Differentiated Prevention Testing and ART delivery for Modified General populations and Key Populations in Nigeria

Society for Family Health Nigeria, 2018

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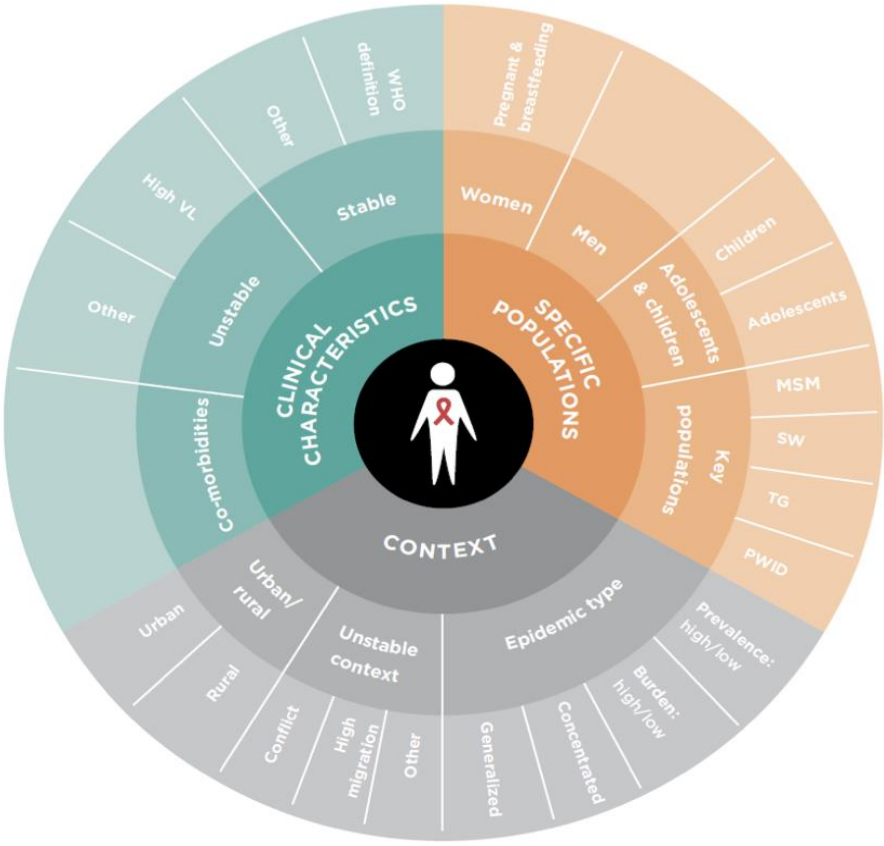
OVERVIEW

- *In the overview, include the service(s) as well as the clients for whom your service is designed What are their clinical characteristics? Which specific sub-populations are they part of? What is the context?*

Figure 1: The three elements – clinical characteristics, specific populations, context



HIV in Nigeria can best be described as a mixed epidemic (generalized and concentrated). This means that HIV prevalence is relatively high in the general population and substantially high among certain sub groups.

Nigeria's HIV epidemic affects all population groups and geographic areas of the country. It is the second largest epidemic globally. Six states in Nigeria: Kaduna, Akwa Ibom, Benue, Lagos, Oyo, and Kano account for 41% of people living with HIV. HIV prevalence is highest in Nigeria's

southern states (known as the South South Zone), and stands at 5.5%. It is lowest in the southeast (the South East Zone) where there is a prevalence of 1.8%. There are higher rates of HIV in rural areas (4%) than in urban ones (3%). (NACA 2015/Nigeria GARPR 2015)

In 2016, Nigeria had 220,000 new HIV infections and 160,000 AIDS-related deaths. There were 3,200,000 people living with HIV in 2016, among whom 30% were accessing antiretroviral therapy. Among pregnant women living with HIV, 32% were accessing treatment or prophylaxis to prevent transmission of HIV to their children. An estimated 37,000 children were newly infected with HIV due to mother-to-child transmission. Among people living with HIV, approximately 24% had suppressed viral loads. Since 2010, new HIV infections have decreased by 21% and AIDS-related deaths have decreased by 6%.

Key populations (KP) are disproportionately impacted by the epidemic, the IBBSS 2014 revealed the following HIV prevalence among Key Populations: Sex workers: brothel-based female sex workers (19.4%); and 8.6% among non-brothel based female sex workers; Men Who Have Sex with Men (23%) and People who inject drugs (3.4%). Interestingly this is higher than the national average of 3.4% reported in the NARHS Plus 2012. In Nigeria, Sex workers, Men who Have Sex With Men and People Who Inject Drugs make up only 3.4% of the population, yet account for around 32% of new HIV infections.

The survey further revealed that Men who have sex with men are the only group in Nigeria where HIV prevalence is still rising. In 2016 they overtook sex workers as the group most affected by HIV in Nigeria, with a prevalence of 23% in 2016. (UNAIDS (2017) 'Data Book). According to the most recent data available, 10% of all new HIV infections in the country occur among men who have sex with men. (NACA (2014)

There are a number of factors that make Key Populations more vulnerable to HIV. These factors include, lack of access to health care/HIV services, Homophobia, low condom use, poverty, limited available services for PWID, unprotected sex, sharing of needles. Others include early sexual debut, very low HIV testing rates, stigma and discrimination, criminalization of same sex relationships, sex work, drug possession and use.

Specifically, stigma and discrimination from health care workers keep away Key Populations from accessing health care services. Other major identified issues affecting Key Populations' access to HIV health services are:

- Long waiting and rigid hours for service provision at the health facilities to access ART
- Ineffective linkage of Key Populations who had tested positive for HIV to access care and treatment due to out-of-pocket cost at the health facility
- Ineffective continuous monitoring of drug compliance and adherence due to the numerous clients (including KP) on ART services at health facilities
- Stigma and discrimination which includes hostile attitudes of health care workers towards key populations which affects their willingness to access health care service in Nigeria
- Many clients on ART reside in hard-to-reach and distant communities from the ART facilities thus contributing to high defaulter rates.
- Lack of understanding of issues affecting key populations
- Inadequate capacity to provide appropriate services to these groups.

Addressing these identified issues is critical to changing the HIV and AIDS trajectory in Nigeria and Sub Saharan Africa.

Based on these issues which calls for urgent needs to design effective ways to ensure Key Populations access to quality and friendly health care services and treatment, the Society for Family Health with funding support from the Global Fund (New Funding Model Grants 2015 - 2017) and USAID (Strengthening HIV Prevention Services for Most At Risk Populations Grants 2012-2017) came up with set of strategies to increase the uptake of HIV Testing and improve access to comprehensive HIV health services among Men Who Have Sex With Men, Sex Workers, People Who Inject Drugs, Most-At-Risk Young Persons, and Most-At-Risk Migrant Miners.
The projects had the following specific key objectives:

- **Global Fund HIV New Funding Model;**
- Reduce new HIV infections, and improve the quality of life for the infected and affected.
- Provide Nigerians with universal access to high-quality, patient-centred prevention, diagnosis, and treatment services for TB, TB/HIV, and drug-resistant TB by 2020, and
- Contribute to the restoration of public confidence in primary health care services in Nigeria, and thereby reverse declines in the utilization of primary health care facilities.
- **SHiPS for MARPs Project**
- Increased organizational capacity of local stakeholders to develop, manage, and evaluate effective HIV prevention interventions and create an enabling environment for service expansion

- Increased access to a comprehensive package of HIV sexual prevention activities at sufficient intensity and quality
- Improved continuum of community- and facility-based prevention, care, and treatment services targeted at Key Populations
- Improved use of data to strategically prioritize and target Key Populations as well as plan HIV interventions emphasizing evidence-informed strategies

In October 1st 2016, the SHiPS for MARPS Project transited from a prevention implementing partner to a prevention, care and treatment partner. This shift in programming was in line with the PEPFAR High Impact Agenda as well as the UNAIDS 90-90-90 cascade. In preparation for this transition, seven of the 12 Drop-in Centres established by the project were upgraded to One-Stop-Shops (OSS) for the provision of Antiretroviral Therapy. The upgrade included the setting up of an on-site laboratory and ensuring adequate space for clinical consultations, counselling, HTS and other required services. In line with the "safe space" concept of the OSS, each facility was equipped with a comfortable waiting room/recreational area which enabled Key Populations to relax and socialise with other peers if they so desired, even if they were not accessing clinical services. This feature was a great selling point for the OSS among project beneficiaries. In 2017, an additional seven OSS (one in each state) were established to address the increase in client numbers as well as the challenge of distance to the initial OSS for some project communities in seven (7) States (Lagos, Rivers, Akwa Ibom, Benue, Cross-rivers, Nassarawa, and FCT Abuja).

The implementation of the full HIV care cascade was primarily achieved by ensuring that the established One-Stop-Shops (OSS) across all project states became fully functional as KP-friendly community centres, providing a wide spectrum of HIV prevention, treatment, care and support services. The key clinical personnel for service delivery were recruited (Clinical Supervisor (Doctor), Pharmacist, Laboratory Scientist, Triage Nurse, Community Nursing Officers and Medical Records Officer) and relevant staff were trained on Antiretroviral Therapy (ART) and Logistics Management of HIV/AIDS Commodities. The project also expanded the pool of Case Management Officers to strengthen successful enrolment into ART and sustained adherence counselling for positive peers. Case Management Officers are trained to manage cohorts of positive peers and provide continuous client follow-up, counselling and support until treatment adherence is achieved. Community/mobile ART services and drug refills were also conducted to complement the services provided at the OSS.

SFH One-stop-shop programme which has been found to be effective in reducing barriers to retention and adherence provides comprehensive health services including HIV and STI screening and treatment services, STIs/HIV Prevention and education services, free HIV/hepatitis B testing, blood sugar test, cervical cancer screening, substance use information and referral services, Psychosocial support, Case management and additional services under one roof to assist key populations with finances and transportation needs.

Other strategies adopted by SFH are engagement in outreach to "hidden" and other hard-to-reach Key Populations communities to provide continuous access to condoms and water-based lubricants, and target specific IEC materials. Resources were made available to articulate effective collaboration aimed at extending HIV prevention, care and treatment services to migrant miners (MSM, PWID and FSWs) in remote and poor hard-to-reach communities.

- ***What challenges is the service responding to? These could be health system or client that how the programme was designed.***

  The major key barriers preventing Key Populations from accessing quality and friendly HIV care are:

  - Ineffective linkage to care and treatment due to out-of-pocket cost, long waiting and rigid hours for service provision at the health facility;
  - Stigma and discrimination which includes hostile attitudes of health care workers towards key populations which affects their willingness to access health care service in Nigeria,
  - Many clients on ART reside in hard-to-reach and distant communities from the ART facilities thus contributing to high defaulter rates.
  - Ineffective continuous monitoring of drug compliance and adherence due to the numerous clients (including KP) on ART services at health facilities
  - lack of understanding of issues affecting key populations and inadequate capacity to provide appropriate services to these groups.
  - High cost of transportation and fees for clinics visits
  - Placement and retention in HIV care of positive clients from hard-to-reach communities on ART coupled with the highly mobile nature of key populations

In line with the National Guidelines on HIV Prevention, Treatment and Care which is aimed at achieving the UNAIDS 90-90-90 goal (see fig 2 below); SFH through the Global Fund and USAID funded grants provided HIV treatment services using the models below:

- ***Facility-based individual models,*** where clients are seen individually within health care / OSS facilities;
- ***Out-of-facility individual models***, where ART refills and in some cases clinical consultations are provided to individuals outside of health care facility
- ***Client-managed group models***, where clients are seen in a group managed by a health care worker, within and/or outside of health care facilities.

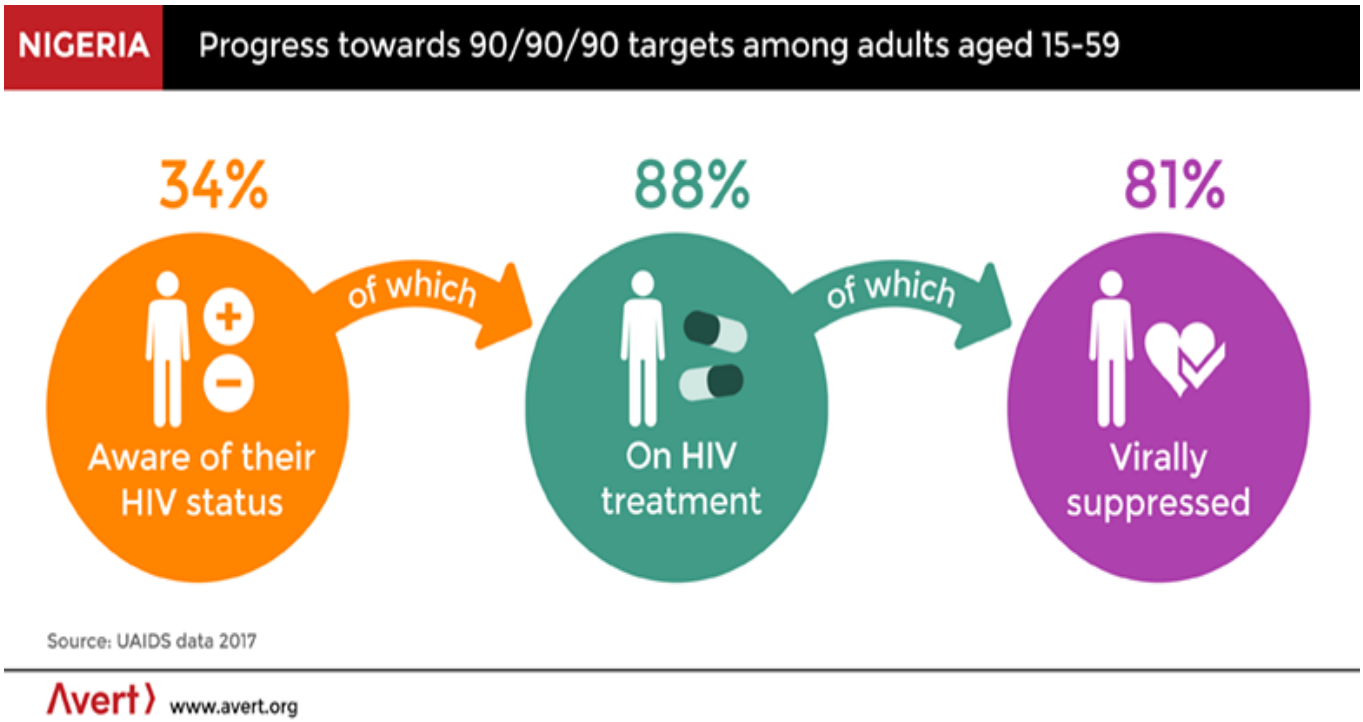


Figure 2: Progress towards 90/90/90 UNAIDS target of ending AIDS by 2030

Learnings from the field

To address these barriers, community-based and decentralized care was adopted as a model for HIV care delivery in providing ART services. The Society for Family Health entered a tripartite arrangement with Oyo State Ministry of Health, partner CBOs/CSOs, and various supported ART health facilities to implement this strategy.

Some of the activities carried out include the provision of HIV prevention education, HIV testing services, linkage to ART care, retention in HIV care, STI screening and condom promotion. Specifically, in Oyo state, these services were provided to migrant miners and Sex Workers in

Komu and Sepeteri Mine Camps, a rural settlement with a population of over 10,000, South West, Nigeria.

A total of 1173 Men who have sex with men, 560 female sex workers and 622 People Who Inject Drugs benefited from the programme. Comprehensive HIV prevention programme which is yielding positive results has been taken to over 50 hard-to-reach communities across focal intervention states targeting Key populations and their clients.

ELIGIBILITY CRITERA

- ***Please provide a more detailed description of who is eligible for your practice example?***
    - ***Are there criteria regarding the duration on ART, duration on same regimen, viral load/evidence of treatment success, etc. to access this model of care?***

ART should be initiated in all adults living with HIV, regardless of WHO clinical stage and at any CD4+ cell count except clients with active tuberculosis (TB) who starts ART within 8 weeks after the start of TB Treatment.

Early ignition of ART is associated with improved survival of patients and reduction of the incidence of HIV infection in the community. The National guideline recommend initiation of ART as soon as possible preferably within two weeks of diagnosis of HIV infection. However, Patient's informed consent should be established before starting ART.

Individuals remain on same regimen except-

I. When there are ADR (adverse drug reactions) found to be debilitating or life threatening, then drugs are substituted.
II. When there is an established treatment failure after viral load results.

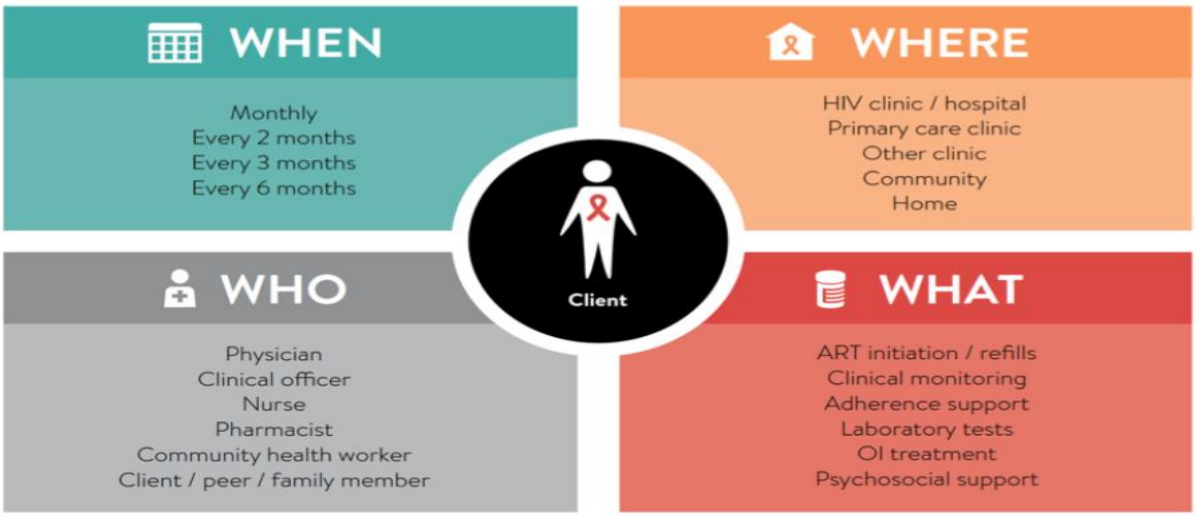
Viral Load

I. Viral load testing has begun and currently, it's done within the 1st six months, 2nd six months and annually after commencement of ART.
II. Results of viral load reveals treatment success for most of the KP especially stable clients.

BUILDING BLOCKS

- *Present the building blocks (Figure 2) of your intervention(s)*
  - *WHEN – at what frequency are clients seen*
  - *WHERE – where is care provided*
  - *WHO –what cadre of staff facilities/provides the services*
  - *WHAT – services are provided*

Figure 2: Building blocks for ART refills



If you do HIV testing – present the building blocks for mobilizing (mass/group, network-based, partner notification and index testing), testing (health facility, non-health facility, community, self-testing) and linking (referral, accompaniment, compensation/incentives, same day ignition, friendly services, tracing)

Table 1: The building blocks of a differentiated HIV testing

	Mobilization	**Testing**	**Linkage**
WHEN	Before and during outreaches, Peer sessions	During mobile outreaches; During Peer sessions (biomedical component) and subsequently every 3 months for HIV negative KPs; Routinely as part of integrated services for KPs at the OSS clinics	Immediately after testing; As soon as client is ready
WHERE	Hot spots, Brothels, Junction towns along highways,	High prevalent areas, Hot spots (clubs, bars, lounges etc), Brothels, Junction towns along highways, Drug bunks,	KP friendly ART facilities, OSS ART Clinics

	Drug bunks, Mine Camps, Peer sessions,	Mining Camps organized network meetings, Community-based, stand-alone testing points, Moonlight Mobile clinics, Specialized clinics (OSS), Drop -in centres, KP Friendly Health Facilities,	
WHO	Self-Referral, Peer Educators, Outreach workers, Program officers, CBO staffs, Peers	Laboratory Scientist, Trained Community/CBO Counsellor Testers	HTS Counsellor Testers, Case Management Officers, PLWH, Outreach Workers
WHAT	Mass/group, network-based, partner notification and index testing	Mobile Outreaches, Peer Sessions, Targeted Stand-alone, Snow ball approach, Partner notification services, Provider Initiated Testing & Counselling, VCT	Referral, Same day Ignition, Accompaniment, Tracing

If you provide ART – present the building blocks for ART refills, clinical consultations, and psychosocial support

Table 2: The building blocks of a differentiated ART delivery model

	ART refills	**Clinical consultations**	**Psychosocial support**
WHEN	Monthly, Every 2 months, and every 3 months	Monthly, Every 3 Months	Monthly
WHERE	One Stop Shop, Inside and out Health Facility/ Communities	One Stop Shop, Communities	One Stop Shop, out Health Facility Communities
WHO	Physician, Pharmacist, Nurse.	Physician	Physician, Pharmacist, Nurse, Adherence Counsellor
WHAT	ART refills, Laboratory test, OI treatment, Clinical Monitoring, Adherence counselling	ART initiation, OI treatment, Clinical Monitoring, Adherence counselling	Adherence counselling, psychosocial support

- ***Describe the intervention HOW***
  - If it is an ART delivery model, what type? (Health care worker managed group, client-managed group, facility-based individual model, or out-of-facility individual model?)

Society for Family Health differentiated service delivery models is grouped into the following three categories:

- **Facility - Based Individual Models**, where clients are seen individually within health care facilities; SFH under the SHiPS for MARPs USAID funded project started the One-Stop-Shop (community-based ART specialized clinics) to strengthens effective linkage along the HIV cascade and improve prevention, care and treatment uptake among key populations in 2016.

  SFH OSS provided integrated services such as HIV Testing and Services (HTS), STI screening and treatment, clinical referrals and ART to Key Populations across seven states of Nigeria's thirty-six states. The seven states are Akwa Ibom, Rivers, Cross Rivers, Benue, Nasarawa, Lagos and the FCT, respectively. The OSS model effectively increased uptake of prevention, treatment as well as prevention-treatment linkage in a more conducive setting that protect the privacy of Key Populations.

  "The OSS is an open community space where Key Populations can walk through the door and get free access to health services, information, ideas and psychosocial support, all with the help of dedicated professionals".

  SFH OSS team is made up of clinical supervisor who is a medical doctor, Nurse, Laboratory scientist, Pharmacist, Adherence Counsellor, Community Nursing Officer, Data officer, Receptionist and office assistant. There are Case Managers whose duty is to link positive clients to the facility and track them when the need arises. One case manager sees to the needs of 10 Positive clients.

- Under the Global Fund HIV New Funding Model (NFM) project which commenced on June 2015 – December 2017, SFH along with the State Ministries of Health, State Agencies for the Control of AIDS, KP community members selected health care facilities who were already providing HIV care and treatment (with funding support from the Global Fund and other donors). The capacity of health care workers from these selected health facilities were

built on the provision of Friendly services to Key Populations with the aim to reduce new HIV infections, and improve the quality of life for the infected and affected as well as promote integrated service delivery among KPs and develop the capacity of the community to implement programmes directly amongst themselves.

Aside the training of Health Care Providers on provision of friendly services to Key Populations, some health care providers were also trained on syndromic Management of Sexually Transmitted Infections (STIs), comprehensive sexuality education, HIV pre- and post-test counselling; safer sex/risk-reduction counselling, condom promotion, and interventions targeted at key populations.

Community-based HIV Counsellor Testers (some are members of the KP community) were also trained to screen Key Populations for HIV and accompanied those who screen positive for HIV, TB and STI to friendly health facilities and ensure rapid initiation on ART and provision of STI Syndromic Management and treatment.

"Under the project, referral is considered completed when a person is referred, registered and enrolled at the referred facility and starts accessing the treatment and/or service(s) for which he or she was referred".

Each enrolled HIV positive clients are managed by trained ART providers based on their clinic appointments for ARV refills, adherence assessment, adherence and psychosocial counselling, clinical check, and viral load collection. These enrolled clients are also members of the facility support groups. Depending on the stability of each client, 1-3 month(s) ART refill are dispensed on clinic appointment day.

During the NFM project, SFH selected 108 Health Care Workers (Doctors, Pharmacists and Nurses) named Stigma-Free Champions from 54 facilities across 9 states (Lagos, Oyo, Anambra, Imo, Edo, Gombe, Kano, Enugu, and Abuja). These Health Care Workers were trained on the provision of Key populations friendly health care services. These states were selected based on epidemiological, empirical evidence and the need to prioritize interventions within a defined geographical location for the purpose of achieving maximal impact. Syndromic management of sexually transmitted infection training was also conducted for 162 health care workers from 54 Key Population friendly health facilities.

- **Out – of - facility individual models:** The clients are seen individually outside of health care facilities with the aim of moving care closer to positive Key Populations identified during the Global Fund HIV New Funding Model project. SFH through Community Based

Organisation and trained HIV Counsellor Testers moved into mine camps and other hard to reach border communities to implement HIV prevention programme with KPs (FSW, PWID and MSM) to attain universal coverage for KPs and bridge populations with HTS as part of a package of prevention services.

The challenges of getting clients in mine camps and distant hard-to-reach communities to health care facilities brought to the fore the need to bring health care services directly to the door steps of those that needs it. Hence, the tripartite arrangement between Society for Family Health, Oyo State Ministry of Health (SMoH), partner CBO/CSO, and the General Hospital Okeho (an ART facility). The arrangement significantly bridged ART access gaps between HIV positive PWID, Sex workers (who are at the camps to take care of the sexual needs of the miners) and migrant miners who have rigid work schedule and live very far away from ART clinics thus making it difficult to keep clinic appointments for care and treatment.

In an attempt to achieve the first UNAIDS 90:90:90 target, the Specialized ART OSS clinics embarked on HTS outreaches to Key Populations located in distant or hard-to-reach communities where immediate ART initiation for HIV positive clients is conducted.

"During the out–of-facility individual models, 1-2 months ART refills are dispensed to stable clients outside of the health facility environment. ART refills are provided to clients directly by facility health workers or collection is done by community nursing officers at specific community locations operated either by community health workers or through a mobile outreach service operated from the facility or SFH supported OSS."

ART refills are distinct from clinical follow up, which takes place 4 - 6 times annually at the facility. These models have helped to reduce challenges encountered by clients in accessing quality health care and ART.

"Work, time and distance to health facilities were serious challenges, bringing services closer to us now have made things a lot easier".

- **Client - managed group models,** where clients meet in a group within or outside of health care facilities

In SFH OSS facilities, clients meet in groups, the health care workers are saddled with the responsibility of managing the provision of ART drug supply, care and support to groups of stable clients. Support Group members meet once a month for 1-2 hour(s) in a session facilitated by health care workers in conjunction with the case management officers (who is also a PLWH). The Health Care Worker provides a brief symptom screen, referral where necessary, peer support and distribution of pre-packed ART to all the members present every 2-3 months (4-6 times a year).

Health talks as well as Peer support are provided during the group meetings. Each member reports on adherence, undergoes a pill count and screening for any new symptoms which are documented on individual client case file. Clients are also allowed to share their individual experience on ART and ask questions. ART refills are collected during the group meeting. Any clients with clinical complaints has the opportunity of seeing a clinician for medical examination. Group members are allowed to send a friend or family member to collect their ART drug supply in the group or a case management officers collect on behalf of each group and carry out community ART refills. Group attendance is marked and signed by those present at the group meeting and other necessary information are entered into the client case file.

- ***Describe the type of service (Government/NGO, community-based, community-led, health facility satellite, DIC, outreach, involving/employing peers)***

Society for Family Health is a registered Nigerian non-profit and non-governmental organization whose mission is to empower Nigerians particularly the poor and vulnerable to lead healthier lives. SFH collaborates with Federal and State Ministries of Health, National and State Agencies for Control of AIDS, Health Care Facilities, Civil Society Organisations, Key population led/friendly Community Based Organisations and Key Community Stakeholders in providing HIV Prevention and treatment services in such a way that creates and ensures access to quality health care services for key populations in poor and vulnerable hard-to-reach communities.

One stop shop specialized ART clinic was established specifically for the Key population sub-groups where trained health care workers provide KP friendly services at the health facility and through community based outreaches. 12 Drop-in centres (DIC) were also established in four focal states to provide HTS and STI syndromic management at the community.

SFH HIV Programmes are being funded by USAID and the Global Fund to Fight AIDS, Tuberculosis and Malaria. The organisation has built the capacity of community volunteers on the provision of comprehensive HIV counselling and testing services; Peer Educators / outreach workers on provision of peer-to-peer HIV prevention messages with emphasis on linkage to care; and health care workers on provision of friendly services to Key populations as well as syndromic management and treatment of Sexually Transmitted Infections (STIs).

- ***What kinds of partnerships are vital to the delivery process?***

The achievements and successes recorded in the use of the differentiated service delivery Models in different sites and communities across Nigeria lies on Society for Family Health's collaborative relationship with diverse organizations.

USAID and Global Fund to Fight AIDS, Tuberculosis and Malaria supports SFH with funding to implement HIV prevention among Key populations. Strong partnership was formed with Federal/State Ministries of Health, National/State Agencies for the Control of AIDS, Local Agencies for the Control of AIDS, Civil Society Organisations, Community Based Organisations (KP led/friendly), some HIV/TB implementing Partners, Public and Private Health Facilities and Key Community Stakeholders which enabled successful delivery of quality health care services to key populations in poor and vulnerable communities in Nigeria.

The various partnerships formed can be grouped into three categories described below:

- **Government:** These are alliances with government institutions who oversee HIV and AIDS intervention at the National, State and Local Government levels to create ownership and sustainability. Some of these institutions are Federal/State Ministries of Health and National/State Agencies for the Control of AIDS, Local Agencies for the Control of AIDS.
- **Implementing Partners:** SFH collaborates with other NGOs who also have funding support to implement HIV/TB programs in order to leverage on their resources (ARV and OIs drugs, viral load analysis, TB referral services among others). This collaboration also helps in avoiding duplication of efforts and double dipping.
- **CSOs/CBOs:** SFH engaged Key population led and friendly civil societies and community-based organizations for implementation of HIV and AIDS prevention and treatment programs

IMPLEMENTING THE INTERVENTION

- ***Describe the highlights of steps to get this service(s) operational***

Key populations in Nigeria experience first-hand stigma and discrimination from health care workers and as such keep away from accessing health care services.

Based on these issues which calls for urgent needs to design effective ways to ensure Key Populations access to quality health care services and treatment, the Society for Family Health with funding support from the Global Fund (New Funding Model Grants 2015 - 2017) and USAID (Strengthening HIV Prevention Services for Most At Risk Populations Grants 2012-2017) came up with set of strategies to increase the uptake of HIV Testing, effective linkages to HIV care and improve access to comprehensive HIV and AIDS health services among Men Who Have Sex With Men, Sex Workers, People Who Inject Drugs, Most-At-Risk Young Persons, and Most-At-Risk Migrant Miners.

The following steps were carried out to operationalize the strategies:

A. **Specialized ART clinic (OSS):**

- Consultation with the state structure, key stakeholders and KP community influencers to elicit support and mobilize the KP community members for the setting up of the OSS facility.

- Specialized ART clinics (OSS) were sited at strategic locations for easy accessibility in collaboration with the KP community members in the seven SHiPS for MARPs states

- Recruitment and training of the OSS Staff on the provision of ART and KP friendly services.

- Quality management / quality improvement committee was set up at the OSS to assess the quality of service delivery. The committee which is headed by the facility M&E specialist, meets once every month to discuss and review the quality of the services provided during the month, identify gaps and suggest recommendations.

- Procurement and Supply Management system to ensure consistent supply of drugs and consumables.

- Collaboration with the engaged CBOs/CSOs to create community awareness, mobilization and referral to the OSS facility.

- Provision of mobile ART services to clients outside the OSS facility through community outreaches for effective involvement and linkage of positive clients in order to achieve the UNAIDS 90:90:90 target.

- Engagement of case management officers (CMOs) to provide care and support services to positive clients placed under them. These CMOs are responsible for follow-up / tracking of positive clients already linked to care and ARV refills when necessary.

- Establishment of support groups for positive clients.

B. GFHIV NFM

- Under the GFHIV NFM project, identification and selection of ART supported health facilities for provision of KP friendly services was done in collaboration with the KP community members, CSOs/CBOs and State Ministries of Health.

- Health care workers from selected health facilities were trained on the provision of "KP friendly services".

- Engagement and training of community members as counsellor testers.

- Partner CBOs/CSOs engaged KP community members as outreach workers and peer educators who provide HIV prevention services and mobilize community members for medical outreaches

- In collaboration with the engaged CBOs/CSOs, community based HTS counsellor testers refer positive KPs to these KP friendly health facilities.

- Positive clients are accompanied by trained counsellor testers and outreach workers (who serves as treatment partners when the need arises) to designated KP friendly health care facilities for service uptake. The outreach workers and counsellor testers are also responsible for follow-up / tracking of positive clients already linked to care and ARV refills when necessary.

- Formation of KP support groups were encouraged in the KP friendly facilities.

- Tripartite arrangement between Society for Family Health, Oyo State Ministry of Health (SMoH), partner CBO/CSO, and the General Hospital Okeho (an ART facility) was reached to provide ART services to clients in mine camps and distant hard-to-reach communities.

- ***Was this a pilot project? Has it been expanded? Taken to scale?***

The ART One-Stop-Shop under the USAID funded Strengthening HIV Prevention Services for Most At Risk Populations project was implemented in seven states (Lagos, Cross-river, Benue, Akwa-Ibom, Nasarawa, Rivers and FCT Abuja) as a pilot project.

In line with National Guideline for HIV Prevention and Treatment which promotes treatment as prevention, "test and start" was rolled out in all the One-Stop-Shop for all HIV positive clients immediately after diagnosis irrespective of their CD4 count or viral load. Adequate antiretroviral drugs were in stock for pre-exposure prophylaxis among high risk and discordant partners/couple. Routine laboratory services, syndromic management of STIs, management of TB and other co-infections screening was available at the OSS.

The project also trained Health Care Workers across the focal states on the provision of friendly services to key populations and syndromic Management of STIs. Key populations showing signs and symptoms of sexually transmitted infections (STIs), low condom use, high risk sex were made to take the test. Partner notification services was cascaded around every positive Key population diagnosed.

The lessons learned from the implementation of the specialized ART (One-Stop-Shop) for positive Key Populations in Nigeria during the USAID funded SHiPS for MARPs project, provided a key background from which informed decisions were made by SFH and Global Fund to incorporate the One-Stop-Shop intervention into the New Funding Model Grant Extension (Jan. 2018- June 2019). It will be instructive to note that at the end of the USAID SHiPs for MARPs projects all OSS were handed over to another implementing partner to ensure continuity

Under the Global Fund Project, the One-Stop-Shop is being implemented in 3 states of Nigeria – Oyo, Imo and Kano as a community clinic for Key Populations with the view to create a safe space for the delivery of a complete cascade of HIV services - focused

prevention, treatment, care and support services. The OSS provides services such as HTS, ART, STI, Partner Notification Service (PNS), social and sexual networks, Post-exposure Prophylaxis (PEP), Counselling services, maintain case finding and improve linkage to services, retention.

An enrolled PLHIV in OSS stays at the site for a 6 months' intensive phase, 6 months sustained phase after which he/she is transited to the public health facility for pipe line filling as a sustainable and exit mechanism of the grant.

- ***Did you train staff? What teaching materials did you use? Was a lot of supervision required?***

  Staff trained included Doctors, pharmacists, lab Scientists, nurses (including triage nurses), counsellor testers, adherence counsellors, and data clerks.

  Health Care Workers - Providing KP-Friendly Services, Syndromic Management of STIs

  Counselor Testers - Natural History and Clinical Staging System of HIV, Risky Behaviours and Methods of Risk Reduction, Overview of HTS, Basic Counselling Skills and techniques. HIV Testing, Monitoring and Evaluation, quality assurance, Referrals and linkages with services and service providers

All teaching materials used were developed from existing national guidelines and training manuals. The teaching materials include:

- **Instructional materials** used includes active learning and assessment facilitation styles, role play, short drama, workbooks, group work, case studies, experience sharing, role play, brainstorming, Icebreakers, flip-chart, colored pens/ cards, and adhesive paste.
- **Graphic organizer** - Diagrams, charts, tables, flow charts, and graphs
- **Facilitators Made Resources** – pre and post-tests, worksheets, daily evaluation, Slides/print out of presentation slides, Group facilitation, Feedback, Power point presentation, micro presentation, facilitators daily assessment

The various trainings were supervised by representatives from Federal/State Ministries of Health, state agencies for the control of AIDS, KPs secretariat and Police Action Committee on AIDS (PACA). Participants were allowed to frequently ask questions/sort clarifications where and when necessary.

- ***What kind of training do clients receive?***

Clients receive training on substance abuse, HIV and opportunistic infection prevention, positive living, HIV Risk behaviours, physical health, nutritional education, drug adherence, personal hygiene, managing stigma and discrimination, importance of viral suppression, partner notification.

- ***How did you track progress? What M&E elements did you build into the model?***

To monitor progress in achieving targets and measure program output and outcomes, the project utilized various tools, approaches, and methodologies to strengthen the existing M&E system to be able to document project achievements and meet the reporting requirements of the donor, Government of Nigeria and other stakeholders. The M&E system is structured at three levels. The first level is at the service outlets operated by various civil society organizations and the OSS where KPs access services directly. All the relevant national Management Information System tools and project specific tools were used for data capturing, aggregation and reporting by service providers.

These included tools such as the HTS register, ART register and the national Minimum Prevention Package of Interventions (MPPI) electronic database as well as some project-specific tools. The tools were used to monitor activity level indicators such as:

- Number of CSOs trained
- Number of KPs reached with MPPI
- Number of KPs tested for HIV and received results
- Number of clients referred to other services
- Number of clients reached with STI management services
- Number of HIV-positive KPs linked to ART or initiated on treatment at the OSS
- Number of HIV-positive KPs achieving viral load suppression.

MIS data was reported into the SFH District Health Information System (DHIS), an established web-based reporting system designed to capture facility-based information. CSO aggregated data from outreach workers at the community level and monthly summary data generated was entered into the DHIS by the CSO M&E Officers. Monthly summary forms were used for data aggregation by service areas and the final data reported through the DHIS. Also at the state

level, the state MIS Officers collated data generated from the OSS and reported this through the DHIS platform.

At the second level of the system, the state Project M&E Officers oversee the activities of service providers to ensure accurate data is captured and reported. The third level is the Head Office M&E unit which generates reports from the DHIS monthly to review achievements reported from the states. Any data quality issue identified is resolved with the states before final data is reported for the month. As the project continued to scale up implementation, project data was analyzed monthly to identify and prioritise high yielding communities. The project continued to provide monthly and quarterly performance data to USAID and Global Fund respectively.

All data reported to USAID and Global Fund were verified for accuracy through Data Quality Assessment (DQA). The capacity of state project teams and CSO partners was built to be able to conduct routine data quality assessments and this was also done periodically by the Head Office team as part of field monitoring and supervision. Findings from the DQA exercises were disseminated at various levels to ensure that prompt corrective measures were initiated to address any data quality issues or gaps identified.

- ***How much do you estimate getting the services operational cost? Where did this money come from?***

The estimated unit cost for getting this services operational for each client is 180 dollars. The projects were implemented with funding support from USAID and the Global Fund.

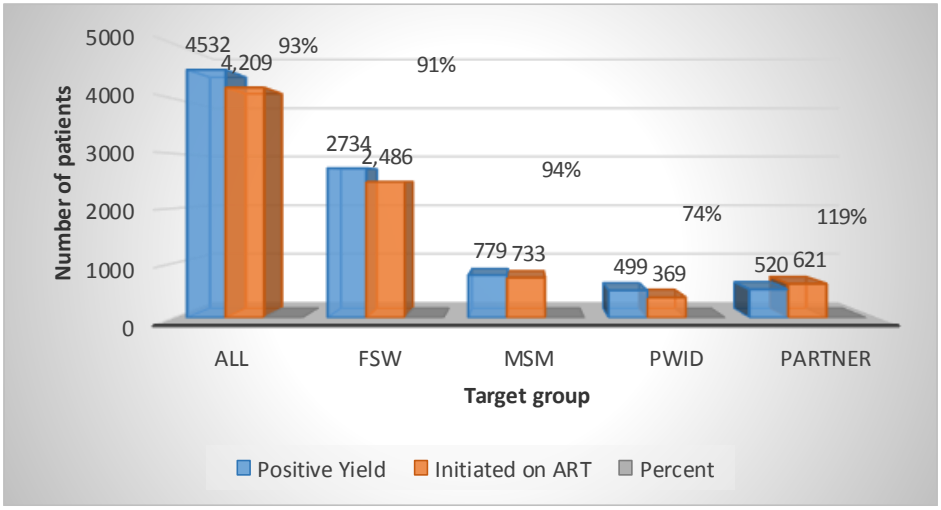
- ***Overall was this feasible?***

Yes

DATA

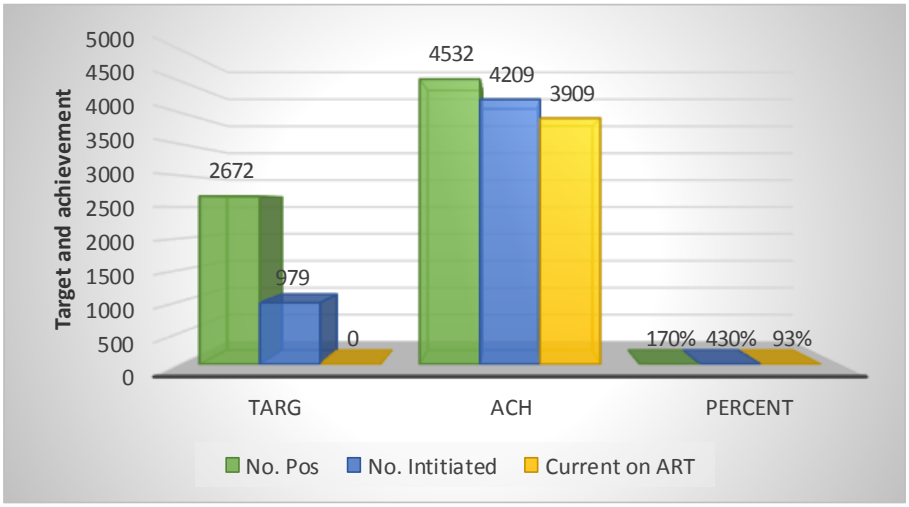
Health Care Providers and Positive Clients were of the opinion that the DSD model has improved access to care and should be sustain and extended to more communities and cover wide range of health and psychosocial support services

Figure 1: SHiPS for MARPs HIV Positivity Yield and Initiation on ART Among Target Groups



Out of 4,532 positive individuals identified, 4,209 (93%) were initiated on ART at the One-Stop-Shops established by the project. Among KPs, MSM had the highest initiation rate, followed by FSWs and then PWID. The 119% achieved among partners of KPs is because Partner Notification Services are not only provided to newly identified positive KPs during the period but also to previously known positive KP who initiated treatment from previous periods.

Figure 2: UNAIDS 90-90-90 Performance in FY17



Project performance on achieving the UNAIDS 90-90-90 goals based on targets shows that annual targets were exceeded. The project achieved 170% of target for positive KPs identified and 430% of target for number of KPs initiated on ART. Out of 4,532 positive KPs identified in USAID focal states, 4,029 (93%) were initiated on ART and 3,909 out of 4,029 (93%) initiated on ART were still on ART.

SUCCESS

What made this a success?

Key results that have been achieved through SFH operated DSD model include reduction of the burden (cost of transport, long waiting time, fear, for clients and health systems, and high retention rates

- The One-Stop-Shop provided a friendly, stigma free and recreational facilities for KPs which encouraged continuous access to care
- High level of team work and professionalism of health care workers in maintaining privacy, confidentiality and providing excellent health care service
- Engagement and Involvement of stakeholders and community members in planning, implementation and delivery of services
- Availability of funds and effective logistics system
- Use of data to review the achievements of the health care service delivery in different models as well as barriers faced by positive clients
- Integration of other services and its provision to KP members especially at the community level with the regular availability of drugs (ARVs, STIs and OIs) improved access to care

CHALLENGE

What challenges arose and how did you respond to them?

Challenges	**How it was Resolved**
Inadequate funds to scale-up to more Hard-To-Reach communities on the GFHIV NFM Grant	ART One-stop-shop was incorporated in to the new GFHIV NFM Extension grant to reach more hard-to-reach communities. Partnered with other ART-supported facilities for provision of ART services to more hard-to-reach communities.
Inability to book, arrange, and or reschedule appointments with clients in care especially when the ART team is not within the communities due non-availability of communication network in most of the hard-to-reach communities.	Frequent visits were made by the case management officers to follow up on those clients in care
Security challenges such as armed robbery on the lonely routes with security	Advocacies were made to community leaders and this led to provision of appointed local community

post/personnel, non-availability of mobile communication networks and very poor or non-existent accommodation	guard men who provided security cover for outreach team.
Limited Space to conduct clinical Examination in mine camps without medical post or clinic	Mobile tents were used as makeshift consulting rooms for the outreach team
Women who visited the ART team for enrolment and refills were perceived by the community to have HIV. This made other women to refuse taking HIV test so as to avoid been labelled HIV positive	The outreach team engaged the community leaders and influencers to address the issue of stigma and discrimination in the community. Provision were also made for drugs to treat other minor illness other than STI and HIV so more people can have access to drugs and thereby reducing stigma around positive clients
Clients giving false contact details which affected retention rate	Case Management Officers were recruited to keep track of the client
Financial constraint which affected clients feeding and access to care	Case management officers and officers who serve as treatment partners usually assist in drug pick up
Migrant nature of positive clients (frequent relocation of clients)	Ensured that clients were properly counselled and linked to treatment partner who knows their where about at every point in time. Those who notified the team of their relocation were given up to 2months drug refill as well as transfer letter to the new facility.
Transport for outreaches and tracking linkages	Funds were provided to support patient escort and tracking services by case management officers and counsellor testers
Over-stretched and Poor staff morale at government and private ART health facilities due heavy workload, increasing patient numbers and lack of resources.	Health facility staff were provided with stipends for transportation, lunch and communication
Overwhelming travels to far communities with bad roads with spill-over effect on both the clients and outreach team for access and provision of care	Drug period was extended to reduce road travels

NEXT STEPS

- ***Do you have plans to expand or take your intervention(s) to scales?***

  The OSS is a tailored and integrated community-based ART clinical services model for the KP and Adolescent sub-groups and is recommended for scale up. The OSS model have been incorporated into three (3) out of the seven (7) states for the KP prevention module on the GFHIV NFM Extension grant. SFH and the KP community recommends the scale up to the entire seven (7) states.

  More health facilities had been trained on the GFHIV NFM Extension grant as KP friendly facilities for referral, care and treatment.

- ***How are you working with government and other partners?***

  The achievements and successes recorded in the use of the DSD Models in different sites and communities across Nigeria lies on Society for Family Health's collaborative relationship with diverse organizations.

  Various partnerships formed can be grouped into three categories described below:

- **Government:** These are alliances with government institutions who oversee HIV and AIDS intervention at the National, State and Local Government levels to create ownership and sustainability. Some of these institutions are Federal/State Ministries of Health and National/State Agencies for the Control of AIDS, Local Agencies for the Control of AIDS.
- **Implementing Partners:** SFH collaborates with other NGOs who also have funding support to implement HIV/TB programs in order to leverage on their resources (ARV and OIs drugs, viral load analysis, TB referral services among others). This collaboration also helps in avoiding duplication of efforts and double dipping.
  - **CSOs/CBOs:** SFH engaged Key population led and friendly civil societies and community-based organizations for implementation of HIV and AIDS prevention and treatment programs.

ANNEXES

- ***Please attached any quotes from clients or providers about preferences, attitudes or experiences with your differentiated service delivery model***
- *"My husband was tested for HIV and found to be positive, he used to be very sick before now but after the test and he was given drugs. My husband has not been sick again – he encouraged me to take the test which I did, though I am negative but I have been supporting him"- Mrs. Savage Adesina said.*

- *"Years passed and I maintained this sexuality as I had more male friends, went to gay parties and had sex often with the male friends but I always use condoms. After I graduated from high school, I had a particular boyfriend whom I thought was HIV negative since he was very young like me. Consequently, I engage with him without condoms." - Feyi*
- *"The staff at the OSS Ilupeju counselled me about living positively despite my status, encouraged me and treated me well despite my sexuality" - Feyi*

- *"Before I came to the OSS, I went to many other hospitals and I have taken different drugs. Then, my friend told me about the OSS and I decided to visit the place with my mother. I was thoroughly counselled before I was tested and after the test my mother and I were counselled with my consent. That was when my mother accepted the result and I felt very relieved for the first time since I discovered my HIV status." - Mary*
- *"The staff at the OSS were very nice to my mother and I. They are also very kind and received me without discrimination. I am no more having fears and I have been taking my drugs regularly as I was advised. I have added weight and no more falling sick" - Mary*

- ***Please include any photos of your model in action***

Health Care Workers attending to clients outside the facility

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