



THE GLOBAL FUND GRANT CYCLE 6
National Aligned HIV/AIDS Initiative
(NAHI)

Compendium of Lessons Learned & Best Practices

NAHI EXPERIENCE

GRANT PERIOD OF IMPLEMENTATION
JANUARY 2021 – DECEMBER 2023



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ACRONYMS

ART	Antiretroviral Treatment
C19RM	COVID-19 Response Mechanism
CIHP	Center for Integrated Health Program
CPHI	Centre For Population Health Initiatives
DSRM	Daily Situation Room Meetings
GF	Global Fund
HALG	Heartland Alliance LTD/GTE
HFR	High Frequency Reporting
IHVN	Institute of Human Virology, Nigeria
M&E	Monitoring and Evaluation
MAT	Medically Assisted Treatment
MHPSS	Mental Health and Psychosocial Support Services,
NSP	Needle Syringe Programme
OST	Opioid Substitution Treatment
PWID	Person Who Inject Drug
SACA	State AIDS Control Agency
SAS	Syringe Access Services
SASCP	State AIDS and STIs Control Programme
SPHCDA	State Primary Health Care Development Agency

PREFACE

The National Aligned HIV/AIDS Initiative, Global Fund Grant Cycle 6 (GF-NAHI GC-6) commenced implementation at a critical juncture for the Nigerian HIV response as it began immediately following the COVID-19 pandemic. The first year of the grant, 2021, presented significant challenges due to the ongoing impacts of the pandemic. To the credit of FHI 360 as Principal Recipient and the eight sub-recipients, the grant was implemented successfully such that by the end of the grant on December 31, 2023, the grant performance received a B-2 rating by The Global Fund.

The GF-NAHI GC-6 implemented several innovative and pathfinding interventions, including:

- Providing services to key and vulnerable populations.
- Identifying challenges to and developing strategies to improve the Prevention of Mother-to-Child Transmission (PMTCT) of HIV with significant learning on what worked or did not work.
- Removing barriers to service delivery for Adolescent Girls and Young Women (AGYW).
- Implementing harm reduction strategies for People Who Inject Drugs (PWIDs) to reduce the risk of HIV and other blood-borne diseases.
- Distribution of HIV self-test (HIVST) Kits to increase access to HIV testing services as an entry point in receiving HIV treatment and care.

This document is one of a series of products that has recorded the efforts of FHI 360 and its Sub-Recipients, which include the Achieving Health Nigeria Initiative (AHNI), Society for Family Health (SFH), Excellence Community Education Welfare Scheme (ECEWS), Network of People Living with HIV/AIDS in Nigeria (NEPWHAN), National AIDS and STDs Control Program (NASCP), and PEPFAR Implementing Partners such as Heartland Alliance LTD/GTE (HALG), Centre for Integrated Health Programs (CIHP), Institute of Human Virology, Nigeria (IHVN), and Centre for Population Health Initiatives (CPHI). It details the pathfinding services provided, lessons learned, challenges faced, and the innovative actions taken to address these challenges.

We acknowledge the contributions of all other project staff who contributed to the first draft of this report in November 2023. Special mention is made of the following people who worked tirelessly to complete these series of report in the closeout period.

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1. USE OF DATA FOR DECISION MAKING AND STATE GOVERNMENT OWNERSHIP OF HIV PROGRAMMES: LESSONS FROM ANAMBRA STATE

Government ownership of HIV Programmes has been a challenge at the state level. The lessons learnt from Anambra State indicate that when government leaders understand and can use data as evidence of action, programme ownership results.

Strategic use of data for sound decision making is required at all levels of HIV/AIDS programming and management. This however has remained a major challenge, especially in the public health space involving a wide spread of stakeholders with government functionaries on the driver's seat, be it at national or state levels. Until now, response to day-to-day challenges in HIV programming and management takes longer to resolve; not only because of unavailability of the right data, but also its presentation in the right form, locale and making it accessible to the right actors in a timely manner for effective use.

During the design of the GF NAHI project, plan was made for High Frequency Reporting (HFR) that would enhance effective data demand and use at various levels, starting from the community, facility and the whole health system. Daily Situation Room Meetings (DSRM) were also planned to serve as the forum where information will be shared, discussed and decisions taken on emerging issues. In the design, DSRM was to be central and easily accessible to all key stakeholders and bring all key actors together to discuss their programme, its challenges and how to mitigate them.

Anambra State is the flagship of the NAHI project (Surge State) where about 70% of the NAHI project data were generated. The development of a dashboard for DSRMs was done in February 2022 and the first ever DSRM was launched in March 2022 with the attendance and participation of key stakeholders such as that Commissioner for Health, Dr Afam Ben-Obidike, representatives from the State Primary Health Care Development Agency (SPHCDA), the State AIDS and STIs Control Programme (SASCP), State AIDS Control Agency (SACA) and several others. Participants saw the application of HFR, and they were able to interact with the dashboard with real time data for the state. The commissioner was so excited at this innovation that he immediately became a regular attendant at the DSRM. This development has expanded to become a health sector-wide practice where executives were becoming more involved with the use of data emanating from the field to make certain types of decisions.

Successes achieved from the implementation of DSRM in Anambra State had been enormous and contributed immensely to the success of The Global Fund project in the state. Government has taken good ownership of the response to the challenges of HIV/AIDS in the state. It is expected that this will open more frontiers for collaboration and cooperation with other partners and agencies for increased participation and more robust response. Within one year of its operation, implementation of DSRM in Anambra State has led to key decisions which include the following:

- Increased ownership in the Response to HIV/AIDS through commitment of additional resources for HIV/AIDS response.
 - Cancellation of fee for services delivered to PLHIVs in government hospitals and government takeover of such payments for clients. The non-payment of fee for services has led to increase in general testing services for number of pregnant women testing services from 77% to 115%.
 - Donation of office buildings in Onitsha and Nnewi clusters by the state government to NAHI project, thus freeing up cost of rents for service provision. The outcome of this gesture by state government has resulted in the expansion of NAHI work in Anambra State with office buildings in the three senatorial districts of the state.
- Demonstrated willingness of stakeholders to support, collaborate and leverage on resources for health in the state.
 - Easy tracking of performance in other disease conditions like COVID-19, high blood pressure, diabetes etc. in collaboration with other departments and agencies within the health sector. This development snowballed into the “Know Your Status” initiative where citizens’ data are reported in the DSRM. This has enabled government to free additional resources for services.
 - Resuscitation of the state Logistics Management Coordinating Unit and the resultant effect of the triangulation of commodity data with service data for effective commodity management in the state.

Finally, based on lessons learned from Anambra State, the same strategy for high frequency reporting through DSRM was implemented in Ebonyi State. With the experience in Anambra State, NAHI management replicated DSRM implementation in Ebonyi and Taraba states. NAHI is getting the attention of stakeholders in Anambra State.

The government of the two states are becoming more interested in the response and participation and are asking relevant questions with regard to data on the service delivery. With the DSRM, there is increased participation of government and other stakeholders in the HIV review meetings in Taraba State as the SRM provided the platform for coordinated reporting at meetings.

Apart from consolidating on the achievement of the introduction of DSRM in Anambra State in GC7, FHI 360 will engage with necessary stakeholders on the implementation of the initiative at the national level.

2. PROGRAMME FLEXIBILITY AND ADAPTABILITY TO EMERGING HIV TRENDS: LESSONS FROM GF NAHI PROJECT

Response to the challenge of HIV and AIDS has been on for close to four decades in Nigeria and enormous resources have been expended in the fight. Although several successes have been recorded and prevalence brought to consistent decline, HIV/AIDS remains a public health concern. For the country to attain its vision of an AIDS-free society with zero new infections, there is need to reengineer the traditional structure and mechanisms for fighting HIV and AIDS and embrace emerging tactics and opportunities.

HIV/AIDS programming commenced in Nigeria in 1986 and reached a crescendo in early 2000s when a prevalence rate of 5.8% was reported. Although national response has yielded declining prevalence and Nigeria is reported to be approaching epidemic control, HIV/AIDS is still a major public health concern. Government of Nigeria in partnership with donors and implementing partners have worked together to put in place programmes that would help Nigeria to achieve the vision of having an AIDS-free Nigeria, with zero new infections, zero discrimination and stigma and zero AIDS-related deaths by 2030.

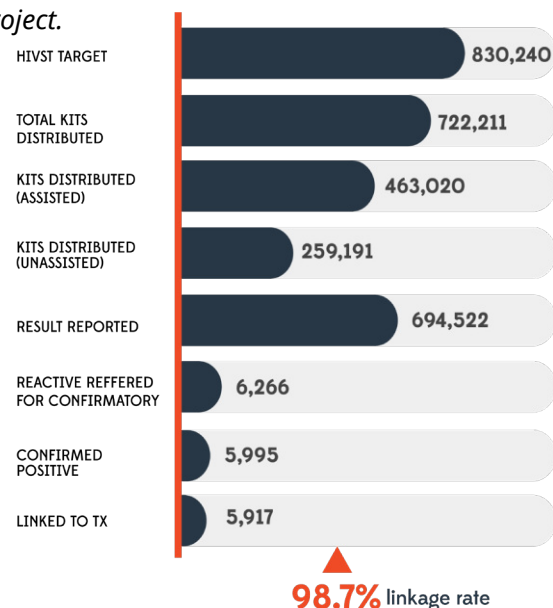
These efforts brought about the birthing of Alignment 1.0 and the Global Fund NAHI project became the flagship of the Alignment initiative. NAHI project is no doubt a success with a yearly overall performance of 60.2% in 2021, 101.2% in 2022 and 102.4% in 2023. One thing that was done differently is the integration of emerging intervention into its original design, bridging all gaps and expanding HIV/AIDS programming space.

The year 2022 is significant to the implementation of the NAHI project. Year 2022 served as the watershed for emerging interventions, especially HIV Self Testing (HIVST), Needles and Syringes Programme (NSP), otherwise known as Harm Reduction, Adolescent and Young People (AYP) Programme and COVID-19 Response Mechanism (C19RM). The integration of these interventions into the NAHI project brought about a change that will reshape HIV/AIDS programming in Nigeria.

2.1. HIV SELF TESTING (HIVST)

HIVST is a process whereby a person who wants to know their HIV status collects a blood specimen, performs a test and interprets the test result in private. Any reactive HIV result from the test must be confirmed by a health worker in accordance with national testing algorithms. By providing an opportunity

Figure 2-1: Performance on HIVST in the NAHI Project.



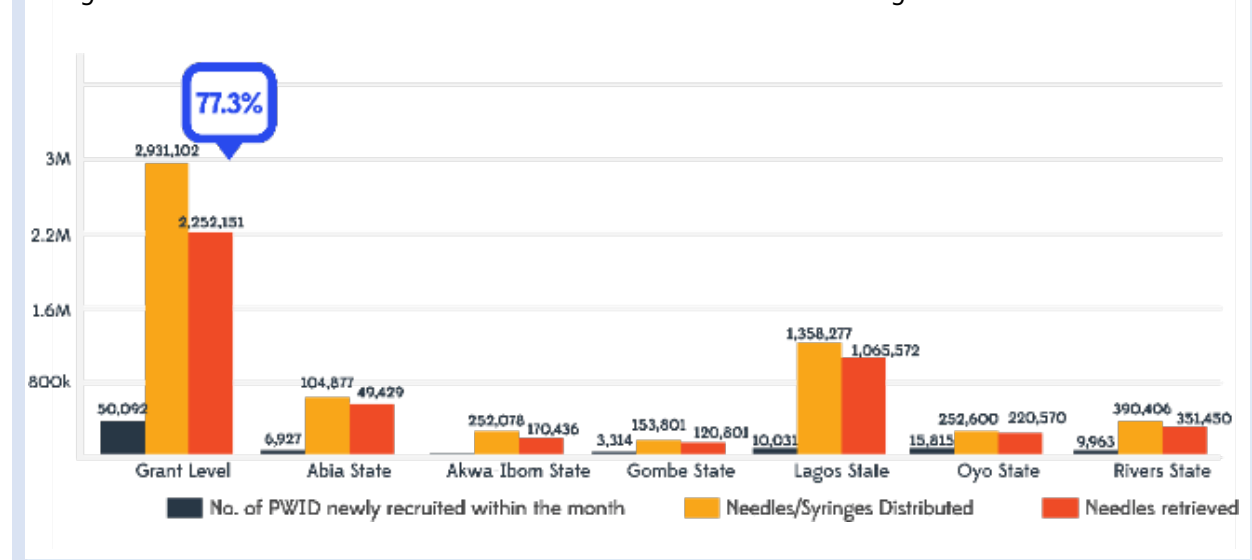
for people to test themselves discreetly and conveniently, HIV self-testing provides people who are not currently reached by existing HIV Testing Services (HTS) with information about their HIV status. The implementation of this intervention in the NAHI project began in August 2021.

Testing in HIVST under the NAHI project contributed 13% to the total number of HIV tests carried out in the project. The contribution of this intervention to identified HIV-positive in the NAHI project stands at 7.9%.

2.2. HARM REDUCTION

The Harm Reduction interventions started in NAHI with the Needles and Syringes Programme. It was a strategy to address the challenges of drug abuse, especially with respect to the association of the menace with HIV/AIDS. Key services in Harm Reduction include Needle Syringe Programme (NSP), Opioid Substitution Treatment (OST), Medically Assisted Treatment (MAT), Mental Health and Psychosocial Support Services (MHPSS), Syringe Access Services (SAS) and Antiretroviral Treatment (ART) among Person Who Inject Drug (PWID). The NSP intervention was introduced into the NAHI project and commenced in August 2022. NSP was implemented in seven states (Abia, Akwa Ibom, Cross River, Gombe, Lagos, Oyo and Rivers) in partnership with four PEPFAR implementing partners (CIHP, CPHI, HALG, IHVN). A total of 2,931,102 needles and syringes were distributed, and 2,252,151 needles were retrieved (77.3%) during NAHI project implementation.

Figure 2-2: Harm Reduction needles distribution vs retrieval cascade August 2022 - December 2023



2.3. ADOLESCENT AND YOUNG PEOPLE (AYP) PROGRAMME

The AYP Programme is an initiative developed to address the menace of HIV and AIDS among adolescents and young people. The AYP programme comprises the Adolescents Girls and Young Women (AGYW) and Adolescent Boys and Young Men (ABYM) initiatives. Like other emerging interventions, the AYP initiative was integrated into the Global Fund's

NAHI project in Nigeria in 2022. AYP work in NAHI started with the AGYW intervention and later grew to incorporate the ABYM intervention.

During the NAHI project implementation, the following number of AGYW were reached with Minimum Prevention Package Intervention (MPPI); 72,115 in 2021; 494,757 in 2022 and 838,044 in 2023. Also, the following number of AGYW were tested for HIV; 65,789 in 2021; 448,406 in 2022 and 574,409 in 2023.

2.4. COVID-19 RESPONSE MECHANISM

The emergence of COVID-19 brought about a major disruption on the health systems, including HIV/AIDS programming in Nigeria. Even after the post COVID-19 peak era, it continued to have devastating impact on the progress towards the 2030 goal of zero infection and AIDS-free society. COVID-19 Response Mechanism (C19RM) initiative was developed to mitigate the impact of COVID-19 on programmes to fight HIV, TB, malaria, and systems for health. C19RM was integrated into the Global Fund NAHI project in 2022 as an add-on to the traditional HIV programming.

A summary of achievements in COVID-19 intervention stands at:

- Total Tested for HIV: 168,479
- Total Positives: 1,682
- Linked to Treatment: 1,627 (96.7%)
- Total PLHIVs on treatment: 1,076
- Percentage contribution of positive clients on treatment to overall clients on treatment: 1.3%

Besides the above four emerging interventions, the year 2022 also witnessed a towering progress in the delivery of HIV services to Key Population, while the NAHI project continued to pioneer the navigation of new frontiers in HIV programming in Nigeria.

3. LESSONS LEARNT AND BEST PRACTICES FROM THE NAHI GC6 PROJECT: PATIENT BIOMETRIC SYSTEM (PBS) IMPLEMENTATION.

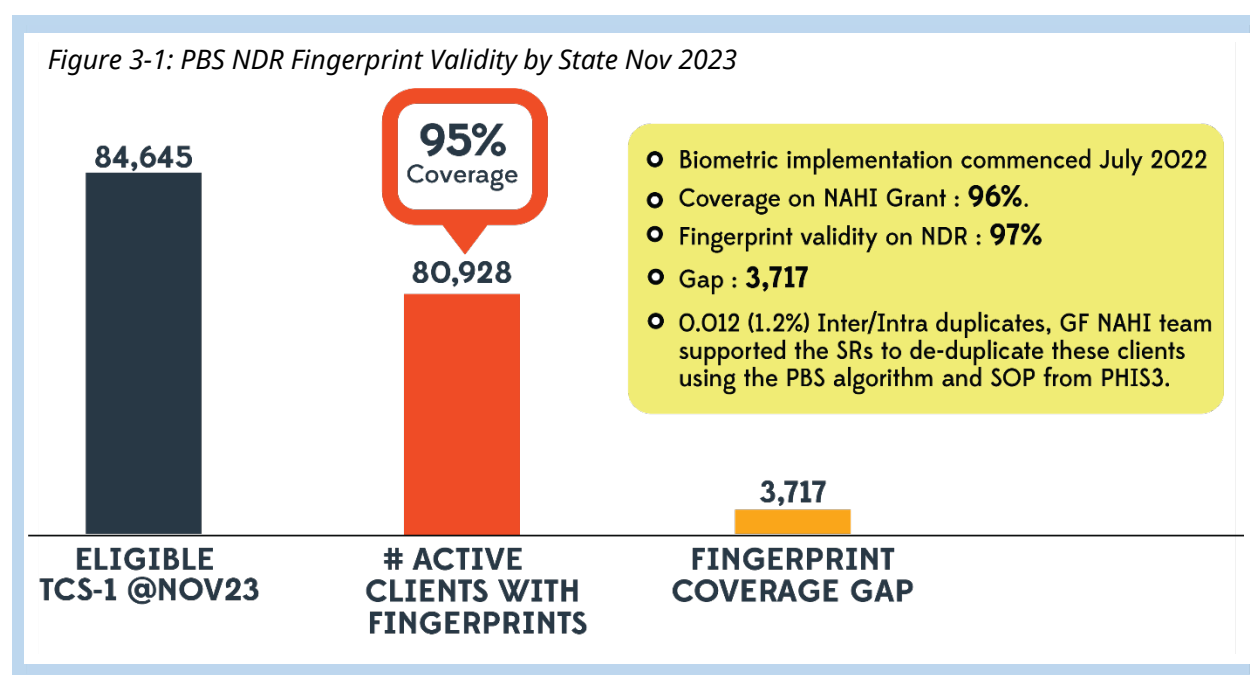
In the effort to get the Antiretroviral (ART) data right, GON mandated all implementing partners in Nigeria to introduce and implement Patient Biometric System (PBS) using an approved protocol and report progress on the National Data Repository (NDR) for stakeholder visibility. The patient biometric were perceived as an alternative tool to verify and validate the accuracy of ART data. The PBS implementation is to capture fingerprint of all PLHIV clients on treatment as their fingerprint will serve as unique identification with security features in the event of the same clients appearing twice in the same facility or migrating to other facility for the same services.

FHI 360 has always been committed to getting the data right long before that became a national campaign in 2020. The NAHI Grant commenced the implementation of a PBS in July

2022, over two years behind PEPFAR IPs. With the support of GF Country Team, the grant implemented a catch-up plan to ensure full coverage of patients in PBS in line with Government of Nigeria (GoN) directive and protocol.

3.1. BIOMETRIC COVERAGE IN NAHI PROJECT

As of November 2023, the coverage and validity of PBS was **96%** with **80,928** clients captured of the total TCS-1 of **84,645**.



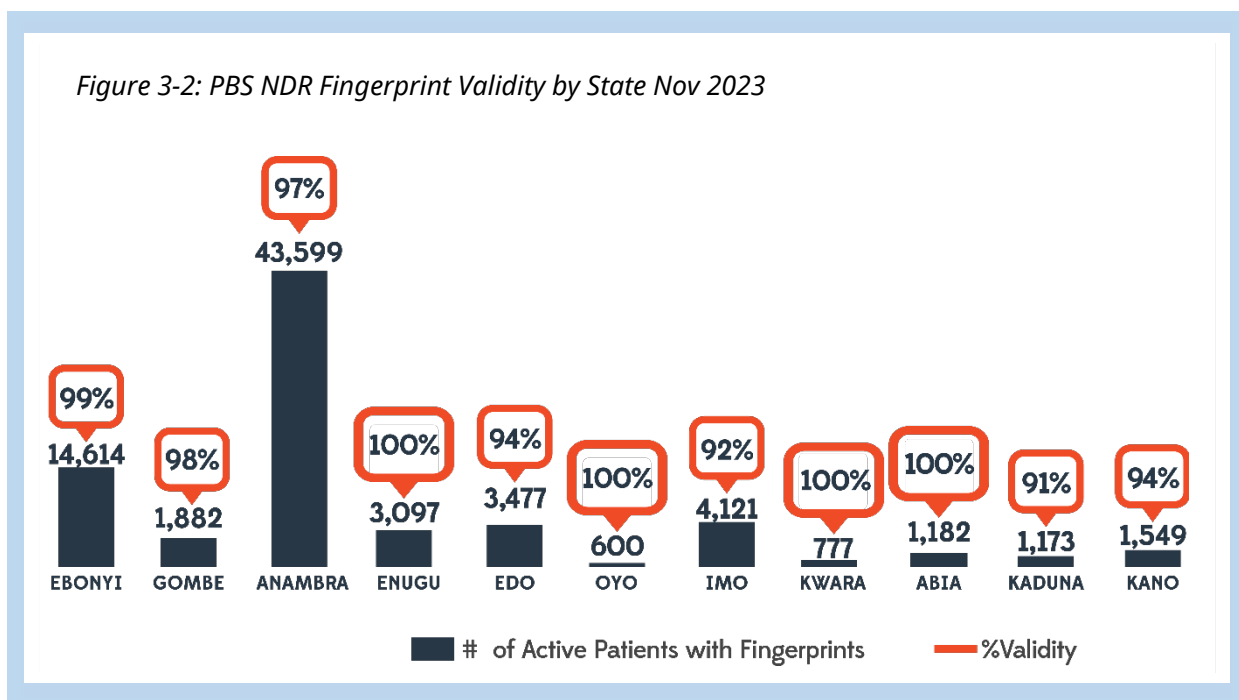
Biometrics Data Validity. Up to the last PBS review in November 2023, the NAHI project has the lowest number of client fingerprint duplicates in the country, with only **966** duplicates (**1.2%**). These are clients that were registered in other non-GF facilities (inter duplicates). The Grant worked with GoN and other PEPFAR partners, especially, the Public Health Information, Surveillance Solutions and Systems (PHIS3), to de-duplicate these clients through an adjudication process as contained in the national protocol.

The state-by-state performance on fingerprint validity is presented in figure below. Eight (8) of the thirteen (13) States had validity above 97%, while four (4) had validity of over 90%, with Plateau state being the only outlier. This is because the KP Program started late in that state

A key challenge faced/lessons learned in this process was incompatibility of the initial procured scanners with the Futronic. Validity issues occasioned by ABS ISO version 2 which made it difficult to reconcile biometric capture from other systems.

while many who transited from other sites within the State's HIV Program had previously been captured elsewhere. The de-duplicating efforts have cleaned out this situation.

Figure 3-2: PBS NDR Fingerprint Validity by State Nov 2023



3.2. KEY STRATEGIES USED IN THE DEPLOYMENT OF PBS, CHALLENGES & LESSONS LEARNED:

The NAHI strategies on PBS implementation on the NAHI GC6 include the following:

A focused PBS System Design/Concept Paper: Design and deployment of biometric schema was in line with the national protocol. This included a detailed review of structure and infrastructure available in all ART sites where BPS is to be deployed. The assessment also took into consideration the needs and type of biometric scanners to procure after which the Futronic with ANSI/INCITS 378:2004 and ISO/IEC 19794-2:2005 standard was recommended for use on the project.

Selection of PBS equipment was done to take care of power challenge, especially at the community level where there is poor or no electricity. A set of Validation Rules was also developed as part of the protocol for

A key best practice here was that to get the clients buy-in and consent for capturing their fingerprints, sensitization, information, education and counselling on the importance of biometrics in ensuring that individual clients receive customized and quality care was provided. Furthermore, the need to avoid data fraud and engender confidence in our program from government and donors were also explained. Clients were further assured of the national data protection laws and that their fingerprints were safe and cannot be used outside of the health care setting. The result of this was great cooperation from clients in providing their fingerprints and even when there was the need to recapture, once the reasons for this was explained the clients cooperated.

implementing PBS in the project. PBS implementation under the NAHI project was designed to accommodate patient capture at the facility and community levels in recognition of the fact that not all **clients will be able to come to the** facility for capture only, given the fact of security and financial challenges, especially for clients on long-term MMSD who may not visit the facility in the next three of six months. The protocol also provides guidance on how to manage client duplication and related issues at all levels – site, state, SR, PR and national.

A key lesson learned was that Clients on MMD6/DSD model could not visit the facility until 6 months' time. This affected the coverage per time. This problem was resolved by identifying who these clients were, and then mobilizing them for biometrics capture before their due dates for review and drug pick up.

1. **Procurement and Distribution of Biometric Scanners:** This step included the identification of the right vendors that could respond to proprietary, standards and maintenance issues seamlessly during implementation. It also involved the development of a logistics system for the rapid distribution of the biometric scanners across all the ART sites and OSS earmarked for implementation.
2. **Awareness creation:** Before physical deployment at the site level, proper awareness creation was made to assure the support and creation of the leadership of facilities. Clients were also made aware of the import of PBS as part of the necessary package for care for them.
3. **Installation and Training:** This critical aspect of PBS deployment involved physical visits to all the sites for installation of the biometric scanners and accessories. The physical visit to all sites was necessary for effective management of issues that are peculiar to each site. Our experience showed that each site had its own issues that included infrastructure, physical structure, human resources, differing skills, facility management, leadership, and other systemic issues. Site installation of PBS included onsite training of relevant staff. To achieve this, a curriculum for site-level training was developed in line with the protocol. The training was designed to cover different categories of staff in the facility such as Data Entry Clerks/Data Officers, Case Managers, Viral Load champions and the cART team. The reason for the expansion of the list of trainees was to ensure that all members of the team can provide PBS service when needed and to facilitate unhindered service at facility or community levels by community teams who embark of cART and mobile caregiving to clients.
4. **Deployment in all Sites:** Mobilization of Case Managers to follow up with clients on DSD and in communities to ensure they come to the facility even outside their

appointment for biometric capture. This was a continuous activity for the case managers who ensured that all clients are reached and taking advantage of other services like viral load monitoring, ARV refills and treatment for other infections.

5. ***Incentivization for Biometric capture:*** As a result of the challenges with insecurity and long-term dispensing of ARVs due to MMSD, clients may not have reason to come to facilities until when sick. In building the catch-up plan, we took inventory of all clients that fell into this category and found about 40,000 indigent clients who live far away from facilities and would require assistance. We then developed an incentivization plan that will assist them to be able to come to facilities and be captured. The incentivization plan therefore made provision for transport fares for identified clients. Through the activation of the incentivization plan, about 95% of the target clients were reached and assisted to access capture in facilities, thus scaling up the total number of clients that accessed PBS services.
6. ***Monitoring of Coverage per facility/per state:*** There was weekly line listing of eligible clients for biometric and tracking of clients and prepare them for biometric capture. Missed opportunities were identified and attended to immediately by either facility based or community ART teams. Monitoring of coverage was jointly done by all the teams such that the clients that were missed by care and support teams are identified by the viral load champions or SI teams.
7. ***Review of Performance:*** Further to monitoring for coverage, PBS implementation also involved regular multistage review of performance at the PR and national levels. Review at the national level for example, requires overlap with PHIS3, NACA, NASCP and other stakeholders during weekly and monthly performance review meetings on the National Data Repository (NDR).
8. ***Building capacity for mobile and community biometric capture:*** This strategy requires provision of computer tablets and biometric scanners to cART or mobile teams for the capture of clients that were not captured or reach out to clients in hard-to-reach communities or clients in peculiar locations that require irregular visits. Training and other capacity building/strengthening activities were carried out to different categories of facility staff for them to be able to operate tabs and scanners without having to wait for SI team.

3.3. CONCLUSION & RECOMMENDATIONS

The implementation of PBS in the NAHI project has met its objectives with over 97% coverage and good performance on NDR. This has resulted in the provision of a more reliable database for client monitoring and better services. Challenges encountered during implementation were overcome. Key recommendations for successful implementation of PBS include ensuring appropriate and relevant design,

awareness creation, capacity building for all categories of care-givers and deployment at co

4. INSTITUTIONALISATION OF QUALITY MANAGEMENT OF HIV RAPID TESTING IN HIV RESPONSE

Preferably, all HIV tests should be conducted by skilled laboratory personnel. However, due to the health seeking behaviours of many Nigerians, the need to decentralise HIV testing became necessary. In Anambra and Ebonyi states the State Quality Improvement Teams (SQIT) were established to facilitate and coordinate quality assurance for HIV testing in the states. This represents a best practice for institutionalising quality management of HIV rapid testing in supported states and critical for ensuring accurate diagnosis and effective management of HIV/AIDS.

In the NAHI project, the following processes were followed to institutionalise quality management of rapid test kits:

- **Planning:** Planning is essential for effectively addressing issues related to quality assurance of HIV rapid testing in the supported states. Assessments of the current state of HIV rapid testing in Ebonyi and Anambra states were done to identify strengths, weaknesses, opportunities, and threats. A detailed plan was developed for this process.
 - Sub-Recipients (SRs) and Stakeholders Engagement: The PR laboratory team worked with the SRs' Laboratory Leads and other stakeholders – GoN- SMOH laboratory directors and hospital management boards to discuss the need for improving HIV rapid testing in the states in a sustainable way.
 - ***Domestication of the HIV Rapid Test Quality Improvement Initiative (HIVRTQII):*** The stakeholders identified this as a need and worked together to develop strategies and guidelines for HIV rapid testing quality management that will be spear-headed by the states. These strategies were to address quality assurance, quality control, proficiency testing, and data management.
 - ***Nomination of the State Quality Improvement Team (SQIT):*** Following the consensus to set up a state team to manage the HIVRTQII in the states, nomination of 10 members each for the states were made. They comprised of senior medical laboratory scientists with specialty in quality assurance from SMOH, tertiary and secondary medical facilities as well as private laboratories.
- **Training and Capacity Building:** The RR and SR laboratory in a five-day training built the capacity of the SQIT on the essential quality assurance requirements for the rapid test, on proper HIV rapid testing techniques, quality assurance procedures, and data management practices.
- **Provision of Reagents and Consumables for Panels:** FH360/GF supported annual procurement of reagents and consumables for the production of dried tubes specimen for HIVRTQII implementation.

- **Production of Dried Tube Specimens (DTS):** The DTS was considered as a good solution for quality assurance material for HIVRTQI implementation because of its enhanced stability at room temperature and ease of storage and use. DTSs were produced biannually using a standardised protocol in the laboratory. The number of DTS to produce each time was based on the number of sites and testing points for each state. They were labelled to cover a period of six months. The panels were also produced to cover for routine quality assurance and proficiency testing both in the health facilities and communities.
- **Distribution of Panel:** Panels were packaged according to the number of testing points in each facility accompanied with written clear instructions on how the DTSs are rehydrated for use. The packages were distributed through the existing state structures and networks and direct transportation within two weeks after production.
- **Analysis at the points of testing:** DTS analysis took place at all the testing points including the communities. The DTSs for proficiency testing are reconstituted and tested like patient's samples, documented on the tools provided and submitted to the SQIT within the time given, usually within one week. Those for routine QA are stored in room temperature and used according to the facility QA policies and each time new test kits were received.
- **Quality Assurance:** Spot checks during supervision visits and CQIs by PR and SRs were measures to monitor the accuracy and reliability of HIV rapid testing and the activities of the SQIT. These included regular checks on proficiency testing results, internal and external quality assessments, and adherence to standard operating procedures.
- **Data Management and Reporting:** Each cycle of the DTS production and distribution were followed by data collation and analysis of results from all the testing points. Robust data management systems to accurately record and report HIV testing results were maintained by the SQIT.
- **Monitoring and Evaluation:** Continuous monitoring and evaluation of the effectiveness of the quality management system for HIV rapid testing in Ebonyi and Anambra states by the laboratory team was in place. Feedback from stakeholders were welcomed and necessary adjustments were made to improve performance.
- **Sustainability:** Throughout the three years of NAHI grant The SQIT team performed this responsibility consistently, developed strategies to ensure the sustainability of

EFFECT ON QUALITY MANAGEMENT

When Quality Management of Kits Testing are institutionalized in HIV Programs, it is possible to ascertain the reliability, replicability and accuracy of tests results.

In the NAHI Grant, and over the grant period, from 2021 to 2023, there was steady increase in the improvement of quality HIV rapid testing services performance from 63% and ended in 94%.

Routine troubleshooting and corrective actions were instated for all non-conformities and failed results and monitored by the SQIT.

the quality management system over the long term. This included building local capacity and fostering ownership among local stakeholders.

Results: Over the grant period, from 2021 to 2023, there was steady increase in the improvement of quality HIV rapid testing services performance from 63% and ended in 94%. Routine troubleshooting and corrective actions were instated for all non-conformities and failed results and monitored by the SQIT.

Lesson Learnt: For continuity and sustainability of quality assurance of HIV rapid testing management intervention in the states, the state actors should be involved, and their capacity built to carry on with any initiative.

Conclusion: By following above steps, institutionalising the quality management of HIV rapid testing can be replicated in other states to improve the accuracy of diagnosis and the effectiveness of quality assurance of HIV rapid testing.

5. THE ROLE OF VIRAL LOAD CHAMPIONS IN INCREASED UPTAKE OF VIRAL LOAD TESTING IN NAHI SUPPORTED STATES

In 2021, the viral load coverage was sub-optimal at 76%. Factors responsible for poor viral load coverage include inadequate follow up of clients for sample collection, inadequate human resources, non-availability of patients' result in their folders, poor lab clinical interface etc. To bolster the uptake of viral load testing and meet the growing demand for accurate HIV/AIDS monitoring, strategic augmentation of human resources presents a pivotal solution that ensures timely and comprehensive testing services for effective disease management. Engagement of viral load champions involved a strategic approach aimed at identifying laboratory professionals who are willing and can effectively advocate for the importance of viral load testing and its role in HIV/AIDS treatment and are able to motivate the clients to go for their tests as at when due. The following steps were considered:

1. **Identify Potential Champions:** Identifying potential champions is crucial for addressing issues related to poor viral load coverage. Champions are individuals who have the influence, interest, and expertise to advocate for and drive positive change. Examples are passionate qualified health professionals. Potential champions are individuals within the community or healthcare system who have competence and passion for HIV/AIDS advocacy and have demonstrated leadership qualities.
2. **Recruitment:** FHI360 ad-hoc staff recruitment processes were followed for the recruitment. This includes identifying potential qualified candidates within the catchment area. The resumes of such individuals are collated and sent to human resources department. HR will in turn conduct a structured interview and select the best candidates fit for the job.
3. **Capacity building:** It is critical to equip the VLCs with knowledge, skills, and resources they need to effectively advocate for and facilitate improved viral load coverage. This could involve training sessions, workshops, or webinars on topics such

as the importance of viral load monitoring, strategies for overcoming barriers to testing, and effective advocacy techniques. FHI360 provided comprehensive training on sample collection for viral load testing, its significance in HIV/AIDS management, and the latest advancements in treatment strategies, as well as management and transportation of samples. Their capacities were well built on the science behind viral load testing and its impact on treatment outcomes.

4. **Empowerment and Support:** Empowering and supporting champions is essential for maximising their impact in addressing issues related to poor viral load coverage. VLCs were provided with the resources and support they needed to effectively advocate for viral load testing and logistical support for tracking and transportation. These include monthly stipends, allowance for call and data
5. **Tailored Messaging:** Tailored messaging is crucial for effectively communicating with different stakeholders involved in improving viral load coverage. The VLCs were equipped with tailored messaging and communication strategies that resonate with the PLHAs. Also, their skills were built to communicate complex medical information in a clear and culturally sensitive manner.
6. **Monitoring and Evaluation:** Monitoring the VLCs involved keeping track of their activities, progress, and impact in advocating for improved viral load coverage. The VLCs were monitored for effectiveness of their activities weekly using a standardised tool.

Results: Owing to the intervention by VLCs in the grant, the viral load coverage increased from 76% in 2021 to 81 % by December 2023.

Lesson learnt: VLCs played key roles in mobilising and motivating individuals to get their viral load tests done, ultimately improving the monitoring and management of HIV treatment.

Conclusion: By following these steps, VLCs can be effectively identified and engaged to drive awareness, promote uptake of viral load testing, and improve treatment services for HIV/AIDS within communities.

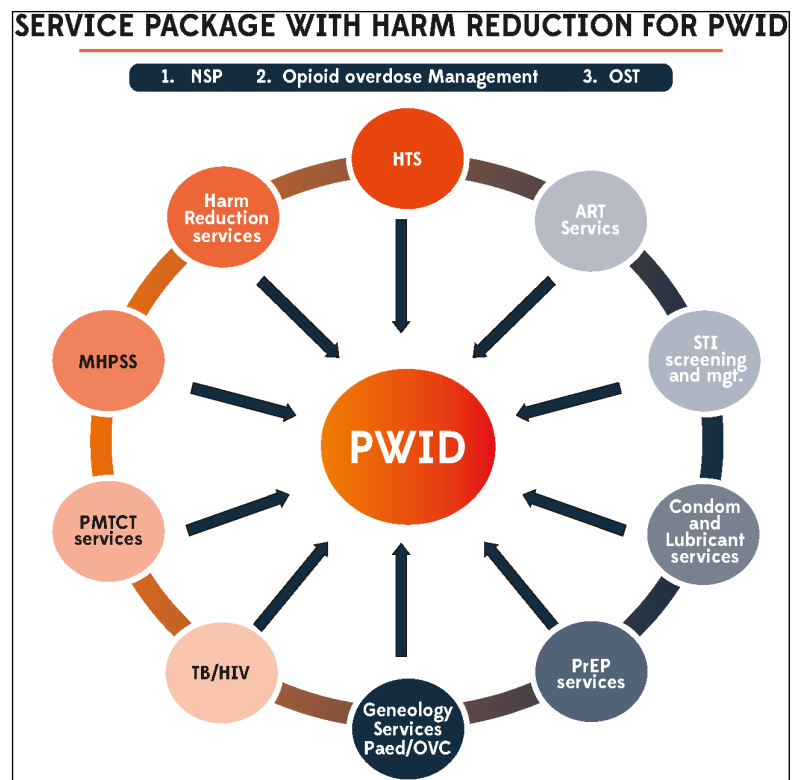
6. HARM REDUCTION

Drug use continues to be high worldwide, and Nigeria is not an exception. People Who Inject Drugs (PWIDs) and their partners contribute about 9% of new HIV infections in Nigeria annually¹. The harm reduction programme in the country aims to reduce the adverse health, social, and economic consequences of the use of legal and illegal psychoactive drugs among PWIDs, without necessarily reducing drug consumption. The harm reduction programme is

¹ Federal Ministry of Health, Nigeria. Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) 2018: Technical Report. Abuja, Nigeria. October 2019.

grounded in justice and human rights. But, that is not usually the case, especially in a country like Nigeria whose laws and policies are not favourable to Key Populations (KPs). The recent increasing number of arrests and harassment of KPs in Nigeria has generated significant discourse in a country where intervention for KPs is gradually being established, despite the challenges. Human rights-related risks and barriers faced by key and vulnerable populations and their service providers have been identified as critical challenges in programming.

The NAHI project was designed to provide comprehensive services to the General Population (GP) and KP with great emphasis on prevention amongst the KPs. Harm reduction was a theme focused on PWID in order to provide them with comprehensive services in HIV. FHI 360 and her SRs in the Global Fund (GF) Round 4 and 5 Projects had established HIV services directed at PWID amongst other KPs. However, three essential components of comprehensive services were lacking. These were NSP, Opioid Substitution Therapy (Methadone), and Medication Assisted Therapy (MAT). This technical brief on best practices and lessons learnt is produced as a documentation of the efforts of the GF-supported NAHI grant (2021-2023) implemented by FHI360. This document provides information on the processes that were undertaken to ensure the effectiveness of services to PWID.



7. GOVERNMENT AND RELEVANT STAKEHOLDERS' BUY-IN AND COLLABORATION VITAL FOR PROGRAMME SUCCESS

Stakeholder Engagement: The NAHI grant identified the need to work with various government entities and other partners to ensure their buy-in and collaboration for programme success. The grant interfaced firstly with the harm reduction National Technical Working Group (NTWG) where a concept paper was produced by the TWG with support from FHI360 to document the design for the harm reduction intervention. This concept paper received wide input from different stakeholders including the UNODC and the GF technical experts.

In order to commence implementation in the states, State Implementation Teams (SITs) for harm reduction were established by FMOH and the NTWG. These teams were made up of key stakeholders at the state level such as appropriate SMOH officials and also included NPF, NDLEA, NSCDC, NHRC, SACA, religious leaders, healthcare workers, and PWID community representatives. This cohort of stakeholders is also represented at the NTWG at the national level.

FHI360 went further to partner with the PWID community to elicit the collaboration and active participation of the community. Entry meetings were conducted with PWID influencers and leadership across the implementation states. These included bunk owners, gatekeepers, and kings of boys. This was done to bring them up to speed with the expectations of the harm reduction programme. Key opinion leaders in the PWID community were recruited as Community Facilitators (CF) to enrol their peers into the programme.

Capacity Building: It was imperative that capacity building was embarked on for all relevant stakeholders including healthcare workers and direct service providers. The PR conducted training of trainers on harm reduction, the NSP model, opioid overdose management, and MAT for all partners implementing the harm reduction intervention nationwide. Representatives of law enforcement agencies such as NPF, NSCDC and NDLEA were also trained on the human rights of KPs, with special focus on PWIDs. Trained partners then stepped down the training to Community Facilitators (CF), CART teams, OSS staff, PWID CBOs, and other stakeholders in the states of implementation.

Service Provision by Community Facilitators: Bunks and hotspots where services will be provided for PWIDs were mapped in the implementation states. Community Facilitators were trained to provide complete harm reduction services like HTS, PrEP, distribution of syringes, condoms, and lubricants, retrieval of used syringes, screening for cervical cancer (female PWIDs), Hepatitis B and C, and vaccination for Hepatitis B among other services. They were provided with carrier bags to convey syringes and other injecting paraphernalia to the bunks. The field workers were also provided ID card to guard against arrest by law enforcement agencies during bunk raids.

Supportive Supervision and Mentoring: FHI360 conducted regular supportive supervision visits to her SRs which were vital in addressing challenges and providing onsite mentoring and capacity building to field officers. The NTWG, with support from the PR, also embarked on joint supportive supervisory visits to implementing partners in the states. The visits afforded needed opportunity to review the quality of harm reduction services provided, data review, and site evaluation concerning MAT service provision.

The PR ensured that drugs and commodities such as needles and syringes, methadone, test kits, condoms, lubricants, and so on were readily available for CFs, other field staff, and healthcare workers.

Effective and efficient application of the best practice on the NAHI grant resulted in the following:

- Successful launch of MAT guidelines and standard operating procedure to foster quality service delivery to PWIDs.
- Increased participation of stakeholders in the scale-up of NSP to five new states and pilot of MAT in four states in GC-7.
- Successful step-down of training to law enforcement agencies which will then lead to a reduction in assault and arrest rates of PWIDs and service providers.

FHI 360 learnt the following key lessons from her harm reduction intervention:

1. Government leadership and active participation in the harm reduction implementation in Nigeria is a major driving force towards achieving success.
2. The law enforcement agencies at national, state and grassroots levels must be carried along to get their buy-in to reduce the incidence of arrests of drug users and service providers involved in NSP.
3. Training on human rights of PWIDs across law enforcement agencies has been beneficial and enlightening especially for the law enforcement agents at state level who further stepped down the training in their states.
4. Effective state entry is key towards achieving success in the implementation of harm reduction in Nigeria.
5. Focus Group Discussions and needs assessment are key to the identification of PWID community needs as well as capacity gaps of field staff.
6. Feedback given by peers on utilisation and acceptance of NSP commodities through the cohort model brought to the fore the need to re-evaluate and prioritize 2-ml syringes rather than 1-ml syringes.
7. Quarterly bunk validation played a vital role in creating access to newer PWID communities including identifying peak hours and relocation spots of displaced PWIDs.
8. Future projections for NSP and MAT commodities including needle and syringe quantification should be evidence-informed and reflect the actual utilisation and unique realities of the community.

In conclusion, the NAHI project implemented by FHI 360 in Nigeria has yielded valuable insights and lessons in harm reduction strategies for drug users, particularly PWIDs. The project emphasized collaboration with government entities and stakeholders and highlighted the importance of buy-in and active participation for programme success. The lessons learnt underscore the significance of multi-sectoral cooperation and targeted interventions in addressing drug-related harm in Nigeria. Though harm reduction was to cover three service areas on the GF-NAHI grant, it only covered two areas.

8. INTEGRATED ECONOMIC EMPOWERMENT, SRH AND LIFE SKILL EDUCATION

INTERVENTION: IMPROVED BEHAVIOUR CHANGE/HEALTH OUTCOMES

Adolescents and Young People (AYP) aged 10-24 years, account for one-third of Nigeria's total population². The 2018 Nigeria AIDS Indicator and Impact Survey (NAIIS) estimates that approximately 180,000 AYP are living with HIV in Nigeria with HIV prevalence especially high among females 20-24 years at 1.3%.³ AYP, especially AGYW, have vulnerabilities for HIV in Nigeria that are strongly linked to gender inequalities and harmful practices. AGYW have low levels of comprehensive knowledge of HIV, HIV risk perception, and access to appropriate Sexual and Reproductive Health (SRH) services. AGYW are also more likely to engage in risky sexual behaviours compared with older females⁴. AGYW are at comparably higher risks of HIV; so, appropriate interventions need to be targeted at them.

Global Fund approved that the AGYW programme be piloted in Anambra and Abia states. These two states had the highest prevalence of HIV amongst AGYW based on NAIIS. Seven other states were identified as having medium HIV prevalence amongst AGYW. The GF-NAHI in 2021 conducted a baseline assessment to inform its programme design for the AGYW intervention. The findings from the assessment were used in directing the programme strategies for interventions for the most vulnerable AGYW in the high incidence LGAs.

The 2021 baseline assessment analysis identified the 15-20 age band, as the most vulnerable population across the two states (Abia and Anambra). The NAHI programme targeted ages 10-24 years in consonance with the WHO definition of adolescents, and to also reap the gains of HIV prevention for early, middle, and late adolescence. The vulnerability factors identified by the assessment were mainly related to risky sexual behaviours caused by poverty and lack of empowerment. The assessment also identified high awareness of HIV among adolescents across these LGAs but poor prevention knowledge and low exposure to HIV testing. Adolescent-friendly facilities, and community HIV Prevention among adolescents were lacking in these states.

The goal of the AGYW component under the GF-NAHI grant was to reduce the HIV risk and lower the HIV incidence among AGYW aged 10-24 years. Services offered to AGYW on the grant include the following: differentiated HIV testing services, condoms and lubricants programming for AGYW and their partners, STI treatment, GBV prevention, ART, PMTCT for positive pregnant AGYW, adherence support services, and increasing adolescent and youth-friendly service delivery among many others.

² United Nations Population Division. World Population Prospects: 2019 Revision

³ Federal Ministry of Health, Nigeria. Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) 2018: Technical Report. Abuja, Nigeria. October 2019

⁴ National Population Commission (NPC) [Nigeria] and ICF. 2019. Nigeria Demographic and Health Survey 2018. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF.

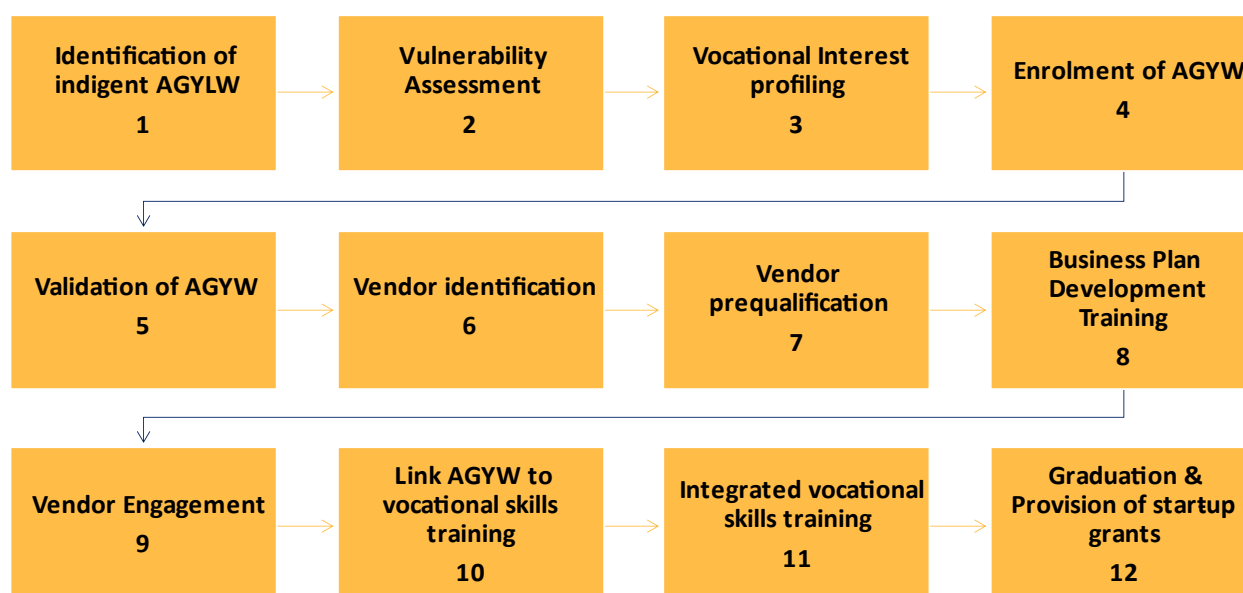
This technical brief captures best practices and insights gained from the NAHI grant's implementation between 2021 and 2023 by FHI360. It details the strategies employed to enhance the delivery of services to AGYW and serves as a documentation of the project's efforts.

Best Practice

As one of the identified interventions addressing the structural drivers of HIV infection among AGYW as recommended by the baseline assessment, the GF-NAHI grant provided start-up grants to AGYW Living with HIV (AGYWLHIV) after empowering them with the relevant vocational skills of their choosing. Although vocational skills training is usually implemented as a standalone intervention, the GF-NAHI grant in line with the combination prevention approach to behaviour change, integrated SRH literacy and life skills education into the training. Indigent AGYWLHIVs were targeted for this intervention following a robust process of identification, eligibility assessment, physical verification, and enrolment.

Stakeholder Engagement. The AGYW implementation team in Anambra State interfaced with relevant stakeholders to seek their buy-in and collaboration. The stakeholders included: Association of Trade Leaders, National Directorate of Employment (NDE), Ministry of Sports and Youth Development, Ministry of Education, Ministry of Women Affairs, Ministry of Health, SACA, SASCP, AYP CBOs, NEPWHAN, and other implementing partners such as Caritas and CRS. All the stakeholders were involved in the process from start to finish. The entire process is highlighted in the chart below.

Figure 8-1: Process for the integrated SRH and economic empowerment activities



Identification and Enrolment of AGYWLHIV. FHI 360 employed a robust and transparent process to select indigent AGYW who partook in the vocational skills training. AGYWLHIV were identified and assessed for eligibility based on their vulnerability, indigence, and interest profiling. AGYW who fit all the required criteria were enrolled into the programme.

Capacity Building. Following the identification and enrolment process, a business plan development training was organised with the following objectives in mind: to share critical aspects of money management with the beneficiaries, to ensure limited funds are utilised optimally, to strengthen their decision and goal setting skills in readiness for their chosen vocations and lastly to provide accelerated vocational skills and entrepreneurship training for indigent AGYWLHIV.

Accelerated Integration of Interventions. A state-wide launch of the start-up grant for indigent girls was carried out in Abia and Anambra states. This was an avenue to strengthen the commitment of the AGYW to the vocational skills training, acknowledge the support of key stakeholders, foster ownership and sustainability, and formally announce the intervention to the state and community actors. The launch signified the commencement of the integrated vocational skills and SRH literacy intervention.

Master craftsmen were recruited and they trained the AGYW on different vocational skills including digital marketing, catering, hairdressing, make-up, tailoring, shoe and bag making, fishery, and hat making, in over 90 vocational centres spread across Abia and Anambra states. AGYW consultants provided weekly life skills and SRH education at the vocational skills training centres where the beneficiaries were enrolled. The consultants were engaged and trained to conduct the education sessions, track beneficiary attendance, and monitor the quality of vocational skills training. A graduation ceremony brought the vocational skills programme to a close where the girls showcased their skills to the public. Participants at the ceremony included all key stakeholders including the parents/guardians of the beneficiaries. Furthermore, start-up kits were procured for all 223 girls trained in Anambra state. However, due to a delay in training vendor engagement processes in Abia, there wasn't enough time to procure start-up kits for beneficiaries in Abia State



Photo 1: A beneficiary of the economic empowerment program in Abia.

The following lessons were learnt from the AGYW intervention:

1. A vital lesson learnt is the relevance of stakeholders such as the National Directorate of Employment (NDE) and the Association of Trade Leaders in Anambra and Abia states in the intervention programme. Collaboration with NDE in Abia State provided multiple training centres in each Local Government Area (LGA) which allowed indigent AGYWLHIV to attend training, close to their areas of residence. The participation of the Association of Trade Leaders was also vital in ensuring the quality

of training, standardisation of curricula, and putting together the list of items needed to start up small-scale businesses.

2. Six to 12 months are needed to adequately train these girls to ensure they benefit greatly from the scheme, as most are in-school AGYW and do not have the time to fully take advantage of the training.

In conclusion, the integration of vocational skills empowerment and SRH literacy within the framework of the GF-NAHI grant stands as a testament to the efficacy of a holistic approach in addressing the structural drivers of HIV infection among AGYW living with HIV. Through meticulous stakeholder engagement, transparent selection processes, and comprehensive training programmes, the initiative not only empowered indigent AGYW but also fostered collaboration among key stakeholders. The successful implementation, evidenced by increased condom use, ART adherence, economic empowerment, and reduced rates of Gender-Based Violence (GBV), underscores the potential of such integrated interventions in achieving sustainable impact and fostering healthier communities. If these lessons are embraced and applied in future endeavours, a significant reduction in HIV incidence among AGYW is assured.

9. MENTOR MOTHERS INITIATIVE: LEAVING NO POSITIVE PREGNANT WOMAN BEHIND

Background

The NAHI grant, implemented over three years, complemented Nigeria's efforts alongside PEPFAR and other partners to move towards HIV epidemic control. FHI360, as principal recipient, oversaw implementation across 13 states, focusing on General and Key Population interventions and programming for AGYW in Abia and Anambra states. The grant aimed to expand access to HIV/AIDS prevention, treatment, care, and support in alignment with the National HIV Strategic Plan goals. Although Nigeria's progress in Prevention of Mother-to-Child Transmission (PMTCT) of HIV is notable, PMTCT service coverage gaps were a challenge during Grant Cycle 6, leading to the development of the National PMTCT Scale-up Plan by NASCP. FHI 360 provided technical assistance to strengthen facilities providing PMTCT services in Anambra and Ebonyi states and enhanced data reporting through the National Data Repository (NDR) from July 2023.

PMTCT of HIV is a critical component in the fight against the HIV/AIDS pandemic. Implementing PMTCT services is complex, requiring a multifaceted approach. NEPWHAN's innovative and successful strategy involved the integration of Mentor Mothers (MMs) living with HIV (PLHIV) into PMTCT programmes. This best practice highlights the exceptional success observed in Anambra and Ebonyi states, where MMs PLHIV have played a pivotal role in achieving outstanding results.

Best Practices in the Mentor Mothers' Initiative

Recruitment and Motivation of MMs: Incorporating MMs into efforts to prevent and ultimately eradicate mother-to-child transmission of HIV has proven highly effective when

executed with precision and efficiency. The GF-NAHI grant enlisted MMs who met specific criteria: they were women living with HIV who had disclosed their status, were open to discussing their experiences with others, and were proficient in the local language. Many MMs were driven by a desire to assist fellow HIV-positive women in their communities, as well as by the prospect of employment, a modest stipend, and opportunities for skill enhancement and training.

Training and Capacity Building: Every MM underwent training sessions led by NEPHWAN/FHI360, delving into subjects like HIV/AIDS, counselling, family planning, nutrition, tuberculosis, and the techniques for leading health education sessions, and community care and support tools. These sessions were also dedicated to honing interpersonal skills, improving communication, maintaining confidentiality, engaging with the community, and mastering the process of conducting home visits.

MMs possess profound insights into the social and cultural obstacles confronting their clients as they strive for better health. By building trust and drawing from shared experiences, MMs can assist clients in surmounting barriers to healthcare. The authenticity of our services, delivered by genuine peers, enables those we serve to grasp and embrace necessary transformations. Our frontline staff, living embodiments of achievement, inspire individuals to make impactful changes, fostering a pathway towards success.

Supervision of MMs: Technical staff offered on-the-job supervision to MMs within the community, overseeing their sessions with clients. They also supervised MMs to ensure they addressed concerns, shared accurate information during health sessions, and completed forms correctly. This oversight ensured the provision of high-quality services and accurate reporting.

Results

The successful implementation of best practices within the NAHI grant led to the following outcomes:

The use of PLHIV MMs in Anambra and Ebonyi states resulted in 100% of HIV-positive pregnant women at every point of care placed on treatment at the end of 2023. This unparalleled commitment contributed significantly to the overall success of PMTCT services.

Traditional programmes face challenges in ensuring timely care for HIV-exposed infants (HEI). PLHIV MMs facilitated a 124% increase in the number of HEI born outside health facilities, brought back for PCR testing within zero -two months of birth. This achievement is a testament to the effectiveness of MMs in ensuring the crucial early care necessary for HEIs.

Programmes lacking PLHIV mentor mothers may experience delays in ARV prophylaxis initiation for new-borns. Hundred percent of HEI born outside the facility, under the guidance of MMs, received ARV prophylaxis within 72 hours of birth. This swift intervention

resulted in an outstanding 99% negative outcome for children born to HIV-positive mothers, highlighting the importance of timely ARV prophylaxis.

Lessons Learnt

From GF-NAHI's Mentor Mothers intervention, several key lessons were gleaned:

- Education and literacy levels of potential MMs should be considered in every context while ensuring reporting tools are easy to fill out and understand for all MMs.
- Consistent and quality training helped the MMs to function effectively in their roles.
- Collaboration with PLHIV support groups is vital for the enhancement of community-based support structures.
- It is important to sensitise health facilities to enhance participation, ownership and sustainability.

In conclusion, the effective implementation of PMTCT services in Anambra and Ebonyi states, with the invaluable contribution of PLHIV Mentor Mothers, highlights the significant role of peer support in healthcare transformation. These established best practices serve as a model for integrating PLHIV Mentor Mothers into PMTCT programmes worldwide, highlighting the potential for enhanced retention rates, improved early infant care, and overall positive outcomes for HIV-positive pregnant women and their children.

10. BACKSTOPPING ARRANGEMENTS AS A PATH TO EFFECTIVE PROGRAMME MANAGEMENT

10.1. BACKGROUND

The Primary Recipients (PR) and Sub-Recipients (SR) relationship when not adequately managed can lead to a dissonance between the PR expectation and the SR's implementation. The PR's oversight responsibility given the complexity of the grant cannot be discharged by a one-off oversight visit or leaving the SRs to work for a long time without feedback. Hence, to mitigate the problem of dissonance and distance between PR and SR, FHI 360 as PR instituted a backstopping arrangement. This arrangement ensured effective oversight of the programme and gave opportunity for real time guidance to the SRs engaged on the grant.

By implementing robust backstopping mechanisms, FHI 360 ensured financial accountability, risk mitigation, and stakeholder alignment throughout the grant cycle. This provides a step-by-step documentation of how the backstopping was used.

10.2. PR STAFF AS PROGRAMME BACKSTOP

The PR staff were assigned to provide programme and technical backstopping oversight at two major levels of grant implementation. These levels are the PR-to-PR backstopping arrangement and the PR to SR backstopping arrangement.

PR to SR backstopping arrangement. This level of backstopping arrangement involved the Programme Management and Finance Units' staff to be assigned to different technical units at the PR level to monitor the unit's implementation and absorptive performance to ensure that all the unit's activities are conducted in compliance with the organisation's and donor's goals, policies, and principles. The backstop is also responsible for escalating implementation bottlenecks and impediments for management interventions which aided in the reduction of poor absorptive performance and its associated risk to the grant.

PR to SR backstopping. To ensure efficient programme implementation and effective outcomes, the PR staff which included the technical, program and operations staff were assigned to different SRs as backstops to provide oversight to them. The peculiarity of this backstopping arrangement was to achieve a comprehensive oversight by the PR to all technical and operational areas on the NAHI grant.

Table 1: PR to SR backstopping arrangement

S/N	IP	PCT Backstop	SI Backstop	PMT Backstop	Finance Backstop
1.	SFH	Joe/Leah	Chioma Ofoegbu/Sarah Ajayi	Timothy Agbidye/ Peter Ajewole	Oldjoe Eneni
2.	AHNI	Uche/Pelumi	Ahmed Babatunde/Cyril Eronmene/Samson Bamidele	Terkaa Simon/ Tine Woji	Fredrick Imador/Nurudeen Imam
3.	ECEWS	Zara	Kevin Ugwuanyi/Taiwo Adisa	Adaku Nwogu	Julius Abunde
4.	NEPWHAN	Obeten	Samson Bamidele/Sarah Ajayi	Christian Ikpe	Ogadimma Ahamefule
5.	NASCP		Samson Bamidele	Oluwakayode Alake/ Tine Woji	Marian Adepoju
6.	CIHP	Joe/Joyce	Samson Bamidele/Ahmed Babatunde/Chioma Ofoegbu	Terkaa Simon	Ogadimma Ahamefule
7.	CPHI	Joe/Joyce	Samson Bamidele/Ahmed Babatunde/Taiso Adisa	Adaku Nwogu	Oldjoe Eneni
8.	Heartland	Joe/Joyce	Samson Bamidele/Kevin	Timothy Agbidye	Fredrick Imador

S/N	IP	PCT Backstop	SI Backstop	PMT Backstop	Finance Backstop
			Ugwuanyi/Sarah Ajayi		
9.	IHVN	Joe/Joyce	Samson Bamidele/Ahmed Babatunde/Cyri Eronmene	Oluwakayode Alake	Marian Adepoju

10.3. DEVELOPMENT OF BACKSTOPPING TOOLS

The programme management team was able to develop tools necessary to aid the expenditure and programme implementation progress on the grant. These tools were shared with the SRs to report on a weekly basis the activities they implemented for each week and their status of implementation. Some of these tools included the weekly expenditure tracker, the weekly travel plan, and the quarterly training plan. These tools were used by the backstops to track these progresses among the SRs and to report these progresses with the grant management on weekly basis during the grant's operations meeting.

10.4. MONITORING OF PROGRAMME IMPLEMENTATION AND TRACKING OF IMPLEMENTATION PROGRESS.

The PR backstop staff were responsible for SR workplan implementation, the changes that were required to make their implementation more effective, the absorptive performance, compliance to grant financial management policies and timely escalation of identified issues to the SR senior management and, where necessary, to the PR management for prompt action.

Some of the core responsibility of the programme management team in backstopping includes: review of the quarterly implementation plan and communication of approvals from management, communication of feedback and updates to the SRs and capacity support to ensure improved programme performance to the SRs. These responsibilities also include weekly monitoring of activity implementation and expenditure tracking, and act as an intermediary between the SR and management to mitigate programme bottlenecks, on the grant among others.

10.5. BEST PRACTICES IN BACKSTOPPING ARRANGEMENT:

- **Proactive Financial Oversight and Capacity Building.** The NAHI grant's implementation integrated a proactive backstopping arrangement for financial management, exemplifying best practices in accountability and compliance. FHI 360's assignment of dedicated staff to monitor sub-recipients' financial activities, coupled with routine capacity building sessions, fostered a culture of transparency and accountability. This approach ensured adherence to budget expenditure,

minimised financial misconduct, and enhanced the financial management skills of SRs.

- **Comprehensive Programme Management Integration.** A notable best practice observed in the NAHI grant's execution was the extension of backstopping principles to encompass broader programme management functions by the PR. This integration facilitated holistic oversight and support to SRs, enhancing programme fidelity and alignment of objectives. By incorporating quality programme implementation, monitoring, and reporting into the backstopping mechanism, the PR promoted effective collaboration and achievement of grant goals.
- **On the Job training mentoring and coaching through the backstopping arrangement.** A key aspect of the backstopping was that the PR staff provided on the job training to the SRs as it pertains to use of the various performance management tools e.g. the budget expenditure tracker, the budget readjustment tracker, understanding the indicators and their measurement, conducting data analysis, use of data for decision making. Once the PR backstop identifies implementation impediments through the Scrum meeting the PR backstops were available to provide the necessary support and guidance.

10.6. LESSONS LEARNT

- **Improved Programme Implementation and Efficiency.** Integrating backstopping mechanisms across various programme management functions proved to be valuable in maximising impact, efficiency and effectiveness.
- **Alignment with Programme Objectives.** By extending the backstopping arrangement beyond financial oversight, the PR ensured comprehensive support and alignment of objectives.
- **Improved Turnaround Time.** With the institution of the backstopping arrangement, the PR was able to address implementation bottlenecks in record time thus ensuring minimal disruption to service provision.

11. APPLICATION OF AGILE/SCRUM PRINCIPLES FOR PROGRAMME EFFICIENCY

11.1. NAHI PROGRAMME MANAGEMENT CONTEXT

Two important programme management indicators that were constantly tracked on the NAHI grant were workplan completion rate and absorptive capacity. In 2021 and commencement of the grant, due to the late start-up of some SRs and the struggle to complete scheduled activities, it became obvious that the PM and Finance team make some oversight interventions to improve workplan completion and absorption.

Integration of Scrum principles into programme management within the NAHI grant exemplified a best practice in fostering adaptability and responsiveness. By adopting iterative planning, regular reviews, and incremental delivery cycles, FHI 360 facilitated dynamic programme management, enabling timely adjustments to evolving needs and priorities. This approach enhanced stakeholder engagement, minimised project risks, and promoted continuous improvement throughout the grant cycle.

This best practice is put together to document how NAHI applied Scrum principles to improving programme efficiency. The following stages/processes were undertaken.

11.2. APPLICATION OF AGILE SCRUM PRINCIPLES

Training in Scrum: Ten staff were trained in the Principles of Scrum to obtain the Professional Scrum Master Certification.

Preparing to Apply Scrum: In preparing to apply scrum to NAHI grant, it was important to consider certain Scrum principles and draw a parallel between these concepts and NAHI programme.

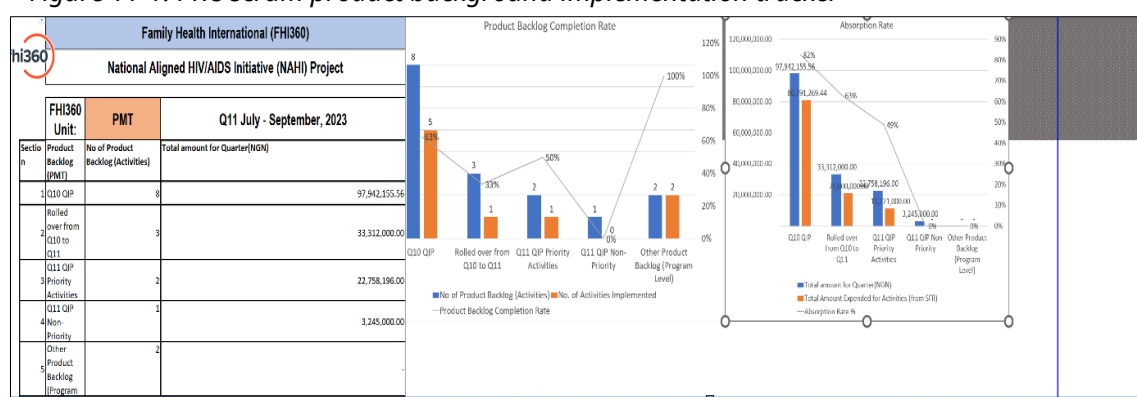
- **Individual and Interactions Over Processes and Tools:** To apply this principle, the NAHI grant first determined the important individuals and their roles in work plan completion and absorption. These individuals are members of the “Scrum Team”: product owner, scrum masters and developers. It was determined that the project director was the product owner in the NAHI grant, the scrum masters were the team leads of units in Prevention, Care & Treatment (PCT), Strategic Information (SI), Laboratory, Procurement and Supply Management (PSM), Project Management (PMT), Finance, Compliance, Procurement, etc. and the developers were the other members of the teams contributing to workplan implementation.

From a workplan management perspective, these scrum masters were responsible for certain modules in the costed workplan. For instance, the product owner as the programme director was responsible for the entire costed workplan, while the thematic leads were responsible for the workplan for different modules. Hence, each of these people had to extract for the entire grant period their workplan and budget

every quarter (QIP) which became the basis of entries into the workplan monitoring tool.

- **A Working Product Over a Comprehensive Presentation.** The NAHI project defined a working product as the completion of a set of workplan activities that helps achieve project output/outcomes.
- **Collaboration Over Contract Negotiation.** Having disaggregated the workplan by Scrum members, it was important to determine how the various Scrum masters will collaborate on an ongoing basis to ensure that despite working independently and individually, they will come together periodically to review their work. The daily Scrum meeting became the avenue for this collaboration where everyone presented their daily increment towards achieving their products (output/outcomes). For example, the Scrum master responsible for the PMTCT module will have the following product attached to him/h(PMTCT module/intervention)
- **Responding to Change Over the Strict Following of Plans.** Each Scrum master took their costed workplan by budget plan and activities as contained in the QIP and produced a sprint backlog. Once the sprint backlog has been inputted based on the QIP, this was transferred to the workplan monitoring tool.
- **Workplan and Budget Monitoring Tool Based on Scrum.** The workplan and budget monitoring tool were designed as an Excel-based tool. (As seen on this screenshot).

Figure 11-1: PR's scrum product backlog implementation tracker



The tool identifies the unit responsible for a group of workplan activities in this case PMT (as highlighted in peach). The next one shows the quarter for which the workplan and budget is being tracked (July-September 2023, ie. Q11). A summary of the PMT product backlog completion rate is automatically generated as a graph to provide information on workplan implementation progress.

The overall indicators are captured in three sections. The first is a table that captures the product backlog from the previous period in this case Q10; the rolled over activities from the previous quarter to the current Quarter (11); the current Q11 activities disaggregated as priority or non-priority based on the application of pareto principles. It is this table that is then translated in the other two sections: i) Product backlog completion rate and ii) Absorption rate.

- **Product Backlog Completion Rate.** The product backlog is a list of prioritised work for a development team in a specified period. In the NAHI grant, the various units/teams developed their product backlogs in the form of Quarterly Implementation Plan (QIPs- see chart below) approved by the Product Owner (Project Director) for the implementation of the activities. The product backlog for specific units is listed in the product backlog tool. As can be seen in Figure 11-1, the key components of the product backlog include product backlog period in quarters, the reporting unit, activity budget lines, and the activity description which describes the product backlog.

As seen in the Figure 11-1 above, the first two bars for PMT shows the progress at the time of the report towards the implementation of Q10 implementation workplan. Here we see that five out of eight activities had been completed representing a 63% achievement. The second set of bars refers to the rolled over activities from Q10 to Q11. The third rolled over activities from Q10 had one implemented as of Q11. Of the two activities for this units for Q11, one had been implemented giving an achievement of 50%. The two other variables on this chat represent the prioritisation for the three activities for quarter.

- **Absorption Rate.** In tracking the financial performance for the grant, the absorption rate was monitored as seen in the second chart in Figure 11-1. The financial absorption rate for this team was 82% for Q10 with NGN80,291,269.44 having been expended out of the total budget for that period of NGN97,942,155.56. Regarding the Q11 absorption rate as at the time of preparing this report, the absorption rate was 63% and of the Q11 budget, 49% of the priority activities had been expended in terms of cost.
- **Sprint Backlog.** The Sprint Backlog is a plan instituted by and for the Developers (members of the Scrum team or unit). Sprint is defined as a period between seven days and four weeks. The NAHI grant adopted a weekly sprint where all “increments”, that is, tasks towards the completion of an activity must be completed. Thus, the sprint backlog as seen below is a highly visible, real-time picture of the work that the Developers (Scrum team) plan to accomplish during the Sprint to achieve the “definition of done”.
- **Daily Scrum Meeting.** The daily Scrum meeting is a 15-minute stand-up meeting conducted by units where developers (team members) meet to discuss the progress of the sprint towards the definition of done. During the Scrum meeting, the developers give updates by answering for themselves three questions: What did I do yesterday? What do I plan to do today? Are there any impediments to my success? These challenges and impediments are escalated to the Scrum master (thematic Lead) or product owner (Project Director) with the specific support required to remove such impediments.

Results. With full application of Agile and of Scrum Principle, the NAHI grant was able to achieve a 102% workplan completion rate and 88% absorption rate by end of the grant.

Lessons Learnt

- **Flexibility and Adaptability in Programme Management.** The application of Scrum principles in the NAHI grant highlighted the importance of flexibility and adaptability in programme management. By embracing iterative planning and regular feedback loops, FHI 360 was able to respond effectively to changing requirements and stakeholder needs, ensuring alignment with project objectives, and maximising value delivery. This lesson underscores the value of agility in navigating complex and dynamic project environments.
- **Continuous Learning and Improvement.** A key lesson learnt from the application of Scrum principles was the importance of continuous learning and improvement. By promoting a culture of reflection, feedback, and adaptation, FHI 360 facilitated ongoing learning and growth among project teams. This emphasis on continuous improvement not only enhanced programme effectiveness but also fostered professional development and innovation, contributing to long-term organisational success.

12. BEST PRACTICES AND LESSONS LEARNED ON HIV SELF TESTING (HIVST)

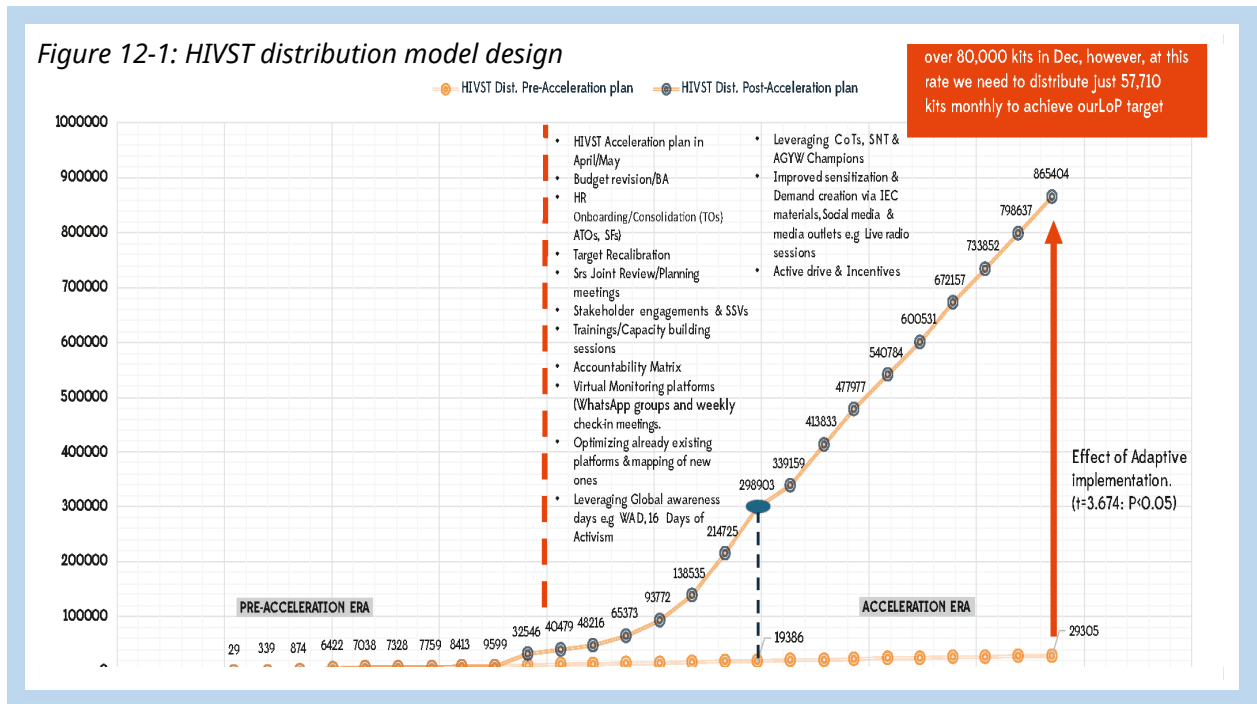
12.1. THE ROLE OF ACCELERATION PLANS IN MEETING PROJECT TARGET

Background

The HIV Self-Testing (HIVST) program, a novel addition to the grant, specifically targeted Key Populations (KP) such as Female Sex Workers (FSW), Men who have sex with men (MSM), People who inject drugs (PWID), and Transgender (TG) individuals. Other demographics that were reached included Adolescent Girls and Young Women (AGYW), Pregnant Women, and partners of PLHIV. The goal was to enhance accessibility to HIV testing services (HTS) for high-risk individuals who may not engage with conventional testing approaches. Additionally, it aimed to empower these target groups to conduct HIV tests independently. Clients who tested positive were subsequently directed for confirmatory testing at nearby healthcare facilities.

The Global Fund NAHI (GF-NAHI) grant initially aimed to distribute 830,240 units of HIST kits over three years; from January 2021 to December 2023. Implementation initially began in three states (Imo, Ebonyi, and Anambra) in July 2021 but progress reviews indicated that the target will be unattainable at that pace.

Figure 12-1: HIVST distribution model design



Consequently, an acceleration plan was developed to have an HIVST distribution forecast which will help achieve the distribution target on the grant. As shown in the figure above, the distribution of HIVST kits stood at 32,546 as of the end of May 2022. The acceleration phase kicked off in June 2022 and spanned through October 2023 leading to a comprehensive review of the budget, strategies, and intervention needs. This technical brief document the best practices employed in the acceleration plan that led to the outstanding achievements recorded in the HIVST programming on the GF-NAHI grant.

Best Practices

FHI360 employed the following best practices in achieving the goals of the HIVST program on the NAHI grant:

- Advocacy and Collaboration with Relevant Stakeholders and Partners:** Collaborating with various stakeholders and partners across the country played a crucial role in implementing the acceleration plan. Advocacy visits were paid to local community leaders and gatekeepers to facilitate community entry and garner support from local communities. Partnerships with organizations like Jhpiego through the HIV Self-Testing in Africa (STAR) project, Clinton Health Access Initiative (CHAI), UNICEF's Youth Alive and Healthy (YaaH) project, as well as with the Government of Nigeria (GoN) entities were instrumental in supporting the intervention. These collaborations facilitated knowledge exchange and provided essential kits for program implementation. Furthermore, already existing platforms were also leveraged for the distribution of HIVST kits. Furthermore, with the support of GoN representatives, supportive supervisory visits were embarked on to monitor, supervise, and mentor field officers who were the main drivers of the acceleration plan.

- **Human Resource (HR) Onboarding and Consolidation:** The grant engaged HIVST-specific HR; Screening Facilitators whose primary responsibility was distributing HIVST kits. They were also tasked with following up with actors in the hybrid TMA approach (Community Pharmacies (CPs), Private laboratories (PLs), and Patent and Proprietary Medicine Vendors (PPMVs)) and ensuring documentation was updated and reported on the EMR. Technical Officers (TOs) and Assistant Technical Officers (ATOs) were also onboarded to drive the acceleration efforts. Other manpower on the grant such as Community Outreach Testers (COTs), Social/Sexual Network Testing (SNT), and Adolescent Girls and Young Women (AGYW) Champions were co-opted to distribute HIVST kits to the target population, follow up for result retrieval, appropriate linkage, and proper documentation.
- **Training/Capacity Building:** The project collaborated with the JHPIEGO HIV Self-Testing in Africa (STAR) project to train selected SRs technical staff, healthcare workers, and key state partners as master trainers on HIVST implementation. The trainees were drawn from the project HIVST implementation states of Imo, Ebonyi, and Anambra. This training strengthened the participants with skills to cascade the training to their colleagues to support the delivery of quality HIVST implementation across project-supported facilities. The training sessions were implemented to educate and provide the teams with the knowledge to implement, document, and develop strategies. This training was critical because it was the first time HIVST would be implemented on the grant. The capacity-building sessions were subsequently spread to all implementation states of the NAHI grant.
- **Improved Sensitization and Demand Creation:** The HIVST intervention, was introduced to the communities through a comprehensive awareness and sensitization campaign. The campaign utilized various methods such as Information, Education, and Communication (IEC) materials, talk shows, and distribution of branded merchandise like t-shirts, face caps, and wristbands, among other strategies. Social media and other media outlets such as live radio sessions were also leveraged to drive demand for HIVST kits. These efforts aimed to effectively educate and engage the communities about the benefits and procedures of self-testing for HIV and other health-related issues.
- **Target Recalibration:** The recalibration of targets for HIVST distribution was a pivotal strategy in enhancing accessibility and efficacy within the grant. By reassessing and fine-tuning distribution goals, the PR and the SRs could align resources and manpower more effectively, ensuring that the distribution target was achieved and subsequently superseded.
- **Sub Recipients (SR) Joint Review/Planning Meetings:** Frequent meetings were held with the SRs to plan for implementation, review and monitor achievements. This was also a platform to proactively deep dive into challenges and issues to ensure smooth implementation of the acceleration plan.
- **Regular Virtual Monitoring Platforms:** Platforms such as WhatsApp groups and weekly check-in meetings were leveraged to effectively and efficiently monitor HIVST-specific human resources on the field. These platforms were also avenues to provide feedback and mentoring to field officers.

- **Leveraging Global Awareness Days:** Global days such as World AIDS Day, 16 Days of Activism, and so on were leveraged to raise awareness and enhance HIVST kits distribution on the NAHI grant.
- **Incentivized Voucher System:** This strategy aimed at incentivizing end users to adopt a relatively new intervention under the grant and to promote the return of results regardless of the outcome. This was accomplished by offering rewards such as airtime, sanitary towels, and other items. The approach deliberately avoided using monetary incentives to prevent the perception that users were being paid to utilize the kits. As a result of this strategy, there was a notable increase in the rate of returned HIV self-testing (HIST) results.
- **Service Provider Fee:** While the incentivized voucher system targeted end users to encourage their participation, the service provider fee approach aimed to motivate patent medicine vendors by rewarding them for each complete cycle, which involved returning and linking every test kit. This dual strategy played a crucial role in driving the return of results and facilitating the linkage to appropriate services, benefiting both end users and service providers alike.

Results

Although the HIVST implementation did not start promptly and faced stock shortages for several months under the grant, substantial progress was achieved by the end of the grant (December 2023). A total of 722,211 HIV self-test kits were distributed, constituting 87% of the target. This distribution significantly contributed to 11% of all HIV testing services provided within the grant. The results returned from these tests amounted to 700,245, showcasing an impressive result retrieval rate of 96%. Furthermore, the linkage rate for all confirmed positive cases identified was exceptionally high at 98.7%, indicating the effectiveness of the intervention in connecting individuals to appropriate follow-up care and support services. Another noticeable outcome of the HIVST programming was the mapping of over 100 private-sector service providers (CPs, PPMVs and PLs) trained on HIVST and co-opted into the program to drive self-testing implementation and augment a hybrid Total Market Approach (TMA).

Key Learnings

- Distribution/Performance can be greatly impacted by Natural disasters and circumstances like floods, security challenges and elections.
- Incentivization of some strategies aided the optimization of self-testing.
- Adequate projections of the needed number of HR is an important pre-requisite in program success.
- Differentiated Service Delivery model of distribution via CPs, PPMVs, PLs, and Drop-in-centers was efficient and effective in attaining the distribution target.
- Total Market Approach: In keeping with the country's vision and approach, this approach utilized PPMVs in the state to distribute HIVST kits from their private stores which are easily patronized by the end users who are also the target population.

In conclusion, the role of acceleration plans in meeting project targets, particularly evident in the HIV Self-Testing (HIVST) program under the GF-NAHI grant, has been instrumental in

driving significant progress and achievements. The introduction of effective and efficient strategies such as incentivized voucher systems, service provider fees, targeted recalibration, and enhanced sensitization efforts have all contributed to the successful distribution of HIV self-test kits and the high return rate of results. These best practices, combined with the dedication of all involved parties, have resulted in remarkable outcomes, including the distribution of over 700,000 HIV self-test kits throughout the life of project, high rates of result retrieval and linkage to appropriate services, and the mapping of private-sector service providers into the program. Key learnings from this experience emphasize the importance of adaptable strategies, incentivization, robust planning, and a differentiated service delivery model in achieving project goals and improving healthcare accessibility for key and vulnerable populations.