Community-Based Collective Care and Resilience Among LGBTQ Populations in Rural Nigeria: The Calabar Case Study

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ABSTRACT

Marginalized communities often develop adaptive support systems to maintain wellbeing in environments characterized by stigma, legal restrictions, and limited institutional protection. In Nigeria, the Same-Sex Marriage (Prohibition) Act has contributed to heightened social exclusion and barriers to healthcare for LGBTQ populations, particularly in rural areas. This study examines how community-based collective care initiatives support resilience, psychosocial wellbeing, and continuity of SRHR/HIV-related services among LGBTQ individuals in Calabar, Cross River State. Using a community-based case study design, the research documents crisis-response strategies implemented after the vandalism of a community center serving LGBTQ individuals. The intervention framework included peer-led psychosocial support, mutual aid mechanisms, safety protocol development, and participatory governance through a community-led crisis committee. Psychosocial outcomes were assessed using the Generalized Anxiety Disorder Scale (GAD-7) among participants (n = 50), while perceived social isolation was measured using the UCLA Loneliness Scale among a subset of participants (n = 30) through pre- and post-intervention surveys. Results indicate improvements in psychosocial wellbeing and social connectedness, with anxiety symptoms decreasing by approximately 30% and loneliness scores declining by 40% following the intervention. These findings highlight the role of community-led collective care models in strengthening resilience and sustaining essential health services among marginalized populations in restrictive social environments. However, findings should be interpreted as exploratory due to the absence of a control group and reliance on descriptive statistical analysis.

Keywords: Collective Care, Community Resilience, LGBTQ Health, HIV service Delivery

INTRODUCTION

Marginalized populations frequently encounter structural barriers that affect access to healthcare, social protection, and community wellbeing. In Nigeria, sexual and gender minorities face heightened vulnerability due to legal restrictions, social stigma, and discrimination. The Same Sex Marriage (Prohibition) Act has been widely associated with increased surveillance, harassment, and exclusion of LGBTQ individuals from essential services, including healthcare and HIV supported programs [5,17]. Research suggests that such legal and social environments can intensify minority stress and discourage engagement with formal healthcare systems [9,13].

In rural settings, these challenges are often amplified by limited healthcare infrastructure and more conservative social norms. As a result, marginalized populations frequently rely on informal networks for solidarity and support to navigate everyday risks and maintain access to resources. Community-based organizations and peer-led initiatives have therefore emerged as important actors in addressing health disparities and sustaining rural support systems among marginalized groups [2,20].

A growing body of literature has examined the intersection between structural stigma, health disparities, and resilience among sexual and gender minority populations. Research has consistently demonstrated that LGBTQ individuals often experience higher levels of mental health challenges compared to the general population, largely due to social exclusion, discrimination, and institutional barriers to healthcare access [3,9]. Structural

stigma, including restrictive laws and discriminatory policies, can further intensify these disparities by discouraging individuals from accessing health services or participating openly in community support systems.

Within the context of HIV prevention and care, marginalized populations such as men who have sex with men (MSM), transgender, and other sexual minorities have been shown to experience disproportionate vulnerability to HIV infection. Global epidemiological studies indicate that these populations often face barriers to HIV testing, prevention services, and treatment programs due to stigma, criminalization, and discrimination within healthcare systems [1,11].

Collective care refers to community-driven practices that emphasize shared responsibility, mutual support, and solidarity in responding to social and health challenges. Scholars have described collective care as an approach that shifts the focus of wellbeing from individual responsibility towards community-based support systems, particularly in contexts where institutional protection is limited [10]. Within public health research, collective care frameworks have increasingly been recognized as strategies capable of strengthening resilience and improving psychosocial outcomes among marginalized populations [4,8].

Research on HIV vulnerability among marginalized populations has consistently highlighted the intersection of stigma, discrimination, and structural barriers to healthcare access. Studies have shown that men who have sex with men (MSM) and transgender populations often experience disproportionate HIV burden due to limited access to inclusive health services and supportive social environments [1,11]. Structural stigma and discriminatory legal frameworks can discourage individuals from accessing HIV testing, prevention services, and treatment programs [3].

Minority stress theory provides an important framework for understanding the psychosocial challenges faced by LGBTQ populations. According to this theory, individuals belonging to stigmatized groups experience chronic stress arising from prejudice, discrimination, and social exclusion, which may negatively affect mental and physical health outcomes [9]. These experiences are often intensified in environment where legal protections are limited and where social hostility toward sexual minorities persists [6].

Community-based resilience strategies have therefore become critical mechanisms for addressing these challenges. Mutual aid systems and peer-led support structures have been documented as effective community responses that provide emotional support, material assistance, and social protection for marginalized populations [10]. Such collective practices have historically emerged during periods of crisis or institutional neglect and can strengthen social cohesion within vulnerable communities [4].

Empirical research also demonstrates that community-led health initiatives can improve access to HIV prevention and care services among marginalized populations. Peer outreach, community education, and safe referral networks often serve as bridges between vulnerable populations and formal healthcare systems [15,19]. These interventions have been particularly effective in contexts where stigma and discrimination create barriers to institutional care [12].

Despite growing recognition of the importance of community-driven health responses, relatively few studies have examined how collective care interventions operate within rural LGBTQ communities in Nigeria. This study contributes to literature by documenting a case study of collective care strategies implemented in Calabar, Cross River State, following a crisis affecting a community-based organization.

CONCEPTUAL FRAMEWORK

This study is guided by a conceptual framework that links collective care practices to psychosocial resilience and continuity of health service delivery among marginalized populations. Collective care refers to community-driven mechanisms through which individuals share responsibility for emotional, social, and mental support during periods of crisis or structural marginalization. Previous research suggests that collective care systems, including peer support, mutual aid networks, and participatory governance structures, can serve as protective mechanisms that buffer the effects of stigma, discrimination, and social exclusion experienced by marginalized populations [4,5].

Within this framework, collective care interventions function as mediating mechanisms that influence psychosocial and organizational outcomes. Peer-led psychosocial support may reduce anxiety and emotional distress among community members by creating safe spaces for shared experiences and mutual validation. Mutual aid systems provide immediate material assistance that stabilizes living conditions and reduces vulnerability during crises. Participatory governance structures strengthen organizational resilience by promoting inclusive decision-making and coordinated crisis responses.

The framework therefore proposes that the integration of these collective care mechanisms contributes to improved psychosocial wellbeing, strengthened social connectedness, and sustained access to HIV and sexual and reproductive health services. Figure 1 illustrates the conceptual relationship between community crisis events, collective care interventions, and resilience outcomes within marginalized communities.

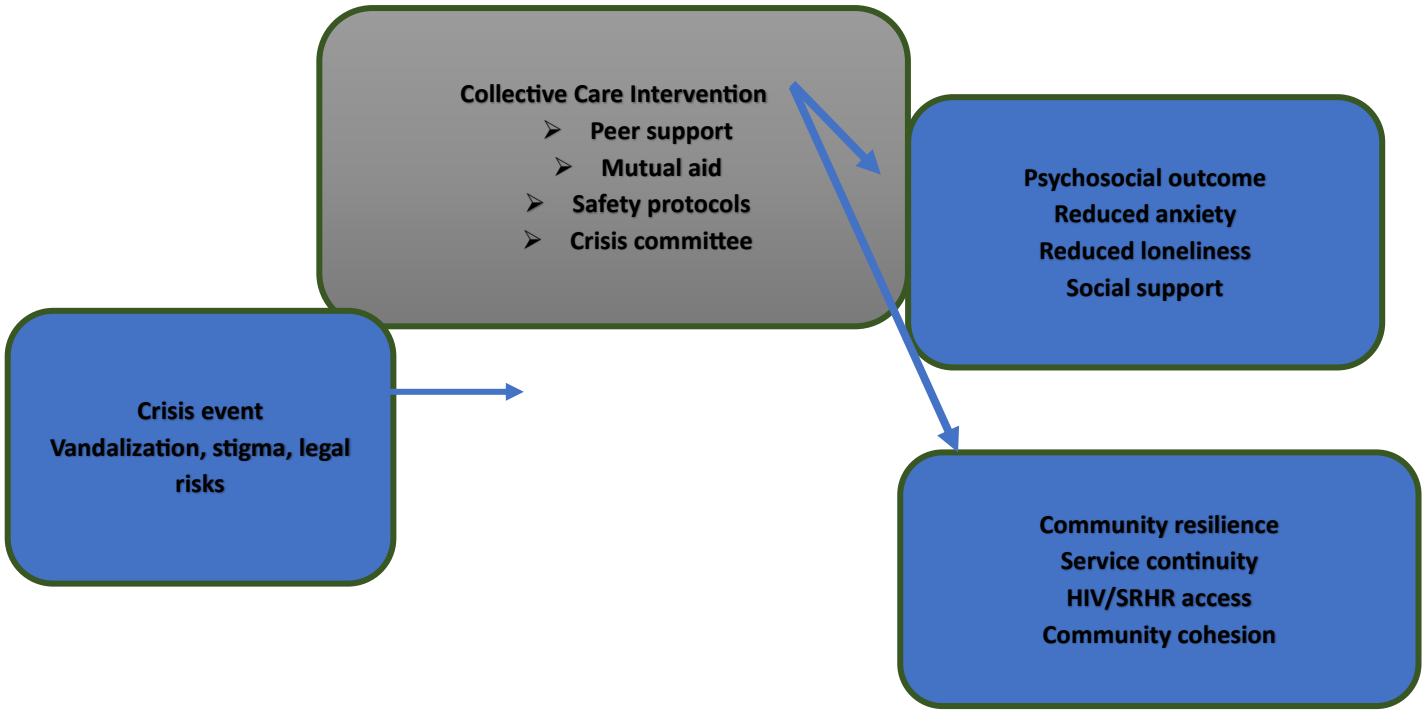

Figure 1 Conceptual Framework of Collective Care and Community Resilience

The conceptual model illustrates the relationship between crisis events affecting marginalized communities, collective care interventions, and psychosocial and service continuity outcomes. As illustrated in Figure 1, the framework positions community crisis events as triggering factors that activate collective care responses. These responses include peer support, mutual aid networks, safety protocols, and participatory governance mechanisms. Together, these interventions contribute to improved psychosocial wellbeing, reduced social isolation, strengthened community cohesion, and continuity of HIV and SRHR service interventions.

The Calabar Case Study

In late 2025, local anti-LGBTQ group vandalized community center used by members of LGBTQ population to access HIV and sexual and reproductive health services. They damaged electrical wiring, facility equipment, building windows, doors, and stole valuable assets. The property owner, however, instead of support, threatened legal action, citing SRHR/HIV-related activities involving LGBTQ people as illegal. This incident severely traumatized staff and frontlines members, disrupted HIV and SRHR planned activities, put client's confidential information at risk of leakage to unauthorize personnel, and increase organization's vulnerability to external threats. The incident highlighted ongoing vulnerabilities affecting sexual and gender minorities in restrictive environments. In response, the organization implemented several community-based collective care interventions aimed at ensuring safety, sustaining HIV, and sexual and reproductive health and rights-related work. This study examines the role of these interventions in supporting resilience, improving psychosocial wellbeing, and sustaining responses to HIV epidemic and sexual and reproductive health and rights within the affected community. The case study approach was selected because it allows for an in-depth examination of community

responses within real-life social and institutional contexts, particularly when studying marginalized populations operating in restrictive environments.

METHODOLOGY

Study Design

This study employed a community-based case study to examine the implementation and outcomes of collective care interventions among LGBTQ populations in Calabar, Cross River State, Nigeria. The case study approach was considered appropriate for capturing complex context-dependent social processes and community-driven responses within a restrictive socio-legal environment. This design enabled in-depth exploration of how localized interventions function in real-life crisis condition affecting marginalized populations.

Study Setting

The study was conducted within a TransLBQ-led community-based organization providing HIV prevention, psychosocial support, and sexual and reproductive health and rights (SRHR) services in Calabar. The research was situated in the context of a crisis event involving the vandalization of the organization's community center, which disrupted service delivery and exposed both staff and beneficiaries to heightened psychosocial and structural risks.

Study Population and Sampling Strategy

The Study population comprised organizational staff and community beneficiaries actively engaged in HIV and SRHR programming. A purposive sampling strategy was employed to ensure the inclusion of participants with direct experience of both the crisis event and the subsequent collective care interventions.

Table 1. Participants Selection Criteria

Inclusive Criteria	Exclusive Criteria
Identification as a member of the LGBTQ community or staff of the organization	Individuals not directly affected by the intervention period
Direct exposure to the crisis event or activity participation in at least one intervention component	Individuals who did not participate in intervention components
Availability for both pre- and post-intervention assessments	Incomplete participation in baseline or endline assessments.
Provision of informed consent	

A total of 50 participants were included in the analysis of anxiety outcomes, while a subset of 30 participants completed additional assessments on social connectedness and loneliness. The reduced subset reflects participants availability and willingness to complete extended psychosocial assessments.

Intervention Description

The collective care intervention was implemented over a 12-week period (October – December 2025) following the crisis event. The intervention was structured around four interrelated components designed to address both psychosocial and structural vulnerabilities.

Table 2. Intervention and Description

Intervention	Description
Peer-led psychosocial support	Trained peer facilitators conducted group sessions and individualized support meetings focused on emotional coping, trauma processing, and shared experience validation. Sessions were held weekly and adapted to participants needs

Mutual aid mechanism	Emergency support systems were activated to provide food supplies, temporary accommodation, and financial assistance to affected individuals. Resource allocation was coordinated through community networks and volunteer support systems
Safety and security protocol	Organizational measures were introduced to strengthen data protection, safeguard confidential client information, and reduce exposure to external threats. This included secure storage systems and revised operational guidelines
Participatory governance	A crisis response committee comprising of staff members and community representatives was established to guide decision-making, coordinate interventions, and ensure accountability. The committee met monthly throughout the intervention period

Data Collection

Data were collected at two time points: baseline (pre-intervention) and endline (post-intervention), within the 12-week intervention period.

Psychosocial outcomes were assessed using the standardized instruments:

1. Generalized Anxiety Disorder Scale (GAD-7): used to measure anxiety symptoms among all participants (n = 50).
2. UCLA Loneliness Scale (Version 3): administered to a subset of participants (n = 30) to assess perceived social isolation and social connectedness.

Both instruments are widely validated and have demonstrated reliability in diverse psychosocial and public health research settings. Data collection was conducted by trained peer facilitators to enhance trust, reduce response bias, and ensure cultural relevance.

Data Analysis

Data analysis was conducted using descriptive statistical methods. Means scores were calculated for pre- and post-intervention measures, and percentage changes were used to assess variations in anxiety and loneliness outcomes over time. Given the exploratory nature of the study, the relatively small sample size, and the absence of a control group, inferential statistical analyses were not conducted. Findings are therefore interpreted as indicative of trends and associations rather than causal relationships.

Ethical Considerations

The study involved a highly vulnerable population operating within a restrictive legal and social context. As such, stringent ethical safeguards were implemented throughout the research process. Participation was voluntary, and informed consent was obtained from all participants prior to data collection. To ensure confidentiality and minimize risk, no personally identifiable information was collected, and all data were anonymized at the point of collection. Data were securely stored with restricted access limited to authorized personnel. Additional protection measures included the use of peer facilitators to reduce risks of inadvertent disclosure, careful selection of safe data collection environments, and assurances that participation or non-participation would not affect access to organizational services. All procedures adhered to internationally recognized ethical principles for research involving human participants, including respect for persons, beneficiaries, and confidentiality.

RESULT

Data collected between October and December 2025 assessed the psychosocial and community outcomes associated with the collective care interventions implemented after the vandalization incident. The results focus on changes in anxiety levels, perceived loneliness, and the reach of community-based support interventions.

Table 3. Changes in Anxiety Levels (GAD-7 Score)

Measurement Period	Average Anxiety Score	Percentage Change (%)
Pre-intervention	13.20	-
Post-intervention	9.20	30

Psychosocial Outcomes

Analysis of the Generalized Anxiety Disorder Scale (GAD-7) scores among participants (n = 50) revealed a notable improvement in psychological wellbeing following the intervention period. Prior to the implementation of the collective care framework, participants reported moderate to high anxiety levels associated with the security incident, disruption of services, and fears related to confidentiality breaches. After the intervention, the average anxiety score decreased from 13.2 to 9.2, representing approximately a 30% reduction in anxiety symptoms. Participants reported that peer support sessions and collective reflection spaces contributed significantly to emotional coping and reduced stress.

Table 4. Changes in Loneliness Scores (UCLA Scale)

Measurement Period	Average Loneliness Score	Percentage Change (%)
Pre-intervention	52.40	-
Post-intervention	31.50	40

Table 5. Community Support and Mutual Aid

Intervention	Number of Staff and frontliners	Support Provide
Emergency food assistance	18	Distribution of food supplies to affected staff and frontliners
Temporary accommodation	6	Short-term housing support for displaced individuals after the incident
Transportation logistics	4	Small emergency stipends and basic needs for staff and frontliners
Peer psychosocial educational sessions	50	Group and one-on-one mental health sessions facilitated by trained peer supporters

Social Connectedness

Perceived social isolation was measured using the UCLA Loneliness Scale among a subset of participants (n = 30). The findings showed a marked improvement in social connectedness following the implementation of community-based care activities. The average loneliness score decreased from 52.4 before the intervention to 31.5 after the intervention, representing an approximate 40% reduction in perceived loneliness. Participants indicated that community meetings, shared reflection sessions, and mutual aid activities helped rebuild trust and strengthen interpersonal relationships within the community.

Community Support and Mutual Aid Outcomes

Mutual aid initiatives played a critical role in stabilizing the wellbeing of affected staff and frontline community members. A total of 28 individuals received emergency support, including food supplies, temporary accommodation, and financial assistance. These interventions were coordinated through peer networks and supported by community volunteers. Participants reported that mutual aid system provided immediate relief during the crisis and helped maintain basic living conditions while the organization relocated to a safer operational space.

Organizational Response and Service Continuity

Despite the disruption caused by the vandalization of the community center, the establishment of a 12-member crisis response committee facilitated rapid organizational coordination and decision-making. The committee implemented safety protocols to protect sensitive records and reorganized program activities to ensure continuity of HIV and sexual and reproductive health and rights services. As a result, the organization was able to resume service delivery within a short period, ensuring community members continued to access HIV prevention support, counseling, and referrals to friendly healthcare providers.

DISCUSSION

This study examined the role of community-based collective care interventions in supporting psychosocial wellbeing, strengthening social connectedness, and sustaining HIV and sexual and reproductive health and rights services among LGBTQ populations in Calabar, Cross River State, Nigeria. The findings demonstrate that collective care strategies implemented following the vandalization of a community center were associated with measurable improvements among participants as well as the continuity of essential community health services.

Psychosocial Wellbeing and Minority Stress

One of the key findings of this study is the 30% reduction in anxiety symptoms among participants following the implementation of peer-led psychosocial support and collective care activities. These findings are consistent with minority stress theory, which suggests that individuals belonging to stigmatized groups experience chronic stress arising from discrimination, stigma, and social exclusion, thereby negatively affecting mental health outcomes [9]. In restrictive socio-legal environments such as Nigeria, where legislation such as the Same Sex Marriage (Prohibition) Act contributes to marginalization, these stressors are often intensified [5,17].

The findings of this study are also consistent with previous empirical research on community-based mental health interventions among marginalized populations. Studies have shown that peer-led psychosocial support interventions can significantly improve mental health outcomes by enhancing coping mechanisms and reducing psychosocial distress [7,8]. Such interventions are particularly effective in contexts where formal mental health services are inaccessible or stigmatized. The magnitude of anxiety reduction observed in this study aligns with the trends reported in similar low-resource and high-stigma settings, suggesting that peer-led collective care models are both feasible and effective. The magnitude of change observed in anxiety scores suggests substantial practical effect, indicating that the intervention had meaningful real-world impact on participant wellbeing, even in the absence of inferential statistical testing.

Peer-led psychosocial appears to have played a central role in reducing distress among participants. These models allow individuals to share experiences with trusted community members who understand their social realities, thereby enhancing emotional validation, resilience, and adaptive coping strategies. This supports existing literature that highlights the effectiveness of culturally grounded, community-based mental interventions among marginalized populations [7,8].

Social Connectedness and Collective Support

The 40% reduction in loneliness scores observed in this study highlights the importance of social connectedness in promoting psychological wellbeing. Loneliness and social isolation have been widely associated with negative mental health outcomes, including depression, anxiety, and reduced engagement with health services [12]. Within marginalized communities, particularly those experiencing stigma and discrimination, collective social spaces serve as essential platforms for emotional support, identity affirmation, and resource sharing [3,13].

These findings are supported by existing literature demonstrating that increased social connectedness is associated with improved psychosocial outcomes. The UCLA Loneliness Scale has been widely used to measure perceived isolation, and reductions in loneliness scores are often linked to improved mental wellbeing and social integration [11]. In this study, collective reflection sessions, peer engagement, and community gatherings helped rebuild social bonds that were disrupted by the crisis event.

Community-based support networks have been identified as protective factors that mitigate the harmful effects of structural stigma and social exclusion [3,4]. In this context, collective care activities strengthened interpersonal relationships and restored trust among community members, which likely contributed to the significant reduction in loneliness observed during the post-intervention assessment. Similarly, the reduction in loneliness scores reflects a meaningful improvement in perceived social support and community belonging, suggesting strong practical significance of the intervention.

Role of Mutual Aid in Crisis Response

Mutual aid initiatives emerged as another important component of the collective care framework. The provision of emergency food supplies, temporary accommodation, and financial assistance helped stabilize the immediate living conditions of affected staff and community members at the forefront. Mutual aid systems have historically been used by marginalized communities to address immediate material needs when formal institutions are inaccessible or unresponsive [10]. In the context of this study, mutual aid served not only as a practical support mechanism but also a means of reinforcing solidarity and shared responsibility within the community. This aligns with previous research suggesting that collective resource-sharing practices can strengthen community cohesion and resilience during crises [4,16]. By mobilizing internal networks and community volunteers, the organization was able to provide rapid assistance to individuals affected by the security incident.

Participatory Governance and Organizational Resilience

The establishment of a community-led crisis response committee further strengthened the organization's ability to respond to the crisis effectively. Participatory governance structures have been associated with improved decision-making, increased accountability, and stronger community ownership of programs [16]. In this study, the committee facilitated coordinated responses to security threats, supported the implementation of safety protocols, and ensured the continuation of HIV and SRHR services. Inclusive decision-making processes also contributed to rebuilding trust among staff and community members affected the vandalization incident. When communities participate in shaping responses to crises that affect them, they are more likely to remain engaged in collective problem-solving and support mechanisms.

Continuity of HIV and SRHR Services

An important outcome of the collective care interventions was the continuity of HIV and SRHR service intervention activities despite the disruption caused by the vandalization of the community center. In many contexts where marginalized populations face stigma and discrimination, community-based organizations play a critical role in connecting individuals to safe healthcare services and providing peer-based health education [15,18]. The rapid implementation of safety protocols and relocation strategies enabled the organization to resume operations and maintain essential services for LGBTQ community members. This finding supports previous research indicating that community-led health initiatives can complement formal healthcare systems and enhance access to services for populations that experience barriers to institutional care [1,2,19].

These findings further validate the conceptual framework proposed in this study, which positions collective care mechanisms as key mediators of psychosocial wellbeing, social connectedness, and continuity of health service delivery in marginalized communities. Although inferential statistical analyses such as p-values or confidence intervals were not conducted, the magnitude and consistency of observed changes across psychosocial indicators suggest meaningful trends. These findings provide valuable practice-based evidence within a real-world community context and highlight the potential effectiveness of collective care interventions in similar settings.

Implications for Community-Based Health Responses

The findings of this study have important implications for public health practice, policy, and community programming.

- The study highlights the critical role of peer-led and community-driven interventions in addressing both psychosocial and structural vulnerabilities among marginalized populations. In contexts where legal and

social barriers limit access to formal healthcare systems, community-based models can serve as effective alternative platforms

- The integration of psychosocial support, mutual aid, and participatory governance demonstrates a holistic approach to health that extends beyond clinical care to include social protection and community resilience.
- Policymakers, donors, and development partners should consider investing in and scaling community-led initiatives that prioritize local knowledge, trust-building, and culturally relevant approaches. Such strategies are particularly relevant in rural and resource-constrained settings where formal support systems are limited [8,9].
- The study underscores the importance of protecting community-based organizations and strengthening safety mechanisms for organizations working with vulnerable populations in restrictive socio-legal environments.

Study Limitation

While the findings provide valuable insights into the role of collective care interventions, several limitations should be acknowledged. First, the study relied on a relatively small sample size, which limits the generalizability of the findings to other contexts. The limited sample size reflects the sensitive nature of research involving marginalized populations in restrictive legal environments where participation in research may expose individuals to social or legal risks. Second, the use of descriptive statistical analysis means that causal relationships between the interventions and observed outcomes cannot be definitively established. Additionally, the absence of inferential statistical testing limits the ability to determine statistical significance of observed changes. Finally, the study focused on a single case study organization in Calabar and experiences in other regions may differ due to variations in social and institutional contexts. The study did not include a control group; therefore, the findings should be interpreted as indicative associations rather than definitive causal effects of the intervention.

Future Direction

Future research could expand on this work by examining similar interventions across multiple community organizations and incorporating longitudinal research designs to assess long-term outcomes. Overall, the discussion highlights how collective care interventions helped address both psychological distress and social isolation while sustaining essential health services with the LGBTQ community in Calabar. The combination of peer-led support, mutual aid networks, and participatory governance created a community-based response that strengthened resilience during a period of crisis. These findings reinforce the potential value of collective care frameworks in supporting marginalized populations facing structural barriers to health and wellbeing.

CONCLUSION

This study examined the role of community-based collective care interventions in strengthening resilience, improving psychosocial wellbeing, and sustaining HIV and sexual and reproductive health and rights (SRHR) services among LGBTQ populations in Calabar, Cross River State, Nigeria.

The findings demonstrated that collective care strategies implemented in response to a crisis event contributed to measurable improvements in mental health and social connectedness among participants. Specifically, reductions in anxiety and perceived loneliness were observed following the introduction of peer-led psychosocial support, mutual aid mechanisms, safety protocols, and participatory governance structures.

These results highlight the importance of community-driven responses in contexts where marginalized populations face legal, social, and structural barriers to accessing formal healthcare systems. By mobilizing internal networks of solidarity and peer support, the organization was able to address immediate psychosocial needs while ensuring continuity of essential HIV and SRHR services.

Although the findings are based on a single case study and should be interpreted as exploratory, they provide valuable insights into how collective care frameworks can effectively support resilience and service continuity

in restrictive socio-legal environments. Strengthening and scaling such approaches may contribute to more inclusive and community-centered health systems.

Declaration

Conflicts of Competing Interest All the authors declare zero financial or interpersonal conflicts of interest that could have influenced the research or the results reported in this research paper.

Availability of data All information regarding this study is presented in this document.

Ethical approval Due to the sensitive nature of the study population and the restrictive socio-legal environment in which the research was conducted, obtaining formal institutional ethical approval posed potential risks to both participants and the implementing organization. As a result, the study was conducted as a community-based programmatic assessment rather than a formal clinical or experimental study. All procedures strictly adhered to internationally recognized ethical principles for research involving human participants, including voluntary participation, informed consent, confidentiality, and the protection of participants from harm. No personally identifiable information was collected, and all data were anonymized at the point of collection. Data collection was conducted in safe and secure environments, ensuring that participation did not expose individuals to additional legal or social risks. These safeguards were implemented to ensure that the rights, safety, and dignity of participants were fully protected throughout the study.

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