DIFFERENTIATED SERVICE DELIVERY OPERATIONAL MANUAL FOR HIV PREVENTION, TREATMENT AND CARE

NATIONAL AIDS AND STIs CONTROL PROGRAMME

FEDERAL MINISTRY OF HEALTH

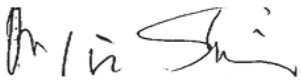
2021

FOREWORD

The Government of Nigeria is committed to safeguarding the lives and health of its citizens through the provision of high quality and standardized HIV prevention, treatment, and care interventions. The 2021 National Differentiated Service Delivery Operational Manual for the prevention, treatment, and care of HIV infection provides much needed guidance and uniformity required to deliver a comprehensive package of high-quality, client-centered interventions that cater to the individual needs of different sub-populations of persons living with HIV. The manual also outlines strategies to reduce and limit the burden on an already overstretched health system and the challenges of health care service delivery both for the patients and the health care workers
Beyond the individual patient, this manual is expected to improve adherence to treatment, care and clients' outcomes, while serving as guidance for tailored interventions that will enable the nation meet the UNAIDS global 95-95-95 goals and achieve epidemic control. This will be made possible by embracing Differentiated Service Delivery models at both facility and community levels.
I am therefore delighted with the timely development of this document that will help in closing the gaps along the prevention, testing and treatment cascade with emphasis on early diagnosis, prompt linkage to care, retention in treatment and viral suppression utilizing client-centred approaches.
This Differentiated Service Delivery Operational Manual clearly outlines service delivery to various sub-populations including, pregnant women and breastfeeding mothers, children, adolescents, adults, and key populations. It also includes procurement and supply chain considerations and how these services will be monitored and evaluated.

There is no doubt that this document was a product of collaborative effort involving government, bilateral and multilateral organizations, civil society, and the academia. I am confident that faithful implementation of its recommendations will further propel the country towards meeting the global targets and achieving epidemic control.

I therefore endorse and recommend the 2021 National Differentiated Service Delivery Operational Manual for HIV Prevention, Treatment, and Care for use in Nigeria especially by individuals and organizations engaged in the provision of HIV service delivery at both facility-level and community-level.



Dr. Osagie E. Ehanire MD, FWACS
Honorable Minister of Health
Federal Republic of Nigeria

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Our special thanks to World Health Organization (WHO) Nigeria, and Catholic Relief Services/FASTER for providing both technical and financial support for the development of this manual.

We wish to acknowledge the remarkable representation provided by NEPWHAN, ASHWAN, APYIN and the KP Secretariat who actively participated in the development of this manual. The enlightened contributions and client perspective that was brought into the process ensures that recommendations were considerate of the welfare and safety of the different sub-populations of PLHIVs.

We reserve special thanks for members of the various National Task Teams, academia, State Ministries of Health, facility-level and community–level service providers for their contributions, as well as experience brought to bear and the commitment shown in ensuring implementation of this manual.

Finally, we commend the NASCP staff under the leadership of the National Coordinator, and especially staff of the Treatment, Care and Support component of the programme that coordinated the activities that ultimately culminated in the successful completion and production of this operational DSD manual.

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EXECUTIVE SUMMARY

The Government of Nigeria has committed to the global goal of ending the AIDS epidemic by 2030. Although Significant gaps still exist in achieving this goal, the development of this differentiated service delivery operational manual will help to close these observed gaps by tailoring services to meet the individual needs of the patients.

The Differentiated Service Delivery manual is an eleven - chapter consolidated document that is based on client-centered approaches which simplifies and adapt HIV services across the continuum of care to better serve individual needs and reduce unnecessary burden on the health system.

The first and second chapters introduces the DSD manual in general and describe the coordination of differentiated service delivery in Nigeria from State level to the local government levels, facility level coordination to community level coordination, pre-implementation stage to implementation stage and building blocks of DSD.

The third chapter three provides guidance on HIV testing services (HTS) within DSD Service delivery model, Core guiding principles to HTS, HIV testing strategies within sub-populations ranging from 0-24yrs including pregnant women, breast feeding mothers and other male partners under mobilization, testing and linkages

Chapter four focuses on Differentiated Service Delivery (DSD) models for pregnant women and breast-feeding mothers, they were classified as either stable or unstable based on their Viral Load as well as their PMTCT experience. It also provided flow chart for the classification of DSD models during PMTCT for pregnant and breast-feeding model as either stable or unstable in terms of WHAT, WHERE, WHEN and WHO provides the services.

Chapter five provides DSD models for children, outlines the criteria for classification of children as either stable or unstable. The various models of care for children and Adolescent were described which includes: Health Care Worker managed group, Client managed group, Facility-based and Community-based. The DSD packages for children and Young Adolescent (up to 14 years) was also described based on what services are provided, where they are provided, who provides the services as well as when they are provided.
In the sixth chapter, the focus is on DSD models for adolescents and young people, services provided during transition from Adolescent to Adult clinics, phases of transition, key elements for effective transition as well as the components of a good transition process were outlined.

Chapter seven provides a detailed guide for DSD models for adults, algorithm for ART initiation from the point of entry to the period of diagnosis, Advanced HIV Disease (CD4<200 or WHO stage 3 or 4), and classification based on Viral load as either stable (VL<1000Cells/ml) or unstable (VL>1000 Cells/ml). The various packages of care for the well, stable and unstable clients were also described based on the building blocks of differentiated service delivery. The Facility based ART delivery models for stable adult clients as well as Community based delivery models for stable adult clients were also described in this chapter.

In chapter eight, DSD models for Key Populations were identified including: Female Sex Workers (FSW); Brothel and Non-Brothel-Based, Men who have Sex with Men (MSM), People who Inject Drugs (PWID), Transgender and Persons who are incarcerated. Other vulnerable populations who are not key populations were identified to include Internally Displaced People (IDPs), mobile populations/migrants, clients of sex workers, women, and youths.

Chapter nine focuses on Laboratory Service Packages for Differentiated Service Delivery which is categorized as person less than two years old and person older than two years old.

Chapter ten focuses on DSD Procurement and Supply Chain Management with Special attention paid to PSM in facility and Community DSD Models.

The eleventh and the last chapter deals with the monitoring and evaluation of all the various DSD models and strategies involved in both facility-level and community-level using indicators to measure impact/effectiveness of the DSD models

Conclusively, the current approach of using a similar model of care for the delivery of HIV services for all patients irrespective of their immunological status, co-morbidities and other peculiarities has been found to be less efficient in achieving national and global targets especially in light of the low prevalence of HIV in our general population. Government is therefore pleased to introduce Differentiated Service Delivery models for use in conjunction with other existing national guidelines and policy documents to facilitate increased uptake of HIV services in both facilities and communities in Nigeria.

Dr Akudo. E. Ikpeazu
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ABBREVIATIONS AND ACRONYMS

ADR	Adverse Drug Reaction	**MDAs**	Ministries Departments and Agencies
ALHIV	Adolescent Living with HIV	**MHPSS**	Mental Health and Psychosocial Services
AHD	Advanced HIV Disease	**MICO**	Meaningful Involvement of Communities
AIDS	Acquired Immune Deficiency Syndrome	**MMS**	Multi Month Scripting
ANC	Antenatal Care	**MMD**	Multi Month Dispensing
APIN	AIDS Prevention Initiative Nigeria	**MNCH**	Maternal, Newborn and Child Health
ART	Anti-Retroviral Therapy	**MOH**	Ministry of Health
ARV	Anti-Retroviral Drug	**M&E**	Monitoring and Evaluation
ATM	AIDS, Tuberculosis and Malaria	**MSM**	Men who have Sex with Men
AYP	Adolescents and Young People	**MTCT**	Mother to Child Transmission
BCC	Behaviour Communication Change	**NACA**	National Agency for the Control of AIDS
CAGS	Community ART Groups	**NACS**	Nutrition Assessment Counselling and Support
CBOS	Community Based Organizations	**NAFDAC**	National Agency for Food and Drug Administration and Control
CCM	Country Coordination Mechanism	**NASCP**	National AIDS/STI Control Programme
CD4	Cluster of Differentiation Antigen 4	**NCD**	Non-Communicable Diseases
CDC	United States Centres for Disease Control and Prevention	**NEPWHAN**	Network of People Living with HIV/AIDS in Nigeria
CFCC	Client and Family Centered Care	**NHLMIS**	National Health Logistics Management Information System
CHAI	Clinton Health Access Initiative	**NPHCDA**	National primary Health Care Development Agency
		NSF	National Strategic Framework
CHBC	Community and Home-Based Care	**NSP**	National Strategic Plan
CHEW	Community Health Extension Worker	**NTTA**	National Task Team on ART
CIHP	Centres for Integrated Health programs	**NTPP**	National Treatment & PMTCT Programme
CISCHAN	Civil Societies Coalition on HIV/AIDS in Nigeria	**OIs**	Opportunistic Infections
CISHAN	Civil Society for HIV/AIDS in Nigeria	**OSS**	One Stop Shop

CLHIV	Children Living With HIV	**PADAF**	Patient ARV Drug Accountability Form
CPS	Community Pharmacies	**PBFW**	Pregnant and Breast-Feeding Women
CPARP	Community Pharmacists ART Refill Project	**PCOST**	Prioritized Community Symptomatic Testing
CRRF	Combined Report and Requisition Form	**PCR**	Polymerase Chain Reaction
CSI	Child Status Index	**PDSA cycle**	Plan, Do, Study, Act cycle
CSOS	Civil Society Organizations	**PDU**	Pharmacy Dispensing Unit
		PEP	Post-Exposure Prophylaxis
CTX	Cotrimoxazole	**PEPFAR**	United States President's Emergency Plan for AIDS Relief
DC	Differentiated Care	**PHC**	Primary Health Care
DSD	Differentiated Service Delivery	**PHDP**	Positive Health, Dignity and Prevention
		PITC	Provider Initiated Testing and Counselling
EID	Early Infant Diagnosis	**PLHIV**	People Living with HIV
FIT	Family Information Table	**PME**	Program Monitoring and Evaluation
EMTCT	Elimination of Mother-to-Child Transmission	**PMM**	Patient Management and Monitoring
FBO	Faith Based Organization	**PMTCT**	Prevention of Mother to Child Transmission
FCT	Federal Capital Territory	**PV**	Pharmacovigilance
FDC	Fixed Dose Combination	**PoC**	Point of Care
FSWS	Female Sex Workers	**PrEP**	Pre-Exposure Prophylaxis
FGD	Focus Group Discussion	**PSM**	Procurement and Supply Management
FMOH	Federal Ministry of Health	**PWIDs**	People Who Inject Drugs
GBV	Gender-Based Violence	**QA**	Quality Assurance
GON	Government of Nigeria	**QI**	Quality Improvement
GICO	Greater Involvement of Communities	**RCT**	Randomized Control Trial
GIPA	Greater Involvement of People with AIDS	**RiC**	Retention in Care
HAART	Highly Active Antiretroviral Therapy	**RoC**	Recipients of Care
		SACA	State Agency for the Control of AIDS
HCWS	Healthcare Workers	**SASCP**	State AIDS/STI Control Programme
HCPS	Healthcare Providers	**SHIPs for MARPs**	Strengthening HIV Prevention Services for Most-at-Risk Populations

HBV	Hepatitis B Virus	**SIDHAS**	Strengthening Integrated Delivery of HIV/AIDS Services
HCV	Hepatitis C Virus	**SMOH**	State Ministry of Health
HIV	Human Immunodeficiency Virus	**SMT**	State Management Team
HIVST	HIV Self Testing	**SOPs**	Standard Operating Procedures
HTS	HIV Testing Services	**SPSS**	Statistical Package for the Social Sciences
IAS	International AIDS Society	**STI**	Sexually Transmitted Infection
IEC	Information Education and Communication	**SWs**	Sex Workers
IHVN	Institute of Human Virology Nigeria	**SWOT**	Strengths, Weakness, Threats and Opportunities
IMHIPP	Integrated MARPs HIV Prevention Program	**TB**	Tuberculosis
IIT	Intermittent Interruption of Treatment	**TBAs**	Traditional Birth Attendants
KPS	Key Populations	**TG**	Transgender
		TPT	Tuberculosis Preventive Therapy
KIIS	Key Informant Interviews	**TWGs**	Technical Working Groups
LF-LAM	Lateral Flow Lipoarabinomannan	**UNAIDS**	Joint United Nations Programme on HIV/AIDS
SSA	Sub-Saharan Africa	**UNICEF**	United Nations Children Emergency Fund
LGAS	Local Government Areas	**USAID**	United States Agency for International Development
LIP	Local Implementing Partner	**USG**	United States Government
LMCU	Logistics Management Coordination Unit	**VL**	Viral Load
LMIS	Logistics Management Information System	**WDCs**	Ward Development Committees
LTC	Linkage To Care	**WHO**	World Health Organization
MAGS	Medication Adherence Groups	**3PL**	Third Party Logistics
MARPS	Most-At-Risk Populations		

OPERATIONAL DEFINITIONS OF TERMS

- **Adolescent and young people friendly health services**: Health services that are accessible, acceptable, equitable, appropriate, and effective for adolescents and young people
- **ART Refill After hours:** This model allows for the clients to collect their drugs outside the recommended ART clinic operation hours. The model is of benefit to clients that have various competing priorities such as school or work schedules.
- **Bunks**: Bunk is derogatory to use for people who use drugs, hotspot is a preferred term.
- **Bunker**: is an underground shelter and was used during wars, this should not be associated with drug user or any KP subgroup.
- **Clusters:** Clusters are processes whereby key populations sit at different locations within a hotspot. At these hotspots, key populations sit in clusters based on their interests, age, sexual preference, social class etc.
- **Community-based HIV treatment and care models:** HIV treatment and care models where services are offered outside the existing health facilities
- **Community ART group (CAG):** Voluntary Community based groups formed by people living with HIV who are taking lifelong antiretroviral drugs
- **Community ART Team (CART):** These are trained service providers that often compose of at least 3 members comprising Clinicians, pharmacists, and laboratory scientists. These teams leverage on providing services to KPs during outreaches and at designated hotspots.
- **Community Pharmacy ART refill:** This is the pickup of drugs by PLHIVs from pharmacists in designated and registered community pharmacies.
- **Community ART Refill Group – HCW led:** These are community-based groups formed by health care providers within a community for ARVs and other medication refills. These healthcare providers may include community health workers, case managers, and other trained volunteers.
- **Community ART Refill Group – PLHIV led:** These are community-based groups formed voluntarily by persons living with HIV within a community for ARVs and other medication refills.
- **Community ART/ Adolescent/peer-led groups:** This is a platform in the community where meetings are routinely held during which ART refills, Medication Adherence reinforcement education and general social support among peers to strengthen retention in care that are peer led with guidance and support from designated Health care workers are provided
- **Community drug distribution points (CDDP):** Designated points within the community where antiretroviral drugs are dispensed to PLHIV on ART

- **Differentiated Service Delivery**: An approach that simplifies and adapts HIV services to better serve the needs of PLHIV and Key populations and reduce unnecessary burdens on the health system.
- **Differentiated antiretroviral therapy (ART) delivery**: A series of management approaches that align with the clinical status of PLHIV and their needs.
- **Decentralization (Hub and Spoke Model):** Refers to the devolution of stable clients from larger, centralized secondary and tertiary facilities (hubs) to smaller more peripheral primary facilities (spokes). This can be either: semi-autonomous model which restricts ART service delivery at PHCs to ARV and medication refills only; or the autonomous model which allows for ART initiation at the PHC level, as well as ARV and medication refills.
- **Fast-track:** Drug pick up by stable clients from the pharmacy. by-passing the regular clinic flow. In this model, ART refill visits are separated from clinical consultations.
- **Facility ART group: HCW-led:** These are health facility-based groups formed voluntarily by support groups of persons living with HIV, who are already meeting regularly at the health facility. They access their ARVs, other medication refills and clinical consultations within the facility, after their meetings, with guidance and support from designated facility Health care workers
- **Facility ART group: Support group-led:** These are health facility-based groups formed voluntarily by support groups of persons living with HIV who are already meeting regularly at the health facility. They access their ARVs, other medication refills and clinical consultations, within the facility, after their meetings at the facility. This process is co-ordinated by a member of the support group.
- **Facility based Child/Teen/Adolescents club (Peer managed):** This is a facility-based model where meetings are routinely held during which ART refills, Medication Adherence reinforcement education and general social support among peers to strengthen retention in care that are peer led with guidance and support from designated Health care workers are provided
- **HIV Testing Services:** The full range of services that should be provided with HIV testing i.e pre-test information and post-test counselling; linkage to appropriate HIV prevention, treatment and care services and other support services.
- **Home delivery:** ART refills are provided to eligible clients directly at their home by community health workers. Commodities flow from the facility to the patient and documentation is made by the community health workers into the facility records.
- **Hot Spots:** Hotspot is a safe space where key populations can be seen in large numbers. Hotspots could be a CBO office, bar, brothel, restaurant, hotel, uncompleted building, bush, private residence etc. Some hotspots are located at open spaces while some are highly private and maybe virtual. A particular hotspot may become inactive if raided by the police or there are threats. Some hotspots are safe for drug use, sexual activities while some are just used for hangout and meetings.
- **Health Care Provider (s) (HCPs):** A HCP is an individual health professional or a health facility organization licensed to provide health care diagnosis and treatment services including medication, surgery and medical devices.
- **Health Care Worker (s) (HCWs):** A HCW is one who delivers care and services to the sick and ailing either directly as doctors and nurses or indirectly as aides, helpers, laboratory technicians, or even waste handlers.
- **Internally displaced persons:** Persons or group of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters and who have not crossed an internationally recognized border.
- **Key populations:** Groups who are at increased risk of acquiring HIV irrespective of the epidemic type or local context" and include sex workers, men who have sex with men, transgender, people who inject drugs (PWIDs), and people in closed settings.

- **Lay providers**: Any person who performs health-care delivery functions and have been trained to deliver specific services but has not received a formal professional or para-professional certificate

- **Mainstream/Standard Care:** This refers to the standard model of care utilized by the facility before the implementation of differentiated service delivery (DSD). At every ART refill visit, the client receives clinical consultations and adherence counselling.

- **Mentor Mothers**: Theses are women who are HIV positive and have passed through the PMTCT cascade intervention with a successful life birth and HIV negative baby as a result of the PMTCT services.

- **Mother infant pair/Mentor mother led:** This model refers to where women who are HIV positive and have passed through the PMTCT cascade intervention with a successful life birth and HIV negative baby as a result of the PMTCT services serve as mentors and ART guides for pregnant women, the breastfeeding mothers and their infants.

- **Multi Month Scripting**: A lengthening of prescribing intervals

- **One Stop Shop**: Service delivery site where multiple services are offered, and clients can access all their needs in one location.

- **One Stop Shop (Hub)**: Refers to a One Stop Shop that acts as a hub to some other one stop shops, community drug distribution groups and community ART groups
- **Point of Care (POC): POC** testing is when patients are tested on-site at a health facility and receive their results during the same visit or day.

- **Near point-of-care'** testing may require some laboratory infrastructure where electricity is consistently accessible, and therefore cannot currently be operated in primary health-care settings with no electricity.

- **Peer led/Support group meetings**: This is a platform where meetings are routinely held during which ART refills, Medication Adherence reinforcement education and general social support among peers to strengthen retention in care that are peer led with guidance and support from designated Health care workers are provided

- **Peer Navigators**: Defined as medication-adherent role models living with HIV who share the same experiences and community membership and who are trained to provide effective services that increase the linkage, retention, and medication adherence of the people they serve.

- **Pharmacovigilance Refers to the detection, assessment, understanding, monitoring and prevention of adverse effects or any other drug-related problem.**

- **Task shifting**: The rational redistribution of tasks among health teams with specific tasks being moved from higher cadre to lower cadre health workers who could be trained to perform the functions.
- **Weekend and Public holidays:** This model allows for the clients to collect their drugs on weekends and/or public holidays, outside the recommended ART clinic operation hours/days. The model is of benefit to clients that have various competing priorities such as school or work schedules.

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CHAPTER 1: BACKGROUND AND OVERVIEW

Nigeria has a national HIV prevalence of 1.3% (NAIIS 2018). As contained in the National Strategic Framework (2021-2025), the country subscribes to the UNAIDS targets of 90-90-90 by 2023 and 95-95-95 by 2030 and the WHO "treat all" policy. To achieve these goals against the background of an overburdened health system and limited access to healthcare services in Nigeria, there is a need to refocus HIV service delivery using a client-centered approach.
The 2016 national guidelines outlined tailored packages of care for PLHIV that recommended the frequency for clinical consultations, ART refills, CD4 count monitoring, and viral load testing, it however did not elaborate on strategies for implementation: facility or community-based models or the monitoring and evaluation of DSD. Due to the uncoordinated implementation of DSD across the country, NASCP in collaboration with WHO and other stakeholders commenced an all-inclusive and participatory process of standardizing DSD activities in Nigeria.

1.1 Introduction

Differentiated Service Delivery, also known as differentiated care is defined as "a responsive, client-centered approach that simplifies and adapts HIV services across the continuum of care to better serve individual needs and reduce unnecessary burden on the health system"
It can be delivered at the facility and/or the community level.
The implementation of DSD activities:

- is patient-focused,
- ensures equipped and functional DSD platforms
- entails community service delivery
- establishes strong linkages between community service delivery systems and mainstream health facilities for optimal management
- supports health system strengthening and coordination.

1.2 Purpose of The DSD Operational Manual

This manual has been developed to guide the implementation and scale-up of DSD activities in Nigeria. The target audience for this manual includes HIV healthcare workers (doctors, nurses, counselors, pharmacists/pharmacy technicians, health information officers, laboratory scientists/technicians, community health workers, etc.), community-based organizations, HIV policymakers, and programmers.
This manual should be used in conjunction with other existing national guidelines and policy documents.

1.3 Roles and Responsibilities of Stakeholders for DSD Implementation

Clients: Clients are primary recipients of care (RoC). Each client qualifies for a model of differentiated care based on eligibility criteria. The client should be educated on the benefits of the model and allowed to take an informed decision with the support of the healthcare provider.

Health care provider: The healthcare providers have the responsibility of identifying suitable packages of care for clients and providing them with all the needed information on the available options so that an ideal DSD model can be selected. They should also provide continuous management for the client.

Health Facility: The health facility ensures the implementation of DSD models appropriate for the level of care as well as the availability of infrastructural and human resources.

Support groups: The support group is a forum for education, mobilization, linkage, support, management, and retention of PLHIV in care.

Community Structures: The community structures should be leveraged for the implementation of DSD. The community-based health workers within these structures should receive adequate capacity building using harmonized training materials, and current national treatment guidelines. The trained community-based health workers and volunteers should ensure the smooth running of DSD models, proper documentation, and reporting of the services provided and appropriate linkages.

State Government: The HIV Control Programme of the State Ministry of Health (SMoH) in collaboration with other relevant ministries, departments, and agencies (MDAs) has the responsibility of coordinating and monitoring the implementation of DSD models in the health facilities providing HIV services in the state. This will entail ensuring that they are abreast with national guidelines and standard operating procedures (SOPs) on DSD. The State AIDS and STIs Control Programme (SASCP) should work with relevant stakeholders to ensure that the health facilities and community structures are implementing the DSD models in line with the national operational plan.

Implementing and Donor Partners: The Implementing Partner supporting the State in the provision of HIV services must work with the State to facilitate the implementation of health facility and community-based DSD models in line with the existing national guidelines and policies. They must commit to reporting the interventions they provide using the national monitoring and evaluation tools.

National Government: The National AIDS and STIs Control Programme (NASCP) of the Federal Ministry of Health is responsible for coordinating all stakeholders including relevant MDAs, donors and implementing partners working on DSD. This includes providing the policy, guidelines, training materials, procurement and supply chain management, data reporting systems and monitoring of the implementation of DSD models across the country. The National Agency for the Control of AIDS (NACA) will continue with the responsibility of provision of resource mobilization and oversight function for the multisectoral DSD implementation response.

CHAPTER 2 : COORDINATION OF DIFFERENTIATED SERVICE DELIVERY IN NIGERIA

Coordination of DSD implementation within the health sector falls under the purview of NASCP This structure shall be replicated at state and local government levels. (see Figure 1 below).

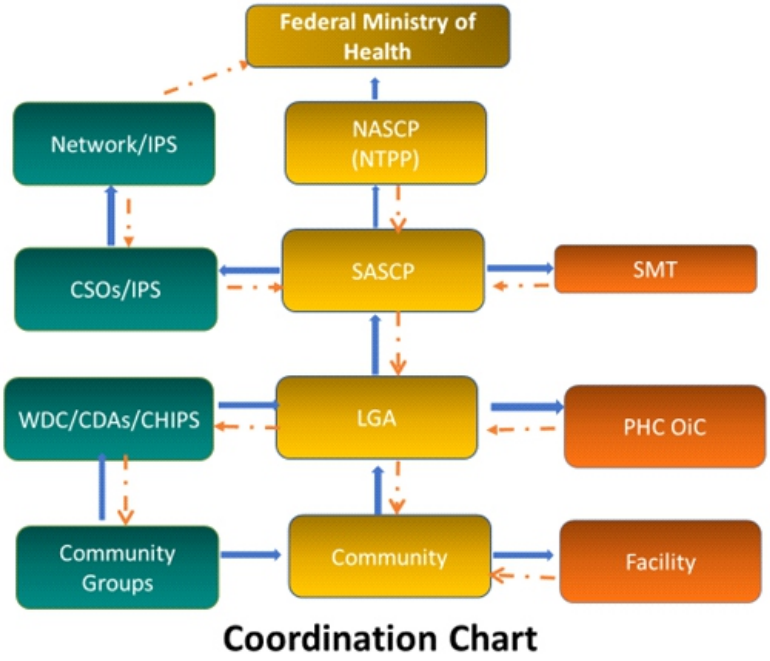


Figure 2.1: Coordination Flow Chart representing the coordination framework

2.1 Pre-Implementation Stage

National-level Coordination

The National Treatment & PMTCT Programme (NTPP) domiciled in NASCP was re-established by the Honourable Minister of Health in 2018 and this has resulted in strengthening coordination of the HIV treatment programme at national, state, local government area, and health facility levels. The process of national-level coordination should involve:

- Maintaining data reporting with clear indicators integrated into existing HIV monitoring (patient management & monitoring and programme monitoring & evaluation) tools for DSD.
- Development of DSD training materials and integrating them into the existing training materials for HIV management. The DSD training modules may also be used as stand-alone in form of updates for health providers who have been trained with the previous training materials.
- Allocation and standardization of codes for the various DSD models which will be used across the country. For example, the multi-month dispensing for 3, 4, 5 and 6 months will be coded accordingly as MMD3, MMD4, MMD5, and MMD6.
- Use of data to propose or set annual national and state targets for differentiated care in line with the UNAIDS 95-95-95 targets for case identification, retention, and viral suppression of clients under DSD.
- Development of DSD-specific SOPs and job aids and integration into existing national documents.

- Instituting operational research and periodic evaluation on the impact of DSD on client outcomes vis a viz retention in care, viral load suppression, linkages, and referrals.
- Conduct of annual DSD programme evaluation at the national level, oversight for biannual DSD programme evaluation at the state level, and quarterly evaluation at the facility and community levels.

State-level Coordination

The pre-implementation, planning, and operationalization of the DSD models in the states should begin with the State Management Team (SMT) on HIV/AIDS, under the leadership of the Honourable Commissioner for Health in each state. Activities at the state level should be domiciled with SASCP with oversight by the SMT. The SASCP shall ensure that a subcommittee on DSD is formed within the state ART Task team.

The state team shall:

- Coordinate DSD activities in the state
- Gather reports of DSD activities from the LACA using the already established M&E framework and approved tools
- Inclusive of DSD data, conduct validation for all HIV data generated from the state
- Send the state HIV reports to the national team biannually for data validation
- Use the pool of master trainers from the national programme to conduct state-level and local government training using national training materials. The state will in turn conduct a step-down training for its facility managers. Ward Development committee members, networks of PLHIV and other community healthcare workers, as appropriate
- Deploy the use of traditional and social media, as appropriate, to raise awareness and transfer information among stakeholders.

Community-level Coordination

The community is an important component of DSD. Eligible clients are differentiated and devolved from the health facilities to community-based structures. The community structures are leveraged on to ensure the successful implementation of DSD. The strategy for community mobilization will be anchored by the Ward Development Committees (WDCs) where they exist, Community Based Organizations and Support Groups of PLHIV. Capacity building activities at the community level should be undertaken before implementation of DSD and should include orientation of community structures. The process of community coordination should involve the following:

1. **Community sensitization by the mainstream facility, implementing partner, CBOs:** The CBO's will coordinate and champion sensitization of community members on the benefits of DSD, and form advocacy action groups to continuously advocate for increased participation of communities where DSD is being implemented.
2. **Advocacy and group mobilization:** Support groups of PLHIV, key and vulnerable populations will spearhead advocacy and facilitate the smooth transition between facility and community DSD platforms. They will achieve this by participating in both the facility-based cluster coordination meetings and WDC meetings where issues relating to effectively coordinating the program at the community level will be discussed.
3. **Criteria for selection of community implementers:** Through the relationship between facilities and community-based organizations, community pharmacies, and support groups will be selected for the implementation of community DSD models using the National Guidelines and Standard Operating Procedures.

4. **Training of selected community implementers:** Selected implementers at the community level will be trained alongside facility implementers on their roles as well as reporting procedures to ensure effective and quality service delivery. There is a need to include the WDCs, CDAs, etc. in the training
5. **DSD Tracking and Performance Monitoring at the community level:** This will be determined by the ART management team. Support Group Coordinators and CSO focal persons will join the facility cluster leads in conducting routine monitoring and supervision at the community level. This routine supervision will also be used as an avenue to identify challenges and best practices, close linkage gaps, and discuss the way forward during each monitoring cycle.
6. **Utilization of social media platforms:** Community actors through the WDCs will also coordinate local media campaigns which will be integrated into pre-existing community information dissemination processes/platforms. The purpose will be to strengthen and share strategic behaviour change interventions using Information Education and Communication (IEC) messages within the community.

Facility level Coordination

The ART management team in each ART facility is headed by the ART coordinator. The team will be responsible for the planning and pre-implementation activities of DSD. The following processes should be undertaken to guide the coordination of DSD at the facility level:

1. Conduct of facility readiness assessment: overall facility coordination should begin with the conduct of a facility readiness assessment. This is for facilities that are not yet implementing any form of DSD activities. This assessment should not be one-off but should be conducted in phases according to what is outlined in the scale-up plan.

Table 2.1: Facility Assessment for DSD

STEPS	HOW TO INTRODUCE DSD IN YOUR FACILITY
1	Establish or strengthen a committee to coordinate DSD activities in line with the national recommendations.
2	Conduct site assessments using the national DSD checklist to: - Determine current practices and challenges in delivering different services to specific groups - Define the subpopulations receiving services in your facility and communities - The assessment team should consist of SASCP, SACA, CSOs, and IPs
3	Review results from the various assessments to determine appropriate model/s to be implemented at the facility
4	Assess additional resource needs
5	- Devise a clear work plan, with key milestones. Designate responsible persons - Implement and monitor the models
6	Document challenges and best practices

2. Capacity building of health care workers: The capacity of relevant health care workers must be built in line with national recommendations. Health care workers should be trained on the various models of DSD, when to devolve clients and when to return them to the mainstream facility. On-the-job mentoring should be a continuous process to consolidate and ensure implementation of what has already been taught.

3. Advocacy and group mobilization: Trained healthcare workers will be responsible for the advocacy and group mobilization of all sub-populations of PLHIV, to explain the benefits of various DSD models and the eligibility criteria for devolvement. Selection of a suitable model by the PLHIV will also be based on the available models implemented by the facility.

4. **Mechanisms for feedback:** To support the implementation of DSD, an effective feedback loop should be established between the facility, PLHIV and community players. This can be achieved during quarterly meetings of the implementers or the recommended three-monthly clinical consultation visits for PLHIV.

5. **Monthly Reporting:** To ensure monitoring and performance tracking, the ART coordinator should ensure reporting in line with established reporting guidelines.

6. **Facility stock monitoring:** The ART pharmacist should ensure follow-up of bimonthly drug utilization reports to prevent 'intermittent interruption of treatment' (IIT) and avoid stock out of commodities from non-reporting. This can be achieved by the pharmacist giving the names of those yet to collect their drugs to case managers for subsequent follow-up.

7. **Reporting route to the State:** The LGA/LACA M&E officers pick up data from all primary healthcare centers within their local government, while reports from Secondary/Tertiary Health Facilities are submitted directly to the SASCP office who will, in turn, report to NASCP.

8. **Utilization of social media platforms:** Members of each DSD model should create a platform with the engagement of a facility focal person for the purpose of information sharing, sending appointment/meeting reminders and establishing a feedback loop.

Coordination of DSD in Special Populations (adolescents, key populations, internally displaced persons)

Coordination of DSD in special populations requires the involvement of representatives of these groups from designing, planning, implementation, monitoring, and evaluation of DSD activities at all levels. The NASCP, other government agencies at federal and state levels, and relevant implementing partners should ensure this meaningful involvement of these special populations.

With the ongoing humanitarian crises in some parts of Nigeria, collaboration with the responsible directorates (NEMA, SEMA) cannot be overemphasized.

2.2 Implementation Stage

Building Blocks of DSD

Clients are offered packages of care based on four building blocks (delivery components) and three elements. These characteristics can be applied across the entire HIV care continuum, for both stable and unstable PLHIV who are new to treatment or on long-term follow-up. The building blocks are:

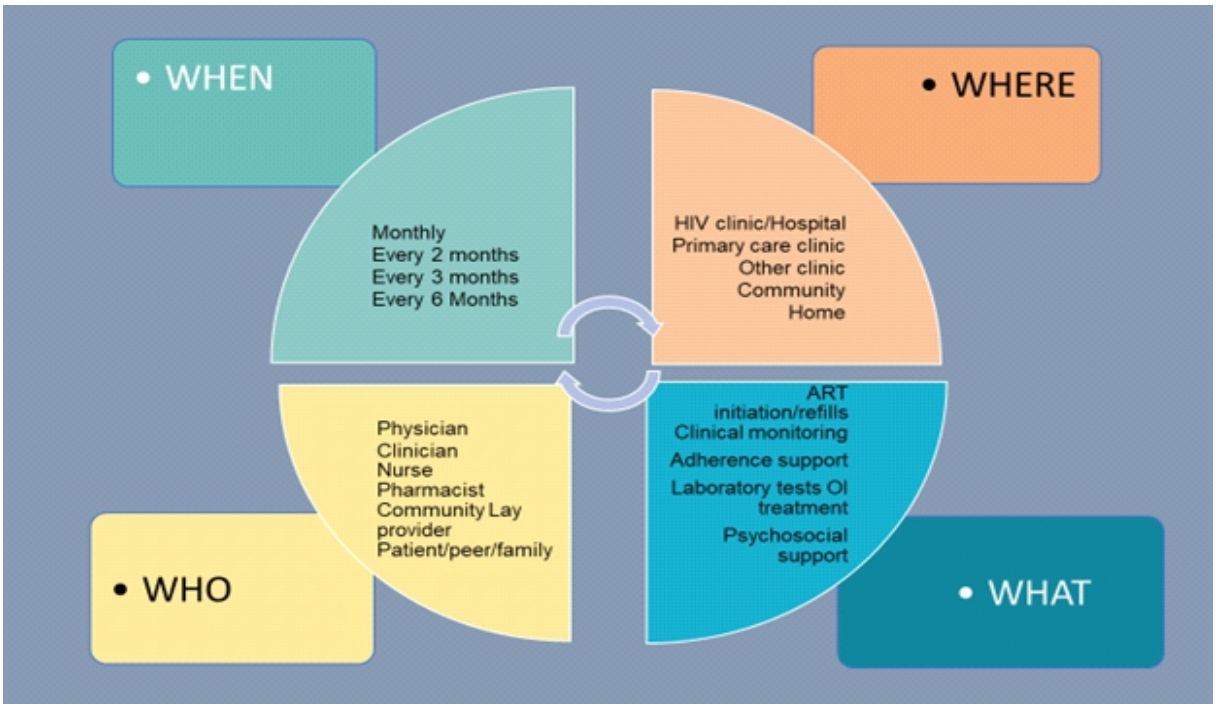


Figure 2.2: Building blocks of DSD

Elements of DSD

The 3 elements are:

- **Clinical Characteristics**
  - Patient stability and associated co-morbidities
- **Specific Populations**
  - Children, Adolescents, Women (Pregnant and breastfeeding), Menand Key Populations
- **Context**
  - Urban or rural location, unstable context (e.g conflict, high migration), patient burden, healthcare worker: patient ratio, epidemic/pandemic and emergency

Patient Categorization for Differentiated Care

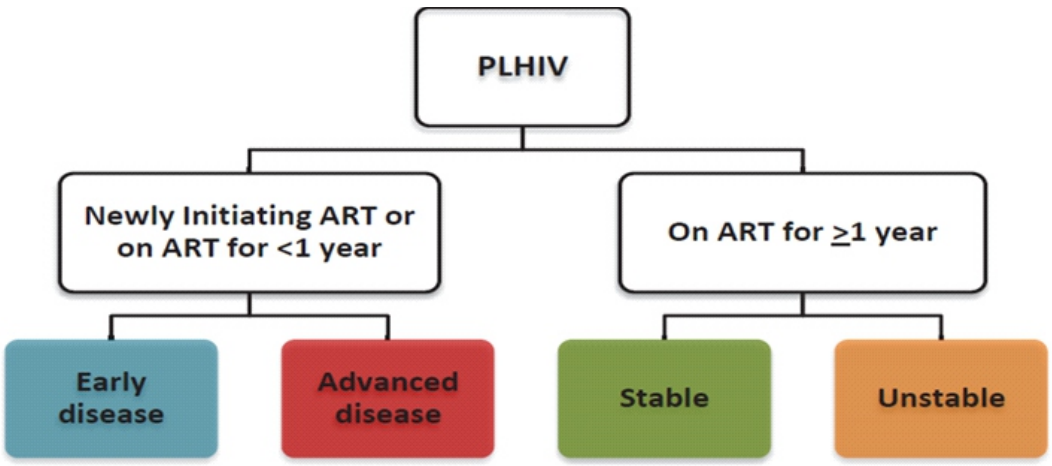


Figure 2.3: Patient Categorization for Differentiated Care

Stability Criteria for DSD

Table 2.2: Stability Criteria for DSD in Children, Adult Men and Non-Pregnant Women

CRITERIA	STABLE	UNSTABLE
Age	Adults, Adolescents and Children > 5yrs	• Children < 5yrs
Duration on ART	On ART for at least one year	• ART naïve patients • On ART less than one year
Clinical status	Clinically stable with no opportunistic infections or current illnesses	• Advanced HIV disease (WHO clinical stages 3-4) • Co-morbidities e.g. diabetes mellitus, heart, chronic liver, and chronic kidney diseases
Adherence	• Adherent with an optimal understanding of lifelong treatment • Age-appropriate disclosure desirable for children and adolescents	• Poor adherence • Orphans and vulnerable children
Treatment	• Evidence of treatment success –Most recent viral load measurements < 1,000 copies/ul • In the absence of viral load monitoring, rising CD4 cell counts or CD4 counts above 200 cells/mm3 • Has initiated/completed TPT • Has no adverse drug reactions that require regular monitoring	• Unsuppressed viral load> 1000 copies/ul • On 2nd or 3rd line regimen • On recently changed regimen < 6months • Experiencing treatment failure
Monitoring	• Does not require close monitoring at the facility level • Regular CD4 count monitoring is unnecessary	• Close monitoring necessary at the facility level • CD4 count monitoring may be required

2.3 Differentiated ART Service Delivery Models

The DSD models span a continuum of care starting from HIV testing services, ART initiation and retention in care, through client ART management based on eligibility criteria and client preferences.

Models of DART Service Delivery in Nigeria

Models for differentiated ART service delivery are broadly classified as facility-based or community-based.

- Facility-based models are HIV treatment and care models where services are offered within the existing health facilities
- Community-based models are HIV treatment and care models where services are offered outside the existing health facilities

Table 2.3: Models of differentiated ART Service Delivery in Nigeria

FACILITY- BASED	COMMUNITY- BASED
Fast track (Individual or Group): stable clients pick their drugs from the facility pharmacy without going through the normal clinic flow, including a doctor's review.	**Community drug distribution points** : These are designated points within the community where ARVs and other medications are dispensed to stable PLHIV.

Multi-month dispensing:** Medication dispensing interval of 3 months and above.	**Community Pharmacy Refills** This is the pickup of drugs by PLHIV from designated or selected community pharmacies.
Health Facility Based ART Group These are health facility -based groups formed voluntarily by support groups of PLHIV who are already meeting regularly at the health facility for ARVs and other medication refills. This can either be client -led or healthcare provider-led.	**Community ART Group (CAG)** These are community -based groups formed voluntarily by PLHIV within a commu nity for ARVs and other medication refills. This can either be PLHIV led, or healthcare worker led. These healthcare workers may include community health workers, case managers, and other trained volunteers.
Decentralization: refers to the devolution of stable clients from larger, centralized secondary and tertiary facilities (hubs) to smaller more peripheral primary facilities (spokes). This can be: - semi-autonomous model restricts ART service delivery at PHCs to ARV /medication refills - autonomous model allows for ART initiation at the PHC level, ARV , and medication refills.	
Adolescent clubs : Groups of adolescents and young people living with HIV for whom age -appropriate, affordable, friendly health services are provided in an accessible and acceptable environment.	
Post Natal Clubs: Groups of women living with HIV who are supported in the postnatal period by healthcare workers and other volunteers like mentor mothers to ensure improved maternal/child health outcomes.	
One-Stop Shops and Mobile Clinics are community- based service delivery sites where multiple services are offered, and clients can access all their needs under one roof targeted specifically at providing services for Key Populations.	
Peer-led: These groups are facilitated by trained peer educators. These educators are trained in screening for HIV, opportunistic infections, and self -testing to offer community testing.	

Culled from the 2020 National Treatment Guidelines

*** **Multi-month dispensing** is not a stand-alone facility or community-based DSD model but an aspect of DSD that relates to multi-month refill of ARVs. MMD is applicable to the different ART delivery models.*

***FAMILY MODEL OF CARE:** is a combination of different models aimed at deepening family support systems to improve HIV case detection and services. This model prioritizes newly identified Children Living with HIV (CLHIV) as the index and uses a family information table (FIT) to screen family members at risk of HIV, address disclosure, facilitate family testing, and ensure linkages of HIV-positive members and prevent new infections.*

Categorization of HIV Clients at the point of ART initiation
Clients who are HIV positive are categorized as either "well" or advanced HIV disease (AHD) depending on the CD4 count or WHO clinical staging and this determines the package of care to be offered. The classification should be done by the ART clinician/nurse. Either criterion can be used to stage the client. The table below shows the criteria for diagnosing these categories:

Table 2.4: Categorization at ART Initiation

Criteria	Well client	Advanced HIV disease
WHO clinical staging	1 or 2	3 or 4
CD4 + lymphocyte count	>200 cells/mm^3	<200 cells/mm^3

Package of Care offered to PLHIV at ART Initiation
The table below shows the package of care for the different groups of PLHIV at the point of ART initiation.

Table 2.5: Package of Care at ART Initiation

PACKAGE OF CARE	WELL CLIENT	ADVANCED HIV DISEASE
WHO QUALIFIES FOR THE PACKAGE OF CARE	A Client with WHO clinical stage 1 or 2 or CD4 count > 200cells/mm^3	A Client with WHO clinical stage 3 or 4 or CD4 count <200cells/mm^3
WHO PROVIDES THE SERVICES	Healthcare workers trained to provide ART services (Clinician, Nurse, adherence counsellor, laboratory , and pharmacy personnel)	Healthcare workers trained to provide ART services (Clinician, Nurse, adherence counsellor, laboratory , and pharmacy personnel)
SERVICE LOCATION	Approved health facilities	Approved health facilities
SERVICE INTENSITY (PACKAGES OFFERED) AND SERVICE FREQUENCY		
CLINICAL CONSULT	**Monthly for the first 2 months, thereafter 2 -monthly for the first year.	** Weekly/Bi -weekly in the first 1 month Admission with daily reviews, if required Monthly for the first 2 months, thereafter 2 -monthly for the first year
ART REFILL	**Monthly for the first 2 months, thereafter 2 -monthly for the first year.	**Monthly for the first 2 months, thereafter 2 -monthly for the first year
MONITORING (INVESTIGATIONS)	Laboratory monitoring tests may differ according to the level of the health care facility and should be done according to the schedule approved in the National Guidelines	Laboratory monitoring tests may differ according to the level of the health care facility and should be done according to the schedule approved in the National Guidelines Additional tests may be indicated based on diagnosed OIs

ANCILLARY SERVICES SUCH AS PSYCHO-SOCIAL SERVICES, INTENSIFIED ADHERENCE SUPPORT, CHRONIC CARE.	**AT EVERY CLINIC CONTACT**	**EVERY WEEK FOR THE FIRST 1 MONTH** **AT EVERY CLINIC CONTACT SUBSEQUENTLY**

Culled from the National Treatment Guidelines 2020
**Adherence counselling/support and clinical screening for TB should be done at every clinic contact.*
***The client should be informed to return to the health facility **IMMEDIATELY** if s/he develops adverse drug reaction(s) or has any complaints.*

Specifically, for the treatment of TB and Cryptococcal meningitis in PLHIV with AHD, prophylaxis for other Ois, and other packages of AHD, refer to the 2020 National Guidelines on HIV Prevention, Treatment and Care and the Protocol of Implementation and Evaluation of the AHD package in Nigeria.

Enrollment into Facility and Community Based DSD Models
For enrollment into any of the DART models, for stable clients, the following criteria must be met:

- Adults, Adolescents and Children > 5yrs
- On ART for at least one year
- Clinically stable with no opportunistic infections or current illnesses
- Adherent with an optimal understanding of lifelong treatment
- Virally suppressed – the most recent viral load measurements < 1,000 copies/ul
- In the absence of viral load monitoring, rising CD4 cell counts or CD4 counts above 200 cells/mm3
- Has no adverse drug reactions that requires regular monitoring

ENROLLMENT INTO FACILITY-BASED DSD TREATMENT MODELS

A) Healthcare worker-led DSD models:

- Groups of stable clients meet for 30-60 minutes
- Health care worker should provide a brief symptom screen, group adherence counselling and 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)
- No client folders are pulled, nor is individual adherence counselling provided.
- Folders are promptly updated by the healthcare worker
- Group members have their viral load taken at one of their annual group visits and are seen individually for clinical review at their next group visit.

B) Fast track:

- A designated facility staff triages eligible clients for fast track DSD model
- Clients go directly to the facility pharmacy or dispensing room, present their client card and collect their ARV refill from their repeat script
- Laboratory investigations e.g., viral load tests are done at designated clinic visits as per guidelines.

C) Key Population DSD models:

- Creation of adherence groups for stable HIV-positive KP clients to support joint treatment management
- Receive bundled antiretroviral medications to distribute within their group
- Allows multi-month dispensing of medication to stable clients during scheduled visits

D) Adolescent DSD models:

- The DSD models targeting adolescents, include the following: multi-month dispensing, clinics on weekends/public holidays and school holiday clinics, youth/teen clubs, family model of care and community ART groups.

Table 2.6: Adolescent DSD Models

Multi Month Dispensing	MODEL TYPE				
	Weekend/Public Holiday Clinics	**School Holiday Clinics**	**Youth/Teens Clubs**	**Family Model of Care**	**Community ART Groups**
Provision of ART refills	Provision of comprehensive one- stop care, including clinical checks, ART refills. May be provided to groups or individuals	Provision of comprehensive one-stop care, including clinical checks, ART refills. May be provided to groups or individuals	Provision of comprehensive one-stop care, including clinical checks, ART refills. Provided to peer groups	Provision of comprehensive one-stop care, including clinical checks, ART refills. Provided to family groups	Provision of screening, refill, counselling, clinical checks

Enrollment into Community DSD treatment models

In these models, 1-3 months ART refills are distributed to stable clients outside of the health facility environment.

A) Community ART Group:

This model requires clients stable on ART to form small groups of 6-10 where they

- Meet at a venue close to all the members' homes the day before or on the day of the groups' scheduled facility visit
- Each member reports on adherence, and undergoes a pill count and brief symptom screen, and peer education which is completed on a group monitoring form
- Each member takes a rotating turn to attend the health care facility for monitoring tests and clinical review whilst collecting ART refills for all members of the group
- There should be an expert patient who is responsible for overall coordination of the group
- All members' ART cards/clinical folders are drawn at the facility and the attending group member reports on the health and adherence of each member on the group monitoring form to the designated mainstream healthcare worker who completes the client ART card/clinical folder
- For Community Drug Distribution points, collecting members return to designated community drug distribution point and distributes the ART refills collected from the mainstream health facility to members.

B) Community Pharmacy Refill Model:

- ART refills are directly provided by a registered Pharmacist to clients at a designated community pharmacy of choice
- Community pharmacies receive ARVs from facilities, store and dispense to devolved eligible clients in the community who come for drug refills at the pharmacies. (*See Annex III for the responsibilities of a community pharmacy and the referring facility).*

C) **Community Drug Distribution Points:**

- ART refills are provided to eligible clients by community health workers or collected by the client from a specific community location operated either by community health workers or through a mobile outreach service or sub-district health service.

D) **Home Delivery DSD Model:**

- ART refills are provided to eligible clients directly at their home by community health workers
- Commodities flow from the facility to the patient and documentation is made by

Criteria for Enrolling Clients under Specific DSD Models

Enrollment into Facility-based DART Models				Enrollment into Community DART Models			
Healthcare worker-led DSD models	Fast track	KP DSD models	Adolescent Clubs DSD models	Community ART Group	Community Pharmacy Refills DSD model	Community Drug Distribution points	Home Delivery DSD model
1-3 months ART refills are distributed to stable clients within the facility				1-3 months ART refills are distributed to stable clients outside of the heal facility environment			
Groups of stable clients meet for 30-60mins; peer support & pre-packed ART distributed to members at 2-3 months; viral load taken annually and clinical review at next visit.	Facility staff triage eligible clients for fast track; on visit, clients move directly to the facility pharmacy or dispensing room; Lab investigations are done at designated clinic visits	Stable HIV+ KP clients join adherence groups to manage treatment; bundled ARVs are received and distributed within the group; stable client can access MMD	**Six DSD model targeting adolescents within and outside the health facility**	Stable clients form groups of 6-10; meet at a central venue; report adherence, undergo pill count and brief symptom screen; members take rotating turn to visit facility for tests and clinical review whilst picking up ART refills	ART refills are provided at a designated Community Pharmacy of choice; Community Pharmacies receive ARVs from facilities, stores and dispenses to eligible clients in the facility	ART refills are provided to eligible clients by community HCWs or collected by the client from a specific location operated either by community HCWs or through a mobile outreach service	ART refills are provided to eligible clients directly at their home by community health workers

Figure 2.4: Facility-based and Community-based DSD Models – Enrollment Criteria

C) **Community Drug Distribution Points:**

- ART refills are provided to eligible clients by community health workers or collected by the client from a specific community location operated either by community health workers or through a mobile outreach service or sub-district health service.

D) **Home Delivery DSD Model:**

- ART refills are provided to eligible clients directly at their home by community health workers
- Commodities flow from the facility to the patient and documentation is made by the community health workers into the facility records.

CHAPTER 3 : HIV TESTING SERVICES WITHIN DIFFERENTIATED SERVICE DELIVERY MODELS

3.1 Introduction

There are multiple approaches for delivering HIV Testing Services (HTS) in Nigeria. The delivery of HTS services aligns with the various DSD models as described in chapter two.

These are generally categorized into health facility-based approaches, community-based approaches, and innovative strategies. The HIV testing service delivery includes mobilization, testing and linkages.

Core Guiding Principles to HTS: The 5Cs

HTS should be delivered using a client-centred approach, which is guided by the "5Cs":

i. Consent
ii. Confidentiality
iii. Counselling
iv. Correct Test Results
v. Connection with Prevention, Treatment, Care, and Support Services

3.2 Flow of HIV Testing Services

HTS begins with demand creation, linkage, pre-test information, diagnosis, post-test information and follow up services. The HTS flow chart cuts across the various DSD models (see figure 3.1 below)

Figure 3.1: HTS FLOWCHART FOR DSD

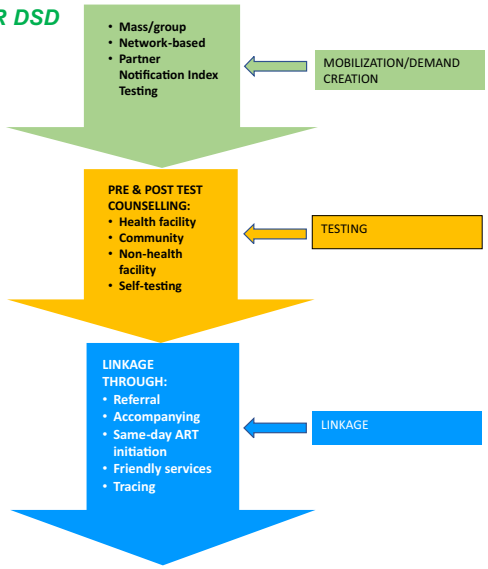


Figure 3.1: HTS Flow Chart for DSD

3.3 HIV Testing Services Strategies

HIV Testing Services can be offered seamlessly either in the facility or community through various strategies. Nigeria has adopted and adapted several innovative strategies for testing as seen in Figure 3.2 below.

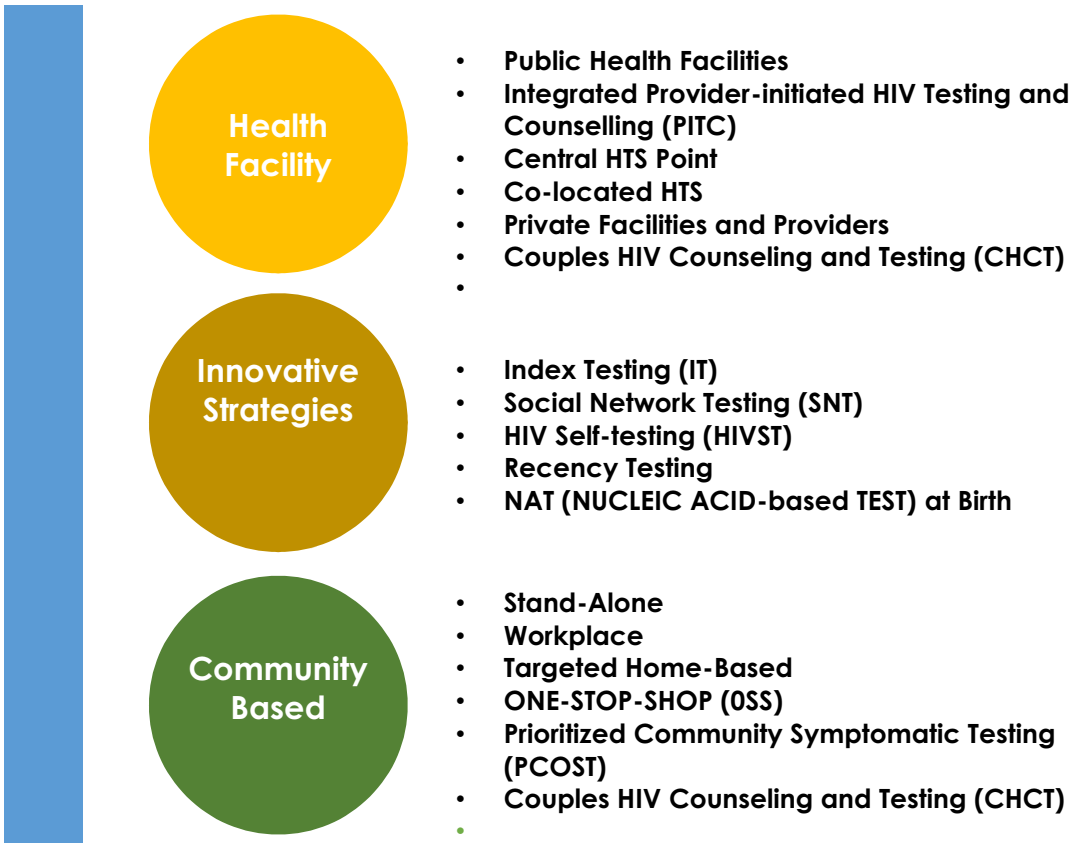


Figure3.3: HIV Testing Service Delivery Approaches in Nigeria

Source: National Guidelines for HIV Testing Services 2017; WHO 2015 Consolidated Guidelines.
For detailed description of the various testing modalities refer to the National guidelines for HIV Testing Services 2017 and National guidelines for HIV Prevention Treatment and Care (FMOH 2020)

3.4 HIV Testing Services for DSD

HIV Testing Services for DSD can be categorized into models for different sub-populations to maximize the opportunities for testing, prevention, treatment, care and support services so as to help achieve the UNAIDS 95-95-95 targets by 2025.The sub-populations are listed below:

- 0-<2years
- 2-9years
- Adolescents and Young adults (10 -24 years)
- Pregnant women and breastfeeding mothers and their male partners
- Adults
- Key populations

The tables below represent these sub-populations in facility and community-based models.

Table 3.1: HIV Testing Services for Children O – < 2 years

	MOBILIZATION		TESTING		LINKAGE	
	0-<2years (Facility)	**0-<2years (Community)**	**0-<2years (Facility)**	**0-<2years (Community)**	**0-<2years (Facility)**	**0-<2years (Community)**
WHO	• HCWs • Mentor mothers • Counselors	• HCWs • Mentor mothers • Counsellors • Trained lay providers • Gate keepers	• HCWs • Mentor mothers • Counselors • Lab Scientist/Technicians	• HCWs • Mentor mothers • Counsellors • Lab Technicians	• HCWs • Mentor mothers • Counsellors • Trained lay providers	• HCWs • Counsellors • Trained lay providers
WHEN	• Birth • 6 weeks or at the earliest opportunity thereafter • 6 weeks after cessation of breastfeeding • Immunization		• Birth • 6 weeks or at the earliest opportunity thereafter • 6 weeks after cessation of breastfeeding • Immunization		• After test result • Immunization • Post-natal Visit	• At birth • After test result
WHERE	• MNCH OPD • Children ward • Immunization • Nutrition clinic • Post-natal clinic	• Congregational centers • Targeted community outreach	• Immunization • Child welfare clinics • PNC • MNCH OPD • Children ward • Nutrition clinic	• Outreaches in the community	• Pediatric clinic • Children ward • Child welfare clinics	• Health Facility
WHAT	• Index testing • EID	• Index testing • EID	• DNA/PCR (Blood & DBS) • VL • CD4% • Genealogy testing • Other Ancillary tests	• DNA/PCR (DBS) • VL • CD4% • Genealogy testing • Other Ancillary tests	• Treatment, Care and Support • Adherence Counseling • Nutritional support/ monitoring • Immunization • CTX/ARV Prophylaxis	• Care and Support • Adherence Counseling

Table 3.2: HIV Testing Services for Children 2 – 9 years

	MOBILIZATION		TESTING		LINKAGE	
	2-9years (Facility)	**2-9years (Community)**	**2-9years (Facility)**	**2-9years (Community)**	**2-9years (Facility)**	**2-9years (Community)**
WHO	• HCWs • Mentor mothers • Counselors • Care givers	• HCWs • Mentor mothers • Counselors • Care givers • Gate keepers	• HCWs • Mentor mothers • Counselors • Lab Scientist/Technicians	• HCWs • Counsellors • Mentor mothers • Lab Technicians	• HCWs • Counselors	• HCWs • Counsellors • Trained lay providers

WHEN	• History of exposure • Immunization	• History of exposure • Outside school hours	• Following exposure • Based on risk status	• Following exposure • Based on risk status • New exposure	• After test result	• After test result
WHERE	• OPD • Children ward • Laboratory • Immunization • Nutrition clinic • IDP camps • Kids club	• Congregational centers • Town hall meetings • Homes • Community recreational centres • Markets	• Child welfare clinics • Immunization	• Congregational centers • Town hall meetings • Homes • Community recreational centres • Markets	• Pediatric clinic • Children clinic • Immunization • Newborn & child welfare clinic	• Health Facility • Community
WHAT	• VL • CD4 • Index testing	• VL • CD4 • Index testing	• VL • CD4 • Other Ancillary tests	• HIV Testing • POC CD4 • Other Ancillary tests	• Treatment, Care and Support • Adherence Counselling • Psychosocial support • Age-appropriate disclosure	• Treatment Care, and Support • Adherence Counseling

Table 3.3: HIV Testing Services for Adolescents and Young Adults 10 – 24 years

	MOBILIZATION		TESTING		LINKAGE	
	Facility	**Community**	**Facility**	**Community**	**Facility**	**Community**
WHO	• Adolescent Peer Educators • HCWs • Counsellors • Lay providers • Adolescent friendly clubs • Peer group	• Adolescent Peer Educators • HCWs • Counsellors • Lay providers • Gate keepers • Community support groups • Adolescent friendly clubs	• HCWs • Counsellors • Lab scientists • Lab Technicians	• Community health worker • Counselors • Lay providers • Peer groups • Lab Technicians	• HCWs • Peer treatment partner • Counsellors • Lay providers	• HCW • Peer treatment partner • Counsellors • Lay providers • Community support groups • Adolescent clubs
WHEN	• Daily • 3 monthly following a negative test result	• Daily • During Community campaigns • Outside school hours • Outreaches	• History of exposure • Before ART initiation • CD4 at baseline • VL 6 months post ART initiation • VL yearly	• History of exposure • 3 monthly following a negative test result	• After test result	

WHERE	• Health Facility (OPD, IPD, Immunization, Nutrition clinic) • HIV Care and treatment clinic • Youth friendly centres	• Youth friendly centres • Media • Congregational centers: clubs, bars, sports club	• Health facilities	• VCT centers • Outreach	• Health Facility • Community support services	• Community
WHAT	• VL • CD4 • Index testing • HIVST	• VL • CD4 • Index testing • HIV Testing • HIVST	• DNA/PCR, • VL, • CD4%, • Genealogy testing, • Other Ancillary tests	• VL • CD4 • Other Ancillary tests	• Treatment, Care and Support • Adherence Counseling • Nutritional support • Immunization, • CTX Prophylaxis	• Treatment Care and Support • Adherence Counseling

Table 3.4: HIV Testing Services for Pregnant Women and Breast-Feeding Mothers

	MOBILIZATION		TESTING		LINKAGE	
	Facility	**Community**	**Facility**	**Community**	**Facility**	**Community**
WHO	• HCWs • Counselors • Mentor mothers	• Counselors • Mentor mothers • Community health workers • Adolescent friendly clubs • Trained TBAs	• HCWs • Counsellors • Lab scientists • Lab technician	• Community health workers • Counsellors • Lab technician • Lay counsellors • Trained TBAs	• HCWs • Mentor Mothers • Peer Navigator	• HCWs • Counsellor • Trained TBAs • Lay counsellor • Mentor mothers • Peer navigators
WHEN	• 1st, 2nd and 3rd trimester • During labour and postpartum period • Every 3 months until 3 months after cessation of breastfeeding	• 1st, 2nd and 3rd trimester • During labour and postpartum period • Every 3 months until 3 months after cessation of breastfeeding	• 1st trimester/1st contact at ANC • 3rd trimester/During labour • Every 3 months until 3 months after cessation of breastfeeding	• 1st trimester/1st contact at ANC • 3rd trimester • During labour • Every 3 months until 3 months after cessation of breastfeeding	• Immediately after test result is received	• Immediately after test result is received • Intra facility linkage • Community testing point to facility
WHERE	• MNCH clinic • OPD, Nutritional clinic • Family planning clinic • In-patient ward	• Via Media • Congregational settings • Markets	• MNCH clinic • OPD, Nutritional clinic • Family planning clinic • In-patient ward • Laboratory	• Congregational settings • Markets	• Immediately after test result is received	• Immediately after test result is received • Intra facility linkage • Inter facility linkage

WHAT	• VL, • CD4, • Index testing • HIVST • HIV Testing	• VL, • CD4, • Index testing • HIVST • HIV Testing.	• HIV Testing • VL, • CD4, • Index Testing • Other Ancillary tests	• HIV Testing • CD4 • Index testing • HIVST • Other Ancillary tests	• PMTCT • ART • Treatment Care and Support • Adherence Counselling • STI management	• Treatment Care and Support • Adherence Counselling, • PMTCT • ART • Family planning, • STI management

Table 3.5: HIV Testing Services for Adults

	MOBILIZATION		TESTING		LINKAGE	
	Facility	**Community**	**Facility**	**Community**	**Facility**	**Community**
WHO	• HCWs, • Counselors • Index client	• Community health workers • Lay providers • Index client	• HCWs • Counsellors • Lab Scientists • Lab technicians	• Community health workers • Counsellors • Lay Providers • Lab technicians	• HCWs • Counsellors • Lay Providers	• HCWs • Counsellor • Lay Providers
WHEN	• At early contact • At client request • Index testing	• During working hours at workplaces • After working hours • Congregational meetings • Markets	• History of exposure • Before ART initiation	• History of exposure • Before ART initiation	• After a confirmatory test result	• Outcome of the test result
WHERE	• IPD • OPD • Infectious disease clinic • Haematology and other specialty clinics • A&E	• Workplaces, • Home-base or door to door • Congregational meetings • Others: Bars, football matches, male community forum, saloon,	• IPD • OPD • Infectious disease clinic • Haematology and other Specialty Clinics • A&E • HTS Site • Laboratory	• VCT centers • Outreaches • Workplaces • Home-base or door to door • Congregational meetings • Others: Bars, football matches, male community forum, saloon	• Health facility	• Health Facility • Community ART Support services
WHAT	• HTS • HIVST • Index Testing • Prevention services e.g., condoms	• HIVST • HTS in combination with other diseases screening. • Prevention services e.g. , condoms,	• Rapid HIV test • VL • CD4 • Other Ancillary tests	• Rapid HIV test • CD4 • Other Ancillary tests	• Treatment Care and Support services • Adherence Counseling • Disclosure • Nutrition • Psychosocial support • Mental health services • Substance abuse counseling	• Prevention services • Adherence Counselling • Treatment, Care, and Support

Table 3.6: HIV Testing Services for Key Populations

	MOBILIZATION		TESTING		LINKAGE	
	Facility	**Community**	**Facility**	**Community**	**Facility**	**Community**
WHO	• HCWs, • Counselors • Peer Educators	• Counselors • Peer Educators/ Navigators • Case Managers • Existing clients • Gatekeepers • Community facilitators • Outreach	• HCWs • Counsellors • Lab Scientists • Lab Technicians	• Community Health workers • Counsellors • Lay counsellors/providers • Case managers • Lab technicians	• Counsellors • HCWs • Peer Educators • Lay providers • Case managers	• Counsellors • Case managers • HCWs • Existing clients •
WHEN	• Daily • During peer support groups meetings and social activities	• Daily • Community campaigns • 3 monthly following a -ve test result • During support group meetings and outreaches • During peer educator (cohort sessions)	• Routinely • At contact • Every 3months • retesting for those negative • At clients' request	• Routinely and during outreaches • Every 3months retesting for those negative • At clients' request • Moon light testing	• After test result	• When screening test are reactive • ANC
WHERE	• OSS • Group meetings • Rehabilitation units • Peer support group platforms	• Social media channels (Facebook etc.) • DiCs • Mobile clinics • Community-based events • CBOs • Hot spots • Congregational settings	• Rehabilitation unit • Peer support group platforms • Congregational settings	• DiC • Mobile clinics • Community (bunks, clubs etc), • VCT centres	**Health Facilities:** • Family planning clinic • ANC Clinic (for pregnant KPs) **Community:** • OSS • CART • FSPs	• OSS • Health care facility • Family planning clinic • ANC Clinic (for pregnant KPs) • Treatment Care and Support
WHAT	• HIV Testing (PITC, CICT, HIVST, Index testing) • Recency testing	• Face-to-face • Online counselling • HIVST • Index testing	• VL • CD4 • Rapid test • Index Testing • other Ancillary tests	• Rapid Test • VL (sample transfer) • CD4 • HIVST • other Ancillary tests • Recency Testing • HIVST • SNT	• Treatment Care and Support • Adherence Counseling • STI management • Mental health and psychosocial support services • Cervical cancer screening • Family planning • Harm reduction services • Human rights and legal services. • Index testing	• Treatment Care and Support • Adherence Counselling • STI management • Family planning • ANC • Cervical cancer screening • Harm reduction services • MHPSS Human rights and legal services.

Conclusion: Individuals tested should be linked irrespective of the result. Negative individuals should be linked to prevention services while positive cases should be linked to treatment.

CHAPTER 4: DIFFERENTIATED SERVICE DELIVERY MODELS FOR PREGNANT WOMEN AND BREASTFEEDING MOTHERS

4.1 Introduction

Mother-to-child transmission (MTCT) of HIV refers to the transmission of HIV from a HIV-positive woman to her child during pregnancy, labour and delivery or breastfeeding. The cascade of prevention of mother-to-child transmission (PMTCT) interventions includes ANC services, HIV testing and treatment, postnatal care including nutrition, family planning services, STI and cervical cancer screening and/or treatment. In addition, interventions for the HIV exposed infant (HEI) include ARV prophylaxis, safe infant feeding practices, early infant diagnosis, nutrition, and immunization.

The facility-based DSD model of care is recommended for all HIV positive pregnant women and breastfeeding mothers as it creates an enabling environment for much needed antenatal care, skilled/safe delivery practices and promotes HIV care for the mother-baby pair.

4.2 Classification of PMTCT Clients The HIV positive pregnant women and breastfeeding mothers can be classified as stable or unstable. This classification is based on the following criteria that would assist in deciding the most appropriate DSD model for the client.

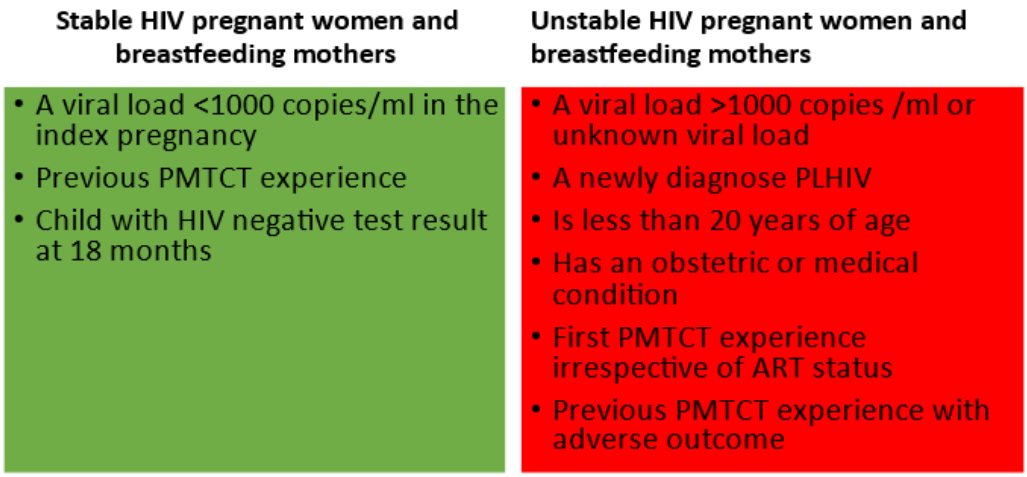


Figure 4.1: Stability Criteria for HIV Positive Pregnant Women and Breastfeeding

Table 4.1: HIV Testing Services for Pregnant Women and Breastfeeding Mothers

TIME OF PRESENTATION	HIV STATUS	WHEN TO TEST
ANTENATAL	Presents with HIV negative result	Re-test in ANC 1st visit
	HIV status unknown	Offer HIV testing at 1st contact in the ANC
	HIV negative result 1st visit	Retest after 3 months if she books early otherwise repeat test early in labour at contact

LABOUR AND DELIVERY	HIV status unknown	Offer HIV testing service at contact
	Presents with HIV status negative in labour	Repeat HIV Testing at labour ward contact and at 6 weeks postnatal/immunization visits and every sixmonths, until cessation of breast-feeding
	HIV status negative from facility ANC	Repeat HIV Testing at labour ward contact and at 6 weeks postnatal/immunization visits and every 6month, until cessation of breast-feeding
POSTPARTUM	HIV status unknown	Offer HIV testing Services at contact, 6weeks postnatal/immunization visits and every 6month, until cessation of breast-feeding
	Presents with a HIV negative result immediate postpartum period	Offer HIV testing Services at contact, 6weeks immunization visit and every 6month, until cessation of breast-feeding

For all HIV positive PBFW, provide PMTCT services as standard of care according to the 2020 National guidelines on HIV Prevention, Treatment and Care. Also screen for common co-

Table 4.2: Differentiated Service Delivery Case scenarios for PMTCT

Stable Pregnant Women and Breastfeeding Mothers	Unstable Pregnant Women and Breastfeeding Mothers
If already in facility, she should continue DSD in the facility. • ART and antenatal clinic visits should be synchronized. If she is in the community model of DSD, she should be linked to a health facility for ANC services by either of the following for her ART services: • Health Care provider led refill group • mentor mother led refill group 	***PMTCT Naïve pregnant women***. Facility based DSD model of care is recommended to ensure PMTCT and safe delivery. ***Pregnant women and breastfeeding mother with medical or obstetrics condition.*** If accessing care in a community DSD, should be referred to facility-based DSD model immediately the diagnosis is made. ***ART experienced pregnant women or breastfeeding mother with viral load above 1000 copies or previous adverse PMTCT outcome in the last confinement.*** • Should be referred to facility -based DSD model of care. ***Pregnant or breastfeeding adolescents*** • Should be referred to facility -based DSD model of care.

Viral Load Testing

HIV plasma viral load is the single most important determinant of mother to child transmission of HIV. All pregnant women should have VL testing performed between 32 and 34 weeks and the result used for decision making within 2 weeks.

Mentor Mothers

Mentor mothers are women who are HIV positive and have passed through the PMTCT cascade intervention with a successful outcome – with an HIV negative baby as a result of the PMTCT interventions provided. They serve as peer counselors for PMTCT clients, provide guidance and support in keeping appointments and promoting antiretroviral drug adherence, retention in care and linkages.

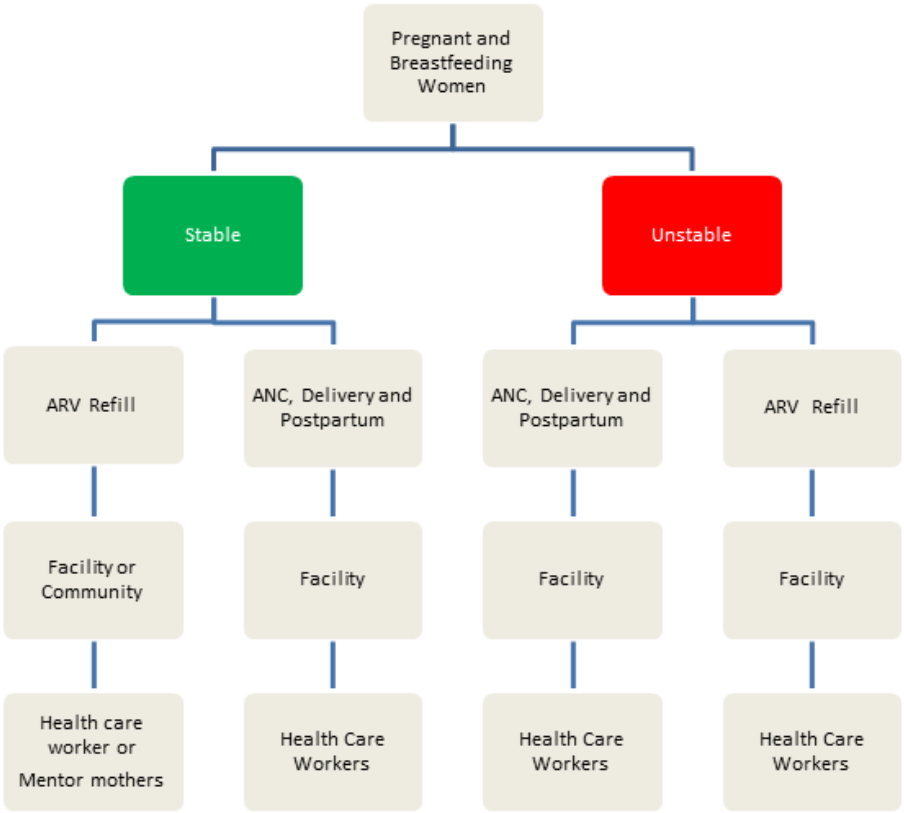


Figure 4.2: Flow chart for PMTCT DSD during pregnancy and breastfeeding

4.3 Post-delivery period

- The post delivery period for the purpose of DSD is from delivery to five years post-partum. This is to ensure that Mother–Infant Pair (MIP) is followed up, taking into account the rapid growth of the under 5-year-old child and frequency of illness that may characterize this period of life. A facility-based DSD model of care is recommended for this period. However, when not feasible the MIP must be linked to a health facility for other maternal, newborn and child welfare services. Mothers with VL>1000 copies/ml should be referred to a facility-based DSD model for intensified ART services.

- HIV exposed babies should be diagnosed with DNA PCR using DBS or NAT at birth (when available), at 6 to 8 weeks of age and 12 weeks after cessation of breastfeeding. The final HIV status of the child should be confirmed by rapid test at 18 months.

ARV Prophylaxis for HIV Exposed Infant (HEI)

ARV prophylaxis for HEI should be available in delivery rooms in all health facilities. For low risk HEI daily Nevirapine suspension should be given for a period of six weeks, while high risk HEI should receive dual ARV prophylaxis (nevirapine and zidovudine) for a period of twelve weeks.

High-risk infants are defined as those:

- Born to women with established HIV infection who have received less than four weeks of ART at the time of delivery;

OR

- Born to women with established HIV infection with viral load >1000 copies/ml in the four weeks before delivery;

OR

- Born to women with incidental HIV infection during pregnancy (this includes women diagnosed in labour) or breastfeeding;

OR

- Identified for the first time during the postpartum period, with or without a negative HIV test prenatally.

Babies delivered in health facilities should be commenced on ARV prophylaxis, as appropriate, immediately after delivery or within 72 hours of delivery (*see section 6.4 of the National HIV guidelines on HIV prevention treatment and care 2020*)

For babies delivered outside health facility, measures should be in place for such HEI to have access to appropriate ARV prophylaxis immediately or within 72 hours of delivery.

Table 4.3: ARV Prophylaxis for Low-Risk Infants with NVP

Infant Age	Daily Dosing
Birth to 6 weeks:	
Birth weight <2.5kg	10 mg (1 ml) once daily
Birth weight =2.5kg	15 mg (1.5 ml) once daily

Table 4.4: ARV Prophylaxis for High-risk HEI

INFANT AGE	NVP DOSING	AZT DOSING
Birth to 6 weeks		
Birth weight < 2.5 kg	10mg(1ml) once daily	AZT 10mg (1ml) twice daily
Birth weight = 2.5kg	15mg(1.5ml) once daily	AZT 15mg (1.5ml) twice daily
6-12 weeks		
	20 mg (2 ml) of syrup once daily	60 mg (6mls) twice daily

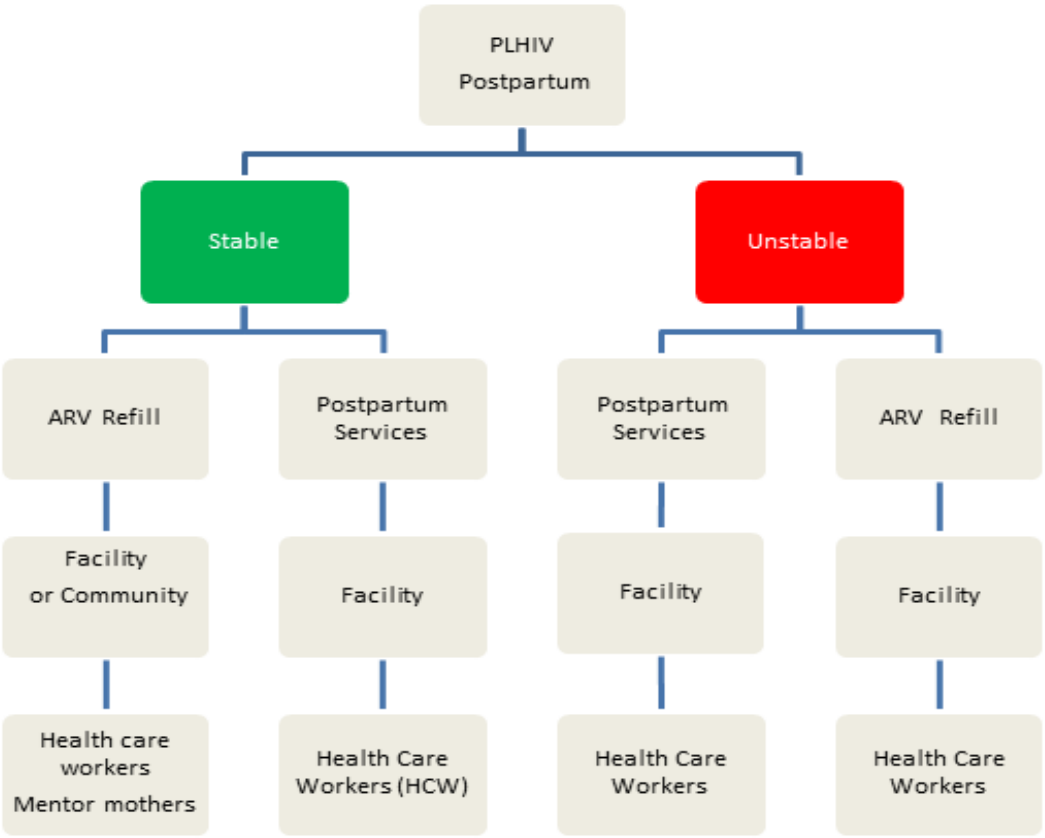


Figure 4.3: Flow chart for PMTCT DSD during Postpartum period

Note:
**After 5 years, re-evaluate the mother-child pair for possible devolvement to community DSD if stable*

DSD for postpartum period
Women who are stable and in facility-based DSD models prior to delivery should continue but clinical consultations should be synchronized with mother-baby pair visits. MMD should be three-monthly only.
Mothers in community-based DSD that fail to deliver in facility could benefit from a modified community-based mother infant paired DSD, that is hinged on the mentor mother model.

4.4 DSD for Special Groups

- ***Sero-discordant Partner***: HIV negative partners of PMTCT clients will require the following differentiated services:
  - Pre-Exposure Prophylaxis (*See sub section 7.2 in the National HIV treatment guideline 2020*)
  - STI Screening and management. (*See sub section 7.8 in the National HIV treatment guideline 2020*)
- ***Pregnant HIV Positive Key Population***: These groups of clients, require an array of services including:
  - STI screening and treatment
  - Substance use assessment and management
  - Psycho-social and Mental Health support.

See Chapter Seven of the 2020 National HIV Guidelines on HIV Prevention Treatment and Care for Details.

CHAPTER 5: DIFFERENTIATED SERVICE DELIVERY MODELS FOR CHILDREN

5.1 Introduction

Differentiated ART (DART) service delivery models for a child should align, if possible, with that of the mother or the caregiver (if also on ART). There are expected changes in a child's life within the space of three months including but not limited to physical, psychosocial, and reproductive changes. It is therefore imperative that children should be enrolled into community-based DART from five (5) years and reviewed at the primary treatment facilities not longer than every three (3) months in any case. However, if at any point after enrollment the criteria for eligibility for community-based DSD are not met, the child is said to be unstable for devolvement and should be promptly referred back to the facility of primary treatment for review and management.

Packages of Care

Children come into care either as clinically 'Well/Stable' or with 'Advanced HIV Disease (AHD)'. Services should be provided based on these categories as shown in the Figure 5.1 below.

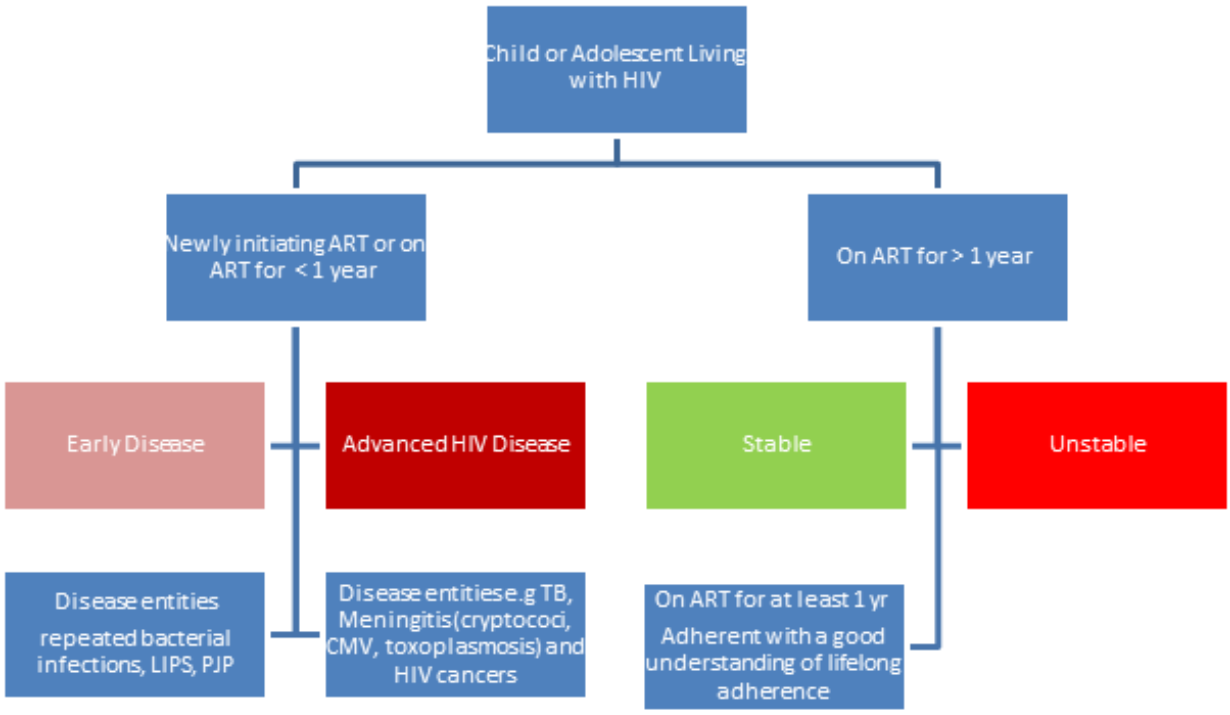


Figure 5.1: DSD Package of Care for Children

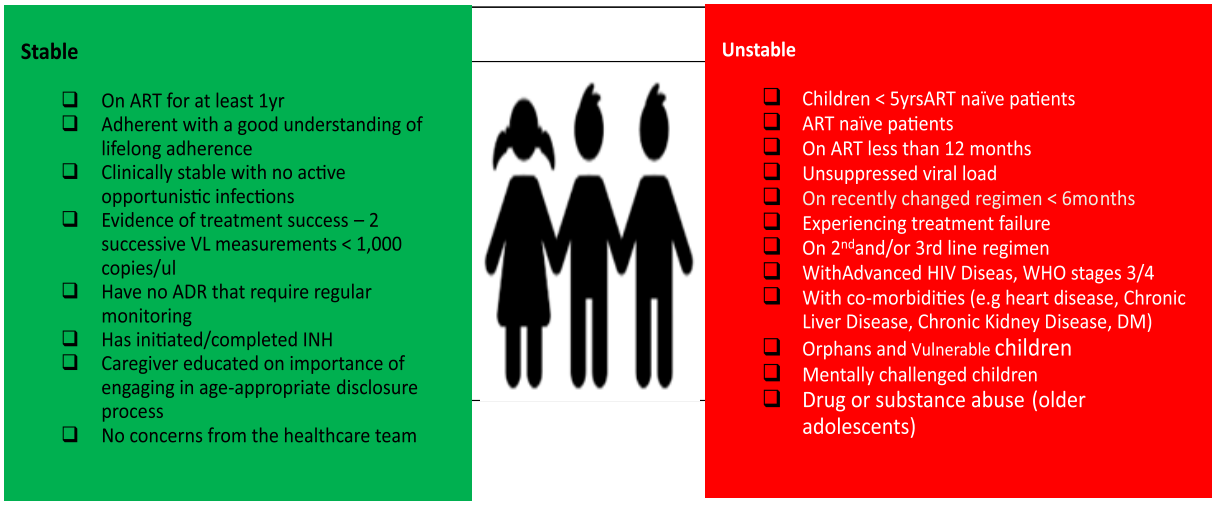


Figure 5.2: Stability Criteria for Children

5.2 Models of Care for Children and Adolescents

The models of care for children and adolescents are:

1. Health Care Worker managed groups
2. Client managed groups
3. Facility-based
4. Community-based

Of these, the family model of care which is a component of both facility and community individual models is key to the care of children and adolescents who are stable and have been devolved. For detailed description of family model of care and other models – see chapter 2 (section 2.3)

Differentiated Service Delivery Models (DSD) for Children and Younger Adolescents (up to 14 years)

All children below five (5) years should not be devolved for HIV services. However, children above five years (5) who are clinically stable and fulfil the criteria for stability (Table 5.1) should be considered for devolvement to the community. Such children should be devolved into models that align with those of their mothers or caregivers where applicable. The children in this age group should be closely monitored and promptly referred back to facility of primary care if found unstable. Multi-months dispensing (MMD) if applicable should not be for more than 3 months.

Table 5.1: Differentiated Service Delivery Models (DSD) for Children and Younger Adolescents (up to 14 years)

Children and Younger Adolescents (up to 14 years)						
Building block	**MMD**	**Weekend/Public holiday Clinics**	**School Holiday Clinic**	**Child/teens club**	**Family Model of Care**	**Community** Community ART groups
WHO	HCWs*	HCWs	HCWs	HCWs	HCWs, parent/caregiver lay workers, counsellors	HCWs, lay workers, counsellors
WHAT	Provision of ART refills	Provision of comprehensive one- stop care, including clinical checks, ART refills. May be provided to groups or individuals	Provision of comprehensive one-stop care, including clinical checks, ART refills. May be provided to groups or individuals	Provision of comprehensive one-stop care, including clinical checks, ART refills. Provided to peer groups	Provision of comprehensive one-stop care, including clinical checks, ART refills. Provided to family groups	Provision of screening, ART refills, counselling, clinical checks
WHERE	Facility Community	Facility	Facility	Facility	Facility	Community mobile clinic
WHEN	Every 3 months	Weekends (frequency may follow refill or clinical check schedule and may be every 3 months when combined with MMD)	Scheduled for every 3 months during school holidays	Frequency may follow refill or clinical check schedule (may be every 3 months when combined with MMD)	Frequency may follow refill or clinical check schedule (may be every 3 months when combined with MMD)	Monthly

*HCWs can include Physicians, Nurses and Pharmacists, Lay Workers, Counsellors, CHEWs, Mentors, and Expert Clients

DSD Service Packages for Children and Young Adolescents (up to 14years).
The three major packages for DSD are described below:

Table 5.2: DSD Service Packages for Children and Young Adolescents (up to 14years)

	Clinical Consults	ART refill	Ancillary Services
WHO	**HCW	HCW	HCW
WHAT	Clinical consults (including TB screening and other OIs) Screen for AHD	ARVs refill OIs prophylaxis (e.g., CTX, INH)	Age-appropriate psycho-social services, disclosure, adherence and nutritional counseling, immunization services Lab. investigations
WHEN	No longer than 3 months interval	Aligned with the frequency of clinical consults*	At every contact with the mother, caregiver of client or with the client/patient (children & Adolescents) where applicable
WHERE	Facility	Facility	Facility, community, home

**The clinic consults of the parents or caregivers should align with the children*
***HCW: Clinicians, Nurses, Pharmacist, Counsellors, and other prescribing health worker*

5.3 Special Scenarios

Children of KP, incarcerated children, those internally displaced, mentally challenged and in boarding schools should also be categorized as stable or unstable based on the criteria listed above (Figure 5.2). Devolvement will also depend on the best suited model for such children in view of their circumstances. Provision should also be available for their caregivers, lay providers, and school matrons to pick up their ART drug refills. Clinical consults for those in boarding schools should be aligned as much as possible with school holidays (*see the National Guidance for HIV Service Delivery in the Context of COVID-19 Pandemic)*

CHAPTER 6: DIFFERENTIATED SERVICE DELIVERY MODELS FOR ADOLESCENTS AND YOUNG PEOPLE

6.1 Introduction

Adolescents and young people (AYP) are often grouped with children or adults even though they face unique issues. They desire to be treated with respect and have their confidentiality protected. Adolescents living with HIV often encounter additional challenges due to loss of parents or other relatives, delayed onset of puberty, difficulty coping with ART adherence, disclosure, stigma, and sexual relationships. Therefore, there is a need to deliberately tailor HIV service delivery to suit the distinct and diverse needs of AYP in Nigeria.

Criteria for Adolescent DSD

Adolescents can successfully be differentiated to facility or community models of DSD based on the earlier criteria for stable and unstable clients (see Figure 5.2).

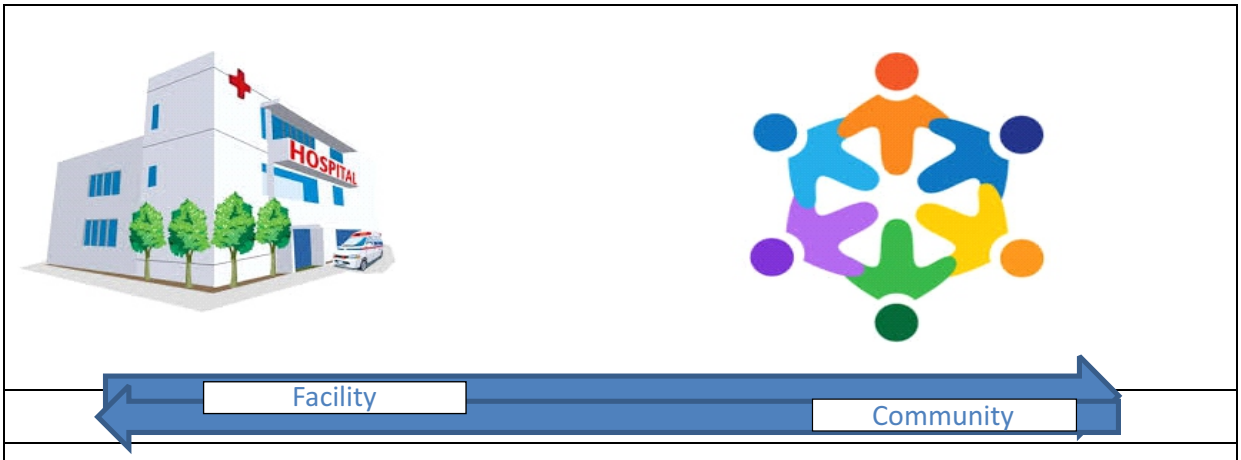
6.2 Transition from Adolescent to the Adult clinic

Transitional care refers to the actions of health care providers designed to ensure the coordination and continuity of services during the movement between health care facilities and or health care providers. The goal of transition is to prepare the adolescent and young adults with HIV receiving child-centred services for adult-oriented health care services through an intentional planned movement that preserves psychosocial and clinical gains. The transitions from adolescent to adult clinics entails different phases, elements, and components.

Phases, Elements and Components of Effective Transition

Figure 6.1: Phases, Elements and Components of Effective Transition of Adolescents to the Adult Clinic

Table 6.1: Building Blocks for Children and Adolescents



Building block	MMD	Weekend/Public holiday Clinics	School clinic	Adolescent support group/ club	Family Model of Care	Community
WHO	HCW	- HCW - Lay providers, - Counsellors†		- HCW - Lay providers - Peer support member - Counsellors	- Parent/caregiver - Lay provider - Counsellors	- HCW - Lay providers - Counsellors - Peer support member
WHAT	Provision of ARV refills	- Clinical checks - ARV refills - Lab tests/ clinical monitoring - Psychosocial support - Treatment of OIs - Adherence - Nutritional support - Peer support - Linkage to livelihood opportunity and vocational trainings	- Clinical checks - ARV refills - Linkage to facility	- ARV refills - Provide support to peer groups - Linkage to facility	- ARV refills - Provide family support - Adherence - Nutritional support - Psychosocial support - Linkage to facility	- Clinical checks - ARV refill - Provision of screening, counselling, - Adherence - Nutritional support - Psychosocial support - SRH - Linkage to facility

WHERE	Facility / Community	Facility/ Community	Facility	Facility/Community	Home	- Community mobile clinic - Community based ART Distribution group managed by adolescent peer - Community pharmacy - Youth clubs,
WHEN	*Every 3 months	Weekends/Public holidays. Every 3 months	Scheduled for every 3 months during school holidays	Every 3 months	Every 3 months	Every 3 months

** MMD for children and young adolescents (below 14 years) should not be more than 3 months.*

The community-based DSD models should be implemented primarily for well adolescents, however, adolescents with AHD and those that are unstable should receive a comprehensive package of care at the facility. For stable adolescents, ART refills should be done every three to six months as indicated and clinical reviews are done at each ART refill visit. ART refills can also take place at the adolescents' clubs or support group meetings. Unstable adolescents should be provided with a comprehensive package of care and managed in the health care facility until stability criteria are met before devolvement. Stable adolescents in the community should receive ARVs through the various distribution groups and monthly home visits are conducted by community volunteers/group leaders. However, when a stable adolescent in the community becomes clinically unstable, he/she should be referred back to the facility for intensified care.

Table 6.2: Differentiated Service Delivery Packages for Older Adolescents (15-19 years) and Young Persons

	Clinical Consultations	***Refills (ART, CTX, INH)***	***Laboratory Test***	***Adherence & other support services***
WHEN	**3-6 monthly as indicated based on stability criteria.	At every visit	VL yearly for the suppressed	At every visit
WHERE	Facility/Community	Facility/Community	Facility laboratory	Facility /Community/home/clubs/support groups
WHO	HCW	HCW/Lay providers/Peer support group	HCW, Lay providers (Rapid test)	HCW/lay providers/ peer support group members
WHAT	• Routine care (Physical examination, CTX, ART, OI screening) • Psychosocial support on stigma • STI screening • SRH services • Dedicated clinics	*ART refill*	• VL at 6 months, 12 months • CD4 • TB screen and other OIs • STIs • Other tests as guided by clinical assessment	• Disclosure • Adherence • Psychosocial services • Health education, counseling, and provision of SRH • Career development – schooling, vocational training, income generating activities

**up to 6 months MMD based on stability criteria

CHAPTER 7 : DIFFERENTIATED SERVICE DELIVERY MODELS FOR ADULTS

7.1 Introduction

Differentiated Service Delivery for adult clients cut across the entire continuum of HIV Care and Treatment. Adults who tested positive for HIV regardless of testing point should be re-tested to confirm the HIV status at the point of enrolment. Various packages of care exist for all categories of adults living with HIV. At enrolment, adults are categorized as either clinically well or with advanced HIV disease (AHD).

7.2 Package of Care

Initiation of ART should be preferably same-day or within one week of diagnosis of HIV infection in line with the test and treat strategy. However, patient's informed consent should be established before starting ART. Clients who are not willing and ready to start ART should receive on-going counselling and education to promote ART initiation and retention in care.

- Counseling and education should be intensified within the first two weeks to one month by scheduled phone calls and the client should be provided with clinic contact numbers for further clarification.
- Clients should be staged using the WHO clinical staging criteria
- Clients should be clinically screened for OI's and other co-morbidities (*Refer to section 8.1.4 of the 2020 National Guidelines for HIV Prevention Treatment and Care).*

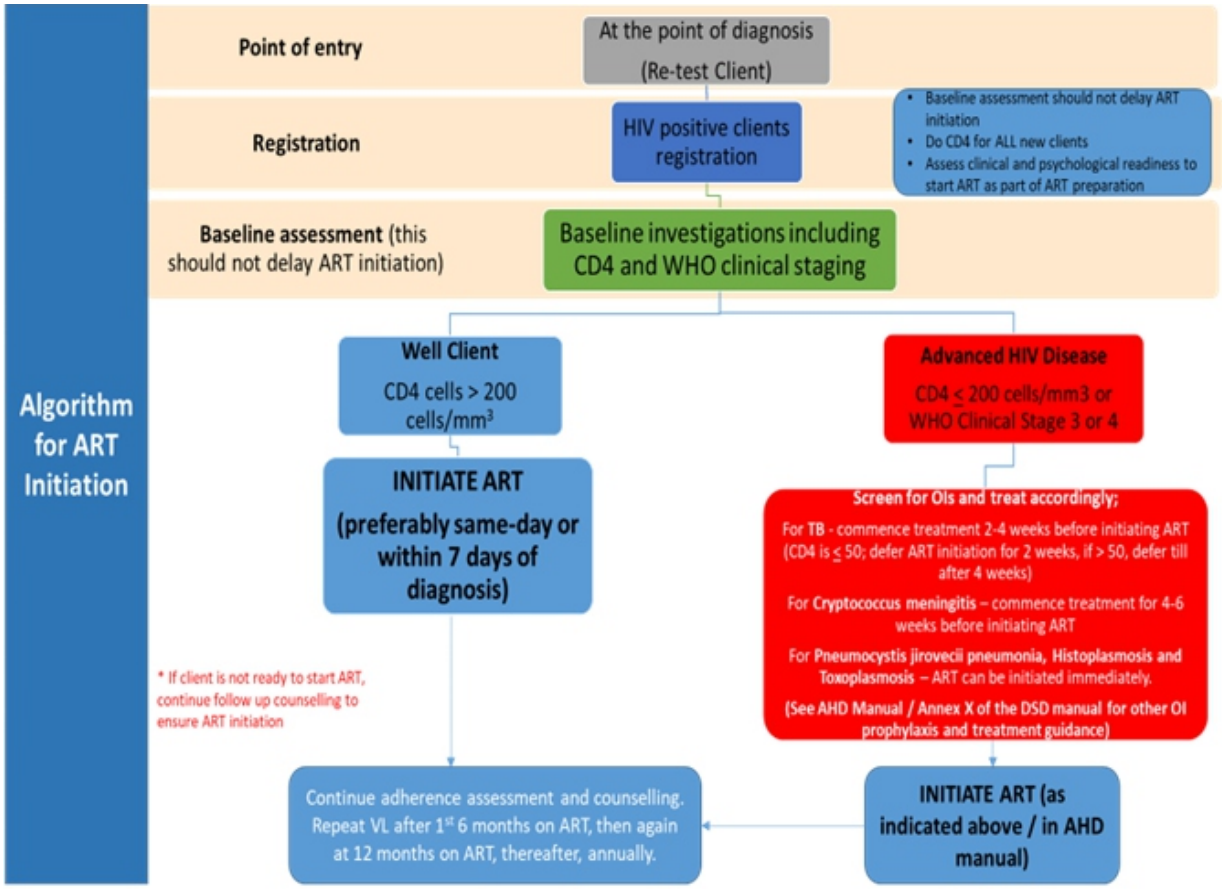


Figure 7.1: Algorithm at ART Initiation

Devolvement into DSD Models for Clients Who Have Received ART for One Year or More
All adults who were assessed and found to be stable after two consecutive suppressed VLs should be devolved to less intensive models of DSD while unstable clients would be devolved to more intensive models of DSD.

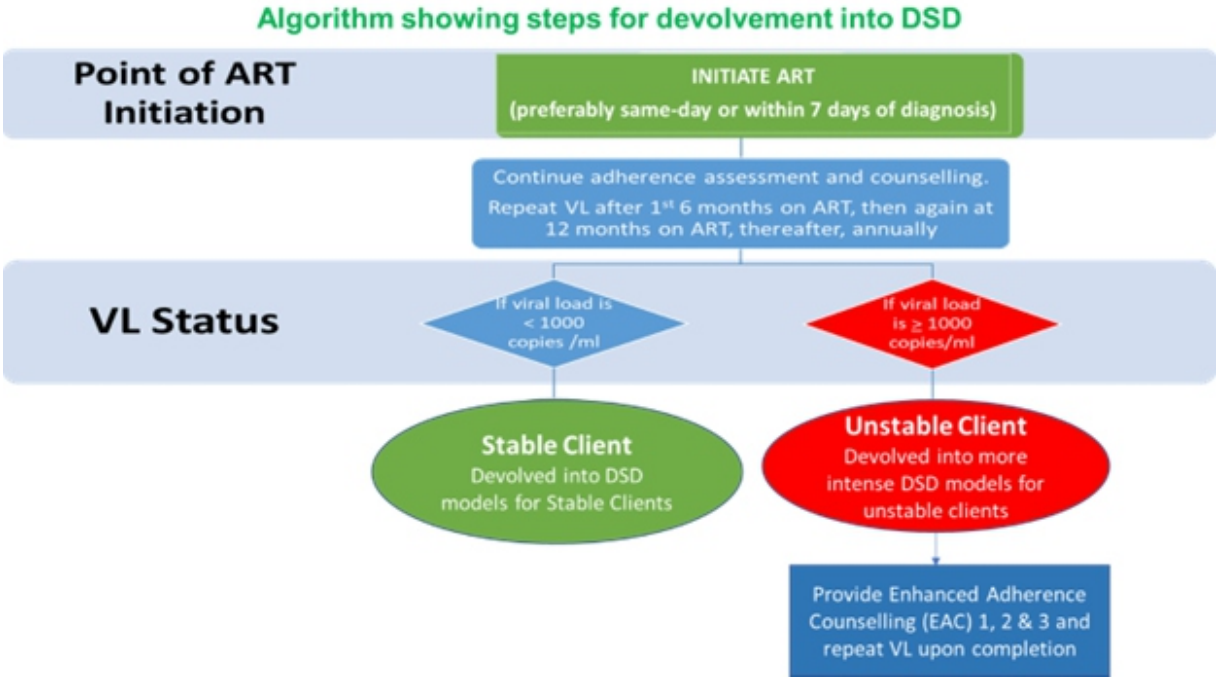


Figure 7.2: Algorithm for Devolvement to DSD Models

Table 7.1: Categorization of Adult PLHIV at the Point of Diagnosis and Recommended Packages of Care

	What	When	Who	Where
WELL CLIENT	▪ Clinical consultation ▪ ART Refill ▪ **Laboratory monitoring tests ▪ Ancillary services	*Monthly for the first 2 months, thereafter every 2 months for the first year (for both clinic consultation and ART refills)	▪ Client with WHO clinical stage 1 or 2 or CD4 count > 200cells/mm^3 ▪ Healthcare providers trained to provide ART services	Approved health facilities
CLIENT WITH ADVANCED HIV DISEASE	▪ Clinical consultation ▪ ART Refill ▪ **Laboratory monitoring tests ▪ ***Ancillary services	* Weekly/Bi-weekly in the first 1 month (for clinical consultation) Monthly for the first 2 months, thereafter every 2 months for the first year (for ART refills) Every week for the first 1 month At every clinic contact subsequently	▪ A Client with WHO clinical stage 3 or 4 or CD4 count <200cells/mm3 ▪ Healthcare providers trained to provide ART services	Approved health facilities

- Adherence counselling / support and clinical screening for TB should be done at every clinic contact.
- *The client should be informed to return to the health facility IMMEDIATELY if s/he develops adverse drug reaction(s) or has any complaints.
- **Laboratory monitoring tests - may differ according to the level of the health care facility and should be done according to the schedule approved in the National Guidelines (see Appendix 1). Additional tests may be indicated based on diagnosed OIs.
- ***Ancillary services e.g., psycho-social services, intensified adherence support, chronic care
  - For well clients - at every clinic contact or as required.
  - For AHD clients – every week in the 1st month, thereafter at every clinic contact.

Table 7.2: Packages of Care for Stable and Unstable Adult Clients

Package of Care	Stable Client (less intensive)	Unstable Client (more intensive)
Frequency of clinical consult	Less frequent – 3 to 6 monthly	Monthly for 3 months or as indicated;
Frequency of ART Refill	Less frequent – 3 to 6 monthly	Monthly for 3 months; subsequently 2 monthly or as indicated
Frequency of monitoring tests and scope	VL monitoring annually Cessation of CD4 count monitoring if viral load testing is available	VL monitoring at the end of 3 months after EAC for unsuppressed patients; subsequently according to National guidelines
Frequency of ancillary services such as: • **psycho-social services** • **intensified adherence support** • **chronic care**	Aligned with clinic visit and ART refill	Monthly for 3 months or as indicated; subsequently aligned with clinic visits

Table 7.3: Differentiated ART Delivery Models for Stable Adult Clients

FACILITY-BASED	COMMUNITY-BASED
❑ Fast-track ▪ Individual Fast-track ▪ Group Fast-track ❑ Facility ART group ▪ Healthcare Worker-led ▪ Support group-led ❑ Decentralization (Hub and Spoke) ❑ *After hours/weekend services	❑ Community Pharmacy ❑ Community ART Refill Group ▪ HealthCare Worker – led ▪ Client-led ❑ Home delivery ❑ Courier services
Multi-month Dispensing (refers to ART refills and cuts across both facility-based and community-based settings)	

** This model is directed at men and any other sub-population as indicated.*

Table 7.4: Facility-based ART Delivery Models for Stable Adult Clients

	WHAT	WHEN	WHO	WHERE
Fast-Track **for individuals and groups**	Clinic consultation	6-monthly	Trained Health care worker (Physician, Nurse)	Health Facility
	ART refill	3-monthly	Trained Health care worker	Health Facility
Multi-month Dispensing	ART prescription and refill	3-6 monthly	Trained Health care worker	Health Facility
Facility ART group ▪ **Health Care Worker-led**	Clinic Consultation, ART Refill, Adherence counselling, Ancillary services	6-monthly (unless otherwise indicated by the prevailing health condition)	Trained Health care worker (Nurse, Pharmacy personnel, Adherence counsellor)	Health facility
▪ **Client-led (support group)**	ART refill, Adherence counselling	3-monthly	ART support group	Health facility
***After-hours/weekend services**	Clinic Consultation, ART refill, Adherence counselling, Ancillary services	3-6 monthly	Trained Health care worker (Physician, Nurse, Pharmacy personnel, Adherence counsellor)	Health facility
Decentralization (Hub and Spoke)	ART refill, Adherence counselling, Ancillary services	Monthly, 3-monthly,	Other Health care workers, (Nurses, Pharmacist, Adherence counsellors, etc	Primary, Secondary or Tertiary health facilities

❑ **This model is directed at men or any other sub-population as indicated*

Table 7.5: Community-based ART Delivery Models for Stable Adult Clients

	WHAT	WHEN	WHO	WHERE
Community Pharmacy	ART refills, Adherence counselling	3-monthly	Community pharmacist	Community
Community ART Refill Group ▪ **Client-led** ▪ **Health Care Worker-led**	ART refill, Adherence counselling ART refill, Adherence counselling, Ancillary services	3-monthly 6-monthly	ART support group Trained Health care worker	Community Community
Multi-month Dispensing	ART prescription and refill	3-6 Months	Trained Health care worker (Physician, Pharmacy personnel, Nurse)	Community

7.3 Integrated Service Delivery

This involves the management and delivery of health services such that clients receive a continuum of preventive and curative services according to their needs over time and across different levels of the health system.

In the context of DSD in HIV care, this can be described as "multi-purpose service delivery point(s)"– either from the client perspective where the client is able to receive coordinated care rather than having separate visits for separate interventions (where feasible) or where a range of services for a catchment population is provided at one location and under one overall manager e.g. One-Stop Shops. **(*WHO Technical Brief No. 1*) Refer to the National Treatment Guideline for more information.**

7.4 Community Pharmacies

Community Pharmacies are privately owned establishments that serve societal needs for both drug products and pharmaceutical services. They deal with different aspects of patient care, dispensing of drugs and advising patient on the safe and rational drug use. Their professional activities also include counseling of patients, dispensing of prescription and non-prescription drugs, drug information to health professionals, patients and the general public, and participation in health-promotion programmes. They maintain links with other health professionals within the health care system.

Community Pharmacy Building Blocks

	ART Refills	Clinical Consultations	Psychosocial support
WHEN	Every 3 months	Every 6 months	Every 3 months
WHERE	Registered Community Pharmacies	Health facility	• Community Pharmacy • Health facility
WHO	Community Pharmacist	Clinician	• Community Pharmacist • Healthcare worker
WHAT	ART Refill	Patients are reviewed for improvement in clinical outcomes. • Take relevant drug history • Assess for ADR • TB screening • Medication adherence	Counselling to address stigma and other barriers to adherence

Figure 7.3: Community Pharmacy Building Blocks

CHAPTER 8: SERVICE DELIVERY MODELS FOR KEY POPULATIONS

8.1 Introduction

Key populations are defined groups who due to specific high-risk behaviors are at an increased risk of HIV infection irrespective of the epidemic type or local context. Also, there are often legal and social issues that increase their vulnerability to HIV. Key populations are important to the dynamics of HIV transmission and in the control of the epidemic.

Key population groups identified for DSD include:

- Female Sex Workers (FSW); Brothel and Non-Brothel-Based
- Men who have Sex with Men (MSM)
- People who Inject Drugs (PWID)
- Transgender
- Persons in closed settings

Other vulnerable populations who are not key populations include Internally Displaced Persons (IDPs), mobile populations/migrants, clients of sex workers, women, and youths.

The following options should be considered for ART service delivery for all KP groups:

- Initiation of ART and continued service delivery at one stop shops (OSSs)
- Initiation of ART and continued service delivery at the facility (KP-friendly)
- Initiation of ART at the facility and continued service at the community (OSS)

Ancillary services required by KPs include legal support, gender-based violence interventions, Harm reduction interventions, mental health and psychosocial services (MHPSS). In all KPs, assessment of substance use should be considered when initiating ART. This can be done at both the community and facility level. This is important to understand potential drug interactions and ensuring client stability.

Key Populations on opioid-dependent treatment can continue to receive ART at the community level (OSS) except for newly diagnosed clients. Such clients can be initiated at the same facility if the ancillary services are available or referred to the nearest OSS or facility with such ancillary services. There have been concerns that hormonal therapy use by transgender persons interact with the ARVs. This potential for drug interaction may require more intense services and adjustment of drug regimen where required.

8.2 Community and Facility Models of DSD for Key Populations

One Stop Shopzs (OSSs): The OSS model is designed to provide comprehensive HIV treatment and prevention services to key populations. Other services provided at the OSS include harm reduction services for PWID, human rights/paralegal services, community center, recreational activities, mental health services, screening for opportunistic infections e.g., TB, cervical cancer screening. Some selected OSSs serve as hubs for distribution of commodities to other OSSs and service delivery points in the community. Service providers at the OSSs are KP community members and medical professionals.

Focal Service Providers (FSP): are HCWs who reside primarily in the community and work with CBOs to provide optimal HIV services to KPs. For details see Table 8.1 below.

Community ART Team (CART): The movement of the CART team into the community ensures that the range and quality of services provided at the OSS is also available to clients during mobile ART enrollment, refills, and outreaches. Data generated from the range of services is transmitted to the OSS.

Registered Community Pharmacy: The activities undertaken are HIVST, adherence counselling, ART refills, and ADR monitoring. See Table 8.1 below for details

Peer led/Support group meetings: This is a community-driven model that increases the ease of tracking clients. Experience sharing is a key component of this model.

Table 8.1: DSD Models for KPs – Community

WHERE SERVICE IS DELIVERED	COMMUNITY LEVEL				
Service Delivery Model	**One Stop Shop**	**Community ART team**	**Focal Service Provider**	**Community Pharmacy**	**Peer Support Group**
WHO	- HCPs* - Paralegals - Human rights lawyers - Counselor testers	- Clinicians - Pharmacists - Nurses - Lab scientists	- Nurses - Community health workers	Registered pharmacists	- PLHIV - Case managers - HCPs - Adherence counselors
WHAT	- HTS - ART enrolment/ initiation - ARV refills (MMD3-6), - STI screening - GBV interventions - MHPSS - Legal support services - Harm reduction - Cervical cancer screening and treatment - TB screening and treatment - Hepatitis screening - PrEP and PEP - TPT/CPT - Cryotherapy	- HTS - ART enrolment/ initiation - ARV refills (MMD 3-6) - STI screening/ diagnosis - GBV interventions - Harm reduction - TB screening - PrEP and PEP	- HTS - ART enrolment/initiation - ARV refills (MMD 3-6) - STI screening/ diagnosis - GBV intervention - Harm reduction - TB screening - PrEP and PEP.	- HTS (Self testing) - PrEP and PEP - ARV refills	- ART enrolment/initiation - ARV refills (MMD 3-6) - STI screening /diagnosis - GBV intervention - TBT/CPT - Harm reduction
WHERE	OSS	- Hot spots - Brothels - Clusters	- Hot spots - Brothels - Clusters	- Hot spots - Brothels - Clusters	- Community centers - Hot spots - Brothels - Clusters
WHEN	Walk in clients	At the point of contact.	At the point of contact.	At the point of contact.	At the point of contact.

*HCPs: Clinicians, pharmacists, lab scientists, nurses, psychologists, adherence counselors, retention officers, medical records, case managers.

Table 8.2: DSD Models for KPs – Facility

WHERE SERVICE IS DELIVERED	FACILITY LEVEL		
Type of Health Facilities	**Tertiary**	**Secondary**	**Primary/peripheral**
WHO	- HCPs - Gender focal persons - Care and support officers	- HCPs - Care and support officers	- HCWs - Care and support officers
WHAT	- ART enrolment/ initiation - ARV refills (MMD 3-6) - STI screening/diagnosis - GBV interventions - MHPSS - Cervical cancer screening and treatment - TB screening and treatment - Harm Reduction - Hepatitis screening - PrEP and PEP - TPT/CPT - Cryotherapy - Management of AHD	- ART enrolment/ initiation - ARV refills (MMD 3-6) - STI screening/diagnosis - GBV intervention - Harm reduction - TB screening - PrEP and PEP - Cryotherapy - Management of AHD	- ART enrolment/ initiation - ARV refills (MMD 3 -6) - STI screening - TB screening - PrEP and PEP
WHERE	Facility	Facility	Facility
WHEN	At diagnosis and as indicated	At diagnosis and as indicated	At diagnosis and as indicated.

KP-friendly Facilities: are health facilities that have trained staff to provide services for KPs (*See Annex III for more details on the criteria for identification of a KP friendly health facility)*.

Stability Criteria for Key Populations

Table 8.3: Stability Criteria for Key Populations

CRITERIA	STABLE (Less Intense)	UNSTABLE (More Intense)
Duration on ART	Consistently on ART for at least 6 months	• ART naïve • On ART less than 6 months
Clinical status	Clinically stable with no opportunistic infections, co -morbidities or current illnesses	• Advanced HIV disease (WHO stages 3-4) • Newly diagnosed Pregnant and breastfeeding FSW/female PWID. • With co -morbidities (e.g heart disease, Chronic Liver Disease, Chronic Kidney Disease, Diabetes Mellitus) • Has suspected OIs e.g TB, Toxoplasmosis, Cryptococcal meningitis • Mentally challenged
Adherence	Adherent with optimal understanding of lifelong adherence	Poor adherence
Treatment	• Evidence of treatment success – two consecutive viral load measurements <1,000 copies/ul • Has initiated/completed TPT • Has no adverse drug reaction	• Transgender on hormonal therapy • Opioid-dependent or receiving drug - dependence treatment services.
Monitoring	• Where viral load is available, CD4 count monitoring is unnecessary. • Suppressed viral load <1,000 copies/ml. • In the absence of viral load monitoring, rising CD4 cell counts or CD4 counts above 200 cells/mm3	• Close monitoring necessary at the facility level or OSS • CD4 count may be required • Unsuppressed viral load

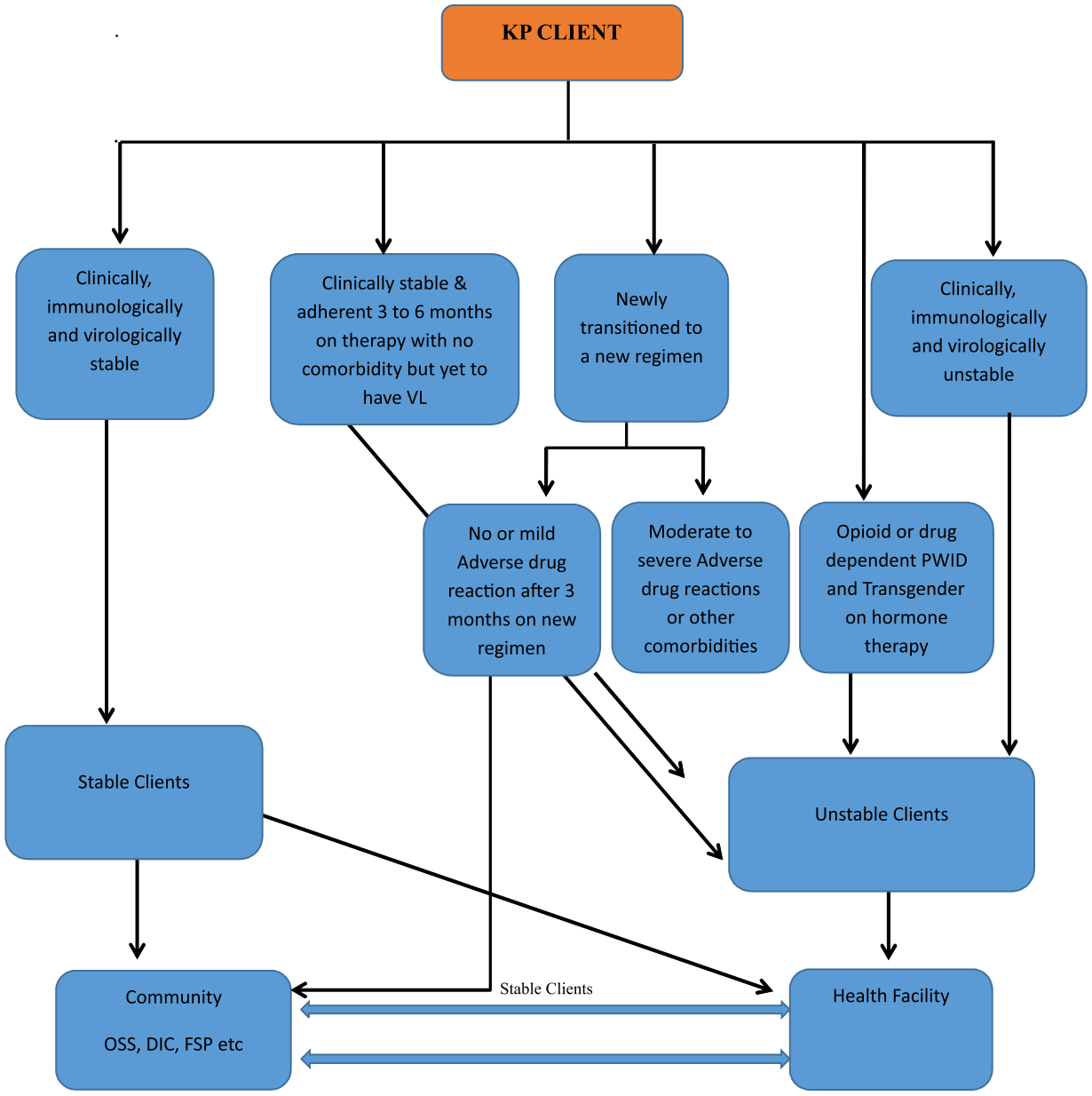


Figure .: Flow Chart for DSD Mechanisms for Key Populations

Unstable Clients

Health facility should elicit response from KPs being initiated on ART to determine injection drug use/substance use dependence or Transgenders on hormonal therapy.

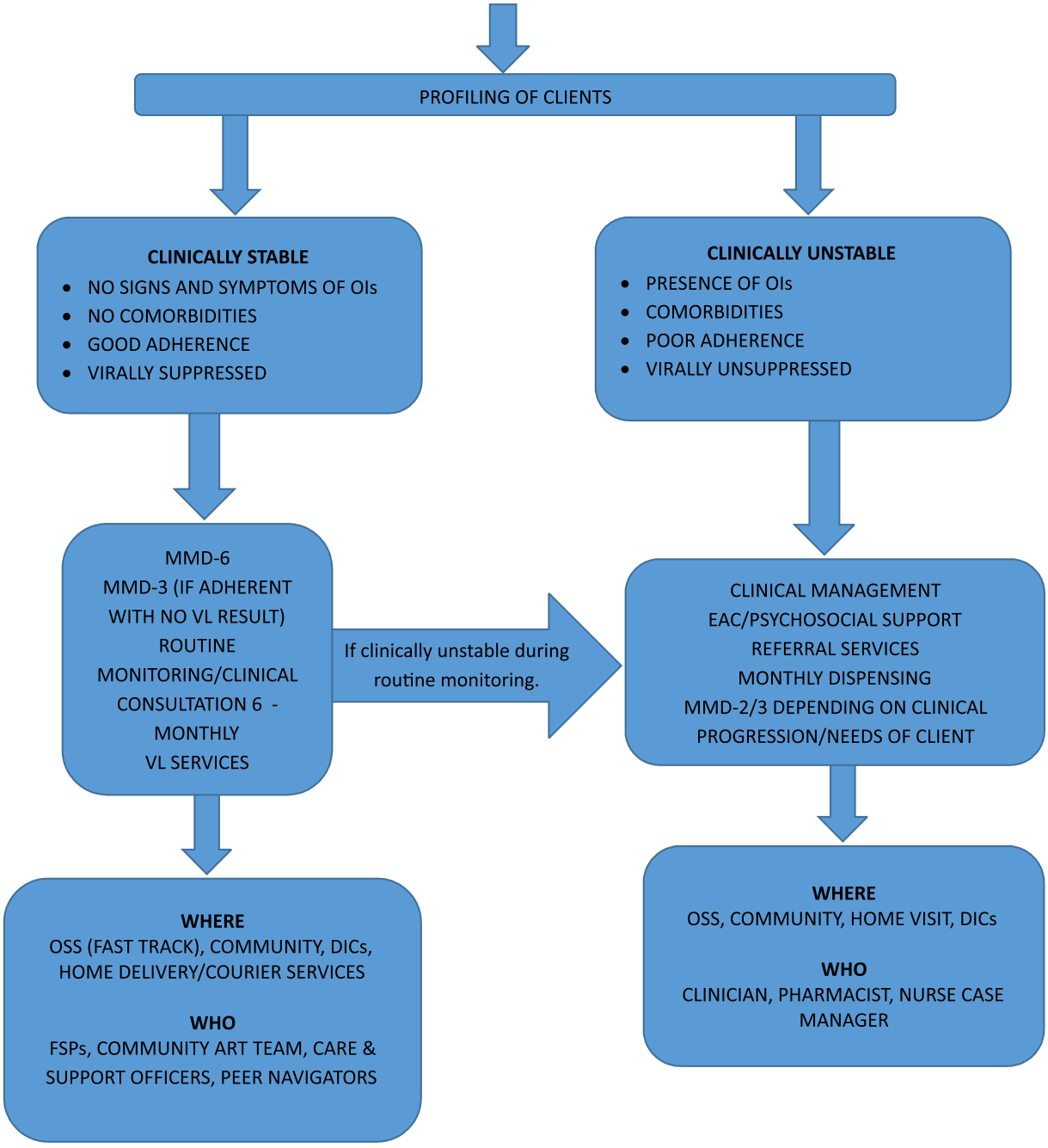


Figure 8.2: Flow Chart for Differentiated ART Delivery and Multi Month Dispensing

CHAPTER 9 : LABORATORY SERVICE PACKAGES FOR DIFFERENTIATED SERVICE DELIVERY

9.1 Introduction

The diagnosis and monitoring of HIV and co-morbidities is an essential component of the continuum of care. Differentiated service delivery seeks to create a client-centered diagnostic process that suits all sub-populations. Under the differentiated service delivery models, laboratory services can be attuned to be more responsive and focused on providing tailor-made services that will improve the outcomes for all sub-populations.

For optimal service delivery, the laboratory workflow will be divided into two categories, based on age as follows:

- Persons less than two (2) years of age
- Persons older than two (2) years of age

Both age categories will be offered laboratory packages of care based on client categorization, as follows:

- Package of care for well patients
- Package of care for AHD patients
- Package of care for stable patient after one year of treatment
- Package of care for unstable patients after one year of treatment

9.2 Laboratory Service Packages for Persons Less Than Two Years

Clients in this category consist of the following:

❖ All HIV Exposed Infants
❖ HIV Positive Infants

Table 9.1: Laboratory Packages for Children Less Than 2 years

Package of care	WHO	WHERE	WHAT
Package of care for well patient	• Health Care Providers • Technician	• Facility	• EID • CD4% and other ancillary tests
Package of care for AHD patients	• Health Care Providers • Technician	• Facility	• EID • CD4% • Screening for OIs and other ancillary tests
Package of care for stable patients after one year of treatment	• Health Care Providers • Technician	• Facility	• VL 6 months after ART initiation
Package of care for unstable patients after one year of treatment	• Health Care Providers • Technician	• Facility	• VL 6 months after ART initiation • CD4% • Screening for OIs

Table 9.2: Laboratory Packages for Children Older Than 2 years

Package of care	WHEN	WHERE		WHO		WHAT	
		Facility	Community	Facility	Community	Facility	Community
Package of care for well patient	• After 6 months of initiation of ART, 12 months and yearly	Laboratory	OSS Centers	• Health care providers • Technician	• Health care providers • Technician	• VL • CD4	• Point of Care/Near Point of Care for VL after 6 months of ART initiation • POC for baseline CD4
Package of care for AHD patients (WHO stage 3 and 4, CD4 ≤200 cells/mm^3)	• At contact • At 6 months, 12 months and yearly	Laboratory	OSS centers	• Med Lab. Scientist • Technician	• Med Lab. Scientist • Technician	• VL • CD4 • GeneXpert • MTB/RIF (Sputum) • TB Lateral Flow Lipoarabinomannan (LF-LAM), • Blood, serum or CSF CrAg • Indian ink staining and culture • Serum or CSF Torch Profile • Histoplasma Urinary Antigen screening	• POC for VL/CD4 • TB-LAM • CrAg test
Package of care for stable patients after one year of treatment	Yearly	Laboratory	OSS Centers	• Med Lab. Scientist • Technician	• Med Lab. Scientist, • Technician,	• VL • CD4	• Point of Care /Near Point of Care for VL after 6 months of initiation of ART • POC for baseline CD4

Package of care for unstable patients after one year of treatment (VL ≥1000cp/ml, CD4 ≤200 cells/mm^3)	3 monthly until stable	Laboratory	OSS centers	• Med Lab. Scientist • Technician	• Med Lab. Scientist, Technician,	• VL • CD4 • GeneXpert MTB/RIF (Sputum) • TB Lateral Flow lipoarabinomannan (LF-LAM), • Blood, serum or CSF CrAg, • Indian ink staining and culture, • Serum or CSF Torch Profile, • Histoplasma Urinary Antigen screening	Refer back to the facility

Key populations receive the same range of testing and care services (refer to existing framework as captured under Table 9.2).

CHAPTER 10 : PROCUREMENT AND SUPPLY CHAIN MANAGEMENT FOR DIFFERENTIATED SERVICE DELIVERY

10.1 Introduction

Procurement and Supply Management (PSM) for HIV programming will build on existing standard operating procedures for logistic management of health commodities to support DSD. However, it is necessary to review the HIV national supply chain systems in the context of DSD to see what adaptations are needed to enable the supply chain support DSD activities.

To implement efficient DSD models at both facility and community levels, it is essential that the national HIV supply chain takes into consideration, the following:

- The additional ARV drugs needed at pickup sites, including the provision of a safety buffer stock.
- The number of clients to be served by MMD (3- 6 months).
- The capacity of local distribution (pick-up) sites to safely and securely store and handle HIV commodities (ARVs/OIs drugs, RTKs, etc.).
- The additional reporting needed by the Logistics Management Information System (LMIS) to track the ARVs/OIs drugs and RTKs through these sites, especially at the community level.
- HIV commodities shelf-life constraints.
- The PSM logistic considerations for the other commodities (apart from ARVs) required to support DSD models.
- The need for ADR monitoring at community DSD models

10.2 Facility DSD Models and PSM

To ensure adequate stock is supplied to support facility MMD for eligible clients, the HIV commodities logistics management will be guided by the routine bimonthly report from facilities to the State Logistic Management Coordinating Unit (LMCU). The facilities are expected to:

- Use the remarks column of the bimonthly CRRF to provide relevant information including number of patients on MMD and MMD scale up plan.
- Use multi-month packs rather than monthly pack to meet the requirements for MMD as this is cost effective and more convenient for clients
- Ensure adequate storage capacity to accommodate drugs for 3-6 MMD

10.3 Community DSD Models and PSM

The Community DSD models have significant impact on the PSM and logistics mechanisms currently in use. The impact is on the immediate supply of commodities and long-term procurement plans. Proper data management is key to inform adequate commodity availability and meet the need of the model and for supply plans. Consideration will be given to waste management at the community level.

Community DSD models for PSM include:

- One Stop Shops
- Community Pharmacies
- Community Drug Distribution Centers (ART refill centers)
- Community ART groups

Table 10.1: Building blocks for Facility and Community DSD Models for PSM

Where	What	Who	When
Facilities	• Receive commodities directly from the central pool and submit their bimonthly CRRF to the NHLMIS directly or through th e LMCU. • Serve as a hub to the r egistered community pharm acies and Community ART groups. • Collect LMIS and ADR reports from the community pharmacies and given feedbacks	Pharmacist, Facility HIV logistics officer	Bi-monthly
One stop shops (Hub)	• Receive commodities directly from the central pool and submit their bimonthly CRRF to the NHLMIS directly or through the LMCU. • Acts as a hub to some other one stop shops, community drug distribution g roups and community ART groups. • Collect logistics data from the CDDGs and CAGs using the PADAF form	Registered pharmacist, HIV logistics officers, Pharm. Tech	Bi-monthly
Registered community pharmacies	Receive commodities from the hub facility and submit bi-monthly CRRF and ADR forms back to the facility	Registered pharmacist	Bi-monthly
Community Drug Distribution Points	• Receive commodities from facilities, community pharmacies and one-stop-shops and deliver to specific patients (not more than 10 patients per group) • Return commodities not delivered within 2 days • Complete appropriate documentation and feedback	Nurses, Community health workers (CHEWs)	Weekly
Community ART Groups	• Receive commodities from facilities, community pharmacies, OSSs and ARV refill centers • Return commodities not delivered within 2days Complete appropriate documentation and feedback	Peer Group, Family groups	Weekly

10.4 Commodity Distribution and LMIS Data Reporting

- Commodity distribution will be done from the hubs to the spokes.
- The facility HIV pharmacist or logistics officer will be responsible for facilitating this transfer with the help of the partners and HIV logistics officers working within the state and local government LMCUs.
- The hub site would either deliver commodities to the spoke or the spokes pick up from the hub.
- The spoke will have electronic and/or paper based LMIS tools (CRRF, ICC, R&T forms etc.) to capture data at the end of the reporting period. This data will feed into the CRRF submitted from the hub site to the NHLMIS platform.
- Documentation and feedback from CDDPs/CAGs will be done using the Patient ARV Drug Accountability Form (PADAF) presented in Annex IV
- Unusable or expired stocks should be returned to the hubs and documented appropriately.

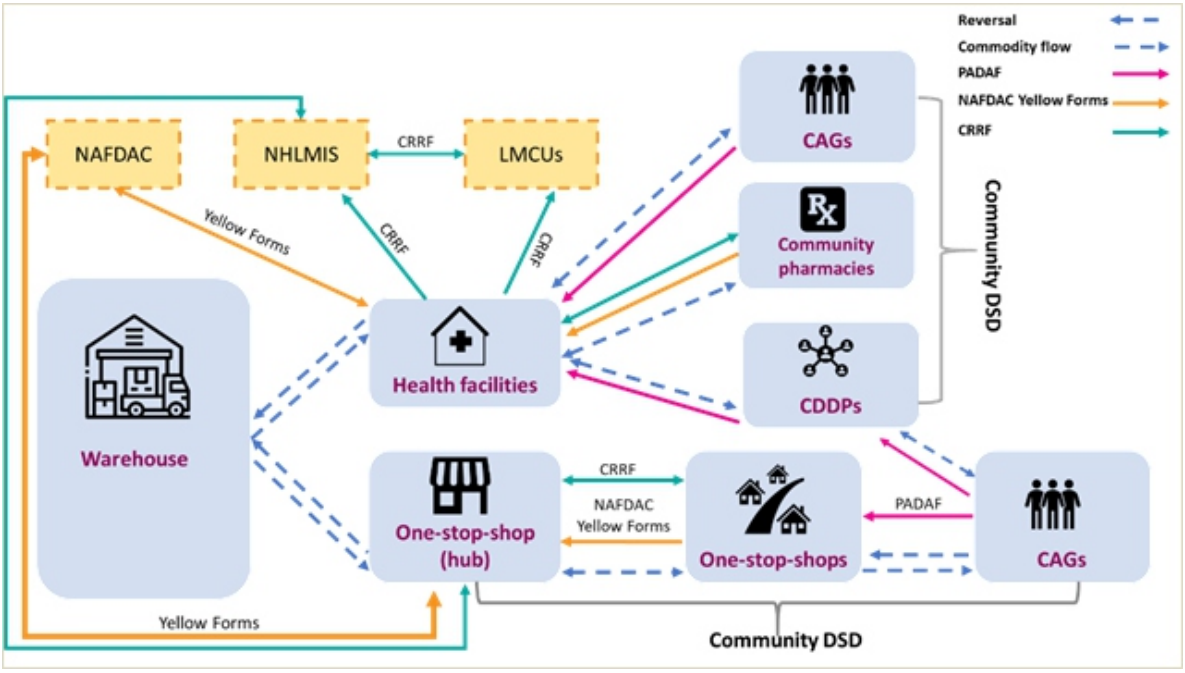


Figure 10.1: Commodity Distribution and LMIS Data Flowchart

10.5 Storage and Waste Management

- The storage condition for the commodities at the spoke level should meet standard storage protocols (refer to Logistics SOP for HIV commodities) for pharmaceuticals.
- Waste disposal entails procedures for collection, storage, and disposal of infectious waste to prevent exposure for workers, patients, and the public.
- Procedures include segregation of infectious waste, posted waste disposal guidance, and secure storage of infectious waste inside and outside the site.
- At the community level, SOPs and Job aids on waste disposal, especially for the HIV Self-Test-kits shall be made available to ensure proper waste disposal.

10.6 HIV Self Testing Logistics Management

HIV Self-Testing logistics shall follow the standard HIV Rapid Diagnostic commodities supply chain protocols, and reporting systems, as captured in the CRRF. The HIVST inventory management will leverage upon existing systems including commodity receipt, storage, and distribution to service delivery sites. Existing national inventory tools will be used to record and

report commodity management. Distribution will follow public and private sector channels through to the last mile distribution process as detailed in the National HIVST Operational Guidelines 2018.

10.7 ART Resupply/Refill in Pandemic and Emergency Situations

The National Guideline for Continuity of HIV Services in Context of Public Health Emergencies details commodity supply mechanisms in emergency situations.

- Where feasible, patients should be provided with 3 – 6 months ARVs and OIs medication to limit frequent facility visits and minimize exposure to infections in pandemics.
- In the event of supply shortage due to border closure, shipment delays etc., commodity resupply should be managed based on quantities available in the facility.
- The HIV services should be devolved to the community to limit the need for facility visits in times of pandemics or public health emergencies
- Buffer stock should be provided to support MMD in the above situations
- Dispatch riders and other third-party logistics (3PLs) shall be engaged to facilitate community and home ARV deliveries

10.8 Pharmacovigilance

The same principles of pharmacovigilance (PV) will obtain as have been clearly articulated in the National Guidelines for HIV Prevention, Treatment and Care, 2020. However, with the decentralization of ARV refills to the communities, it is important to emphasize PV for community DSD models.

- Reporting on ADRs will be done at the spokes (Community Pharmacies, OSSs) using the FMOH ADR screening form and NAFDAC ADR reporting form popularly called the "Yellow Form". These forms will be made available to the spokes by the hubs (facilities and OSS (hub))
- ADR from patients getting ARV refills through CAGs and CDDPs will be reported to the OSS or CPs linked to these points using the PADAF (Annex XX)
    - The community pharmacies and One-Stop-Shops will then document the information from PADAF in the yellow form
- The hubs will collate the yellow forms and submit to NAFDAC based on protocols detailed in the National Guidelines for HIV Prevention, Treatment and Care, 2020

CHAPTER 11 : MONITORING AND EVALUATION

11.1 Introduction

Monitoring and Evaluation (M&E) is an essential part of DSD with emphasis on clearly delineated service flows and identification of documentation points, tools, and responsible persons. This would guide data capturing, analysis and reporting, while facilitating informed decision making for the programme, enable reporting of necessary indicators, and evaluate DSD. For clarity and ease of alignment with the current National M&E Plan, M&E for DSD has adapted processes and tools for DSD monitoring, evaluation, supervision, and continuous quality improvement (CQI) systems.

11.2 Process and Documentation Flow

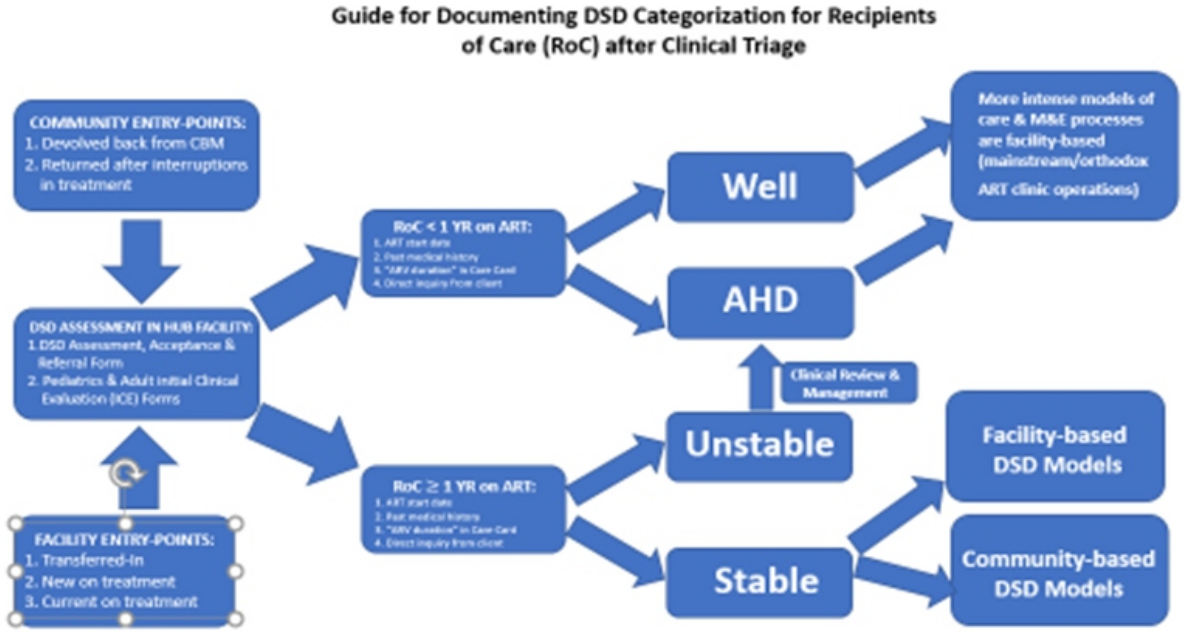


Figure 11.1: Categorization for Differentiated Service Delivery Models

The categorization structure for DSD models will ensure that all known models of practice in Nigeria are coded and thus, easy to quantify and reported for the National HIV programme. All relevant PMM and PME tools will carry this model categorization as a reference legend to guide service providers, data abstractors and researchers.

Table 11.1: Legends for Model Categorization

FB. Facility-based Models	CB. Community-based Models
FBM1 Fast-track	**CBM1** Community Pharmacy ART refill
FBM2 Facility ART group: HCW-led	**CBM2** Community ART Refill Group: HCW - led
FBM3 Facility ART group: Support group-led	**CBM3** Community ART Refill Group: PLHIV – led
FBM4 Decentralization (Hub and Spoke)	**CBM4** Adolescent Community ART/ peer-led groups
FBM5 After hours	**CBM5** Home delivery
FBM6 Weekend and public holidays	**CBM6** OSS
FBM7 Child/Teen/Adolescents club (Peer managed)	
FBM8 Mother infant pair/Mentor mother led.	

**All program reports will have data dis-aggregated by age and sex to facilitate granular reviews for sub-populations of interest*

11.3 Performance Monitoring

Table 11.2: Performance Monitoring – DSD Indicators

Category	Indicator Description
Global Indicators	❖ PLHIV who have suppressed VL: Percentage of PLHIV on ART (for at least 6 months) who have virologic suppression.
Programme Monitoring Indicators	❖ Percentage of PLHIV on ART newly enrolled in DSD models during the reporting period. ❖ Percentage of facilities providing DSD model during the reporting period. ❖ PLHIV on ART: Percentage of PLHIV receiving ART at the end of the reporting period.

See Appendix 1 for DSD Indicator Definition Table.

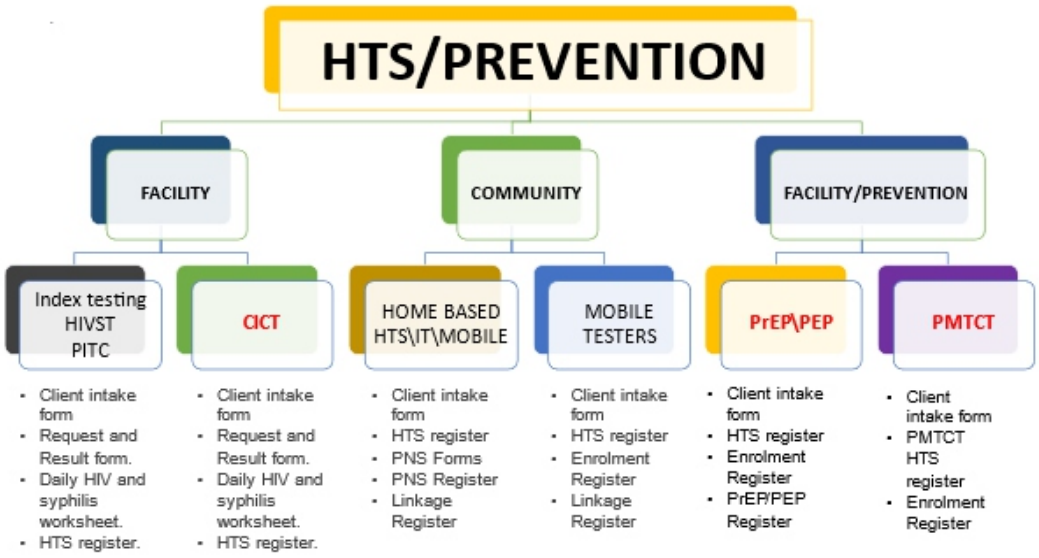


Figure 11.2: HTS Process Flow Chart

HIV Testing Services (HTS) are to be differentiated within the health facility and community as applicable. The existing tools for HTS are modified to record and report all DSD related data within the health facility and the community. Based on the available entry points that may exist in the health facilities, clients should be provided with the preferred DSD related HTS and documented in the HTS client intake form as appropriate.
At community level, the entry points could be either home-based or mobile testing. For either of the settings, clients should also be provided with the preferred model of HTS and documented in the HTS client intake form as appropriate.
The HTS registers should be used to capture data in the client intake forms in both facilities and communities for different sub-populations (see HTS chapter).
Note: The HTS tools (HTS client intake form, HTS Register, request & result forms, PNS register and referral forms) are modified to capture DSD data (health facility or community) as well as the models and should be completed by the assigned healthcare worker.

DSD for HIV Treatment and Clinical Monitoring Services

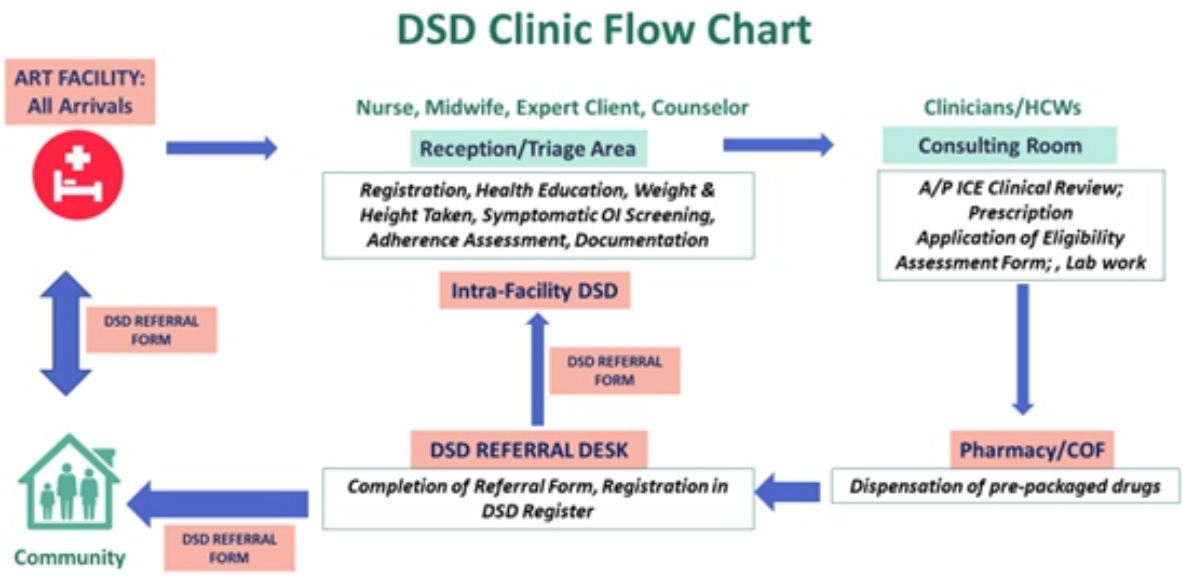


Figure 11.3: DSD Clinic Flow Chart

11.4 Documentation Processes for Tools

Documentation Processes for DSD Assessment and Acceptance Form – ART Clinics

- All recipients of care presenting in an ART clinic should be reviewed with requisite paper tools or clinic encounter forms for EMR
- Clinical review should include assessment of DSD eligibility using the DSD Assessment and Acceptance form.
- Devolvement to DSD models for stable clients should be indicated on pharmacy order forms and laboratory/VL request forms.
- A triplicate Assessment and Acceptance form is used to devolve the patient into model of care. The first copy should be taken by the client to the DSD contact person for documentation and returned to the client's folder for filing, the second and original copies should be taken to the referred DSD platform. The service provider at the DSD platform

will keep the original copy but will return the second copy to the facility as a proof of patient been onboarded to his/her DSD platform and for medication pickup.

- Devolvement of stable clients into DSD models and the duration of refills should be documented into the ART care card.
- DSD model should be updated in the appropriate section of the ART register.

Documentation processes for DSD Monitoring Register – community HCW

- HCW should receive the original copy of the Assessment and Acceptance form from the devolved clients and onboard them into the model.
- The DSD Monitoring Register must be used to capture clients at every visit three-six months.
- At every refill visit, devolved clients will be assessed for eligibility for less intense DSD models offered – if ineligible or due for a VL test, assessment and acceptance form is used to document findings and a completed assessment and acceptance form and referral form are used to send the client back to their hub facility.
- All DSD service providers are to maintain up-to-date documentation of the appropriate pharmacy tracking tools supplied.

11.5 Data flow From Community to Health Facility

HTS Data Flow

From the flow chart below, HTS data flow comes from two entry points – facility and community. From the extreme right, the middle box provided a list of data collection forms and cards which would be compiled into the HTS, HIV self-testing and index registers. Content of these registers feed into the HTS and Index Monthly Summary Form (MSF) at the end of the month. From the facility point of entry, work sheets, cards and forms provide client level information used to compile the HTS, HIV self-testing and Index registers. The summaries of information in these registers are now entered into the EMR while all information captured in the EMR feeds into the NDR and DHIS for viewing at the State/National level.

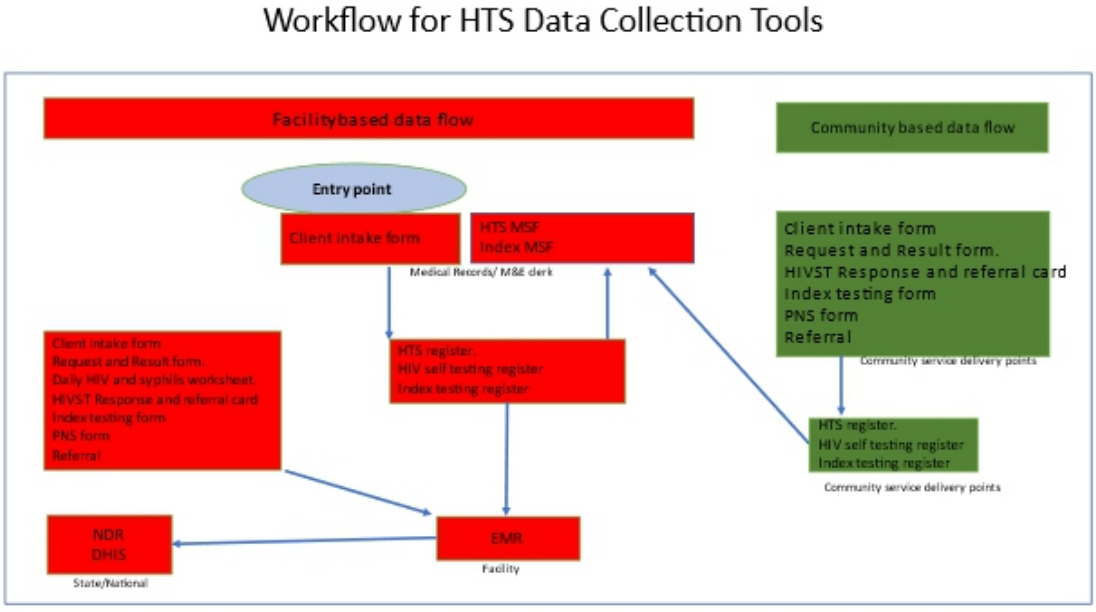


Figure 11.4: Workflow for HTS Data Collection Tools

PMTCT Data Flow

PMTCT data flow – Stable women who were devolved to the community and become pregnant are encouraged to return to the facility for ANC care but should be left in the community if they insist on ART pick up in the community. In such instance, the DSD monitoring register in the community will be used to capture their data. The maternal cohort register will capture their model of care (please refer to the National Health Sector DCT Users' Guide)

ART Data Flow

The flow chart below illustrates data flow from clients devolved to a less intense community-based model of care (green boxes) captured at the community service delivery point by focal persons using the community DSD monitoring register which feeds into the facility register monthly. The Data from clients devolved to less intense facility-based model of care (green boxes) is captured using the client Care card already domiciled in the facility and feeds into the facility-based DSD register. All the data from the facility DSD register is fed into the Art register and Monthly summary form (MSF) subsequently. Data from clients on more intense model of care flows through the traditional care to the ART register and MSF. Devolved patients use the traditional tools and data flow when visiting the clinic for the traditional clinic visit. Also observe that tools at each service delivery point is listed in the colour coded boxes.

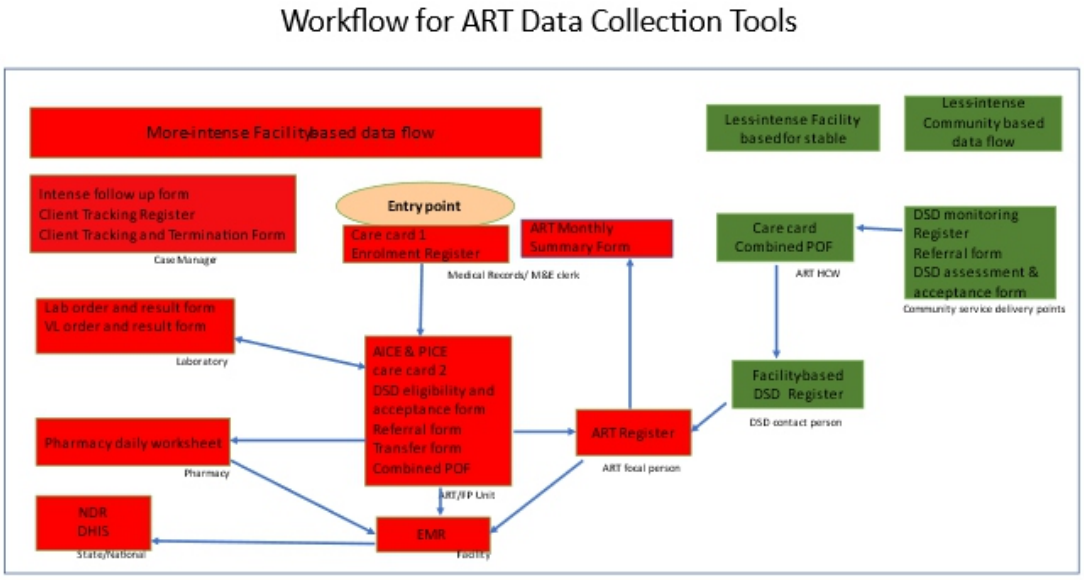


Figure 11.5: Workflow for ART Data Collection Tools

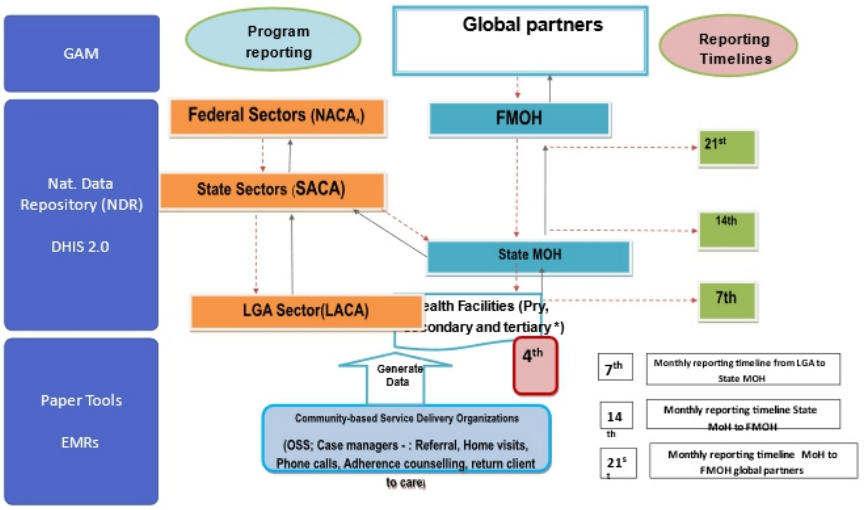


Figure 11.6: Data reporting timeline

11.6 Data Quality Assurance (DQA) for DSD Models

Data Quality Assurance for DSD models will be executed in line with existing M&E Working Group standards by selecting community service delivery points as well as related indicators (kindly refer to National Integrated Guidelines for processes and procedures).

11.7 DSD Evaluation Procedures

The first goal of DSD is to provide client-centered care. This is when care is tailored to each client's need. The second is to reduce the burden on the health facilities.

Client Satisfaction monitoring and Feedback on Quality of Services

The questionnaire should focus on monitoring client satisfaction with the use of structured, self or interviewer administered questionnaires which must be completed for selected clients annually (see Appendix 2 for the Client Satisfaction monitoring tool).

Process flow for Client Satisfaction Surveys will include:

- Identification of clusters to be surveyed monthly/quarterly.
- Random selection of clients to be interviewed using a random number table.
- Contact selected clients in advance of interview dates and secure informal consent to participate.
- Schedule face-to-face or telephone interviews and obtain informed consent.
- Administer questionnaire, enter responses, collate completed questionnaires and send to the State Management Team.
- Analyze data and disseminate comprehensive results.

Facility and HCW assessment

HCW satisfaction should be monitored utilizing structured, self or interviewer-administered questionnaires which should be completed for selected HCW annually. The current health facility supervisory checklist should be used for assessment of health facilities annually.

Operational Research

The facility and community DSD models should be evaluated through implementation research and surveys.

Some key questions that may help in the design of the implementation research are:

- Does the research aim to answer specific questions concerning implementation and scale up?
- Does the research clearly look at the ease of operationalizing the DSD at different points of HIV care?
- Does the DSD model take into context the peculiarity of individual clients to maximize the client-centered care?

Supervision of DSD

The health facility DSD contact person, supported by the QI focal person, is responsible for overseeing the DSD implementation progress for the cluster of DSD service providers in his/her geographic region under the coordination of the LGA LACA and SASCP with a goal of ensuring routine reporting according to the timeline and timely upload to NDR and the DHIS.

Joint DSD data performance review should be conducted monthly at the health facility level by the quality improvement team or the HIV patient management team and the leaders of all community DSD models linked to the health facility. During these meetings, the team should discuss the progress of DSD, the challenges faced and possible QI projects that address these challenges. Performance reports should be reviewed at LGA and state level during the SMT

monthly meetings. The uptake of DSD and coverage should be reviewed on a quarterly basis during data review meetings and integrate findings during routine supervisory visits.
The DSD model supervisory tools will be an adaptation of the National Supervisory Checklist (see appendix 2) and supervisory review meetings (cluster, hub facility and SMT) will be used to track progress of these routine assessments.

11.8 Continuous Quality Improvement for DSD

Continuous Quality Improvement (CQI) for DSD will be implemented in line with National Guidelines for CQI and the Nigeria Quality Assessment Measures.
CQI activities are recommended as follows:

1. Performance measures with assessment and dashboards.
2. Quality improvement projects should be implemented as appropriate.
3. Annual CQI review meetings to evaluate findings from assessments done.

11.9 Human Resources for M&E

Human resources to ensure data entry, maintenance, collation, and reporting must form a key component of the planning and activation of DSD models. Key roles with M&E responsibilities to be considered in planning and supervision of DSD models include:

Table 11.3: M/E Related Roles and Responsibilities for DSD Service Providers

	DSD Service Provider/Health Care Work						
Responsibilities	**HCW (Hub Facility)**	**DSD Contact Person**	**DSD Lay Worker/ Group Leader**	**Pharmacist/ Pharm Tech (Hub Facility)**	**DSD Pharmacist/ ARV Dispenser**	**Med. Records Officer/ Data Entry Clerk (Hub Facility)**	**State & National M&E Team**
Ensures high quality documentation in Hub facility	X			X		X	
Ensures high quality documentation in DSD platform (with support from DSD platform management)		X	X		X	X	
Participate in DSD Coordination meetings and QI projects	X	X	X	X	X	X	X*
Participate in Monthly Data Review meetings in Hub Facility	X	X		X		X	

Ensures timely collation and reporting of DSD services to State & National M&E Teams		X	X			X	X
Ensures completion of all QI initiatives and surveys	X	X	X	X	X	X	X*
Ensures timely completion of DQA activities		X	X			X	X*
Completes DSD Assessment, Acceptance and Referral Form (distributing/filing copies appropriately)	X	X	X				
Documents DSD status/updates in ART Care Card and ART Register	X					X	
Documents DSD status/updates in DSD Monitoring Register		X	X				
Complete Pharmacy & Supply Chain tools including ADR Report (Hub ART facility)	X			X			
Complete Pharmacy & Supply Chain tools including ADR Report (DSD platforms)		X	X		X		
Ensures timely return of client to Hub Facility for clinical review or VL monitoring		X	X				
Mentor team in linked DSD platforms on documentation and reporting						X	X*
Ensure data entry into paper reporting tools (MSFs)						X	X
Ensure data entry into digital reporting tools/repositories (DHIS, EMR, NDR)						X	X
Support collation, analyses and reporting through SASCP and NASCP M&E pipelines						X	X
Conduct quarterly analysis of DSD indicators using summary registers, bi-annual data validation and NDR.						X	X
Provide TA to medical records teams and HCWs in Hub facilities, regional and national teams on M&E implementation and best practices.						X	X
Support regular review, quantification, print and distribution of DSD tools.						X	X
Support state and national program data review meetings						X	X
Support data analytics, visualization, and operational research.						X	X

**Subject to availability of the State & National M&E team members*

Use of unique identifiers will be the minimum standard for communicating patient status and DSD model and all records for transmission and analyses will be de-identified.

ANNEXES

Annex I

DSD FACILITY SELF-ASSESSMENT TOOL (FSAT)

The DSD facility self-assessment tool (FSAT) captures information/data on HIV-related programming in the facility based on the health system building blocks, including quality improvement. The objectives of this FSAT facility self-assessment is to:

- Facilitate the conduct of a facility-based SWOT analysis of current strengths and weaknesses of the health systems that are relevant for the implementation of DSD
- Assess the models the facility can implement
- Gather information to help design QI projects to close the gaps, and
- Provide information to the facility, community, IP's and NASCP on the optimal technical support for the facility

1. Name of Facility:
2. Local Government Area:
3. State:
4. Physical address:

Total number of clients on ARVs:

	Access to HTS		
1	Is HTS offered in your facility		
2	How many testing points are available within the facility (OPD, IPD, TB, Nutrition, Immunization, etc)		
3	Is index testing offered in your facility		
4	How many staff are trained to provide HTS		
5	Is HTS available during working hours every working day		
6	Is HTS available during working hours on weekends		
7	Number of clients tested in the last 1year (disaggregated by sex)	Male	Female
8	Number of clients tested in the last 1year	0-9 yrs:	
		10-19 yrs:	
		>20 yrs:	
9	How many staff members are trained to perform DBS for EID		

10	Are screening forms (Risk Stratification forms) used at testing points in the facility to identify children who should be tested	
11	Are adolescent peers involved in mobilizing other Adolescents for testing	
12	Is there an appointment system at the facility	
13	How many Health Care workers provide ART services at the facility?	
	• Doctors	
	• Pharmacists	
	• Nurses	
	• Adherence Counselors	
	• Lab Scientists/Technicians	
	• Mentor Mothers	
	• Others	
14	How many days of the week are ARVs given to clients?	
15	From what time are ARVs provided and until what time	
16	What maximum refills are given routinely to stable clients	
17	What is the schedule of clinical follow up at the facility	

Annex II

PACKAGE OF CARE FOR ADVANCED HIV DISEASE

- Screen clients with Advanced HIV Disease (AHD) for OIs (TB, Cryptococcal meningitis, Pneumocystis jirovecii, Histoplamosis, Toxoplamosis, etc) and initiate on ART as soon as possible preferably within one week if there are no AHD-related OIs. Specifically, the following treatment course(s) are recommended:
    - For TB, ART initiation should be delayed and commenced 2-4 weeks after initiation of TB treatment; if CD4 < 50cells/mm^3 – start ART 2 weeks after, if CD4 > 50cells/mm^3, start ART 4 weeks after commencing TB treatment.
    - For Cryptococcal meningitis, ART initiation should be delayed and commenced 4-6 weeks after commencement of treatment for Cryptococcal meningitis.
    - Histoplasmosis: ART can be commenced immediately
    - Pneumocystis Pneumonia: ART can be initiated immediately
    - Toxoplasmosis: ART can be initiated immediately
    - Severe bacterial infections: ART can be commenced immediately
- Prophylaxis for OIs should be provided for all clients with AHD (***Refer to Chapter 8 of the 2020 National HIV Prevention, Treatment and Care Guidelines and the AHD Implementation Manual).***
- Clients with AHD should have intensified adherence support and receive ongoing counselling and education to promote retention in care.
- Clients with AHD on ART should be educated on IRIS and OIs and report immediately they notice such features. Health care workers should have a high index of suspicion for IRIS, ADRs and other OIs. Clients should be educated on possible complications but reassured that they are usually transient and would abate in the course of treatment.

Annex III

Roles and Responsibilities

Community Pharmacist

- **Provide pharmaceutical care services to all clients:** The Pharmacist shall be responsible for dispensing ARVs, OI prophylaxis and adherence assessment. Active Pharmacovigilance (PV) should also be carried out to monitor clients for Adverse Drug Reactions (ADRs) and report using the NAFDAC forms.
- **Be wholly responsible for refilling prescriptions:** These responsibilities shall not be delegated to a non-pharmacist.
- **Provide Drugs/Commodities Logistics services:** The Pharmacist shall keep inventory records and proper storage of all ARVs/OIs and other commodities supplied, fill and ensure timely submission of the Bimonthly Combined Report Requisition Form (CRRF)
- **Ensure adequate provision of space, staffing and clinic hours**
- **Implement Provider Initiated Testing and Counseling (PITC)** and ensure adequate linkage to care for ART initiation at the facility.
- **Ensure timely Submission of Reports:** Accurate programmatic reports shall be submitted as at when due.

The Referring Facility

The referring facility should ensure the following:

- Monitoring and supervision of community pharmacy ART services
- Supply of HIV commodities to community pharmacy and timely submission of CRRF
- Care providers at the site will support adherence, referrals, identify defaulters and initiate tracking and feedback
- The site medical record system facilitates access of patient information in a confidential and ethical approach
- Optimal quality at every POS in line with appropriate National guideline and Standard Operating Procedures (SOPs).

Criteria for Identification as a KP friendly health facility:

- Must create safe, friendly and stigma free environment tailored to KP needs.
- Should provide gender diversity and inclusivity training for her staff.
- Ability to collaborate with KP-led CBOs to support continuum of care.
- Ability to provide and support accountability mechanisms for KP quality of care and human rights.
- Willingness to provide mental health and psychosocial services.
- Skills and willingness to manage STI peculiarities in KPs (e.g., anal warts and cervical cancer).

Annex IV

Patient ARV Drug Accountability Form (PADAF)

Complete at time of Enrolment in CAG/CDDP

A. ART Distribution Form for Community ART Group/Community Drug Distribution Point Patients

Client Unique ID: _____

Hospital Number: _____

Date of Enrolment into CAG/CDDP: DD _____MM_____YYYY_____

Community ART Group/Community Drug Distribution Point: _____

Patient Phone No:_____ Group Lead Phone No:_____

Complete at the time of Collection and Distribution

ARV Regimen: ***Please tick appropriate regimen dispensed to the patient below***

TLD	**TDF/3TC/EFV 400**	**ABC/ 3TC/ DTG**	ABC + 3TC + EFV400	AZT + 3TC + LPV/r	AZT + 3TC + ATV/r	TDF + 3TC + ATV/r	TDF + 3TC + LPV/r

Drug Refill Date _____

Quantity Dispensed: Please tick

30 Tablets	1 pack	☐	2 packs	☐	3 packs	☐	4 packs	☐	
90 Tablets	1 pack	☐	2 packs	☐	3 packs	☐	4 packs	☐	

Date of Next Refill _____

B. Patient Review Section (If yes to any of the questions below, refer to clinic for further evaluation and agree on clinic appointment date; notify Group coordinator at facility)

Sides Effects/Complaints (please tick)

Headache	Itching	Rashes	Weakness	Insomnia	Dizziness	Vomiting	Diarrhea	Numbness	Nightmares	Others
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pregnant (please tick) YES ☐ NO ☐ NOT APPLICABLE ☐

Name/Signature of Dispenser:

Name, Signature or thumb print of client upon receipt of the ARVS

Date

APPENDICES

Appendix 1

DSD INDICATOR DEFINITION TABLE

1. PLHIV who have suppressed VL: Percentage of PLHIV on ART (for at least 6 months) who have virologic suppression
Program Area: ART
DESCRIPTION
Precise Definition(s): Number of PLHIV on ART for at least 6 months who have suppressed viral load (<1000 copies/mL) during the reporting period.
Purpose/Justification: It measures clinical outcomes in terms of virologic suppression among PLHIV on ART. V irologic suppression is a reflection of quality of care in ART programs and a reflection of patient adherence to treatment.
Numerator: Number of PLHIV currently on ART with a viral load test result <1000 copies/mL during the reporting period.
Denominator: Number of patients on ART for at least 6 months with a VL result in a medical or lab record during the reporting period. Estimated number of people living with HIV (population based)
Disaggregation: ▪ Sex (Male, Female) ▪ Pregnancy status ▪ Breastfeeding status ▪ Age (<1, 1–4, 5–9, 10-14, 15–19, 20–24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+ years) ▪ Indication for viral load test (targeted monitoring, routine monitoring) ▪ DSD models (Facility-based, Community-based) ▪ KP types (MSM, FSW, PWID, TG, Persons in Custodial Centers)
How to measure: Programs are to routinely capture this data from all ART clinics and review it annually. This indicator monitors the percentage of documented viral load results of PLHIV on ART for at least 6 months with a suppressed Viral Load result (<1,000 copies/ml). This allows ART programs to monitor individual and overall programmatic responses to ART as measured by virologic suppression. This indicator will provide data on PLHIV who have a viral load (VL) test in the past 12 months and the percentage who were virally suppressed at the most recent test.
Method of calculation: Numerator/denominator.
Unit of Measurement: Percentage
Data Sources: ART register, Viral Load Monitoring Register, EMRs
Frequency of collection: Monthly
Frequency of reporting: Monthly
Location of Data Storage: Facility Medical Records Unit

2. Percentage of PLHIV on ART newly enrolled into DSD model during the reporting period
Program Area: ART
DESCRIPTION
Precise Definition(s): Number of PLHIV on ART newly enrolled in non -mainstream ART models during the reporting period
Purpose/Justification: This indicator tracks uptake of non-mainstream ART services among PLHIV on ART in order to compare trends of new enrollment over time
Numerator: Number of PLHIV on ART newly enrolled in a differentiated ART service model during the reporting period
Denominator: Number of PLHIV currently on ART during the reporting period
Disaggregation: ▪ Sex (Male, Female) ▪ Age (<1, 1–4, 5–9, 10-14, 15–19, 20–24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+ years) ▪ Model (Facility-based, Community-based)
How to measure: The numerator is generated by counting the number of PLHIV who were differentiated into an ART service model, either within the facility or to the community during the reporting period. PLHIV are counted the **first time** they are devolved into a differentiated service model.
Method of calculation: Numerator divided by the denominator
Unit of Measurement: Percentage
Data Sources: DSD monitoring register, Electronic patient- level data
Frequency of collection: Monthly
Frequency of reporting: Quarterly
Location of Data Storage: Facility Medical Records Unit

3. Percentage of facilities providing DSD model during the reporting period.
Program Area: ART
DESCRIPTION
Precise Definition(s): Percentage of facilities with at least one patient enrolled in a DSD model
Purpose/Justification: As the country rolls out DSD, it will be useful to know the acceptance of DSD especially according to model type. This indicator tracks the coverage of DSD among facilitie s providing ART in order to compare uptake of diverse DSD model
Numerator: Number of DSD facilities offering DSD model of care during the reporting period
Denominator: Total number of facilities providing ART services during the reporting period

Disaggregation: ▪ Sex (Male, Female) ▪ Age (<1, 1–4, 5–9, 10-14, 15–19, 20–24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+ years) ▪ Model (Facility-based, Community-based) ▪ Type of model ▪ facility level
How to measure: The numerator is generated by counting the number of facilities with at least one patient enrolled into a DSD model either within the facility or to the community during the reporting period divided by the total number of facilities providing ART services within the reporting period.
Method of calculation: Numerator divided by the denominator
Unit of Measurement: Percentage
Data Sources: DSD monitoring register, Electronic patient- level data, MSF
Frequency of collection: Monthly
Frequency of reporting: Quarterly
Location of Data Storage: Facility Medical Records Unit

4. PLHIV on ART: Percentage of PLHIV receiving ART at the end of the reporting period
Program Area: ART
DESCRIPTION
Precise Definition(s): Percentage of PLHIV receiving ART during the reporting period
Purpose/Justification: This indicator measures progress towards providing ART to all people living with HIV, that is, treatment coverage, taking into account total attrition during the reporting period. World Health Organization (WHO) currently recommends treatment for all people living with H IV to achieve viral suppression. This indicator is central to accountability for national health sector strategic plans, effective programme management and donor programming. It is essential to measurement of the second 95 target, i.e. 95% of the estimated PLHIV who know their status are accessing ART by 2025.
Numerator: Number of PLHIV on ART during the reporting period (programme data). For key populations, survey data may be required.
Denominator: Estimated number of people living with HIV (from models, such as Spectrum AIM).
Disaggregation: ▪ Sex (Male, Female) ▪ Age (<1, 1–4, 5–9, 10-14, 15–19, 20–24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+ years) ▪ Regimen (1st line, 2nd line, 3rd line) ▪ Pregnant women, breastfeeding women, ▪ DSD models (Facility-based, Community-based) ▪ KP types (MSM, FSW, PWID, TG, Persons in Custodial Centers)

How to measure: The numerator is generated by determining the number of people living with HIV on ART at the end of the last reporting period plus the number of PLHIV initiated on ART during the reporting period, taking into account attrition status by the end of the rep orting period. Attrition analysis should be conducted as part of reporting on this indicator. The current on ART count should be equal to the number of PLHIV on ART at the end of the previous reporting period plus the newly initiated on ART, transferred i n and restarted on ART minus patients exits (died, stopped treatment, transferred out, or are lost to follow-up) during the reporting period All HIV-positive pregnant women and breastfeeding mothers on ART should be part of this indicator. ART taken only for the purpose of Pre-exposure (PrEP) and Post-exposure (PEP) prophylaxis should NOT be counted in this indicator.
Method of calculation: Numerator divided by the denominator
Unit of Measurement: Percentage
Data Sources: ART Register, EMR, Population based estimates
Frequency of collection: Monthly
Location of Data Storage: Facility Medical Records Unit

Appendix 2

CLIENT SATISFACTION QUESTIONNAIRE

A. Respondent's profile

1. Gender: ☐ Female ☐Male ☐Prefers not to answer
2. Age in years: _____
3. What category of differentiated care are you currently in?

☐Well ☐Unstable ☐ Advanced ☐Stable

B. Satisfaction with the service delivery point (SDP)/facility

Variable	Yes	No
Are you satisfied with the travel distance to the location where you receive care		
Are you satisfied with the level of confidentiality in the place?		
Do you have a comfortable area to stay/sit while awaiting your turn to be attended to?		
Are you satisfied with the environment the site is located?		
Is the period (day and time) when the facility attends to clients satisfactory to you?		

C. Satisfaction with the Human Resources at SDP

Variable	Agree	Neutral	Disagree
The numbers of staff (or peers) that attend to people are enough?			
The staff (or peers) that attend to people have satisfactory information as it relates to HIV care			
The staff (or peers) that attend to people are knowledgeable enough to attend to complaints that I may have or refer me to the appropriate place?			
I am comfortable that the staff (peer) attending to me will keep our discussions confidential			

D. Satisfaction with time spent at service delivery point/facility

Variable	Adequate	Not Adequate	Too much
Time spent at records/retrieving cards (where applicable)			
Time spent at counselling and consultation			
Time spent for physical examination (where applicable)			
Time spent for adherence counselling and dispensing medication			
Time spent in the laboratory (taking samples for test)			
Overall time spent at the service delivery point			

E. Service availability at SDP

Services	Available	Not available	If not available, do you think it should be available? (Y/N)
Consultation with healthcare worker			
Vital signs measurement and physical examination			
Counselling on health care and positive living			
Adherence counselling & Dispensing			
Laboratory services/sample collection			

F. Final rating and remarks

1. On a scale of 1 to 5 with 1 being extremely poor and 5 being extremely good, rate your overall satisfaction with the care and services you are receiving here?

2. Briefly tell us on how to improve your care in this site/facility:

Appendix 3

HCW SATISFACTION MONITORING ASSESSMENT TOOL

		Yes	No	Prefer not to answer	Comments
1.	The management of this hospital is supportive of me				
2.	I receive the right amount of support and guidance from my direct supervisor				
3.	I am provided with all trainings necessary for me to perform my job.				
4.	I have learned many new job skills in this position				
5.	I feel encouraged by my supervisor to offer suggestions and improvements.				
6.	The management makes changes based on my suggestions and feedback				
7.	I am appropriately recognized when I perform well at my regular work duties				
8.	The facility's rules make it easy for me to do a good job				
9.	I am satisfied with my chances for promotion.				
10.	I have adequate opportunities to develop my professional skills				
11.	I have an accurate written job description.				
12.	The amount of work I am expected to finish each week is reasonable				
13.	My work assignments are always clearly explained to me.				
14.	14.My work is evaluated based on a fair system of performance standards				
15.	My work is evaluated based on a fair system of performance standards				
16.	My department provides all the equipment, supplies, and resources necessary for me to perform my duties				
17.	The buildings, grounds, and layout of this facility are adequate for me to perform my duties				
18.	My coworkers and I work well together				
19.	I feel I can easily communicate with members from all levels of this facility				
20.	I would recommend this health facility to other workers as a good place to work.				
21.	How would you rate this health facility as a place to work on a scale of 1 (the worst?) to 10 (the best)?				

Name of the Health Facility	
Address	
Telephone Number	
Date Assessment Completed	
Name and Position of Person(s) Completing Assessment	
Level of Facility	
Type of Facility Public ☐ Private ☐ Faith-based ☐	Services Provided: ART ☐ TB ☐ General ☐ OPD ☐ DSD ☐

Appendix 4

DSD ASSESSMENT, ACCEPTANCE AND REFERRAL FORM

DSD ASSESSMENT AND ACCEPTANCE FORM

Mark 'X' where applicable

State: Local Government Area:

Facility Name:

Hospital Number: Unique ID:

Patient's Name: Surname First Name

Sex: Male Female Age: years Telephone Number: Marital Status:

Patient's Descriptive Address:

LGA of Residence: Community of Residence:

DSD Eligibility Assessment

Mark 'X' where applicable [0] = No, [1] = Yes

On ART for at least 1 year?	[0]	[1]	Has completed TB Preventive Therapy (TPT)	[0]	[1]
Adherent with a good understanding of lifelong adherence?	[0]	[1]	Does not have TB co-infection?	[0]	[1]
Clinically stable with no opportunistic infections?	[0]	[1]	Not Pregnant? (if female)	[0]	[1]
Have no ADR that require regular monitoring?	[0]	[1]	Not breastfeeding? (if female)	[0]	[1]
Evidence of treatment success – 2 successive VL measurements ≤ 1000copies/ml?	[0]	[1]	Does not have a child on ART less than 3 years old?	[0]	[1]
Most recent VL less than or equal to 6 months?	[0]	[1]	Has no co-morbiditie (e.g Heart dx, Chronic Liver Dx, Chronic Kidney Dx, DM)?	[0]	[1]
Is on a current regimen for greater than 6 months?	[0]	[1]			

Total score

Eligible for DSD if score equals 13 for female and 11 for male

VL Test

VL Test Result: copies/ml Date of VL Test result: dd/mm/yyyy

Eligibility and Acceptance

Eligible for DSD? Yes No Client accepts DSD? Yes No

Client DSD Models

Mark 'X' as applicable

Facility-Based Models		Community-Based Models	
FBM1 - Fast-track		CBM 1 - Community pharmacy ART refill	
FBM2 - Facility ART group: HCW led		CBM 2 - Community ART Refill Group: Healthcare Worker – led	
FBM3 - Facility ART group: Support group led		CBM 3 - Community ART Refill Group: PLHIV – led	
FBM4 - Decentralization (Hub and Spoke)		CBM 4 - Adolescent Community ART/ peer-led groups	
FBM5 - After hours		CBM 5 - Home delivery	
FBM6 - Weekends and Public Holidays		CBM 6 - One Stop Shop	
FBM7 - Children/Teen/Adolescent Club (Peer managed)			
FBM8 - Mother infant pair/Mentor mother led			

Comments:

Completed by: Designation:

Signature: Date: / /20

Version July 2021

Appendix 5

COMMUNITY DIFFERENTIATED SERVICE DELIVERY (DSD) MONITORING REGISTER

Community Name: **LGA:** **State:** **Name of DSD Model:** **Linked Facility:** **Month/Year**

Mark 'X' where applicable

S/N	Visit Date (d/mm/yy)	Patient's Name (Surname,Other Name)	Hospital Number	Unique ID	ART Start Date (d/mm/yy)	Sex M	Sex F	Age (yr)	Telephone Number	Patient's Address (Descriptive)	Pregnancy Status Y	Pregnancy Status N	TB Screening (Write code)	CX Screening (Write code)	Adherence (Write code)	ARV Regimen (Write code)	ARV Dispense Duration (in days)	VL Test Result (Copies/ml)	VL Test Date (dd/mm/yyyy)	Next Appointment Date	DSD Discontinuation (Reason for Discontinuation)

TB Screening Code:
1. **No signs** = no signs or symptoms of TB
2. **Presumptive TB** = Patient with signs and symptoms of TB and referred for evaluation
3. **IPT** = Currently on INH prophylaxis
4. **Confirmed TB** = Patient has active TB
   4a. Confirmed with GeneXpert
   4b. Confirmed with CXR
   4c. Confirmed with LF LAM (check guidelines)
5. **TB Treatment** = Currently on TB treatment

CX Screening Code:
1 = No signs or symptoms suggestive of CX
2 = Signs and symptoms suggestive of CX and referred for laboratory investigation
3a = Negative CX results
3b = Positive CX results (awaiting treatment)
4 = Currently on CX treatment

Adherence Code
Estimate level of adherence for once daily ART using the following table

	% Missed doses per month	
G (Good)	≥ 95%	≤ 1 dose
F (Fair)	85-94%	2-4 doses
P (Poor)	<85%	≥ 5 doses

Regimen Code

Adult 1st Line Regimens:
1a = 3TC+EFV(or FTC)+DTG
1b = 3TC+EFV(or FTC)+HPV400
1c = ABC+3TC+DTG
1d = 3TC+EFV(or FTC)+HPV

Adult 2nd line regimens:
2a = AZT+3TC+ ATV/r
2b = 3TC+EFV+ PI*/r
2d = AZT+ 3TC +LPV/r
2e = AZT+ 3TC+EFV/r
2f = AZT+ 3TC+ DTG+LPV/r
2h = 3TC+EFV+DTG

Adult 3rd Line Regimens:
3a = DRV/r+DTG or 3-2TRF+
3b = DRV/r+2INSTIs or ETV

Paediatric 1st Line Regimens:
1g = 3TC+EFV(or FTC)+DTG
1h = ABC+3TC(or FTC)+ DTG
1i = ABC+3TC+ LPV/r
1j = 3TC+EFV(or FTC)+ HPV400 or VED

Paediatric 2nd Line Regimens:
2g = AZT+3TC+LPV/r
2i* = ABC+3TC (FTC)+EFV400
2k = AZT +3TC +ATV
2m = ABC+3TC+ RPV

Paediatric 2nd Line Regimens:
2a = AZT+3TC+LPV/r
2b = AZT+3TC+ ATV/r
2c = 3TC+EFV+ ATV/r
2d = 3TC+ 3TC+ LPV/r
2e = AZT+3TC+(ATV/r or DTG)
2f = ABC+3TC+(ATV/r or DTG)
2g = AZT+3TC+LPV/r
2h = ABC+3TC+LPV/r

Paediatric 3rd Line Regimens:
3a = DRV/r+2INSTIs or (RAL) + 1-2 NRTIs
3b = DRV/r+2INSTIs or ETV

Appendix 6

FACILITY DIFFERENTIATED SERVICE DELIVERY (DSD) REGISTER

Facility Name: State: LGA: Month/Year:

Mark 'X' where applicable

S/N	Visit Date (dd/mm/yy)	Patient's Name (Surname, Other Names)	Hospital Number	Unique ID	ART Start Date (dd/mm/yy)	Sex		Age (yrs)	Telephone Number	Patient's Address (Descriptive)	DSD Model (Write code)	Name of DSD Model/Location	ARV Regimen (Write code)	VL Test Result (Copies/ml)	VL Test Date (dd/mm/yyyy)	Next Appointment Date (dd/mm/yyyy)	DSD Discontinuation (Reason for Discontinuation)
						M	F										

DSD Model Code

Facility Based:

Community Based:

ARV Regimen Code

Code for Discontinuation:

1. Poor adherence
2. Adverse drug reaction
3. Presumptive TB
4. [illegible]
5. Unsuppressed viral load
6. Pregnancy
7. Comorbidities
8. Others

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