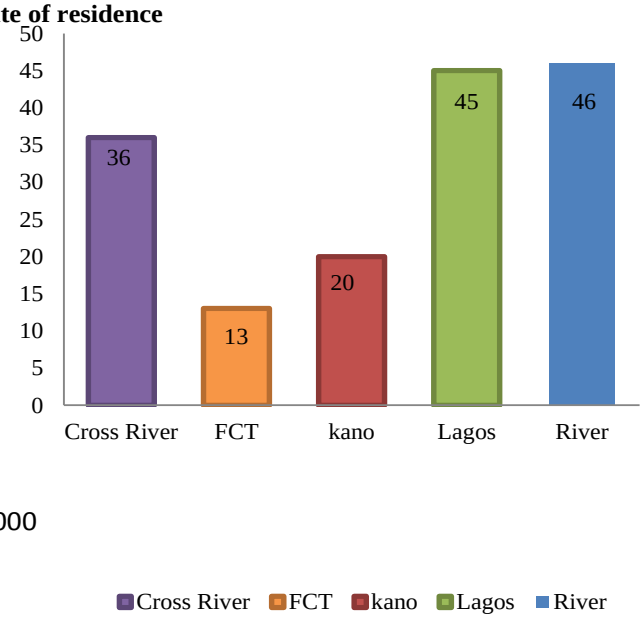


Figure 18 above shows significant difference in MSM who reported program influence on other aspects of their lives by state of residence. Results suggest that Rivers (46%) and Lagos (45%) than Cross River (36%), Kano (20%) and FCT (13%) reported more MSM who were influenced by the IMHIPP project on two other aspects of their lives (P-value = 0.000). Other significant results presented in Appendix I includes religion, and types of economic activity.

### *Objective 4: Creating an Enabling Policy Environment*

The forth objective of the IMHIPP focuses on policy and advocacy for a more-friendly environment for MSM to access health information and services both at the state and the federal levels, and the involvement of development partners especially those working with MARPs. The main strategy employed by IMHIPP for achieving this objective is capacity building on health policy and advocacy based on human right principles, and negotiations and dialogue with key policy and decision makers at all levels of governance and institutions.

MSM friendly environment is examined from two perspectives; (1) health policy and advocacy, and political environment and advocacy.

### *Enabling Environment at the State Level*

Results of this evaluation suggest that across the four states visited and FCT, IMHIPP created solid platforms of engagement at the SACAs and FACA which are the main coordinating body of HIV/AIDS activities in these states, and FCT.

#### *Cross-River State Platforms of Engagement*

Findings from Cross River State Agency for the Control of AIDS (CRSACA) demonstrated strong collaboration and linkages achieved at the state level. Reports showed that HA through Improved Male Health Initiative (IMH-I) created platforms for reaching MSM in the state, and used evidence based advocacy to bring CRASACA and other implementing agencies on board. CRSACA reported that HAN provided better understanding on how to reach an hitherto, difficult to reach sub-group of MARPs. Most important, HAN/IMH-I was proactive in reaching stakeholders on HIV/AIDS in the state, and they participated in the prevention technical working groups and other technical groups on HIV/AIDS. Reports also suggest that HAN/IMH-I was actively involved in the last world AIDS day and one of IMH-I staff headed a sub-committee for the activity.

In a continued effort to build platforms, HA/IMH-I have started having linkages with LACAs at the local levels thus, bringing advocacy to the very grassroots.

Except below, captures in sum HAN/IMH-I engagements to create better environment for MSM in the state.

*"First in trying to gain entry (into the MSM community), to also have ehh ... knowledge of that community. But what I can say is the fact that, they were also very proactive in engaging with some other major stakeholders in the state like SACA for example, I mean I believe that the fact that they have being interfacing with us, sharing information with us. Right? too has helped, they are highly involve in all the (HIV) response that are happening in the state, they're members of the technical working group on prevention, they are members of the broad technical working group that we have in the state, so I just want to believe that the fact that they are involve in all our collating platforms in the state, they are interfacing closely with civil society network in the state, they are engaging major stakeholders including the local action committee in the state and all that, has significantly contributed from our assessment for them to have gained the kind of support they have.* ***" (Representative, CRSACA).***

Other key stakeholders that HAN/IMH-I were involved with in the state are NEPWHAN and CiSHAN. IMH-I engaged NEPWHAN on a number of activities including meetings and capacity building and trainings on Positive Healthy, Dignity, and Prevention (PHDP). Also, CiSHAN reported that HAN/IMH-I were usually represented in most of their meetings but would like to see more engagement and collaboration in the future.

*Rivers State Platforms of Engagement*

River State Agency for the Control of AIDS (RIVSACA) reported that they have had series of engagement with HAN and Initiative for Advancement of Humanity (IAH) including attending the project's retreat organized in Calabar in 2012, and have made several presentations at activities organized by HAN/IAH in the state. RIVSACA reported that SACA and HAN/IAH is planning a joint mapping effort on interventions for MARPs in the state. Also, report suggests that HAN/IAH have been included in the state yearly work plans which will enable them to participate in state sponsored activities on a regular bases. With the level of collaboration, findings showed that IAH stands a good change of receiving the World Bank HAF fund if they are able to submit a competitive proposal. The statement below speaks to the level of collaboration between HAN/IAH and RIVSACA which has developed within a short period of time.

*"Prevention activities that we have done, we always invite them to our coordinating meetings we equally attended their retreat at Calabar, we have equally gone to their areas (office) where they are staying to give some talk on prevention and we have agreed with them to do something, on the most at risk person (the MARPs) because we want to map out, to do a mapping of MARPs in Rivers State. We want to collaborate with them seriously so as to help us do the mapping exercise. Apart from that we have equally ask them to give us some of their data some time ago so that we will be able to input their data, in terms of MSM, the MARPs especially the MSM and their client on what they have being doing and how they have ... with those of them that are positive, in fact the HCT service cases, They have given us data on their HCT services, (which) helped us to input some activity for MARPS in our work plan which we will send to world bank for funding. So they are part of (our) work plan because they give us insight on what they are doing the services they render to maps and all of it, so we are really very close with them. "* ***(Representative, RIVSACA).***

Results of this evaluation showed that HAN/IAH established good platforms of engagement with CiSHAN and NEPWHAN Chapters in the state. CiSHAN reported using HAN/IAH facility for capacity building, and had a summit which HAN/IAH participated. Information sharing was another key activity that the collaboration benefited from. Also, reports showed that a member of the HAN/IAH staff is now the secretary of CiSHAN in the state which is an indicator of the capability and human potentials of IAH. HAN/IAH also collaborated with NEPWHAN on technical support, and attended meetings at FHI, and SFH as well.

*Lagos State Platforms of Engagement*

The Lagos State Agency for the Control of AIDS (LASACA) representative reported that HAN and The Initiative for Equal Rights (TIER) informs the agency on all their activities. HAN/TIER participate in LASACA monthly meetings which is a forum for the agency and all stakeholders working on HIV/AIDS to provide update on their respective activities and share experiences. LASACA reported that they work directly with TIER which is a welcome development on sustained engagement in the future.

Findings also showed that TIER participated in project management trainings conducted for 160 CSOs staff in the state. Reports also showed that HAN/TIER made several presentations on what they stand for and their activities in the state. Below are statements from LASACA representative highlighting areas of engagement with HA/TIER in the state.

> *"… TIER is one of the few NGOs that is working on MARPs most especially MSM we know them to be very active in the area of the HIV response actually targeting the risky population most especially the MSM. Most of their activities they do they carry the Agency (LASACA) along any time they want to have an activity, the Agency is informed of whatever program they want to carry out, then of cause, most of the NGOs that is working within the State are mandated to give monthly report of all the activities there are carried out in the State, and to some extend they do that. There is an officer in charge of that to confirm how regularly it is, because it is expected every month and we do have a stake holders meeting that they all are expected to bring all their activities report even if they don't conduct any in that month they will inform us whatever that transpired within that month. … I know for workshop they have been part of it, they made several presentations they asked for opportunity to make presentations at the stakeholders meeting to enlighten people about their activities and intervention and how to deal with MARPs because they have experience in the field in these areas especial in MSM like I earlier said. "* ***(Representative, LASACA).***

Also, findings suggest that HAN/TIER had good working relationships with NEPWHAN and CiSHAN Chapters in the state. NEPWHAN reported that they invite TIER for meetings and do attend theirs as well. Also, NEPWHAN reported that they contribute to capacity building on home based skills especially on positive living among TIER support group members. Also, CiSHAN reported some form of engagement with TIER but the level seemed to be lower.

*Kano State Platforms of Engagement*

In Kano, findings showed that platforms of engagement were just getting to be created due to the nascent nature of HA in the state. In general, the Kano State Agency for the Control of AIDS (KASACA) reported that the relationship with HAN/AGE was quite cordial. It seemed that the project has been able to gain some credibility through participation in KASACA meetings and vice versa and this provided opportunities for the project to be better understood. HAN/AGE platforms of engagement was strengthened by their role in the HIV prevention committee in the state and the financial backing provided by the project. Within the short period of engagement, KASACA has come to terms with HAN/AGE potential contributions on MARPs issues in the state. The agency is planning to leverage HAN/AGE expertise in the mapping of MARPs that is planned for the state. Below are quotes to support the level of collaboration reached with the KASACA.

*"You know our relationship is quite cordial because a ... he was here and just on I think is it up to 4 weeks ago; we also have prevention committee but were taken care by Heart Land. We have prevention committee all the IPs that are involving in the HIV prevention are members including somebody from women affairs, ministry of education, and it was inaugurated in the ministry of health last month. And, Heartland Alliance champions it."* ***(Representative, KASACA).***

*Federal Capital Territory (FCT) Platforms of Engagement*

Federal Capital Territory (FCT) Agency for the Control of AIDS (FACA) responses on linkages and collaboration with HA and International Center for Advocacy and Rights to Health (ICARH), the local implementing partner were insightful. FACA embraced the opportunity to work with HAN/ICARH due to the HIV prevalence among MARPs (especially MSM) in FCT and the need to stem the spread among this sub-group in FCT. FACA reported that HAN/ICARH worked assiduously in the past three years to created platforms for MSM engagement in FCT, and made the agency to realize neglected MSM issues and how to reach this key MARPs sub-group. FACA also reported that HAN/ICARH have been useful in developing strategic and operations plans, and mapping of MARPs conducted by the agency. And the agency have equally participated in HAN/ICARH capacity building on how to provide friendly MSM services, with plans to use similar training model for health professionals in FCT. Below are words right from a key representative of FACA to substantiate the level of collaboration achieved.

*"....is been so wonderful we have been working closely there is nothing we do here that they are not involved they are always part of the activities, even when we developed our operational plan they were part of us, and we developed our FCT strategic plan and work plan they were part of us it has been total in relationship……. they have been inviting us to some of their activities and they also report to us what they are doing in FCT in fact in our fact sheet that we normally do quarterly in FCT intervention you see them occurring so they do report to us……They brought to the four burner the challenges that are been faced by MSM to me is very important at least they have made us to understand and appreciate that they are issues that we have neglected for so many years, so HA has been able to prove to us .They have also in FCT been able to bring the group together, they have a platform very strong one in FCT that we also relate with when we have our program."* ***(Representative, FACA).***

As the report in all the states and FCT shows above, the IMHIPP has been able to create and sustained platforms to positively affect the health policy and implementation environments in the state. However, the project has not been fully accepted by key MDAs yet. Findings suggest that there are still covert resentment and stigmatization of HAN and LIPs among other development partners in the states and FCT. This may be due to the focus on MSM mainly which creates negative impressions and reluctance to fully engage the project in a cultural and socially hostile environment against MSM.

***Enabling Environment at the Federal Level***

The environment at the federal level will be examined from (1) the health policy and right health perspectives, and politics and legislation on gay rights in the country.

*Health Policy Environment*

Findings suggest that IMHIPP successfully built platforms of engagement with NACA at the national level similar but not of the same intensity as in the states and FCT. NACA reported that HAN participated actively in the national prevention technical working group, and were actively involved in joint annual reviews. Also, reports from NACA suggest that they attended HA open house and other activities but cautioned on the need to be more focused on programming for MSM health issues rather than their rights/orientation, and the need to include other MARPs in order to gain more acceptance at the national and state level.

NEPWHAN headquarters in Abuja corroborated the findings from the states on the platforms of engagement between HAN and their state coordinating offices. Key platform of engagement reported by NEPWHAN representative is the trainings conducted by HA including; palliative care, home based care, the peculiarities of MSMLWHA, and counseling and testing among others. Reports suggest that HAN enhanced the process of producing support group manual, and operations manual. Findings showed that NEPWHAN provided the mechanism for support group formulation and mentoring to enhance skills on how to operate support groups. They also provide technical skills for sustaining the group and compliance to the principles of positive living among MSMLWHA. Except below supports the findings on the collaboration between HAN and NEPWHAN at the federal and state levels.

*"And ehnm , so they (HA) are a very important partner for us because they are doing a great job, which ought to be part of our own job that we have denied in the first place but now they are making us to understand that this is something very important and that we cannot deny it, so we've come in terms to recognize these support group existence and our state coordinators in all the state that Heartland Alliance is working and they are all receiving a very good mentorship from Heartland Alliance, especially in the ehnm Kano, Lagos, hmm Rivers State and Ehnm Cross River State. I think Heartland Alliance has done Series of trainings for the coordinators of NEPWHAN at the state levels and their members, members of the support groups as well you know ehnm on palliative care trainings, home based care trainings for MSM living with HIV, and then counseling trainings, because we all as a counselor you know we also need to get the skills, on how to deal you know with difficult clients or Most at Risk Population, which we are doing, because we at NEPWHAN we have been doing a generalized intervention but Heartland Alliance is trying to bring pictures into the darkness and then we are saying that we can design a specific programs you know and then address some specific need."* ***(Representative, NEPWHAN).***

Overwhelmingly, results of this evaluation showed that while a more conducive environment for MSM friendly service provision has been created through the various platforms of engagement at the SACA, and NACA, there is still a long way to go with respect to general and open acceptance of MSM and their peculiar needs among institutions and health professionals across the states visited and FCT. The program has not been able to elicit buy-ins from the majority of stakeholders at the MDAs and health facilities visited.

*Political & Legislation Environment*

Report showed that the current political stance on gay rights and the bill at the national assembly had cascading negative effects on earlier in route made to increase MSM access to health services throughout the country. Evidence from the states and FCT showed that once the bill was made public, the number of MSM that hitherto freely visited the community center reduced considerably, and the community centers in some states were closed for a while before re-opening. Coupled with the bill are the sensitive unfavorable cultural and religious contexts that present fine-lines for program implementers to thread in various communities to reach MSM with HIV/AIDS information and services.

Many OCs and PEs reported that since the news of the gay bill came to light, many MSM stopped visiting the community center, and it became more challenging to identify and recruit potential program participants in the community. Most state governors and state houses of assembly took a cue from the gay bill. Findings showed that many MSM have gone underground and many natural "hot spots" have disappeared as well. Development partners, and other stakeholders will need to set-up a mechanism for engaging the bill and negotiating its relevant parts before it gets passed into law by the three arms of government.

***Institutional Enabling Environment***

*Community Center*

The community center is a unique feature of the IMHIPP designed to provide a congenial environment for MSM and their partners to access HIV/AIDS information and services, relax, and be themselves. It is more of a safety-net for all community members irrespective of age, sociocultural background, economic status, and affiliations. All states and FCT visited have a community center which takes a prominent part of the LIP office building.

**Table 17: Percent of MSM according to access to & use of community center**

| | **Percentage (%)** |
|---|---|
| **Total (N)** | **436** |
| | |
| **% who reported making use of community center** | **87%** |
| ***Frequency of use of community center*** | |
| % not at all/no response | **17%** |

| | |
|---|---|
| % everyday | **7%** |
| % at least once a week | **51%** |
| % less than once a week | **25%** |
| **Total** | **100%** |

Findings in Table 17 showed that the majority (87%) of MSM reported that they used the community center. About half (51%) visited the center at least once a week, a quarter (25%) visited less than once a week, and 17% had not visited the center nor responded to the question on visit. Findings from qualitative data suggest that project participants enjoy a variety of things from the center including; commodities like condoms, lubricant, HIV/AIDs information, and counseling and testing information/services. Also the center is perceived as friendly by the majority of MSM because it is a place for social interaction, confidence building, and skills acquisition as well. Suggestions on how to make it better were mainly on increasing the space, more ICT presence including computers, and indoors and out-door games.

*"In the past people did not have place to hang out of course they had secret places but since HA came the IMHIPP project has been able to provide a safe place in form of the community center were folks, gay people, lesbians, FSP come in within close confine to express themselves and play, interact and all that, and aside playing and all that they receive services, more especially in prevention, receive condoms, lubricants and some IEC materials, HCT. And they equally receive services like palliative care services and after testing positive they are referred, and followed, and enrolled them in the program where palliative care unit provide them with home base care and support … I think the achievement I can't begin to name then one after the other. The key achievement so far, I have been able to mention a few now the HIV awareness has grown, behavioral change has improved within the MSM community even at grass root people now access HCT services without been forced to because they are now aware of the importance of been tested even those that tested positive have taken ownership of their lives and they are accessing treatment and all that"* ***(HA field staff, Rivers)***.

## MANAGEMENT ISSUES

This section discusses issues surrounding the implementation of the IMHIPP in the states visited and FCT.

### *Program Strengths & Weaknesses*

*Program Strengths*

- Findings of this evaluation suggest that the design of the project which included having key HAN staff seconded to (program, M&E, and administration and finance) co-locate with the LIPs staff combined with regular TA visits from HAN in Abuja is a key strength of the project since this enabled close mentoring, coaching, and transfer of knowledge and skills on a continuous bases. The intensity of this approach may have contributed to rapid skills transfer and capacity building of the LIPs staff within a short space of time.

- A key strength of the IMHIPP project is the concept of using community members to cater for their own need. Findings showed that the majority of staff at the LIPs were community members some of whom started as PEs when they joined the project but gradually moved along the lather to become OCs, and program staff well equipped to provide other members with services.

- The community center is a unique idea that brings MSM, irrespective of background and works of life, together providing them multiple services targeting individuals depending on their respective needs. It served as a rallying point for all MSM to come together and share concerns and experiences, and thus reinforces self-identity and confidence building.

- Another key uniqueness of the project is the support group created for MSMLWHA to network and gain experience and skills on positive living, and behaviors towards re-infection.

- The health referral systems put in place has benefited many MSMLWHA, and encouraged the majority to access health care without stigma and discrimination. The IMHIPP unique approach on the referral system, unlike others, is that it identifies specific hospitals/clinic, health personnel, and individuals that are willing and ready to provide service to MSM. Aspects of the referral system that need attention included prompt feedback from the health facility personnel and MSM themselves.

- A key strength of IMHIPP and probably more grounded at the LIPs level is the passion and innate desire of staff to see the project succeed and benefit the target population of which they belong. This passion in itself is an inherent sustainability inertia that may take the project from one level to the next into the future.

*Program Weaknesses*

- A key program weakness is the lack of ARV treatment as part of the services provided to MSMLWHA. Also, it does not cater for other opportunistic infections such as other STIs like gonorrhea, syphilis, and other ailment like malaria. This aspect of the program weakness was reiterated by MSM throughout the period of evaluation in the field.

- Also, lack of integration of HTC services into the program is another major weakness. It was quite challenging to track and follow-up with program participants referred to other facilities for HTC. However, efforts were made to attenuate this challenge by leveraging on test kits from other USIPs to conduct HTC in some program sites.

- Another key weakness of the project is lack of a comprehensive health care facility located at the community center aside testing tool kit. Findings of this evaluation suggest that a majority of MSM prefer a one-stop-shop where they can get all health information and services including diagnoses and treatment for STIs and other common ailments.

- Economic empowerment component of the IMHIPP is weak in general. Findings suggest that MSM received vocational skills through the project but no seed fund to demonstrate and make it viable. It is important to note that providing MSM with economic activity may help to reduce the spread of HIV among those that were unemployed.

- A key weakness is the inflexibility of the project funds for vital activities that where not originally on budget but became crucial and important as the project evolved. Also, related is the cost of maintaining international partnership which cost a bit more compared to using nationals.

***Challenges & Constraints***

Key challenges and constraints are examined in this report as they relate to the project participants, LIPs staff, and the project as a whole based on reports from various stakeholders who participated in the evaluation.

*Project Participants: Challenges & Constraints*

The challenges and constraints below were mainly those reported by MSM.

- Stigma and discrimination still predominant in MSM localities and may continue to be there for some time to come.
- By dressing and behaving feminine some MSM put themselves and their friends at risk of stigma and discrimination.
- Self-stigma and discrimination still prevalent among MSM especially against MSMLWHA.
- The strong religious and moral values of the societies and household that MSM live whether in the northern or southern parts of the country affects their lives adversely.
- The project does not make provision for antibiotics and or immune boosters like nutritional supplements.
- There are challenges with drug adherence among MSMLWHA sometimes due to lack of food to eat, poverty, or negative attitudes to taking drugs.
- Some working class MSM especially MSMLWHA reported that they were discriminated against on the job.
- The referral system did not provide adequate tracking of loss to follow-up either with respect to health services or home based care.
- There are reports of community members forming clicks and groups according to social class and affiliations which may be tantamount to unity and progress for a common goal.

*Local Implementing Partners (LIP): Challenges & Constraints*

Challenges and constraints reported by LIPs staff and other stakeholders are listed below according to key thematic areas.

***Program Implementation***

- PEs reported that their workload is increasing because of the need to reach larger number of MSM without corresponding increase in the number of PEs or logistical arrangements to cater for this.
- Many MSM reported the desire to be engaged in skills acquisition and those who were able to learn a skill needed seed capital to get established.
- In most states visited, MSM reported lack of privacy in the HCT sites, and the lack of

comprehensive site that would include ARV and STIs treatments.

- The community centers have not been able to attract MSM from all age groups and socioeconomic status.

- Reports from program staff of some LIPs showed that the support groups needed to be re-grouped into smaller units for more effectiveness and impact.

- Evidence suggest that some level of discrimination against MSMLWHA still exist at some local chapters of NEPHWAN.

***Monitoring & Evaluation***

- M&E related staff (OCs) reported that it was becoming challenging to meet performance targets especially with the hostile political environment.

- Monitoring of project participants involves a well-planned logistics including having genuine phone numbers, and adequate funds to make phone calls.

***Administration & Finance***

- OCs & PEs reported that they have not been involved in exchange or training workshop outside their locations which would have enriched their knowledge and skills for better performance.

- The PEs and OCs in all the states and FCT reported that their remuneration is not commensurate to the effort that they put into the job.

- PEs in all states and FCT reported challenges of not having any form of identification (i.e. Project Identity Cards) of themselves in the community that they work. There were reports of security harassment due to lack of proper identification.

- LIPs staff reported insufficient computers for the project, especially for OCs. Also, there were indications that the majority did not have Internet facilities which affected timely reporting.

- A major challenge of the LIPs is inadequate staff to cater for the growing number of MSM communities in the states and FCT.

- Staff of some of the LIPs also complained of poor welfare including; lack of enrollment in pension and insurance schemes.

- Another issue raised mostly by OCs is inadequate office space to accommodate the teaming community members and staff. In all the states visited and FCT, OCs were all sharing one office without adequate seating arrangements and materials to work with.

- Another key issue mentioned by some LIPs staff is logistical challenges due to lack of project vehicles to move around especially during monitoring visits.
- Also, lines of reporting and communication were sometimes not clear with respect to HAN field staff vis-à-vis the LIPs executive director and HAN staff in Abuja.
- Difficult terrains and seasonal changes abound in some states which make monitoring and visits especially in some riverine areas difficult.
- Delay in funds release was reported by some LIPs and sometimes lack of adequate communication from HAN Abuja about funds release to LIPs account and inadequate communication about reasons for some budget lines that were not approved.
- Staff reported that maximum petty cash limit of 100,000 thousand naira per month is usually too small to meet the daily office needs for cash which slows the implementation of certain activities of the project.

*Heartland Alliance, Nigeria: Challenges & Constraints*

Challenges presented here are mostly related to the HAN office in Abuja and the implementation of the entire project as a whole.

- Perhaps the most obvious challenge phased by the project is the unfriendly environment accentuated by the same-sex bill of 2011. This bill was seen as a major challenge by all categories of stakeholders who participated in this evaluation.
- Findings suggest that development partners are yet to be adequately sensitized on the HAN main goals and objectives which may in-turn result in more acceptance and collaboration.
- A key challenge reported is the restricted lines of funding for a project that started with a number of unknowns and changes. The project ought to have included flexibility in funding to enable prompt response to changes that were deemed necessary.
- Also, key is the limited funding that affects vertically all aspects of programming on the project. Findings of this evaluation suggest that the project has been overstretched financially to achieve results.
- The project did not include formal training for HAN staff to gain more top-of-the-line knowledge and skills to tackle MSM issues better.
- Evidence suggest inadequate autonomy of HAN office in Abuja to make programming/administrative decisions without differing to HQ in Chicago, USA.

- Results of the evaluation also showed a lack of operations research to fine-tune strategies and aid the implementation process of a project that had many unknowns for maximum outcomes.

- Project scope is limited in terms of the geographical coverage of the country. Several potential states with MSM are not benefiting from it.

*Program Sustainability*

A key component of the IMHIPP is sustainability which is inherent in the design and implementation process. This section examines plans and actions taken for sustaining the project in the long-run.

- The first main indicator of sustainability is capacity building i.e. equipping local implementing partner's staff with knowledge and skills on how to run HIV prevention programming independently. Findings showed that the LIPs staff are already implementing activities independently with minimal supervision.

- The sub-granting component of the IMHIPP is to actually demonstrate and measure level of sustainability during the life of the project. Two LIPs are currently on the sub-grant and reports suggest that they are coping well with the responsibilities involved.

- Some LIPs have invested in profit making ventures such as business centers, Internet café, poultry, fishing, catering, and bead making, sale of household goods among others. Findings suggest that these are not in large scale commercial venture yet, but are yielding some profits used to leverage activities implemented by the project.

- Also, there are attempts to raise funds from well-to-do community members but this has not been explored well.

- Other sources of funding for LIPs are through grants proposal writing. Some LIPs have recorded success in this regard more than others. It is interesting to see the transition from responding to Expression of Interest (EoI) to receiving grants (e.g. FCT—IHVN, and NED, and Lagos—OSIWA, AJWS, Astra Foundation).

- HAN over the years have been able to re-orientate government agencies and built platforms of engagement on importance of MSM in HIV prevention programming. This new direction with respect to MARPs by NACA, SACA and FACA is likely to be sustained well into the future.

- Plans to transition HAN into indigenous entity in Nigeria will further entrench and strengthen MSM health programming in the country on a more permanent bases.

## BEST PRACTICES & LESSONS LEARNED

***Best Practices***

- The approach of using members of the intervention community to design and implement projects can be taken as a best practice. This was reiterated by most stakeholders who participated in this evaluation because of the successes recorded among the MSM community in the four states and FCT covered by the project.

- It was a general consensus among those who participated in this evaluation that co-location of HAN staff with the LIPs in the state is another best practice because staff of the LIPs were able to acquire necessary knowledge, skills, and on the job coaching and do-it-your-self training which rapidly built their capacity within a short period.

- Another best practice is the support group system for MSMLWHA which is one of a kind in the country. Only MSMLWHA are represented in the group which support each other on a number of issues with the goal of living healthy, positively and confidently.

- Another best practice is the community center which is a rallying point for all MSM participating in the project. It serves as a focal point for connectivity, social interaction, and a sense of belonging to all.

***Lessons Learned***

- Stakeholders that were skeptical and did not accept MSM programming some years back, have changed their position as a result of persistent engagement using hard evidence based information.

- There is the need to factor in political environment into programming which implies conceding certain level of risk and uncertainly in programming for MSM.

- It may not be possible to record the desired successes and impact in MARPs programming without adequate component on MSM issues.

- The use of female PEs in some states helped to reduce stigma and discrimination earlier experienced among MSM in their communities.

- Determination is key to success in an invisible and impossible sub-group of a population.

- Being pro-active and updating stakeholders with relevant information can help to build platforms of engagement and relationships within a short period of time.

- Sub-granting has helped to strengthen the financial systems of LIPs because it exposes

them to all aspects of financial accountability and responsibility.

- Advocacy is not a one off thing but continuous engagement of all relevant stakeholders to achieve desired results is key.

## CONCLUSIONS

This evaluation examines the effectiveness, and quality of IMHIPP in reaching MSM in Cross River, Rivers, Lagos, Kano states and the FCT. It reviews gaps, and challenges in program implementation, lessons learned, and recommendations for the future.

*Background:* MSM were fairly evenly distributed across Cross River, Rivers, Lagos states, and FCT, with the smallest proportion in Kano state the newest on the project. The majority were urban residents, aged 29 or younger (85%), mostly protestant, with at least secondary education (94%), and of low socioeconomic status (86%). The conclusions below are presented based on the four key program objectives.

*Sexual Activity:* The majority of MSM started sex at age 20 or younger, and were involved in anal or oral sex mostly (83%), and about half (53%) reported that they were versatile. The majority used condoms (89%) and lubricant (92%) in last same-sex sex, and had sex for pleasure (65%). Also, the majority (81%) ever had sex with female partner, and had ongoing relationship (66%), and used condoms in last sex with female partner (71%). Findings showed that bisexual relationship varied significantly by state of residence and FCT.

Findings suggest that MSM community is sexually active and "serial monogamy" and variety of sexual practices are commonly practiced in the project states and FCT. Also, there seem to be a general consensus among MSM that in same-sex sex, it is more enjoyable to be a receiving than an insertive partner. It is likely that future sexual practices among MSM will favor bisexual relationships. This has important implications for HIV prevalence in the future.

Project achievements are presented below based on the IMHIPP objectives in the cooperative agreement.

### *Objective 1: Organizational & Technical Capacity of Local MSM/LGBT Organizations*

- Findings showed that LIPs staff received both formal and informal trainings in HIV prevention programming through continuous TAs in-house by HAN staff co-locating with a corresponding LIPs staff on each thematic area. Results showed that the trainings received led to increased knowledge about HIV/AIDS, and re-orientation on safer sex, positive behavior change, self-esteem, and responsibility to self and to other community members. Also, LIPs received capacity buildings on palliative care which reflected in the quality of services provided to support groups and home based care and support to MSMLWHA.

- LIPs staff received series of project management and administration trainings which empowered them to have organograms with departments, and functions and board of directors. In addition, LIPs staff were trained on how to develop grant proposals, and grants sourcing which enabled two LIPs to now access grants on their own.

- Aside human architecture set in motion, physical infrastructure were also put in place by the project in the form of providing office space, office equipment, communication facilities, and staff emolument.

***Objective 2: Reaching MSM with HIV Prevention Services***

- Most MSM (over 90%) who participated in this evaluation reported that they received information/services about HIV/AIDS, correct condom use, condoms, lubricants, and HIV counseling and testing (77%). Smaller proportions (less than 50%) of MSM received information/services on ARV, laboratory services, IGA, nutritional support, social support, and referral. Also, less than half (42%) received 9 to 12 information/services about HIV/AIDS and only 39% received 5 to 8 information/services. Access to information/services varied significantly by state of residence, education, religion, socioeconomic status, and types of economic activity.

- Results suggest that most MSM accessed HIV/AIDS information through several channels including; radio, TV, newspapers/magazine/comics, billboards, posters, health education program, community meetings, friends, and HAN/LIPs PEs. Most MSM had access to at least seven sources of information about HIV/AIDS, and this varied significantly by state, residence, education, socioeconomic status, and type of economic activity.

- On knowledge about HIV/AIDS, most well-known ways of preventing HIV among MSM were; correct condom use (85%), and use of sterilized objects (56%). Most MSM (90%) agreed that there is a difference between HIV and AIDS, and less proportion (65%) mention the difference, and only one-fifth (21%) reported that HIV can lead to AIDS. This gap in knowledge about HIV and AIDS should be addressed in future programming.

- The majority of MSM reported that an HIV person can look healthy, and the reason reported by most (81%) is by HIV drug adherence. Only 19% reported that HIV does not show on the face, and only 2% reported that it takes time to manifest. This is another gap in knowledge that has implications for unprotected sex.

- The most common STI known by MSM is gonorrhea (90%), and only a small proportion know syphilis and not much knowledge about other STIs. The most common disease that MSM had are; genital or anal discharge, genital or anal warts, genital ulcers/sores, and urinary pains.

- IMHIPP had functional referral system in place for MSM to access friendly health care services from friendly health personnel both in the private and public sectors. But a weak follow-up mechanism may have led to substantial loss to follow-up at the point of going for or returning from health facilities. This has implications for the M&E system in place and the challenges to monitoring and follow-ups.

***Objective 3: Palliative Care Services for MSM Living with HIV/IDS***

- Most MSM interviewed know where to test for HIV, had done the test and reported negative. Also, most MSMLWHA reported accessing friendly discrete health services from designated health facilities, and were attended to by friendly doctors. Results suggest that the referral systems were credible, and MSMLWHA enjoyed the good will of the health personnel at the facility who had linkages with HAN. Many MSMLWHA were however, not able to access health services that were not leveraged by other implementing partners. Future programming need to examine how to improve access to health services for MSMLWHA.

- Findings showed that support groups (one of its kind in Nigeria) were fully registered with NEPWHAN and functional in three states and FCT, while registration for the fourth was in process during the fieldwork of this evaluation. NEPWHAN supported the groups with skills on how to manage a support group, living positively, drug adherence, re-infection issues etc. Findings showed that MSMLWHA benefited significantly from the group which has increased in most states and now needs breaking into smaller groups for effectiveness.

***Project Involvement and Behavior Change***

- The majority of MSM (83%) reported that they were able to say no to sex without condoms, would continue to insist on condoms (63%), and only a small proportion would end the relationship if partner continue to insist (26%). Future programming would need to examine how to increase the proportion of MSM who would terminate relationship if partner insist on sex without condoms. This will certainly have more impact on HIV prevention efforts in the country.

- Findings suggest that condom use in the last same-sex sexual intercourse varied significantly by age, education, and religion, and condom use in last sex with female partner varied significantly by religion. Also, results showed that IMHIPP has had most influence on condom use during sex among MSM who participated in this evaluation, but not commensurate influence on number of sexual partner, avoiding casual sex, abstinence from sex, and avoiding unscreened blood and sharp objects. And only about one-third (39%) reported influence on 2 to 3 of 8 components of behavior change, and only 5% reported four components. Future programming should include other aspects of behavior change for more impact.

- The majority of MSM (83%) reported influence on other aspects of behavior change i.e. improved confidence, self-respect, more responsibility to self and others.

***Objective 4: Creating an Enabling Policy Environment***

- Findings suggest that the project established platforms of engagement with SACAs, FACA, at the state levels and NACA at the federal level through continuous evidenced

based advocacy and networking. Platforms of engagement established included prevention technical working groups, trainings and workshops, participation at retreats, open house, and review and other meetings. Other platforms of engagement were established with NEPWHAN, and CiSHAN, and in some states FHI and SFH. It seems that the level of relationship developed with the government and other agencies were related to the number of years that the LIP has been established.

- Results of this evaluation suggest that there are still covert resentment and stigmatization of HA/LIPs by other development partners who were not comfortable with the project working only with MSM. Future programming may need to examine how to enlist and collaborate with these partners in other to leverage more on their services that may be needed by MSM. Most important, integrating other MARPs i.e. FSWs, and IDUs into IMHIPP will help to soften ground for better relationship and collaboration with other development partners.

- Results of this evaluation showed that HAN built platforms of engagement and collaboration with NACA not of the same intensity as those with SACA at the states and FCT. Platforms of engagement and collaboration included participation in national prevention working groups, joint reviews of documents and standard manuals, participation at trainings and workshops, and involvement at other meetings as well. Findings suggest the need to use caution in clearly delineating between MSM rights to health vis-à-vis rights to sexual orientation during advocacy and other MARPs included in future programming.

- HAN established platforms of engagement with NEPWHAN national coordinating office in similar ways as it did with their corresponding office at the state.

- The gay rights and same-sex bill had negative effects both at the state and national levels. Coupled with this is the adverse cultural and religious environment and how this affects supply and demand for health services by MSM.

- Reports showed that the majority of MSM use the community center which served variety of functions i.e. supply of HIV prevention commodities, HIV/AIDS information, counseling and testing, social interaction, confidence building, and skills acquisition.

**Management Issues**

*Key Strengths:* These include, intensive capacity building of local LIPs through co-location of HAN staff with LIPs staff, frequent oversight visits from HAN Abuja, and periodic TAs from HA HQ in Chicago, USA. Other strengths include; programming using community members as implementers; community centers as focal point for accessing information and services, and social interactions; and health referral system in place for MSM; and commitment and passion of HAN and LIPs staff.

*Key Weaknesses:* These are mainly demand for services created by the project without adequate supply with respect to ARV treatment, STIs and malaria treatments, and other ailments; inadequate comprehensive health services at the community center; and weak economic empowerment strategies reiterated by most MSM who participated in this evaluation.

*Challenges and Constraints:* Those directly related to MSM include; stigma and discrimination still predominant in the society; culture and religious negative reactions; and difficulty in adhering to drug regimen by MSMLWHA.

For LIPs, the challenges are; high PEs workload, inadequate skills acquisition and transition to self-employment program; inadequate privacy at HCT units; lack of comprehensive health services; inadequacy of community center to reach all spectrums of MSM; and large MSMLWHA support groups that needed to be divided into small groups. Other LIPs related challenges and constraints include; poor PEs and OCs remuneration, lack of Identity Card for PEs, inadequate ICT presence at the offices especially computers; inadequate staffing, lack of pension and insurance scheme for staff, and inadequate office space for OCs. Others are, lack of project vehicles to enhance logistics, unclear lines of reporting between HAN program advisors and LIPs executive director to HAN head office in Abuja, difficult geographical terrain in some states, delay in funds release and lack of clear communication on line item funds not released, and inadequate monthly petty cash vote.

Challenges and constraints linked directly to HAN Abuja permeates the entire IMHIPP. These include, unfriendly same-sex bill of 2011, inadequate sensitization of most development partners working on MARPs, financial inflexibility, limited funding, lack of formal technical trainings for HAN staff, lack of some autonomy for HAN to make certain decisions, lack of operations research embedded in IMHIPP, and limited geographical coverage considering the potential unreached MSM population in the country.

*Sustainability:* Efforts on sustainability are in terms of capacity building of LIPs staff to continue programming for MSM after IMHIPP ends, knowledge and skills in sub-granting acquired by the LIPs, small business ventures initiated by some LIPs, attempts to solicit support form well-to-do MSM, grants through proposal writing, and platforms of engagement built with MDAs mostly SACA, and NACA and with CSOs like NEPWHAN, and CiSHAN in particular.

*Best Practices:* Key best practices highlighted included; using MSM as implementers of program for themselves; HAN staff co-location with LIPs staff; the community center concept; and the unique support group system for MSMLWHA.

*Lessons learned:* Lessons learned by stakeholder who participated in this evaluation are; opposing stakeholders can be convinced by persistent hard evidence based advocacy, need to include policy and political factors in programming for MSM; MSM should be key component of MARPs programming for effectiveness; pro-active engagement of stakeholders is key to sustaining their interest; project sub-grants to LIPs helped to further strengthen their financial systems.

## RECOMMENDATIONS

The following are recommendations based on the findings of this evaluation on the four project objectives, management issues, sustainability, best practices, and lessons learned.

*Objective One: Organizational & Technical Capacity of Local MSM/LGBT Organizations*

- Evidence showed that capacities of LIPs staff have been substantially enhanced over the years and these have translated into behavior change, skills and experience in programming for other community members. Gaps in training that need to be examined in the future include exchange program for LIPs staff both within and outside the country, to gain firsthand experience of similar programs. This will boost that ingenuity to explore new ways of programming for effectiveness.

- Evidence suggest that there are many MSM not reached by the program in states visited, and perhaps, many more in states not involved in the IMHIPP. Future programming need to broaden coverage and improve access by identifying, registering, strengthening, and nurturing more local MSM organizations to work in new states across the country.

- A key component of knowledge sharing and better quality of service is the need to form a coalition of MSM friendly organizations that will continuously advance the welfare and improved services and care for MSM.

*Objective Two: Reaching MSM with HIV Prevention Services*

- Evidence of this evaluation showed that MSM engaged in several types of sexual practices and multiple sexual partners, and serial monogamy is common. Programming should educate MSM more on personal hygiene and the need to play safe in order to reduce their changes of contracting HIV and other STIs.

- Most MSM who participated in this evaluation reported consistent condom use while few mentioned other ways of preventing HIV. Programming would need to step-up campaign to increase MSM knowledge about other means of preventing HIV in the future. Increased knowledge would have substantial impact on MSM behavior change in the future.

- Another aspect of knowledge that needs program attention is the difference between HIV and AIDS. Findings showed that only a few MSM (2%) know the two key differences between HIV and AIDS i.e. HIV is not visible on the face, or takes time to manifest. This gap in knowledge need to be addressed in order to increase MSM sensitivity to contracting HIV. It is also important to address gaps in knowledge about other STIs aside gonorrhea and syphilis.

- Findings showed that HIV/AIDS information/services, sources of information about HIV/AIDS, knowledge about HIV/AIDS, and knowledge about physical symptoms of

HIV/AIDs among others, were statistically significant by selected background characteristics. For effective and maximum results, future programming for MSM should consider these background factors i.e. state of residence, age, residence, level of education, religion, socioeconomic status, and type of economic activity.

*Objective Three: Palliative care Services for MSM Living with HIV/AIDS*

- Evidence showed that about 15% of MSM who participated in this evaluation were HIV positive and 37% of these were not on any form of treatment. Programming need to identify factors that led to this gap in access to treatment and ways to bridge the gap in the future.

- In general, MSM reported that they received quality service at the friendly health facilities that they visited. This evaluation observed that quality health services received by MSM were mainly due to the good will of the health personnel connected to the IMHIPP. In order to institutionalize friendly service provision to MSM, there is the need to get the buy-ins of health facilities management and staff trained specifically on the sensitivity of MSM health issues and how to deal with them. Also, there is the need to leverage more on services of other implementing partners in order to increase MSMLWHA access to the treatment of STIs and other opportunistic infections.

*Project Involvement & Behavior Change*

- Evidence from this evaluation established degrees of self-efficacy to use condoms among MSM. Findings showed that the majority (83%) would say no to sex without condoms, a lower proportion (63%) would continue to insist on condom use, and less than one-third (26%) would terminate relationship if partner insist on sex without condoms. Programming would need to increase the proportion of MSM who would terminate relationship with partner who insists on unprotected sex.

- The major behavior change reported by most MSM is condom use, and few mentioned change in other sexual behavior. Also, 39% reported two components of behavior change, and 5% reported four components of behavior change. Program implementers would need to examine why changes are minimal or not taking place in other aspects of behavior with a view to reversing the situation.

- There is the need to capitalize on changes reported by MSM in other aspects of their lives including confidence, self-respect, taking responsibilities, and helping others, which varied significantly by state of residence, religion, and types of economic activity. These changes may be emphasized in future programming in order to record more gains in sexual behavior change.

*Objective Four: Creating an Enabling Policy Environment*

- Significant in-route was reported on platforms of engagement and collaboration created with SACA at the state and NACA at the national levels. Other significant platforms were created with NEPWHAN and CiSHAN as well. These platforms of engagement need to be strengthened and sustained well into the future in order to create more traction for MSM programming and favorable health policies at these levels, and perhaps, transfer of total ownership, sustainability and coordination on MSM health issues to the government agencies in the future.

- Collaboration with other MDAs and development partners working on HIV/AIDS were not so pronounced or obvious at the time of this evaluation. Efforts should be made to bridge this gap in collaboration so as to leverage on their services to increase MSM access to other needed health services and care.

- In order to reduce covert stigma and discriminations from other MDAs and development partners, it is important to review current advocacy strategies to clearly delineate between MSM right to health and MSM right to sexual orientation. Also, it may be necessary to include other MARPs especially those with natural affiliations to MSM i.e. FSWs and IDUs in programming geared to create more friendly professional environment to implement the program.

- With respect to the political environment for MSM programming in the country, it is necessary for stakeholders to engage the same-sex bill and its relevant parts. One approach to engaging the bill is to stimulate public education on the components of the bill and relevance to the different social institutions and contexts in Nigeria. Public enlightenment of the bill is necessary to spur debate, and perhaps a revisit to the bill to attenuate its effect and make it more realistic.

- In order to improve on MSM friendly health services environment, it may be necessary to train more health professionals (especially those in the public sectors i.e. general and teaching hospitals), on MARPs friendly services provision which in the short-run could improve access to health care for this sub-group, and in the long-run contribute to reducing HIV prevalence in the country.

*Management Issues*

- Strengths of IMHIPP include; co-location, MSM programming for themselves, community center, support group for MSMLWHA, and health care referral system should be continued and sustain into the future. The community center should be made friendlier by providing more in-doors and out-door recreational facilities, and a comprehensive health care facility should be part of the mix to ensure that the center is a one-stop-shop for MSM. In this wise, the community center should be more spacious to accommodate these additional activities.

- A major weakness that needs to be rectified is the gap in economic strengthening for unemployed MSM. Skills acquisition and seed money should be provided to transition unemployed MSM to self-employment. This will go a long way to reduce the risk of transactional and unprotected sex among them.

- It is important to break existing support groups into smaller units to make them more responsive to the needs of members, and the health care referral systems need to be revived with more monitoring mechanisms put in place to forestall loss to follow-up and drug adherence among community members.

- It may be necessary to set-up a review committee to look into the welfare of PEs and OCs who are the frontline, grassroots implementers of the IMHIPP to ensure that their morale and quality of work are not compromised. Also, it may be necessary for the review committee to examine other LIPs key challenges like logistics, office space, conditions of service including insurance and pension scheme for staff, and financial challenges discussed above.

- With respect to HAN staff, future programming should examine ways to provide more formal technical trainings to enhance their expertise, create room for more participation in decision making towards converting the office to a full fleshed Nigerian legal entity. Also, it is important to incorporate more flexibility in funding streams and make operations research embedded in the programming process of IMHIPP.

- Efforts on sustainability by LIPs, (except capacity building), have been fragmented initiatives of individual LIP. There should be concerted efforts from HAN in Abuja to work with each LIP on investment platforms that would yield long-term returns. This may be coupled with efforts on grant seeking proposals submitted to probable funders.

- Lastly, best practices highlighted in this report should be encapsulated and strengthened in the future. Likewise, lessons learned should be factored into future programming for maximum impact at the end of IMHIPP.

## APPENDIX ONE: TABLES

**Table: Percentage of MSM by selected background characteristics and indicators of sexual behavior and condom use**

| Background Characteristics | Last same-sex sex used condoms | Last same-sex sex used lubricant | Currently have sexual relationship with opposite sex | Last sex with female partners used condoms | Ever had sex for money or material gains |
|---|---|---|---|---|---|
| **Total (N)** | 420 | 417 | 378 | 370 | 413 |
| **State of Residence** | | | | | |
| **Cross River** | 92% | 86% | 62% | 85% | 19% |
| **FCT** | 84% | 94% | 77% | 69% | 33% |
| **Kano** | 83% | 92% | 60% | 53% | 38% |
| **Lagos** | 91% | 93% | 57% | 59% | 23% |
| **River** | 93% | 94% | 73% | 79% | 26% |
| **P-value** | 0.158 | 0.230 | 0.046 | 0.000 | 0.070 |
| **Residence** | | | | | |
| **Urban** | 89% | 92% | 64% | 70% | 28% |
| **Semi-Urban** | 87% | 87% | 82% | 82% | 7% |
| **Rural** | 92% | 96% | 79% | 77% | 31% |
| **P-value** | 0.835 | 0.552 | 0.170 | 0.545 | 0.184 |
| **Age group (in years)** | | | | | |
| **20 or younger** | 92% | 92% | 58% | 63% | 29% |
| **21 - 29** | 88% | 93% | 70% | 77% | 27% |
| **30 or older** | 89% | 92% | 59% | 55% | 25% |
| **P-value** | 0.594 | 0.973 | 0.093 | 0.002 | 0.893 |
| **Religion** | | | | | |
| **Traditional/Muslim/Other** | 77% | 87% | 64% | 58% | 38% |
| **Catholic** | 98% | 90% | 64% | 71% | 16% |
| **Protestant** | 92% | 94% | 69% | 75% | 23% |
| **P-value** | 0.000 | 0.120 | 0.631 | 0.024 | 0.007 |
| **Highest level of schooling** | | | | | |
| **Primary/Quranic only/None** | 85% | 90% | 63% | 69% | 30% |
| **Secondary** | 92% | 93% | 65% | 68% | 30% |
| **Tertiary** | 88% | 90% | 67% | 80% | 27% |
| **P-value** | 0.403 | 0.576 | 0.872 | 0.101 | 0.814 |
| **Socioeconomic status** | | | | | |
| **Low** | 90% | 91% | 67% | 70% | 30% |
| **Medium/high** | 88% | 98% | 59% | 76% | 9% |
| **P-value** | 0.758 | 0.050 | 0.205 | 0.420 | 0.001 |
| **Type of economic activity involved** | | | | | |
| **Unemployed** | 89% | 95% | 64% | 72% | 27% |
| **Petty trading** | 85% | 88% | 72% | 62% | 31% |
| **Paid employment** | 89% | 92% | 71% | 77% | 17% |
| **Others** | 92% | 88% | 62% | 70% | 35% |
| **P-value** | 0.601 | 0.139 | 0.470 | 0.303 | 0.055 |
| | | | | | |

Note: statistical significance is at 0.05, 0.01, and 0.001 levels.

**Table: Percentage of MSM by selected background characteristics and cumulative index on number of services received**

| Background Characteristics | Four or less | Five to eight | Nine to twelve |
|---|---|---|---|
| **Total (N) = 436** | | | |
| **State of Residence** | | | |
| **Cross River** | 16% | 32% | 52% |
| **FCT** | 10% | 47% | 43% |
| **Kano** | 45% | 25% | 30% |
| **Lagos** | 15% | 40% | 45% |
| **River** | 17% | 48% | 35% |
| **P-value** | | 0.000 | |
| **Residence** | | | |
| **Urban** | 17% | 37% | 46% |
| **Semi-Urban** | 35% | 41% | 24% |
| **Rural** | 29% | 64% | 7% |
| **P-value** | | 0.000 | |
| **Age group (in years)** | | | |
| **20 or younger** | 17% | 44% | 39% |
| **21 - 29** | 18% | 36% | 46% |
| **30 or older** | 23% | 49% | 28% |
| **P-value** | | 0.093 | |
| **Religion** | | | |
| **Traditional/Muslim/Other** | 31% | 34% | 34% |
| **Catholic** | 17% | 32% | 51% |
| **Protestant** | 14% | 45% | 41% |
| **P-value** | | 0.003 | |
| **Highest level of schooling** | | | |
| **Primary/Quranic only/None** | 33% | 52% | 14% |
| **Secondary** | 22% | 42% | 36% |
| **Tertiary** | 15% | 26% | 59% |
| **P-value** | | 0.000 | |
| **Socioeconomic status** | | | |
| **Low** | 17% | 37% | 46% |
| **Medium/high** | 30% | 51% | 19% |
| **P-value** | | 0.000 | |
| **Type of economic activity involved** | | | |
| **Unemployed** | 19% | 46% | 35% |
| **Petty trading** | 25% | 33% | 42% |
| **Paid employment** | 25% | 46% | 29% |
| **Others** | 9% | 22% | 69% |
| **P-value** | | 0.000 | |
| | | | |

Note: statistical significance is at 0.05, 0.01, and 0.001 levels.

**Table: Percentage of MSM by selected background characteristics and cumulative index on sources of information on HIV/AIDS**

| Background Characteristics | Six or less | Seven to eleven | Twelve or more |
|---|---|---|---|
| **Total (N) = 436** | | | |
| **State of Residence** | | | |
| **Cross River** | 14% | 30% | 56% |
| **FCT** | 9% | 45% | 46% |
| **Kano** | 5% | 55% | 39% |
| **Lagos** | 2% | 55% | 43% |
| **River** | 16% | 46% | 38% |
| **P-value** | | 0.001 | |
| **Residence** | | | |
| **Urban** | 8% | 42% | 49% |
| **Semi-Urban** | 12% | 65% | 24% |
| **Rural** | 18% | 75% | 7% |
| **P-value** | | 0.000 | |
| **Age group (in years)** | | | |
| **20 or younger** | 12% | 45% | 43% |
| **21 - 29** | 9% | 44% | 47% |
| **30 or older** | 8% | 53% | 39% |
| **P-value** | | 0.576 | |
| **Religion** | | | |
| **Traditional/Muslim/Other** | 12% | 45% | 43% |
| **Catholic** | 8% | 34% | 58% |
| **Protestant** | 9% | 50% | 41% |
| **P-value** | | 0.193 | |
| **Highest level of schooling** | | | |
| **Primary/Quranic only/None** | - | 67% | 33% |
| **Secondary** | 13% | 53% | 34% |
| **Tertiary** | 7% | 29% | 64% |
| **P-value** | | 0.000 | |
| **Socioeconomic status** | | | |
| **Low** | 8% | 42% | 50% |
| **Medium/high** | 14% | 65% | 21% |
| **P-value** | | 0.000 | |
| **Type of economic activity involved** | | | |
| **Unemployed** | 12% | 51% | 36% |
| **Petty trading** | 7% | 48% | 46% |
| **Paid employment** | 7% | 58% | 35% |
| **Others** | 5% | 20% | 75% |
| **P-value** | | 0.000 | |
| | | | |

Note: statistical significance is at 0.05, 0.01, and 0.001 levels.

**Table: Percentage of MSM by selected background characteristics and composite knowledge on the difference between HIV and AIDS**

| Background Characteristics | No knowledge of difference | One component of knowledge | Two component of knowledge |
|---|---|---|---|
| **Total (N) = 436** | | | |
| **State of Residence** | | | |
| **Cross River** | 17% | 81% | 2% |
| **FCT** | 17% | 74% | 9% |
| **Kano** | 25% | 75% | - |
| **Lagos** | 7% | 93% | - |
| **River** | 20% | 80% | - |
| **P-value** | | 0.000 | |
| **Residence** | | | |
| **Urban** | 16% | 81% | 3% |
| **Semi-Urban** | 6% | 94% | - |
| **Rural** | 18% | 82% | - |
| **P-value** | | 0.606 | |
| **Age group (in years)** | | | |
| **20 or younger** | 11% | 86% | 3% |
| **21 - 29** | 17% | 81% | 2% |
| **30 or older** | 21% | 79% | - |
| **P-value** | | 0.295 | |
| **Religion** | | | |
| **Traditional/Muslim/Other** | 29% | 68% | 3% |
| **Catholic** | 13% | 83% | 4% |
| **Protestant** | 12% | 86% | 2% |
| **P-value** | | 0.002 | |
| **Highest level of schooling** | | | |
| **Primary/Quranic only/None** | 19% | 81% | - |
| **Secondary** | 20% | 79% | 1% |
| **Tertiary** | 12% | 84% | 4% |
| **P-value** | | 0.131 | |
| **Socioeconomic status** | | | |
| **Low** | 18% | 80% | 2% |
| **Medium/high** | 8% | 89% | 3% |
| **P-value** | | 0.142 | |
| **Type of economic activity involved** | | | |
| **Unemployed** | 16% | 82% | 2% |
| **Petty trading** | 20% | 75% | 5% |
| **Paid employment** | 13% | 83% | 4% |
| **Others** | 17% | 82% | 1% |
| **P-value** | | 0.567 | |
| | | | |

Note: statistical significance is at 0.05, 0.01, and 0.001 levels.

**Table: Percentage of MSM by selected background characteristics and composite knowledge about physical features of a person living with HIV**

| Background Characteristics | No knowledge | One or two components of knowledge | Three or more components of knowledge |
|---|---|---|---|
| **Total (N) = 436** | | | |
| **State of Residence** | | | |
| **Cross River** | 7% | 81% | 12% |
| **FCT** | 10% | 71% | 18% |
| **Kano** | 21% | 75% | 4% |
| **Lagos** | 7% | 86% | 8% |
| **River** | 3% | 88% | 9% |
| **P-value** | | 0.002 | |
| **Residence** | | | |
| **Urban** | 8% | 82% | 10% |
| **Semi-Urban** | 18% | 65% | 17% |
| **Rural** | 11% | 75% | 14% |
| **P-value** | | 0.363 | |
| **Age group (in years)** | | | |
| **20 or younger** | 11% | 79% | 10% |
| **21 - 29** | 8% | 82% | 10% |
| **30 or older** | 8% | 80% | 12% |
| **P-value** | | 0.923 | |
| **Religion** | | | |
| **Traditional/Muslim/Other** | 18% | 76% | 6% |
| **Catholic** | 2% | 85% | 13% |
| **Protestant** | 7% | 81% | 12% |
| **P-value** | | 0.002 | |
| **Highest level of schooling** | | | |
| **Primary/Quranic only/None** | 19% | 62% | 19% |
| **Secondary** | 11% | 80% | 9% |
| **Tertiary** | 7% | 83% | 10% |
| **P-value** | | 0.161 | |
| **Socioeconomic status** | | | |
| **Low** | 9% | 80% | 11% |
| **Medium/high** | 8% | 84% | 8% |
| **P-value** | | | |
| **Type of economic activity involved** | | | |
| **Unemployed** | 10% | 78% | 12% |
| **Petty trading** | 10% | 80% | 10% |
| **Paid employment** | 4% | 87% | 9% |
| **Others** | 10% | 82% | 8% |
| **P-value** | | 0.569 | |
| | | | |

Note: statistical significance is at 0.05, 0.01, and 0.001 levels.

**Table: Percentage of MSM by selected background characteristics and reported cumulative change in behavior about HIV/AIDS**

| Background Characteristics | No change | One aspect of behavior | Two aspects of behavior | Three aspects of behavior | Four or more aspects of behavior |
|---|---|---|---|---|---|
| **Total (N) = 436** | | | | | |
| **State of Residence** | | | | | |
| **Cross River** | 6% | 18% | 33% | 30% | 13% |
| **FCT** | 3% | 15% | 40% | 37% | 5% |
| **Kano** | 2% | 14% | 48% | 32% | 4% |
| **Lagos** | 4% | 18% | 32% | 45% | 1% |
| **River** | - | 6% | 45% | 47% | 2% |
| **P-value** | 0.000 | | | | |
| **Residence** | | | | | |
| **Urban** | 4% | 15% | 38% | 37% | 6% |
| **Semi-Urban** | - | 12% | 41% | 47% | - |
| **Rural** | - | 4% | 43% | 50% | 3% |
| **P-value** | 0.552 | | | | |
| **Age group (in years)** | | | | | |
| **20 or younger** | 4% | 9% | 38% | 44% | 5% |
| **21 - 29** | 4% | 17% | 39% | 35% | 5% |
| **30 or older** | - | 12% | 38% | 45% | 5% |
| **P-value** | 0.405 | | | | |
| **Religion** | | | | | |
| **Traditional/Muslim/Other** | 2% | 17% | 48% | 30% | 3% |
| **Catholic** | 6% | 15% | 28% | 45% | 6% |
| **Protestant** | 3% | 13% | 38% | 42% | 6% |
| **P-value** | 0.281 | | | | |
| **Highest level of schooling** | | | | | |
| **Primary/Quranic only/None** | 5% | 19% | 43% | 33% | - |
| **Secondary** | 3% | 14% | 36% | 43% | 4% |
| **Tertiary** | 5% | 15% | 43% | 29% | 8% |
| **P-value** | 0.269 | | | | |
| **Socioeconomic status** | | | | | |
| **Low** | 4% | 15% | 41% | 35% | 5% |
| **Medium/high** | 2% | 8% | 25% | 59% | 6% |
| **P-value** | 0.007 | | | | |
| **Type of economic activity involved** | | | | | |
| **Unemployed** | 3% | 16% | 32% | 43% | 6% |
| **Petty trading** | 3% | 7% | 52% | 31% | 7% |
| **Paid employment** | 2% | 10% | 39% | 48% | 1% |
| **Others** | 6% | 20% | 44% | 25% | 5% |
| **P-value** | 0.014 | | | | |
| | | | | | |

Note: statistical significance is at 0.05, 0.01, and 0.001 levels.

**Table: Percentage of MSM by selected background characteristics and reported cumulative influence on other aspects of life**

| Background Characteristics | No influence | One aspect | Two aspects | Three or more aspects |
|---|---|---|---|---|
| **Total (N) = 432** | | | | |
| **State of Residence** | | | | |
| **Cross River** | 5% | 44% | 36% | 15% |
| **FCT** | 17% | 70% | 13% | - |
| **Kano** | 21% | 57% | 20% | - |
| **Lagos** | 9% | 44% | 45% | 2% |
| **River** | 3% | 49% | 46% | 1% |
| **P-value** | | | 0.000 | |
| **Residence** | | | | |
| **Urban** | 11% | 53% | 31% | 5% |
| **Semi-Urban** | - | 47% | 53% | - |
| **Rural** | 4% | 43% | 54% | - |
| **P-value** | | | 0.054 | |
| **Age group (in years)** | | | | |
| **20 or younger** | 10% | 53% | 31% | 6% |
| **21 - 29** | 11% | 50% | 36% | 3% |
| **30 or older** | 9% | 61% | 27% | 3% |
| **P-value** | | | 0.620 | |
| **Religion** | | | | |
| **Traditional/Muslim/Other** | 19% | 69% | 11% | 1% |
| **Catholic** | 13% | 52% | 31% | 4% |
| **Protestant** | 6% | 46% | 42% | 6% |
| **P-value** | | | 0.000 | |
| **Highest level of schooling** | | | | |
| **Primary/Quranic only/None** | 5% | 57% | 38% | - |
| **Secondary** | 9% | 52% | 36% | 3% |
| **Tertiary** | 12% | 53% | 28% | 7% |
| **P-value** | | | 0.230 | |
| **Socioeconomic status** | | | | |
| **Low** | 11% | 53% | 32% | 4% |
| **Medium/high** | 3% | 48% | 44% | 5% |
| **P-value** | | | 0.092 | |
| **Type of economic activity involved** | | | | |
| **Unemployed** | 8% | 50% | 37% | 5% |
| **Petty trading** | 22% | 53% | 20% | 5% |
| **Paid employment** | 5% | 50% | 40% | 5% |
| **Others** | 11% | 57% | 28% | 3% |
| **P-value** | | | 0.041 | |
| | | | | |

Note: statistical significance is at 0.05, 0.01, and 0.001 levels.

**Table: Percentage of MSM by selected background characteristics and those who reported that they are able to say no to sex without condoms**

| Background Characteristics | Able to say no to sex without condoms | Strongly agree with the statement: Capable of abstaining from sex if choose to do so |
|---|---|---|
| Total (N) | 434 | 436 |
| State of Residence | | |
| Cross River | 59% | 86% |
| FCT | 95% | 64% |
| Kano | 95% | 66% |
| Lagos | 86% | 73% |
| River | 88% | 60% |
| P-value | 0.000 | 0.008 |
| Residence | | |
| Urban | 83% | 72% |
| Semi-Urban | 82% | 71% |
| Rural | 89% | 54% |
| P-value | 0.700 | 0.351 |
| Age group (in years) | | |
| 20 or younger | 79% | 74% |
| 21 - 29 | 82% | 73% |
| 30 or older | 91% | 58% |
| P-value | 0.146 | 0.087 |
| Religion | | |
| Traditional/Muslim/Other | 94% | 65% |
| Catholic | 81% | 79% |
| Protestant | 80% | 71% |
| P-value | 0.010 | 0.432 |
| Highest level of schooling | | |
| Primary/Quranic only/None | 95% | 71% |
| Secondary | 87% | 70% |
| Tertiary | 75% | 75% |
| P-value | 0.002 | 0.761 |
| Socioeconomic status | | |
| Low | 82% | 71% |
| Medium/high | 89% | 70% |
| P-value | 0.180 | 0.476 |
| Type of economic activity involved | | |
| Unemployed | 86% | 67% |
| Petty trading | 87% | 64% |
| Paid employment | 90% | 68% |
| Others | 68% | 86% |
| P-value | 0.000 | 0.016 |
| | | |

Note: statistical significance is at 0.05, 0.01, and 0.001 levels.

## APPENDIX TWO: LIST OF DOCUMENTS

Baseline Assessment of MSM Policy and programming in Nigeria. (March 2010)
Cooperative Agreement No.620 – A- 00- 09- 00015- 00, Integrated MSM HIV/AIDS Prevention Program (IMHIPP) in Nigeria. (October, 2009)
Heartland Alliance for human Needs &Human Rights–IMHIPP (December 2009- monthly Report)
Heartland Alliance for Human Needs &Human Rights—IMHIPP (January –March, 2010 Quarterly Report)
Heartland Alliance for Human Needs &Human Rights—IMHIPP (April – June, 2010 Quarterly Report)
Heartland Alliance for Human Needs &Human Rights – IMHIPP (July–September, 2010 Quarterly Report
Heartland Alliance for Human Needs & Human Rights –IMHIPP (October1, 2010—September 30, 2011 Annual FY 2010 Progress Report)
Heartland Alliance for Human Needs & Human Rights –IMHIPP (October –December 2010 Quarterly Report)
Heartland Alliance for Human Needs & Human Rights –IMHIPP (November 2, 2010)
Heartland Alliance for Human Needs & human Rights –IMHIPP (January –March, 2011 Quarterly Progress Report)
Heartland Alliance for Human Needs & Human Rights –IMHIPP (April – June, 2011 Quarterly Report)
Heartland Alliance for Human Needs & Human Rights-IMHIPP (July-September, 2011 Quarterly Report)
Heartland Alliance for Human Needs & Human Rights—IMHIPP (October- December, 2011Quarterly Report)
Heartland Alliance for Human Needs &Human Rights –IMHIPP(January –March, 2012 Quarterly Progress Report)
Heartland Alliance for Human Needs & Human Rights –IMHIPP (April – June, 2012 Quarterly Report)
Heartland Alliance for Human Needs & Human Rights –IMHIPP (July- September, 2012 Quarterly Progress Report)
Report of Internal Midterm Assessment (September 2012)
Network of people living with HIV/AIDS in Nigeria –NEPWHAN (January 19, 2013)

## APPENDIX THREE: LIST OF INSTRUMENTS

IMHIPP Mid - Term Evaluation: FGD Guide of MSM Volunteer Caregiver
IMHIPP Mid – Term Evaluation: FGD Guide for Outreach Coordinator
IMHIPP Mid – Term Evaluation: FGD Guide for Men who have Sex with Men Living with HIV/AIDS (MSMLWHA)
IMHIPP Mid – Term Evaluation: FGD Guide for Peer Educators
IMHIPP Mid – Term Evaluation: FGD Guide for Men who have Sex with Men (MSM)
IMHIPP Mid – Term Evaluation: KII Guide for USAID Staff
IMHIPP Mid – Term Evaluation: KII Guide for Health Facility Staff/ Volunteer Medical Doctors
IMHIPP Mid – Term Evaluation: KII Guide for MSM Female Sex Partner
IMHIPP Mid – Term Evaluation: KII Guide for MDAs &USIPS Staff
IMHIPP Mid – Term Evaluation: KII Guide for NEPWHAN &CISHAN Key Staff
IMHIPP Mid – Term Evaluation: Group Interview Guide for HA Field Office Staff
IMHIPP Mid – Term Evaluation: Group Interview Guide for LIPs Staff
IMHIPP Mid – Term Project Evaluation MSM Questionnaire

## APPENDIX FOUR: LIST OF PEOPLE CONTACTED

**USAID Nigeria Staff, Abuja**

| | |
|---|---|
| Abioye Kalaiwo | Program Manager (STP) |
| Duke Lawrence Ogbokor | HMIS Manager |
| Pamela Gado | Program Manager (HCT) |

**Heartland Alliance Staff Headquarters, Federal Capital Territory (FCT), Abuja**

| | |
|---|---|
| Boniface Ochonye | Chief of Party |
| Dr. Emmanuel Godwin | Deputy Chief of Party |
| Fatiya Askiederin | Strategic Information Officer |
| Winifred A. Gunpil | Director of Finance & Account |

**Heartland Alliance Field Staff, (FCT) Abuja**

| | |
|---|---|
| Ayande Dorcas | Nurse |
| Uchechi Kalu | Account Advisor |

**MDAS & USIPS, (FCT) Abuja**

| | |
|---|---|
| P.A. Abdullahi | HOD Nursing Garki Hospital, Abuja |
| Dr. Uche Okoro | Program Manager (FACA) |
| Omoshehm Victor | National Secretary (NEPWHAN) |

**Community Base Organization/ NGOs**

**The International Center for Advocacy & Rights to health (ICARH), FCT, Abuja**

| | |
|---|---|
| Ifeanyi Orazulike | Executive Director |
| Kadori Audu | Program Officer |
| Chull Stanley | M&E Officer |
| Nnolum Ebuka .A | M&E Assistant |
| Ochoma Stanley | Acc/Admin Officer |
| Udeh Emmnuel .E. | Acc/Admin Assistant |
| Ucheme Ononaku | Care officer |

**Peer Educator (FCT) Abuja**

| | |
|---|---|
| Daniel Mark Fred | Peer Educator |
| Kuss Abba Sambo | Peer Educator |
| Cyprain Gaiya | Peer Educator |
| Dominic O. Dominic | Peer Educator |
| Temple Sylvester | Peer Educator |
| Peterson Hoajonw | Peer Educator |
| Richard Yalayo | Peer Educator |

**Outreach Coordinator (FCT) Abuja**

| | |
|---|---|
| Remigu Emodi | Outreach Coordinator |
| Chukwwuemeka Okoro | Outreach Coordinator |

| | |
|---|---|
| Nnunani Ikechukwu | Outreach Coordinator |
| Daniel Kalu | Outreach Coordinator |
| Benjamin Ibe | Outreach Coordinator |
| Ayuba Doroh | Outreach Coordinator |

**Heartland Alliance Staff, Cross River**

| | |
|---|---|
| Paul Umoh | Program Advisor |
| Fanen Silas Ninga | Case Manager |
| Ebe Wandaku | Accountant |

**Community Base Organization/NGOs**

**Improved Men Health Initiative (IMH-I**), Calabar

| | |
|---|---|
| Wisdom Iyang | Program Officer |
| Valor Bassey | Program Officer |
| Ifeanyichuku Obike Nwabusi | Accountant |
| Stanley NtaPalliative | Care Officer |
| Ekon Victor George | SIA |
| Rose Ita Ikpeme | Office Assistance |

**Peer Educator Cross River State**

| | |
|---|---|
| Godwind Okokon | Peer Educator |
| Akpabio Etefia | Peer Educator |
| Tony Eyo | Peer Educator |
| Owan Pius | Peer Educator |
| Micheal Akan | Peer Educator |
| Teddy Effiong | Peer Educator |
| Jimmy Edem | Peer Educator |
| Johnson Maws | Peer Educator |
| King K | Peer Educator |

**Outreach Coordinator Cross River State**

| | |
|---|---|
| Ekpenyong Bassey | Outreach Coordinator |
| Ubong Effiong | Outreach Coordinator |
| Shadrak Amobi | Outreach Coordinator |
| Ikpembe Ita | Outreach Coordinator |
| Offiong Eyamba | Outreach Coordinator |
| Destiny Archibong | Outreach Coordinator |

**Heartland Alliance Field Staff, Kano State**

| | |
|---|---|
| Ahmaed Shehu | Accountant |
| Abubakar Ahmed | Case Manager |

**MDAS & USIP, Kano State**

| | |
|---|---|
| Dr. Saadatu Sand | Director General (KSACA) |
| Ali Baba Isyaku | Coordinator (NEPWHAN) |

| | |
|---|---|
| Fatima A. Ibrahim | Executive Director |

**Community Base Organization/NGOs**
**Advocatde fpor Grassroots Empowerment (AGE), Kano**

| | |
|---|---|
| Nassin .A.Sallau | Executive Director |
| Odeyemi Temitope | Program Officer |
| Ibrahim Kabir A | Strategic Information Officer |
| Muhammad Abdallah Riskuwa | Member |
| Agie Muhd Auwac | Admin& Finance |
| Ismail Mohamad | Logistics |

**Peer Educator Kano State**

| | |
|---|---|
| Eche Fedinard | Peer Educator |
| Malik Haruua | Peer Educator |
| Auwalu Idris | Peer Educator |
| Nuhu Ibrahim | Peer Educator |
| Ibrahim Mond | Peer Educator |
| Dauda Ahmad Sani | Peer Educator |

**Outreach Coordinator Kano State**

| | |
|---|---|
| Yahaya Hassan | Outreach Coordinator |
| Ali Bubu | Outreach Coordinator |
| Tasiu Musa | Outreach Coordinator |
| Muhammad | Outreach Coordinator |
| Ismail Mohammed | Outreach Coordinator |
| Agie M. Auwal | Outreach Coordinator |

**Heartland Alliance Staff, Lagos State**

| | |
|---|---|
| Daramola Christianah | Capacity Advisor |
| Arinola E. Olayem | Accountant Advisor |

**MDAs & USIPS, Lagos State**

| | |
|---|---|
| Dr. Ogi Paul O | Medical Officer |
| Olusola Samuel | Counselor |
| Okoh Florence | Counselor |
| Dr. Shola Ogunton | Medical Officer |
| Dr. O.O. Fisher | Sexual prevention officer |
| Michael Essien | PP |

**Community Base Organization /NGO**
**The Initiative for Equal Rights (TIER), Lagos**

| | |
|---|---|
| Makanjuola Oluwk | Deputy Chief of Party |
| Ohazurume chisom | Strategic information officer |
| Adebo Joy | Care Manager |
| Oke Temitope | Program Officer |

**Peer Educator Lagos State**

| | |
|---|---|
| Faye Charles | Peer Educator |
| Peter Kiss | Peer Educator |
| Morris O. Michael | Peer Educator |
| Gbenga | Peer Educator |
| Eric Nwanso | Peer Educator |
| Oldipe Olubiji | Peer Educator |

**Outreach Coordinator Lagos State**

| | |
|---|---|
| Jonathan | Outreach Coordinator |
| Tumbi Crown | Outreach Coordinator |
| Adola Yomi | Outreach Coordinator |
| Princewill Achebiri | Outreach Coordinator |
| Austine Afaha | Outreach Coordinator |
| Onitilo Taiwo | Outreach Coordinator |
| Hussain Idrees | Outreach Coordinator |
| Jonathan Tammy | Outreach Coordinator |

**Heartland Alliance Field Staff, Rivers State**

| | |
|---|---|
| Lucky Apumaga | Accountant |
| Dike Akamriocha | Case Manager |

**MDAS & USIPS, Rivers State**

| | |
|---|---|
| Dennis Otobo | State Coordinator |
| Grace Ebeve | CMO |
| Dr. Yemi-Jonathan Julie | Program Officer Rivers/Abia |

**River State LIPS**

| | |
|---|---|
| Charles Benson | Program Officer |
| Austine Oladopa | Executive Director |
| Ojerwe Clement | Palliative Care |
| Mark .D. Ndukwe | Human Right Officer |
| Hart Daniel | Strategic Information Officer |

**Peer Educator River State**

| | |
|---|---|
| Chamberlin Brown | Peer Educator |
| Darlington Amadi | Peer Educator |
| Gina Samuel | Peer Educator |
| Daries Akoye | Peer Educator |
| Chelsea Brown | Peer Educator |
| Ibisiki Loveday | Peer Educator |

**Outreach Coordinator River State**

| | |
|---|---|
| Charles Pepple | Outreach Coordinator |
| Bestman | Outreach Coordinator |
| Mark David | Outreach Coordinator |
| Mba Rose | Outreach Coordinator |
| Awuegbu Klinto | Outreach Coordinator |