Determinants of Access to Healthcare Among Trans Women in North Central Nigeria

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Introduction

Trans women lack visibility and support in Nigerian society. They are often subjected to physical and verbal abuse based on gender. Intolerance perpetrated against trans women in Nigeria is based on many factors, such as religion, culture, legal structures, and political climate. Trans women are not accepted in religious and cultural circles. Most religious groups in Nigeria perceive trans women as an aberration. Furthermore, there are no legal structures in place which protect the rights and existence of trans women. Political discourse in Nigeria is silent about issues relating to trans women. This situation breeds intolerance and violence against trans women. Despite these challenges, trans women still exist and continue surviving in Nigerian society.

All of the above factors, present barriers for trans women in accessing Nigerian health services. This paper aims to investigate how trans women in Nigeria deal with the challenges of their situation and consequently, the extent to which they can access healthcare.

Section I presents an overview of the context of healthcare provision in Nigeria. Section II outlines the state of existing knowledge about the determinants of access to healthcare for trans women in North Central Nigeria. Section III describes the method and findings of the present study. Finally, conclusions and recommendations for future work in this important area are presented.

Section I – the Context of Healthcare Provision in Nigeria

Nigeria is made up of 36 states and the Federal Capital Territory (FCT), Abuja which are grouped into six geo-political zones: North East; North West; North Central; South East; South West and South Kombo. The states which comprise the North Central are: Niger, Kogi, Benue, Plateau, Nassarawa, Kwara and the FCT, Abuja. There are various estimates concerning the population of Nigeria. This is because the last population census was held in 2006 and estimates rely on yearly population growth rate projections. The World Bank (2018) estimates the population of Nigeria to be 195,874,740 people. The Department of Foreign Affairs and Trade, DFAT (2018) finds that there is poor access to healthcare in Nigeria, because demand for public healthcare exceeds supply. Apart from inadequate access to healthcare, the quality of medical service is insufficient. Most Nigerians are unable to afford healthcare. According to The Economist Intelligence Unit (2017), the country is among the five lowest performing countries in the area of equity of access to healthcare. The five lowest performing countries in regard are as follows: Nigeria, Democratic Republic of Congo, Cambodia, Ethiopia and Bangladesh. Each of these countries are populous and economically disadvantaged.

In Nigeria, health services are provided by the government (federal, state, and local); non-governmental organizations; religious organizations; communities and private individuals. Irrespective of the various health service providers, user fees (i.e., immediate cash payment required to access healthcare services) are required from patients to access healthcare services. The percentage of patients who have healthcare insurance is negligible.

Section II – Background to the Study

The healthcare needs of trans women are diverse. They include general healthcare, gender affirming hormone therapy and surgical procedures, as well as psycho-social support. In addition, trans women require regular screening for sexually transmitted infections (STI) and HIV. UNAIDS (2014) estimates that 19% of trans women globally are living with HIV and chances are 49 times higher for trans women to acquire HIV than other adults of reproductive age. Due to this fact, sexual health clinics which focus on key populations in response to the HIV epidemic in Nigeria, often provide services to trans women.

Most of these clinics are trans-friendly and provide treatment for STIs and HIV. However, they do not cover other health needs of trans women.

Several factors determine whether trans women in North Central Nigeria have access to healthcare. They will be explained in this section.

Family Ties and Support

The level of support which trans women in central Nigeria receive from their families vary. In general, trans women are more likely to be supported if their families have higher literacy, greater exposure to information and enlightened social networks, live in an urban area, are of higher socio-economic status, and/or are non-religious.[1] Trans women who have greater support from their families generally have better access to healthcare than those who face hostility and ostracism from their families. Rider et al. (2018) as well as Gower et al. (2017) agree that when families are supportive, patients are protected from discrimination by other people. These patients are protected psychologically because they have family members to turn to when they face discrimination and other forms of maltreatment. By contrast, rejection from family is directly and indirectly detrimental to health.

Level of Education

The level of education that trans women in Nigeria have attained is a significant determinant of access to healthcare. Trans women who have achieved, for example, a bachelor's degree (or beyond), are likely to have better knowledge about healthcare procedures that are available to them. This subset of trans women better understand the benefits, dangers and intricacies of trans affirming healthcare. Furthermore, they are information-seeking, and this often translates to better health outcomes. The opposite is the case when levels of education are low.

Exposure

Urbanization and travel lead to interaction with like-minded people and experience-sharing. This facilitates exposure to trans community, information and support, and increase health seeking behavior among trans women. Latunji and Akinyemi (2018) define health seeking behavior as steps taken by individuals in search of a solution to health problems. Individuals with low health

1 Some Christian groups in Nigeria accept trans women more than others.

seeking behavior are more likely to turn to alternative methods, such as self-medication, traditional healers, and patent medicine vendors[2].

Trans women who are exposed to a broader trans community and resources are more likely to seek healthcare beyond services available in Nigeria. Closely related to this phenomenon is the awareness created when trans women are exposed to media, especially the internet and social media. The ability to connect and share information with other trans women has significant implications on accessing healthcare in North Central Nigeria. While health services physically located in Nigeria are often unable to cater to the needs of trans women, if their financial situation allows them, trans women can access some health services over the internet. Online consultations, medication online orders and bookings for medical 'tourism' can all be found in the digital space. The community of trans women in Nigeria is divided between those who are exposed to additional information and access, and those who are not, with the former experiencing generally better health outcomes.

Income Distribution

Income distribution is an important determinant of access to healthcare among trans women in North Central Nigeria. Trans women who have a means of livelihood have better access to healthcare because they can afford to pay for healthcare services when necessary. On the other hand, trans women who do not have viable revenue streams have difficulties in accessing healthcare. With the lack of health insurance for many people in Nigeria, personal income is vital for accessing healthcare. The higher the income of a trans women is, the easier it is to pay for medical services out of pocket.

The World Bank (2015) notes that out of pocket spending accounts for significant expenditure on healthcare in Nigeria, where the public sector spends less than or around 1% of GDP on healthcare. Meanwhile, the World Health Organization (2014) estimates that health accounted for only 8% of budgetary spending in Nigeria. Low overall spending on health services has the additional effect of driving prices for health services up, in contrast to countries with systems of universal health insurance.

2 In Nigeria, *Patent Medicine Vendors* are government approved shops which sell medicines to members of the public often without prescriptions.

Quality and Quantity of Healthcare

Trans women's perceptions about the quality of healthcare available also affect the possibilities of access. Negative perceptions of the healthcare system are rife, and well founded. Most health services do not address the needs of trans women with regard to hormonal treatments, sexually transmitted infections, cosmetic procedures, gender affirmation surgeries, etc. Due to a significant lack of these services in the Nigerian healthcare system, trans women often resort to self-medication, with advice from other trans women within their social circles. Trans women with low economic resources turn to alternative medicine (i.e., traditional medicine) and untrained personnel. Often these untrained personnel pretend to be medical professionals for the treatment of sexually transmitted infections, like chlamydia, gonorrhea, syphilis, genital warts, etc. Also, some health facilities pose significant risk to patients due to unsafe practices. Alsulami, Conroy and Choonara (2013: 995-1008) state that unsafe care is characterized by wrong prescriptions, over-dosage and poor hospital hygiene, which often results in the death and disability of patients. Perceived notions of unsafe care circulating in social networks among trans women in decrease these women's willingness to access the available care. They avoid these health facilities and instead attempt to refer themselves to facilities which they perceive as safe and efficient.

Lack of Expertise in Trans Medicine

Trans women are not officially recognized in Nigerian society. Additionally, most medical professionals lack the medical expertise to treat the health needs of trans women. One of these needs is the prescription of gender affirming hormone therapy. Since few medical professionals in Nigeria are competent or willing to provide this kind of care, many trans women rely on the experiences of other community members and engage in self-medication. Nigeria does not have a strict system of medical prescriptions; therefore, patients are able to purchase medicine over the counter without a prescription. Self-medication occurs when trans women treat medical conditions on their own, without the supervision of a health professionals. The practice of medically unsupervised self-medication may lead to undesired outcomes. Sanchez, Sanchez and Danoff (2009) reiterate that doctors' lack of expertise in trans medicine is a major impediment to healthcare access. Trans women are rightfully hesitant to consult a doctor who may not understand their issues due to lack of expertise. Unger (2015) as well as Vance, Halpern-Felsher and Rosenthal (2015)

assert that expertise in trans medicine is lacking because it is not taught in conventional medical curricula. These factors make practitioners in general medicine ignorant when it comes to diagnosis and treatment of health conditions faced by trans women. Furthermore, Vance, Halpern-Felsher and Rosenthal (2015) add that most doctors are unable or unwilling to undertake trans specific procedures such as implants (breast, buttock and cheek), and they are unlikely to understand that trans women face a higher risk of cardiovascular diseases, cancer, depression/anxiety and alcohol/substance use. All of these factors mean that trans women are less willing to consult with doctors regarding their health needs, and when they do, the quality of care that they receive is low.

Attitude of Health Professionals in Nigeria

The attitude of health professionals in Nigerian hospitals also determines the access to healthcare for trans women. Unfortunately, Nigeria does not have legislation which protect trans women from discrimination perpetrated by doctors, nurses, ward attendants and other healthcare professionals. Owing to this, trans women in central Nigeria report unsavory practices from healthcare professionals such as: physical and verbal abuse, extra waiting times, improper/refusal of care, invasion of privacy, verbal abuse, etc. These health professionals include: doctors, nurses, lab technicians, para-medical staff, ward attendants, etc. When health professionals in Nigerian hospitals do not treat trans women with respect, trans women are unlikely to use such health services in the future.

Given this discriminatory environment in medical settings, community friendly clinics (i.e., community friendly drop-in centers and One Stop Shops, OSS) are on the rise in Nigeria. However, these friendly services are restricted to STI and HIV treatment. When they need other medical care, trans women must turn to general medical services and they are again exposed to discrimination.

Criminalization

According to Carroll and Mendos (2017), Nigeria is among the 57 countries of the world where it is a crime to be trans. Significant numbers of trans women in Nigeria are afraid of coming out to receive healthcare because they can be charged with impersonation by the police, which is a criminal offence in Nigeria (Carroll and Mendos, 2017). Makofane et al. (2012) establish a rela-

tionship between criminalization of trans women and the upward incidence of HIV among this key population. They conclude that decriminalizing trans identity will improve acceptance in society, increase access to healthcare and address the health risks associated with spread of HIV within this community. Governments of countries where being trans is criminalized need to emulate other progressive nations where trans people are legal and accepted. This is a vital precondition for improving the health of the trans community.

The Role of Traditional Medicine

Alongside Western medicine, traditional medicine is widely practiced in Nigeria. In comparison to orthodox (mainstream) medicine, traditional medicine is relatively affordable, within reach and locally available. Skills and resources (i.e., roots, seeds, herbs, potions, etc.,) are passed on from one generation to another and practitioners are found in many communities around Nigeria. The World Health Organization refers to traditional medicine as Traditional, Complementary and Alternative Medicine (TCAM)[3].

The medicines in TCAM are often herbal and unique to communities and ethnic groups all over Nigeria. Apart from the use of herbs, Adinma, Azuike and Okafor-Udah (2015) note that some TCAM approaches in Nigeria incorporate faith-based methods with the use of spirituality and prayer. The cost of TCAM is relative to the ailment being treated and the practitioners providing the service. Notions of the efficacy and cost effectiveness of TCAM fuel its popularity among some trans women. Thus, some trans women prefer TCAM over mainstream healthcare. While this is not inherently problematic, in some cases accessing TCAM can reduce propensity to access mainstream medicine. This has implications, for example, for the spread of HIV, because patients who are not accessing mainstream HIV medications are more likely to have detectable viral loads and spread HIV to others (Elsinger, Dieffenbach and Fauci (2019).

3 In Nigeria, TCAM are indigenous healthcare practices which exist outside the mainstream health system.

Section III – the Present Study

Purpose of the Study

This study aimed to further investigate the above-identified determinants of access to healthcare among trans women in North Central Nigeria. Participants were asked about their level of education and type of employment, their degree of exposure to information on trans health issues, whether they had health insurance or paid out of pocket for healthcare, the extent of family support and whether families were involved in paying for healthcare. In this way, the study identified whether trans women in North Central Nigeria had access to mainstream healthcare and investigated reasons why or why not. For those who did not have access to mainstream healthcare, the study identified the alternatives that they turned to and why.

Method

The study employed a survey (qualitative and quantitative) which used an open-ended questionnaire to enable respondents express themselves freely without the restriction of close ended questions. Copies of the questionnaire were administered to trans women in North Central Nigeria with the use of research assistants. The studied population was trans women in the following states (i.e., regions) of North Central Nigeria: Plateau, Benue, Niger, Nassarawa, Kwara, Kogi, and the Federal Capital Territory (FCT) Abuja. These five states were selected for the study due to the presence of community friendly (i.e., trusted) health centers in these areas, which provide HIV and STI services to trans women. The research assistants were indigenous to the study locations. They were ethnically competent and understood the terrain. In each of these locations, one research assistant facilitated data collection, while in Abuja, there were two research assistants assigned to this task due to the size of the city. Data collection was anonymous due to legal restrictions and the respondents were assured of confidentiality. Toward the end, identifiers such as names, addresses and telephone numbers of the respondents were erased. Due to the hard-to-reach nature of study population, the research assistants employed a snowballing referral system, in which the initial trans women selected for the study (who were identified in community friendly health centers) suggested other prospective respondents. Participation in the study was voluntary. Some copies of the questionnaire were orally administered to respondents who were not literate or had linguistic challenges due to preference

of an ethnic Nigerian language. The ethnic competence and linguistic ability of the research assistants ensured that this limitation was overcome.

Findings

The study had 124 respondents spread across locations in Nigeria

Table I: Geographical Distribution of Respondents

s/n	Location	Respondents	Percentage
1	FCT/Abuja	34	27.4%
2	Benue	20	16.1
3	**Nassarawa**	**26**	**20.9**
4	Niger	23	18.6
5	Plateau	21	17
	Total	124	100

The FCT/Abuja had the highest number of respondents because it is cosmopolitan and because there were two research assistants working in the area **identifying respondents for the study.**

Table II: Age of Respondents

s/n	Age Brackets	Respondents	Percentage
1	21-25	25	20.2
2	26-30	31	25
3	**31-35**	**28**	**22.6**
4	36-40	27	21.8
5	Over 40 years	13	10.4
	Total	124	100

The respondents of the study were predominantly younger. The study was unable to reach large numbers of trans women who are older, especially those who are over 40 years of age. This does not necessarily mean that they do not exist in Nigeria.

Table III: Levels of Education

s/n	Education	Respondent	Percentage
1	Tertiary	21	16.9
2	Trade Qualifications	36	29
3	**Secondary School**	**26**	**21**
4	Primary School	33	26.6
5	No Formal Education	8	6.5
	Total	124	100

A significant percentage of respondents (29%) had trade qualifications such as: hair dressing, nail artistry, make-up, event planning, interior decorating, dress making, catering, etc.

Table IV: Employment

s/n	Employment	Respondent	Percentage
1	Self Employed	109	87.9
2	Formal Employment	15	12.1
	Total	**124**	**100**

While a significant number of respondents are self-employed in the private sector others are employed in formal settings with an identified employer. Respondents indicated that self-employment among trans women in Nigeria enables them escape criticism and discrimination from employers and colleagues in formal work settings. With self-employment, they are masters of their own businesses and are not accountable to anyone.

None of the respondents in the study had health insurance, including those respondents in formal work settings. Thus, they have to pay for healthcare out of pocket. This places a financial burden on the respondents. In addition, only 18 respondents (14.5%) received support from their families in order to pay healthcare bills. The lack of family support is a significant barrier, which affects access to healthcare among the remaining 106 (85.5%) re-

spondents. These respondents indicated that they did not receive any support from families towards healthcare costs because their relatives did not approve of their gender expression. Families in Nigeria are often close knit and it is normal to contribute towards healthcare costs of family members. However, this is not the case for these respondents whose families consider the lives they live as an aberration.

Levels of education and exposure to information among respondents in the study had significant consequences vis-à-vis awareness of trans health issues. As indicated earlier, 8 (6.5%) of the respondents had no school education. However, all the respondents indicated that they have access to information about trans topics and issues from informal social networks of trans women, and that this significantly affects their health seeking behavior. 104 respondents (83.8%) indicated that access to information via informal social networks among trans women is the most significant source of information on trans health issues. Information sharing among the respondents is an important channel of transmission for health-related information that in turn influences health seeking behavior of the respondents. In spite of the willingness of participants to seek to access healthcare, the rate of access to mainstream health services is low. 98 respondents (79%) indicated that they self-medicate, buy from patent medicine vendors or access TCAM and that these are the best options available to them considering their circumstances. Low propensity to access mainstream healthcare is based on the fear of facing stigma and discrimination from healthcare workers and perceived lack of trans-specific expertise in healthcare providers. Both significantly affect quality and quantity of healthcare for trans women. These factors were identified by many respondents as barriers to accessing mainstream healthcare.

From the study population, 108 respondents (87%) indicated that they are unable to access mainstream healthcare because they are unable to pay, especially for hormone therapy and surgeries. Thus, they resort to cheaper alternatives such as self-medication, patent medicine vendors and TCAM. Lower or unreliable income, due to the high rate of self-employment, leads to decreased inability to pay for health insurance or for mainstream healthcare. In some instances, respondents also reported preferring TCAM over mainstream healthcare because they believed it would be more effective; for example, in the prevention or treatment of STIs. All the respondents agreed that criminalization fuels fear of being reported by healthcare providers, and that hostile attitudes by mainstream doctors further reduce propensity to access these services.

Conclusion and Recommendations

Access to healthcare is vital in the lives of trans women in Nigeria. This community requires transition-related care, general medical care and also specialist care for HIV prevention and treatment. Factors that can limit trans women's access to care include: low family support, low levels of education, low income, low quality of available care, poor expertise and hostile attitudes among health professionals, as well as previous experiences of stigma and discrimination. Many of these factors are inter-related and lead to undesired outcomes, including over-reliance by trans women on alternative practices such as self-medication and TCAM.

This situation requires action from relevant stakeholders in the healthcare system, especially funders and program implementers. These establishments should consider the implementation of unique models of healthcare provision that consider the predicament of trans women in Nigeria. This can include (but may not be limited to) broadening the current approach of community friendly centers, so that as well as HIV and STI testing and treatment, these centers can provide other essential medical services to trans women. These facilities are already considered safe points of access to healthcare by many trans women and could therefore play an important role in broadening the variety of health services that trans women can access.

There is an urgent need for community-inclusive research by health services about trans women in Nigeria. For example, TCAM can be cost effective and accessible form of healthcare for trans women, but there is a need for the efficacy of particular treatments to be scientifically verified. Research and its subsequent application are needed to interrogate beneficial intersections between the healthcare needs of trans women in Nigeria and TCAM practices.

In the long run, it will be necessary to set up legal structures in Nigeria modelled on the example of other progressive countries where trans women are accepted and protected by law. This would reduce the stigma and discrimination that trans women face and remove some of the barriers that they encounter as they access healthcare. The decriminalization of trans identity may pave way for legal gender recognition in Nigeria and acceptance of trans people. It is vitally necessary to advocate for legal and cultural change so that trans people are no longer perceived as an aberration in Nigerian society, but rather as a unique population with health needs that should be catered for. Trans people, like all citizens, have a right to healthcare in order to realize their full potential in society.

References

Aaron, O. (2016): Growing Recognition of Transgender Health. In: Bulletin of the World Health Organization, 94, pp. 790-791.

Adinma, E.; Azuike, E. and Okafor-Udah, C. (2015): Pattern and practice of complementary and alternative medication amongst patients in a tertiary hospital in Nigeria. In: European Journal of Preventive Medicine, 3, pp. 44–48.

Alsulami, Z.; Conroy, S. and Choonara, I. (2013): Medication errors in the Middle East Countries: A systematic review of the literature. In: European Journal of Clinical Pharmacology, 69(4), pp. 995-1008.

Asuzu, C.C.; Elumelu-Kupoluyi, T.; Asuzu, M.C.; Campbell, O.B.; Akin-Odayne, E.O. and Lounsbury, D. (2017): A pilot study of cancer patients' use of traditional healers in the Radiotherapy Department, University College Hospital, Ibadan, Nigeria. In: Psychooncology, 26(3), pp. 369-376.

Asscherman, H.; Giltay, E.J.; Megens, J.A.; Pim de Ronde, W.; Van Trotsenburg, M.A.A. and Gooren, L.J. (2011): A long-term follow-up of mortality in transsexuals receiving treatment with cross-sex hormones. In: European Journal of Endocrinology, 164(4), pp. 635-642.

Babajide, K.; Crowell T.A.; Nowak, R.G.; Adebajo, S.; Peel, S.; Gaydos, C.A.; Rodriguez-Hart, C.; Baral, S.D.; Walsh, M.J.; Njoku, O.S.; Odeyemi, S.; Ngo-Ndomb, T.; Blattner, W.A.; Robb, M.L.; Charurat, M.E. and Ake, J. (2016): High prevalence of HIV, chlamydia and gonorrhoea among men who have sex with men and transgender women attending trusted community centres in Abuja and Lagos, Nigeria. In: Journal of the International AIDS Society, 19, p. 21270.

Baral, S.D.; Poteat, T.; Stromdahl, S.; Wirtz, A.; Guadamuz, TE. and Beyrer, C. (2013) Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. In: Lancet Infect Dis, 13(3), pp. 214-222.

Becasen, J.S.; Denard, C.L.; Mullins, M.M.; Higa, D.H. and Sipe, T.A. (2018): Estimating the prevalence of HIV and sexual behaviors among the US transgender population: a systematic review and meta-analysis, 2006-2017. In: Am J Public Health, 109(1), pp. e1–e8.

British Medical Association and the Commonwealth Medical Trust (BMA and COMMAT, 2007): The Right to Health: A tool kit for health professionals. London: BMA.

Carroll, A. and Mendos, L.R. (2017): State Sponsored Homophobia 2017: A world survey of sexual orientation laws: criminalisation, protection and recognition (12th ed.). Geneva: ILGA.

Celkis, P. and Venckiene, E. (2011): Concept of the Right to health. In: Jurisprudence, 18(1), pp. 269-286.

Department of Foreign Affairs and Trade (DFAT, 2018): DFAT Country Information Report Nigeria [online]. Sydney: Australian Government. Available at: https://www.dfat.gov.au/sites/default/files/country-information-report-nigeria.pdf (Accessed 22 November 2021).

Eisinger, R.W.; Dieffenbach, C.W. and Fauci, A.S. (2019): HIV Viral Load and Transmissibility of HIV Infection: Undetectable Equals Untransmittable. In: Journal of the American Medical Association JAMA, 321(5), pp. 451-452.

Gerwen, O.V.; Munzy, C.; Austin, E.; Musgrove, K. and Jani, A. (2019): Prevalence of STIs and HIV in transgender women and men: a systematic review. In: Sexually Transmitted Infections, 95, p. A335.

Global Library of Women's Medicine (2016): Integrated Competencies for Medical Practice [online]. Available at: https://www.glowm.com/integrated-competencies (Accessed 22 November 2021).

Gower, A.L.; Forster, M.; Gloppen, K.; Johnson, A. Z.; Eisenberg, M.E.; Connett, J.E. and Borowsky, I.W. (2018): School practices to foster LGBT supportive climate: associations with adolescent bullying involvement. In: Prev Sci, 19(6), pp. 813-821.

Guadamuz, T.E.; Wimonsate, W.; Varangrat, A.; Phanuphak, P.; Jommaroeng, R.; McNicholl, J.M.; Mock, P.A.; Tappero, J.W. and Van Griensven, F. (2011): HIV prevalence, risk behavior, hormone use and surgical history among transgender persons in Thailand. In: AIDS Behav., 15, pp. 650–658.

Haas, A.P.; Rodgers, P.L. and Herman, J.L. (2014): Suicide Attempts among Transgender and Gender Non-Conforming Adults: Findings of the National Transgender Discrimination Survey [online]. New York and Los Angeles: American Foundation for Suicide Prevention and The Williams Institute. Available at: https://escholarship.org/uc/item/8xg8061f (Accessed 22 November 2021).

Herbst, J.H.; Jacobs, E.D.; Finlayson, T.J.; McKleroy, V.S.; Neumann, M.S. and Crepaz, N. (2008): Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review. In: AIDS Behav., 12, pp. 1–17.

James, P.B.; Wardle, J.; Steel, A.; and Adams, J. (2018): Traditional, complementary and alternative medicine use in Sub Saharan Africa: a systematic review. In: BMJ Glob Health, 3(5), p. 000895.

James, S.E.; Herman, J.L.; Rankin, S.; Keisling, M.; Mottet, L. and Anafi, M. (2016): The Report of the 2015 U.S. Transgender Survey [online]. Washington, D.C.: National Center for Transgender Equality. Available at: https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf (Accessed 22 November 2021).

King, M.; Semlyen, J.; Tai, S.S.; Killaspy, H.; Osborn, D.; Popelyuk, D. and Nazareth, I. (2008): A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people. In: BMC Psychiatry, 8(70), pp. 1-17.

Lagarde, M. and Palmer, N. (2011): The impact of user fees on access to health services in low- and middle-income countries. In: The Cochrane Database of Systematic Reviews, 4, p. CD009094.

Latunji, O.O. and Akinyemi, O.O. (2018): Factors Influencing Health Seeking Behaviour Among Civil Servants in Ibadan, Nigeria. In: Annals of Ibadan Postgraduate Medicine, 16(1), pp. 52–60.

Makofane, K.; Gueboguo, C.; Lyons, D. and Sandfort, T. (2012): Men who have sex with men inadequately addressed in African AIDS National Strategic Plans. In: Global Public Health, 8(2), pp. 129-143.

National Bureau of Statistics (NBS, 2018): Demographic Statistics Bulletin. Abuja: NBS.

Nemoto, T.; Iwamoto, M.; Perngparn, U.; Areesantichai, C.; Kamitani, E. and Sakata, M. (2012): HIV-related risk behaviors among kathoey (male-to-female transgender) sex workers in Bangkok, Thailand. In: AIDS Care, 24, pp. 210–219.

Onifade, A.A.; Ajeigbe, K.O.; Omotosho, I.O.; Rahamon, S.K. and Oladeinde, B.H. (2013): Attitude of HIV patients to herbal remedy for HIV infection in Nigeria. In: Niger Journal of Physiological Science, 28, pp. 109–112.

Operario, D.; Nemoto, T.; Iwamoto, M. and Moore, T. (2011): Unprotected sexual behavior and HIV risk in the context of primary partnerships for transgender women. In: AIDS Behav., 15, pp. 674–682.

Peters, D.H.; Garg, A.; Bloom, G.; Walker, D.G.; Brieger, W.R. and Hafizur Rahman, M. (2008): Poverty and access to healthcare in developing countries. In: Ann NY Acad Sci, 1136(1), pp. 161-171.

Rider, G.N.; McMorris, B.J.; Gower, A.L.; Coleman, E. and Eisenberg, M.E. (2018): Health and Care Utilization of Transgender and Gender Non-

conforming Youth: A Population-Based Study. In: Pediatrics 141(3), p. e20171683.

Sanchez, N.F.; Sanchez, J.P. and Danoff, A. (2009): Health care utilization, barriers to care, and hormone usage among male-to-female transgender persons in New York City. In: Am J Public Health, 99(4), pp. 713– 719.

The Economist Intelligence Unit (2017): Global Access to Health Care: Building Sustainable Health Systems [online]. Available at: https://impact.economist.com/perspectives/perspectives/sites/default/files/Globalaccesstohealthcare-3.pdf (Accessed 22 November 2021).

The Free Dictionary by Farlex (2018): Health Care [online]. Available at: https://www.thefreedictionary.com/health+care (Accessed 22 November 2021).

The Joint United Nations Programme on HIV/AIDS (UNAIDS, 2014): Transgender People [online]. In: UNAIDS (2014): The Gap Report. Geneva: UNAIDS, pp. 214-228. Available at: https://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf (Accessed 22 November 2021).

The World Bank (2015): Current Health expenditure (% of GDP) [online]. Available at: https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS (Accessed 22 November 2021).

The World Bank (2018): Nigeria [online]. Available at: https://data.worldbank.org/country/NG (Accessed 22 November 2021).

The World Bank (2019): The World Bank in Nigeria. Overview [online]. Available at: https://www.worldbank.org/en/country/nigeria/overview (Accessed 22 November 2021).

Unger, C.A. (2012): Care of the transgender patient: A survey of gynecologists' current knowledge and practice. In: Journal of Women's Health, 26, pp. 114–118.

United Nations (2015): Universal Declaration of Human Rights [online]. Available at: https://www.un.org/en/udhrbook/pdf/udhr_booklet_en_web.pdf (Accessed 22 November 2021).

Vaisvila, A. (2009): Theory of Law. Vilnius: Justitia.

Vance, S.R.; Halpern-Felsher, B.L. and Rosenthal, S.M. (2015): Health care providers' comfort with and barriers to care of transgender youth. In: Journal of Adolescent Health, 56, pp. 251–253.

Verster, A. (2016): Growing Recognition of Transgender Health. In: Bulletin of the World Health Organization, 94, pp. 790-791.

Winter, S.; Diamond, M.; Green, J.; Karasic, D.; Reed, T.; Whittle, S. and Wylie, K. (2016): Transgender people: Health at the margins of society. In: The Lancet, 388(10041), pp. 390-400.
World Health Organization (WHO, 2011): Prevention and Treatment of HIV and Other Sexually Transmitted Infections Among Men Who Have Sex with Men and Transgender People: Recommendations for a public health approach [online]. Available at: http://apps.who.int/iris/bitstream/handle/10665/44619/9789241501750_eng.pdf;jsessionid=83B4B92629034454B996C97B76B8C658?sequence=1 (Accessed 22 November 2021).
World Health Organization (WHO, 2014): WHO Traditional Medicine Strategy 2014-2023 [online]. Available at: https://apps.who.int/iris/bitstream/handle/10665/92455/9789241506090_eng.pdf (Accessed 22 November 2021).
World Health Organization (WHO, 1946): Constitution of the World Health Organization. [online]. Available at: https://treaties.un.org/doc/Treaties/1948/04/19480407%2010-51%20PM/Ch_IX_01p.pdf (Accessed 29 January 2022).