

# Lessons Learned from the introduction of advanced HIV disease package of care in Nigeria

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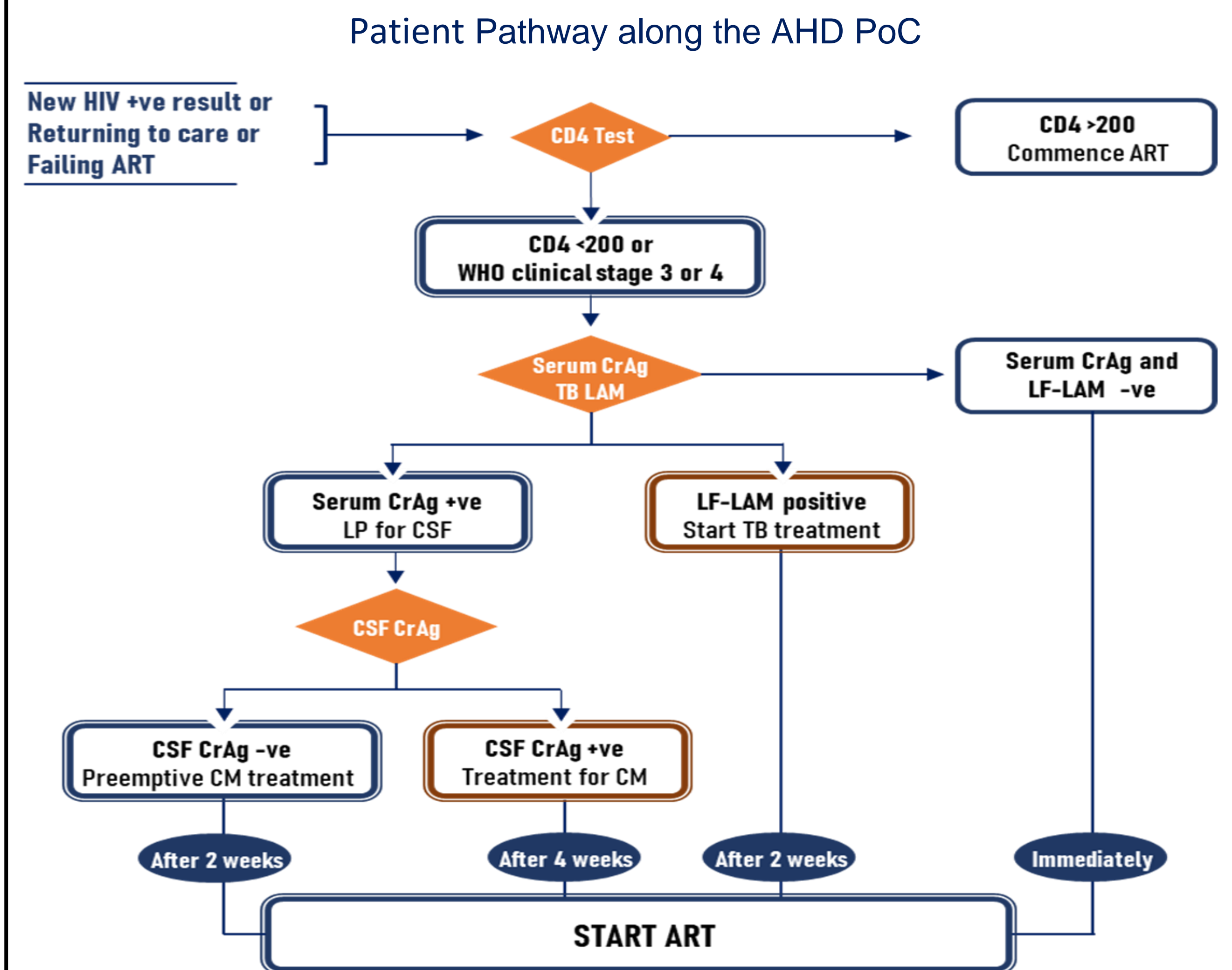
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## Background

In Nigeria, an estimated 32% of PLHIV who received CD4 tests in 2018 had Advanced HIV Disease (AHD) and this population had the highest mortality. Despite this, a package of care for AHD (AHD PoC) was not clearly defined in-country. Baseline CD4 testing was deprioritized since the onset of Test and Treat policy, while screening and management of opportunistic infections was sub-optimal. In 2020, using the WHO AHD guidelines, the Nigeria Ministry of Health (MOH) developed an AHD PoC. This abstract outlines the process and lessons learned from introducing the AHD PoC in Nigeria.

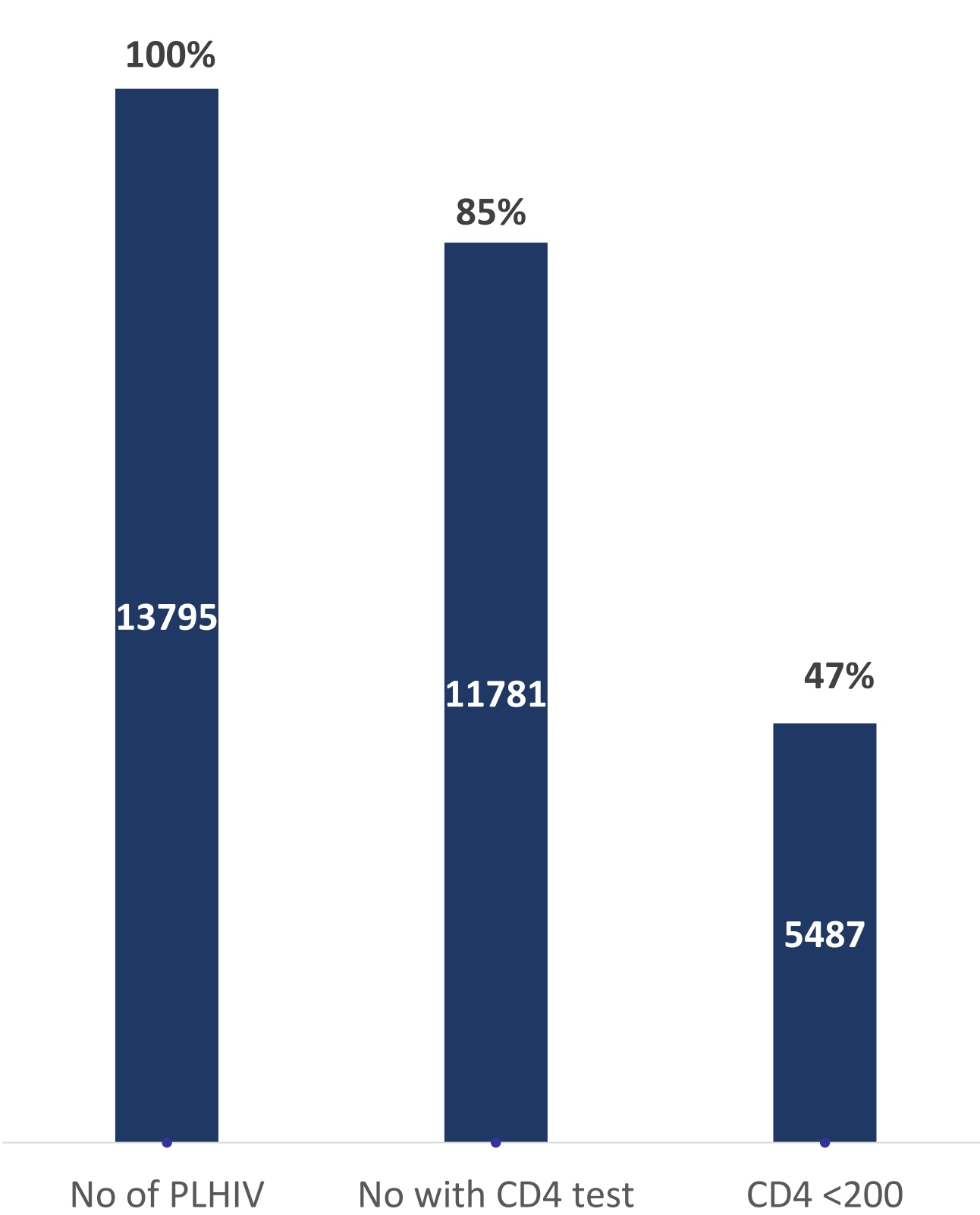
## Description

- The Nigeria MOH constituted a working group in 2019 to develop and oversee implementation of the AHD PoC in-country. The working group included the Academia, HIV Funding and Technical Partners and the Nigeria MOH.
- The first phase of implementation involved 28 facilities across 4 high-burden states that account for 31% of national HIV burden (Lagos, Akwa-Ibom, Rivers, Anambra).
- In 2020, National guidelines, training materials, and reporting tools were reviewed to include the AHD PoC.
- Healthcare-worker (HCW) capacity was built to implement AHD PoC. Commodities were distributed and facility implementation commenced in February 2021.
- Newly identified PLHIV were screened for AHD. Those with AHD were screened for Tuberculosis and Cryptococcal-Meningitis (CM), followed by rapid ART initiation and intensive adherence support.
- The data from the first phase of implementation from February 2021 – September 2022 was analyzed.

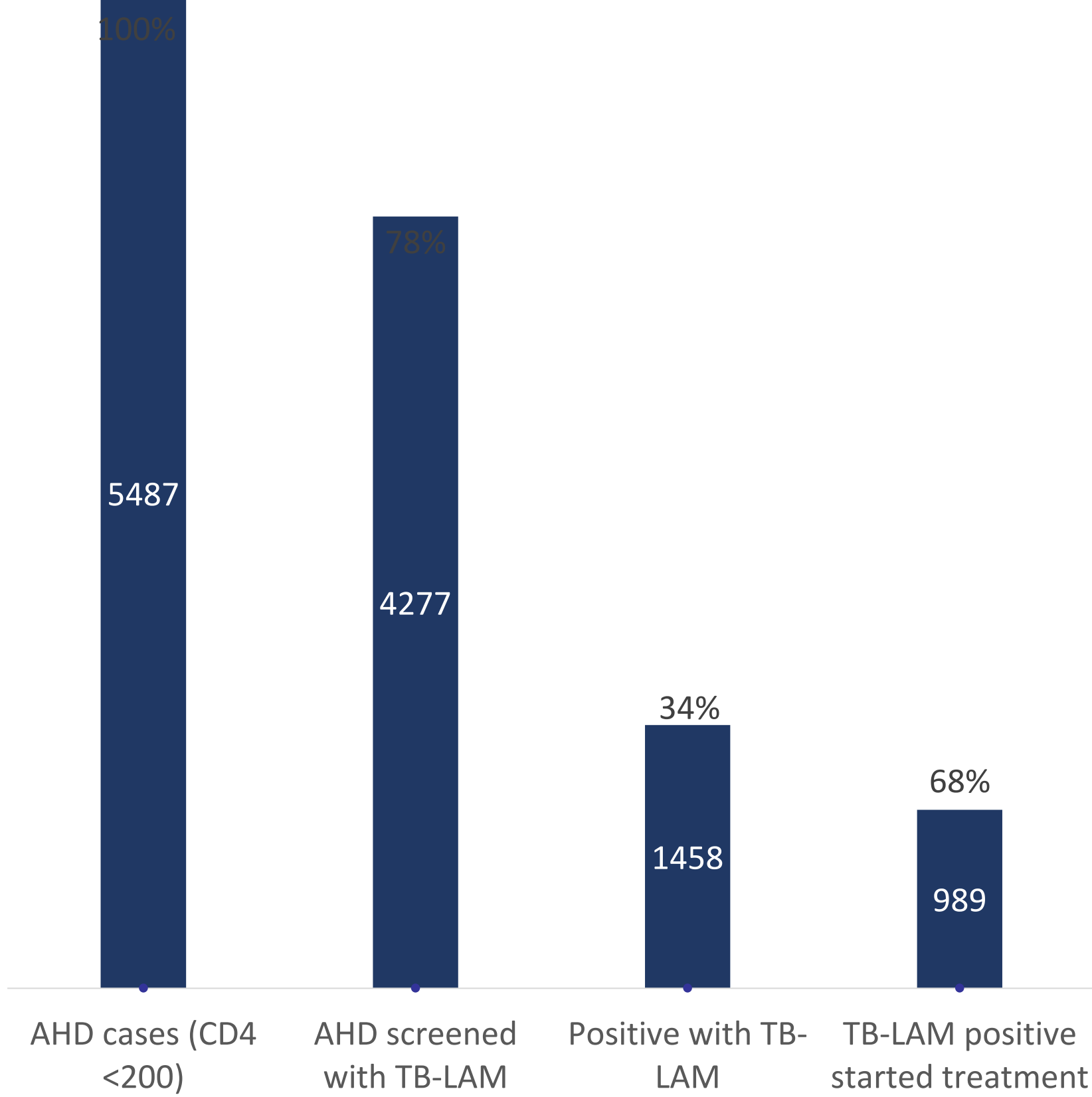


## Lessons Learned

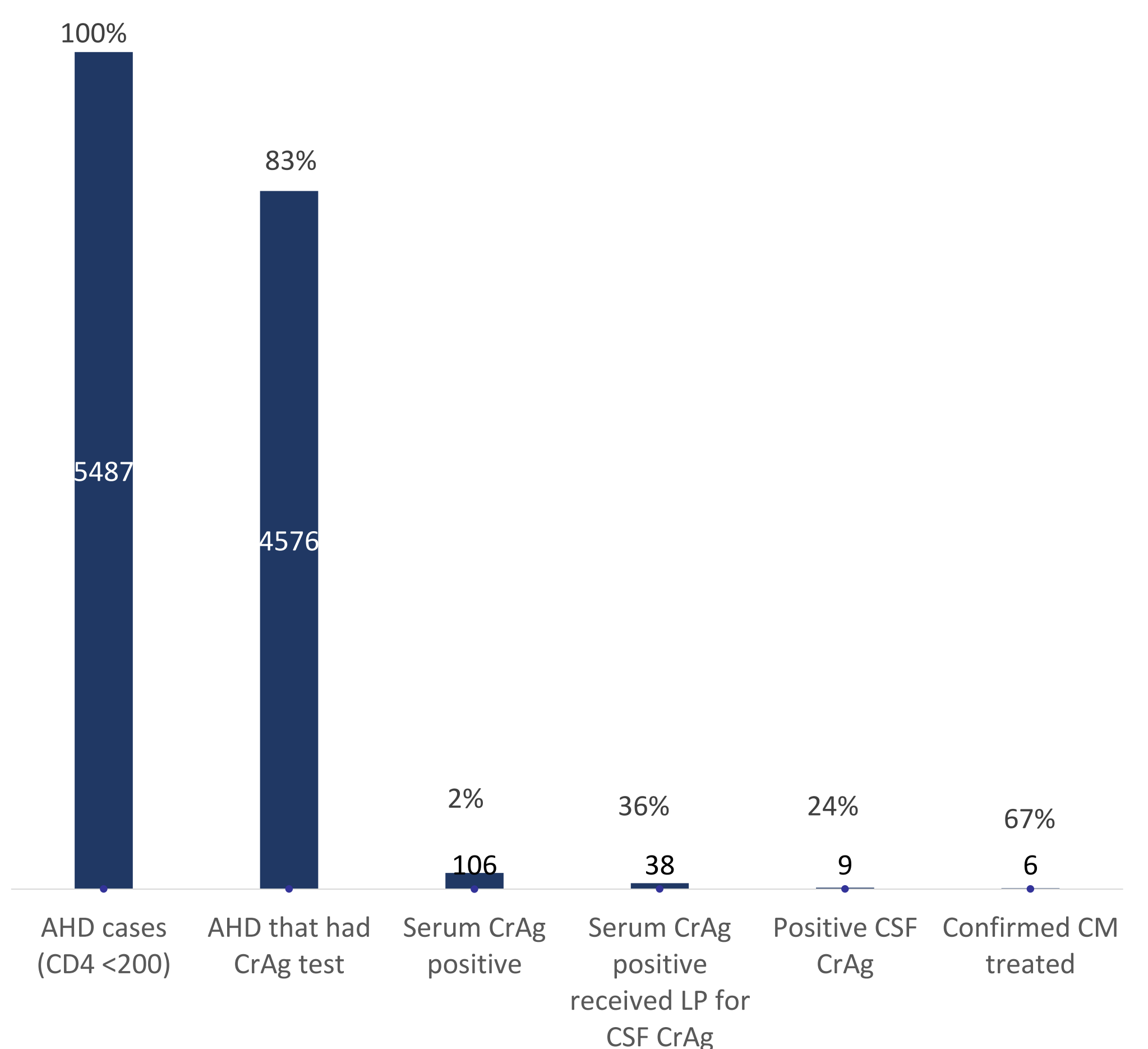
CD4 testing cascade



TB LF-LAM cascade



CrAg cascade



- Even though the AHD PoC recommends CD4 testing for newly identified HIV clients, those failing on treatment and returning to care, however, during implementation, onsite practice showed CD4 testing for mainly new clients. The scale-up of AHD PoC should address all operational gaps to enable CD4 access to all eligible clients.
- Poor access to adjunct commodities contributed to observed gaps in TB LF-LAM and CSF CrAg testing. Programming for CrAg and TB LF-LAM tests should consider adjunct commodities vital to close gaps observed across the cascade, particularly lumbar-puncture packs for CSF CrAg and urine cups for TB LF-LAM.
- The observed gap in CSF CrAg testing was due to the poor uptake of LP. This was as a result of patient apprehension for LP, lack of LP commodities, out-of-pocket payment and HCW capacity gaps. Considering HCW capacity gaps for lumbar-puncture (LP) at some facilities, a hub-and-spoke model will be ideal for scale-up and LP referral mechanisms should be strengthened. Patient literacy and adequate resources are needed to optimize LP uptake.

## Conclusion

- Implementation of the AHD PoC increased TB and CM case-finding among PLHIV and could potentially reduce mortality, however, more effort is required to effectively implement AHD PoC using a public health approach. The National HIV Program has commenced the scale-up of the AHD PoC using lessons learnt from the first phase of implementation.

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