# Nigeria

## Key Populations' Strategic Priorities

## Introduction

By the end of 2024, Nigeria's National Key Population (KP) programme operated through differentiated service delivery models across most states, with PEPFAR supporting efforts in 32 (of 36 States), as well as the Federal Capital Territory (FCT); and Global Fund to Fight HIV, TB and Malaria coordinating with government in four additional states. The country had 29 KP service delivery sites and the programme utilised the Federal Ministry of Health approved and endorsed One Stop Shop (OSS) model as a "hub", and peer educator outreach workers (including virtual outreach) as "spokes" to provide community-centred services for and with KPs where they live and work. These OSSs provided services to men who have sex with men (MSM), people who use/inject drugs (PWUD), sex workers (SW), and transgender persons (TG). They offered access to HIV prevention services, HIV testing, antiretroviral therapy (ART) and pre-exposure prophylaxis (PrEP), supplemented with wrap-around services to address co-morbidities, including sexually transmitted infection (STI) diagnosis and treatment, TB prevention services, random blood sugar, viral hepatitis screening and treatment, orphan and vulnerable children services, mental health and psychosocial services (MHPSS), gender-based violence (GBV) mitigation, among other general community support services. While impressive, OSS at times had service gaps, especially for transgender persons and people who use/inject drugs, due to stigma, data opacity, coverage issues, a lack of targeted programming as well as inadequate resources for harm reduction and other interventions. In total, it was estimated that over 600,000 KPs were receiving HIV prevention services, with just under 230,000 KPs enrolled in ART.

Over the past six months, Nigeria has experienced significant and ominous shifts in KP programming due to the US funding cuts, resulting in major disruptions to service access, a lack of tracking of any data on KPs, as well as an uptick in serious physical, mental health, morbidity and mortality for KPs. OSSs were either closed or renamed and programmes transitioned to serve more general populations. For example, Heartland Alliance LTD/GTE suspended all their KP-focused prevention programming, and focused services solely on treatment. In Rivers, Delta and Abia States, implementation of KP programming shifted to more general service delivery with implementing partners (Diadem Consult, CARITAS Foundation and Excellent Community Education Welfare Scheme) renaming their OSSs, transitioning staff and programing to serve more general populations with no mention of KP-competent services.

Centre for Population Health Initiative in Lagos funded by DoD-HJMRI was also changed their KP programming to a more general HIV programme. Since February 2025, APIN and Society for Family Health (SF) in Benue, Oyo, Ondo State transferred all KPs clients to general population facilities without involving KP community based organisations.

KP peer outreach staff are no longer providing life saving prevention and treatment services, including psychosocial support. All mobile outreach services implemented by capacitated and competent KP- led organisations were also suspended. These disruptions have caused major anxiety among KP communities, and implementing partners (IPs) have tried to bridge the gaps through integration for KP services.

Nationally, nine SW-led organisation members of the Coalition of Sex Worker Rights Movement (COSWRIM) and 29 MSM-led organisations affiliated with the Open House Network (OHN), Network for Rights and Community Inclusion and the MSM-TG Network, 6 organisation of Trans and Intersex Network, 16 organisations from Nigeria Network of People who use Drugs (NNPUD) and Drug Harm Reduction Network (DHRAN) are currently non-operational.

For people who use drugs (PWUD), as of December 2024, harm reduction services were already in limited supply, and since January 2025, no new supplies have been delivered in states such as Abia, Gombe, Kwara, Akwa Ibom, and Lagos.

As of mid-2025, the Nigerian KP response faces dire challenges, with many members reporting lack of access to KP-competent ARV services, and no prevention services. These deficits are compounded by a lack of GBV response, MHPSS, and other emergency services. Of the 120 organisations who are a part of the Nigeria Key Populations Health and Rights Network (formerly the KP Secretariat), only two report receiving minimal "bridge funding" from

private funders or prior social enterprise schemes to maintain limited services. Most KPs have been forced to return to mainstream health facilities for their ARVs, where persistent stigma, discrimination, and fear of disclosure of their KP identity or HIV status limit uptake, especially among transgender people and transgender SW community members who report high levels of mistreatment.

**What does the data say about HIV prevalence among KPs in Nigeria[1]?**

- Transgender individuals (TG): 28.8% (95% CI: 27.4–30.2%)
- Men who have sex with men (MSM): 25.0% (95% CI: 23.7–26.3%)
- Female sex workers (FSWs): 15.5% (95% CI: 14.3–16.4%)
- People who inject drugs (PWID): 10.9% (95% CI: 9.9–11.8%)

**Where is Nigeria on the 95/95/95 track[2]?**

- 94% of people living with HIV know their status
- 98% of those who know their status are receiving antiretroviral therapy
- 95% of those on treatment have achieved viral suppression

**Where are Nigerian KP's on the 95/95/95 track[3]?**

- Transgender individuals (TG): N/a
- Men who have sex with men (MSM): 39%:39%:98%) (FY24 Q1)
- Female sex workers (FSWs): 81%:81%:95% (FY24 Q1
- People who inject drugs (PWID): 39%:38%:99% (FY24 Q1)

## KP Community Core Priorities

## 1. Antiretroviral Therapy (ART) and Service Continuity

Nigeria's KP programme has the following components for ART; antiretroviral therapy (ART) initiation and follow-up, viral load testing and monitoring, adherence support through community ART groups or peer navigators and treatment of opportunistic infections. These services were accessible to KPs through differentiated service delivery (DSD) models to improve access such as community ART refill clubs, one-stop shops (OSS), drop-in centres (DICs), and mobile outreach units. These services were not always accessible to all KPs due to stigma and while community-based ART distribution and mobile outreach existed, they remained limited in scale and inconsistent in coverage across states.

After the funding cuts, 88% (32/36) of the states offering ART to PLHIV were affected. Only an estimated 29[4] sites or facilities including those serving the general population attended by KPs providing or supporting treatment for KPs living with HIV remain operational in June 2025 compared to December 2024. None of the KP led sites that offered service delivery supported by PEPFAR remain open. The 11 organisations offering KPs services that remained open changed their names and functions to offering services to the general population instead of KP specific services. Access to services by the communities moved from the OSS to the local vendor medicines (chemist).

[1] https://pubmed.ncbi.nlm.nih.gov/39379313/ [2] https://radionigeria.gov.ng/2025/07/22/nigeria-closing-in-on-unaids-95-95-95-hiv-target-nascp/
[3] PEPFAR Midpoint report [4] Data from KP leaders working across Nigeria

**Non-negotiable Priorities:**

- **Restore PrEP access by re-establishing oral and injectable PrEP access points within community-led DICs** to reverse coverage declines and meet current demand among KPs, while also expanding condom and lubricant distribution to ensure their consistent availability for key populations.
- **Invest in KP-led social enterprise initiatives for sustainability of HIV programs** and advancing human rights initiatives beyond donor cycles.
- **Expand access to harm reduction services and products to all states abandoned by PEPFAR,** ensuring that People who use/inject drugs are not left behind and can access life-saving care regardless of location.
- **Protect structural interventions and expand enabling policies:** Given the hostile legal and socio-political environment in Nigeria for SWs, TGs, MSM and PWUDs, structural interventions must remain funded and scaled. For example, address transgender community exclusion from government reporting templates that only recognise binary biomarkers, and Priorise, domesticate and enforce the HIV anti-stigma and discrimination law and violence against persons prohibition law by state governments to ensure quality services at general health delivery centres.
- **Prioritise local and community ownership including investment in KP-led structures for sustainable long-term programming:** Transition from donor-dominated programmes to local ownership and control with direct funding mechanisms. Address the current reality where only one sex worker and three MSM-owned and managed clinics exist to provide comprehensive services, as well as other KP groups who rarely operate their own OSSs.
- **Sustain community-led prevention and peer navigation** to ensure peer-friendly HIV prevention information, commodity distribution, linkage to services, and adherence support.
- **Advocate and invest in the inclusion of SOGIESC in the medical curriculum** for all health practitioners in public facilities to ensure access to services, KP sensitivity, data privacy, and anti-discrimination to sustain service access.
- **Maintain and fund community-led monitoring (CLM)** as an accountability mechanism for tracking the impact of the KPs programme.
- **Prepare for LEN rollout:** Restore foundational systems to ensure Nigeria is ready to fully implement the Global Fund-supported introduction of injectable Lenacapavir for PrEP among KPs.

| Strategic Element | Current Status | Annual Funding Required | Notes |
|---|---|---|---|
| **ART commodities** | Available but only in general facilities | $1,889,551 | Ensure that ART is available at community-led clinics |
| **KP-specific ART sites** | 90% terminated as the KP specific sites changed to serving general populations. | $5,609,291 | Clinical programmes at KP-service delivery sites need to be restored.<br><br>6 non-KP led clinics are functional, they no longer operate as KP clinics but as general population clinics, while the three KP led clinics are self funded by the organization |
| **Peer cadres and Outreach Workers support** | 100% terminated | $12,076,480 | Restore community peers to ensure that KPs have community support and support peer outreach, mobile services, and facility-based support. Each peer Cadre receiving a monthly stipend of $50 and each Peer educator a stipend of $130 |
| **KP-friendly public sites** | Limited due to unfriendliness | $3,339,385 | Stigma reduction interventions need to be reintroduced along with facility-level KP competency training. |
| **Viral load (VL) monitoring** | Not available at community level | $100,000 | Community-level mobile clinic facilities were terminated and KP cannot access VL services closer to them. |
| **TB diagnosis and prevention** | Limited access | $100, 000 | TB screening and management should be provided at all primary health centres |

**ART Funding Gap:** Approximately **$23,114,707** annually to restore comprehensive, peer-supported ART services for KVPs.

**What is the cost of inaction?** A lack of access to ART for KPs in safe spaces will lead to increased disengagement from care, increased HIV transmission, increased AIDS related mortality and morbidity and will undermine Nigeria's HIV response.

## 2. Primary Prevention

KPs in Nigeria continue to have a disproportionately high rate of recent infections. Effective case finding and client-centred comprehensive services that delivered services in safe spaces in a non-discriminatory manner remained a high priority. The prevention programme for KPs included HIV testing services (HTS) including provider-initiated, self-testing, and community-based approaches as one of the entry points for prevention, condom and lubricant distribution, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), behavioural interventions — including peer education, counselling, and risk reduction planning, sexually transmitted Infections (STI) screening and treatment, cervical cancer screening, contraceptive services, gender-based violence (GBV) prevention and response, needle and syringe programmes (NSP), opioid substitution therapy (OST), e.g., methadone overdose prevention and naloxone, hepatitis B and C screening and vaccination/treatment, among others. However, access to services such as STI management, condoms and lubricants, oral PrEP remained inadequate. Prior to the cuts, the number of KPs reached with HIV prevention interventions by Q4 in 2024 was 1,515,699 (through Q4) which was an achievement of 317.11% showing that the demand was already larger than the access KPs in Nigeria were receiving.

Since January 2025, KP-specific mobile prevention and treatment outreach efforts have stopped in most states, especially impacting hard-to-reach and diverse KP populations. There has also been a lack of physical and virtual peer outreach workers encouraging members to seek services. These closures have reverberated throughout KP communities, with many clients not motivated to seek out services at public health facilities[5].

After the funding cuts, KP community members report recurring stock-outs of HIV test kits, PrEP, STI diagnostic and treatment medications, condoms and lubricants across several facilities, including in many of the mainstream and stigmatising public facilities where KPs are now being referred. Community HIV testing for KPs has also been significantly impacted due to disruptions in the community health workforce. In facilities that do have commodities, some KPs are being charged double the standard amount, resulting in increased untreated STIs in the community[6].

In January long-acting injectable PrEP, specifically cabotegravir (CAB-LA), was introduced and launched in Nigeria as a new HIV prevention option. Initiated in only in Lagos as a pilot, supply chain and community-based distribution efforts have been thwarted due to the funding cuts e.g. CAB LA access at the USAID funded pilot through the Initiative for Equal Rights' health facility was halted after the USAID funding pause in January 2025. Currently, the remaining CAB-LA vials available in the State have not been distributed to the community since May 2025.

While the Global Fund supported commodities for the provision of harm reduction services for clients who use drugs in Lagos, Rivers, Cross rivers and Akwa Ibom, PEPFAR was expected to support all costs associated with service delivery and programme implementation which have since greatly affected access to services. Other comorbidities such as Hepatitis B and C screening and vaccination services, while never prioritised, continue to be deprioritised for the community.

[5] Community-led monitoring coordinated by NKPHRN and NEPHWAN [6] Community impact assessment on the impact of the funding freeze in Nigeria

| Strategic Element | Current Status | Annual Funding Required | Key notes |
|---|---|---|---|
| **Oral and injectable PrEP Commodities** | KP specific service closed across KP specific centres and rebranded to general populations | $59,078,751 | Restore PrEP access, including supply chain and last-mile delivery and |
| **PrEP sites and KP friendly sites** | KP-led PrEP site closed/ rebranded to general populations | $16,042,643 | Restore closed KP-specific PrEP sites with peer support to increase access and scale up KP sensitisation as general health facilities require KP-specific service capacity and training |
| **Demand creation and awareness building** | Prevention Demand Creation | $8,419,900 | Expand demand creation for oral and injectable PrEP including Lenacapavir and CAB- LA |
| **Demand creation for new PrEP products and broader prevention awareness** | Unavailable | $4,319,900 | Create demand for new PrEP products |
| **Support for policy amendments to include new PrEP products** | Needs update to include new PrEP products | $1,046,919 | Update policy and SOPs to include new PrEP options |
| **Prevention Commodities** | Supply chains disrupted | $1,600,000 | Condoms, lubricants, and HIV self-testing kits need to be restored and distributed through community networks |
| **MAT sites, safe injecting equipment** | Gaps in community-level access and | $3,291,760 | Restore last mile support for harm reduction |

**Prevention Funding Gap:** Approximately **$93,799,873** annually to restore comprehensive, peer-supported Prevention services for KPs.

## 3. Community Infrastructure

Based on KP community input and government endorsement and support, Nigeria was on track to strengthen and sustain a dynamic, robust and expansive KP programme, offering evidence- based differentiated service delivery (DSD) models for HIV services. Over 18 years in the making, Nigeria's coordinated national KP strategy and programme had developed core standards for DSD services, including KP-specific OSSs, mobile outreach strategies (including virtual programming), often with the goal of being implemented by KPs themselves. In addition, the national programme offered KP-competency training for professional and line staff from mainstream public health facilities, towards greater integration of services. IPs worked with KP-led and KP-competent organisations in most states to offer comprehensive HIV services, including HIV testing, counselling, ART, oral PrEP and condom/ lubricant availability, mental health and psychosocial support, STI diagnosis and treatment, gender-based violence mitigation and prevention, among others. In January 2025, Lagos-based IPs also initiated injectable PrEP services.

While each state and IP had its challenges, investments and government interest were growing in KP-led and competent CSO partners to implement these services. Services were stronger in urban areas, with pilot sustainability strategies started in Lagos by state government accreditation of KP-focused OSSs, thus seeing cost reimbursement from the National Health Insurance Scheme (NHIS) for such services as community-based HIV/ STI/TB testing and treatment. Mobile outreach (including virtual) was supported mostly in larger urban centres, with limited and inconsistent coverage in smaller urban centres and rural areas. Since the funding cut, only a few KP-led OSSs that offer limited services and ability to meet demand are still functional e.g. Greater Women Initiative for Health and Rights, located in Rivers State, Community Health Initiative for Youth in Nigeria in Niger State, International Centre For Advocacy On Right To Health in FCT and Olive Right to Health Initiative (ORHI) located in Nasarawa State and FCT). All of them have either longstanding funding for efforts or private foundation and individuals who have supported them with emergency funding for a few months. There is a massive gap in terms of meeting KP-specific needs. Mobile outreach efforts have been halted in several hard-to-reach areas due to lack of funding and specialised wraparound services at over 80 One-Stop Shops have been disrupted in one way or another. The stigma faced by KPs has risen by 95% as communities no longer have safe spaces for engagement and to access services which is especially higher among MSM, transgender people and LBTQ sex workers whose stigma was high even before the funding cuts[7].

**Drop-In Centres and Safe Spaces**

Most KP organisations report stigma, discrimination and violence (SDV) at public health facilities. Many KPs fear ill treatment or arrest if they visit public health facilities and if they disclose their identity. In particular, transgender and gender non-conforming individuals continue to face increased stigma and verbal abuse at both primary healthcare centres and tertiary hospitals across states. While some health workers trained under KP-competent service delivery frameworks remain committed, noticeable gaps exist among staff members with hostile attitudes. The national government via National Agency for the Control of AIDS (NACA) has been open to increasing KP-competent services at government facilities. For example, NACA was in partnership with Clinton Health Access Initiative (CHAI) in Kano and Imo states to offer KP-competency training for workers in government facilities and the community to address this gap.

With the loss of funding, infrastructure that supported efforts to address structural barriers to HIV epidemic control for KPs have collapsed. Various organisations had secured funding from public, private, government and individual sources to provide services such as GBV mitigation food provision, emergency shelter and economic empowerment activities; noting these services were implemented via PEPFAR or GFATM supported OSSs, however, funded by alternative means. Without these additional services, KP clients are not motivated to seek care in more mainstream facilities.

[5] Data from CLM reports and the community impact assessment on the impact of the funding freeze in Nigeria

Nationally, nine sex worker-led organisational members of the Coalition of Sex Worker Rights Movement (COSWRIM) and 17 men who have sex with men (MSM)-led organisations affiliated with the Open House Network (OHN) and the MSM-TG Network are currently non-operational. As of September, the 29 DICS and OSS's have closed, the sites that had remained open received a close out letter and were expected to return office assets.

**Peer Navigation Programmes**

Peer-led outreach, peer navigation, and case management models were being scaled to meet the enormous task of reaching all KPs in need. With OSSs as a base, both physical and virtual safe spaces were being created and utilised for KP community members to access information and get their questions answered. These efforts were in the process of formalising what for decades had been conducted on an informal basis.

Unfortunately, limited budgets and often low stipends for peer outreach workers inhibited efforts and at times caused burn out. Engagement of some IPs that were not as KP-competent and treated some KP leaders with disdain were also a challenge. While the national response was engaging the Ministry of Justice to reduce police intimidation, at times rogue police officers would threaten or actually arrest KPs, including in some instances peer outreach workers providing outreach services.

After the funding cuts, only two organisations offer GBV response, psychosocial support, and services such as food provision, emergency shelter, and mental health support. The others have faced serious service interruptions, and there are no plans for referrals to other facilities. The sex workers organisations DICs within theCOSRIM network no longer provide peer HIV services.

As of September, peer navigators have been terminated.

**Engagement in National HIV Planning**

After many years, KP community leaders united around a common national Nigeria Key Populations Health and Rights Network (NKPHRN) - comprising Eight (8) KP National Networks, to work alongside Network of People Living with HIV and AIDS in Nigeria (NEPWHAN) as a national level advocacy effort. The NKPHRN has raised the level of KP community engagement at the national level, and has worked with government, donors and IPs to integrate greater KP voices and lived realities into HIV programming. The NKPHRN and its members are increasing organising power for meaningful engagement in national and state-level HIV planning processes, as well as with processes to influence donor commitments.

The loss of funding has weakened KPs 'capacity to engage with stakeholders and participate in technical and review meetings. There is limited space for meaningful engagement in national and state-level HIV planning processes at has led to limited KP voices in decision-making. Evidence gathering, community consultations, and documentation of lived experiences have declined, eroding the data needed to influence policy and programme direction. Sustainability planning is still happening; however, as a result of the funding gaps, the continuity of meaningful investment in KP-led structures in the country is unclear given that the only source of funding to sustain national KP structures is from Global Fund.

**Community-led monitoring**

Under PEPFAR and GFATM, numerous KP-led CSOs were capacitated and contracted to conduct regular community-led monitoring (CLM) processes, offering direct feedback and support to health facilities and OSSs serving KPs. With robust data collection systems spearheaded by NEPHWAN under the GC7 funding covering 13 States, KP communities have increased their abilities to make change at the site, local, state and national levels. However, the TB and ACOMIN Networks, implemented in 23 States, have limited KP engagement in their CLM processes. After the funding cuts only the GF CLM continues to be implemented. The KP-led CLM funded by PEPFAR was terminated.

| Component | Current Status | Annual Funding Gap | Explanation |
|---|---|---|---|
| **National KP coalition** | Lacks funding | $2,539,370 | KP organisations need funding to coordinate and support community members. |
| **KP advocacy and accountability organisations** | Organisations ceased or reduced operations | $7,319,200 | Support KP organisations to resume advocacy and service provision for KPs. |
| **Legal and rights protection services and violence prevention services** | Support for structural interventions were fully terminated. | $4,097,497 | Train health care workers and police to protect rights for KP and work with KPs to conduct activities that support their rights. |
| **Community-led monitoring** | All programmes ceased operations | $10,298,000 | Support four organisations conducting community-led monitoring. DICs are costed in the ART section |

**Community Infrastructure Funding Gap:** Approximately **$24,254,067** annually to rebuild essential community systems and protective mechanisms.

**What is the cost of inaction?** The community infrastructure is critical to the overall success of the KP programme. Should the KP programme's community infrastructure not be supported fiinding KP populations who are often hiding due to stigma and fear of arrest will be harder. KPs will not longer be able to easily protected themselve and seek treatment affecting the overall success of the HIV programme.

## 4. Data and Monitoring Systems

Access to KP-specific data declined significantly due to service disruptions, staff losses, and weakened supply chains. Before the funding freeze, community organisation were able to find link and retain KP in friendly service delivery sites where there data was collected and shared with national systems for better overall HIV programming. However, after the funding cuts, KP sites were closed or refocused to serve the general populations breaking down data collection systems that captured critical KP data. The funding cuts also led to the loss of KP disaggregated data as general service delivery sites do not offer safe space for KPs to self identify while receiving services to allow the continuation of data collection. Transgender communities have been particularly impacted, as they often face extreme stigma, discrimination and violence, and are excluded from government reporting templates that only recognize binary biomarkers.

**Non-Negotiable Priorities**

- **Restore high-quality, disaggregated data for all populations,** including TGs for an effective prevention and treatment programme.
- **Restore staff who supported data collection.** This includes data clerks, health records and information officers and M&E officers including peer educators and field officers/outreach workers.

| Strategic Element | Current Status | Funding Required | Key notes |
|---|---|---|---|
| **Disaggregated data** | Not collected | $6,043,352 | Restore and maintain a high-quality, disaggregated data |
| **Data reporting staff** | Currently not funded | $6,043,352 | Support data collection by restoring funding support for M and E and peer educators |

**Data and Monitoring Systems Gap: $12,086,704** annually to rebuild data and monitoring

**What is the cost of inaction?** Planning for the KP programme needs KP disaggregated data for the HIV program to effectively plan a successful overall response. The lack of KP data will lead to poor programming due to a lack of understanding of access by the most critical populations.

## Summary of proposed cost of the Nigeria Key Population Plan

**Targeting and Costing Methodology**

In Nigeria, the methodology used the National population size estimates from PEPFAR and UNAIDS KP Atlas. Where lacking an estimate for TG, a standard percentage from the region is used. We considered the percentage of KPs that need prevention services (set initially at 90%). We further estimated KP living with HIV using HIV prevalence from PEPFAR or the KP Atlas. Where lacking prevalence data, a standard percentage from the region is used. We had considered % of KPLHIV in need of treatment services (set initially at 100%). To meet the Nigeria budget, the country will focus on 100% of treatment and 100% as indicated below. Prisoners and clients of FSW are not included in the costing exercise.

The itemised costing of each intervention is found on this link: Nigeria Targeting and Costing

| Nigeria Priorites | Costs | Total | Cost per target | General costs | GBV | Testing | TX | Biomedical Prev | STI | MAT |
|---|---|---|---|---|---|---|---|---|---|---|
| **Priorites** | **Costs** | **$154,255,344** | **$186** | **$11,233,418** | **$496,351** | **$6,626,104** | **$22,466,230** | **$101,239,658** | **$11,484,833** | **$708,750** |
| | **Percent of total** | | | **7.28%** | **0.32%** | **4.30%** | **14.56%** | **65.63%** | **7.45%** | **0.46%** |
| | | National Targets | | | | | | | | |
| Targets | KP Treatment | **150,700** | | | | | | | | |
| | KP Primary Prevention | **679,100** | | | | | | | | |
| | Total | **829,800** | | | | | | | | |

## Methodology

This rapid strategy and costing exercise was designed as a structured assessment process to capture country-level impacts of foreign aid transitions and identify essential services requiring continued investment for KPs. The methodology began with orientation to a standardised Excel worksheet framework designed to systematically capture country coalitions' assessments across three critical domains: ART service delivery, HIV prevention programming, and community infrastructure (including civil society engagement, community-led monitoring, community mobilisation, and advocacy capacity).

The assessment process examined three distinct time periods: baseline status at the end of 2024, immediate impacts following foreign aid transitions that began in January/February 2025, and current conditions as of June 2025. Country coalitions collected quantitative and qualitative data through surveys, key informant interviews, organisational assessments, and coalition consultations to document service disruptions, funding gaps, and programmatic changes across these timeframes.

Following data collection, coalitions engaged in facilitated consensus-building processes to analyze findings, identify priority concerns, and develop collective views on current programming status. Through these discussions, coalitions articulated their "essentials"—critical activities, services, and investments necessary to maintain effective HIV responses for KPs in their contexts. This worksheet was used as the basis for a strategy narrative, developed by the GBGMC support team, that included a summary table of priority interventions requiring funding and attention.

## Nigeria Team

Leaders of key population (KP) networks and community-led organizations convened in Abuja for a physical strategy meeting to reflect on pressing challenges, emerging opportunities, and the collective vision for advancing the rights, health, and well-being of key populations in Nigeria.

The meeting provided a platform for meaningful engagement, inclusive dialogue, and evidence-based reflection. Representatives from diverse key population constituencies shared lived realities, community-led research, and programmatic lessons, which guided the deliberations and strengthened the relevance of the discussions.

Through a participatory and consensus-driven process, the leaders collectively identified and agreed on a set of priorities that reflect the immediate and long-term needs of key populations. These priorities are anchored in community expertise, human rights principles, and a shared commitment to equity and justice.

The outcome of this meeting reaffirms the leadership of key population communities in shaping advocacy and programming, while also serving as a unified framework for engagement with government, development partners, and other stakeholders. The priorities developed represent not only the aspirations of KP communities but also a call to action for stronger partnerships, accountability, and investment in community-led response

## The Team

We thank the many advocates, organisations, and government partners who participated in national consultations and supported the drafting of each plan. Your leadership and lived expertise are at the heart of this work.

This country planning journey was powered by the unwavering spirit and vision of communities who believe HIV responses must be led by those most impacted. Country team listed here;

Mobile Foundation for Health Security and Rehabilitation (MHSR)

Youth Awake for Better Society (YABS)

Greater Women Initiaive for Health and Right (GWIHR)

Happiest Ones Health Support And Rights Initiative

Think Positive Live Positive Support Initiative

Maintaining Healthy Behaviour Initiative

Equal Health and Rights Access Advocacy Initiative-EHRAAI

Response to Health and Rights Initiative (RHRI)

Centre for Reproductive and Health Guide Initiative

Golden Women Initiative Nigeria (GOWIN)

New Wave Initiative for Adolescent and Women (NWIAW)

Good Women Association

Society for Human Health Essential Development Program (SoHHEDP)

Round Care Development Initiative

Access to Health and Rights Development Initiative (AHRDI)

Harmony Caregivers Foundation (HCF)

Inclusive care foundation (ICF)

Royal women health and rights initiative

Improved Sexual Health & Rights Advocacy Initiative (ISHRAI

Human and Health Right Support Initiative (HRI)

The Initiative for Equal Rights (TIERs)

Mistletoe Community Health & Right Initiative

Community Health Initiative for Youths in Nigeria (CHIYN)

Global Women's Health, Rights and Empowerment Initiative (GWHREI)

Olive Right to Health Initiative (ORHI)

Initiative for Health and Right (IHR)

The Momentum Support Initiative (TMSI)

Drug Free Preventive Healthcare Organisation (DAPHO)

Taimako Health Support Initiative (THSiN)

TIMED Nigeria

Coalition of Sex Workers Rights Movement in Nigeria (COSWRIM)

Network for Rights and Community Inclusion (NERCI)

Open House Network

Trans/Intersex Network Nigeria (TIN)

MSMTG Network

Drug Harm Reduction Advocacy Network (DHRAN)

Nigeria Network of People who use Drugs (NNPUD)

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