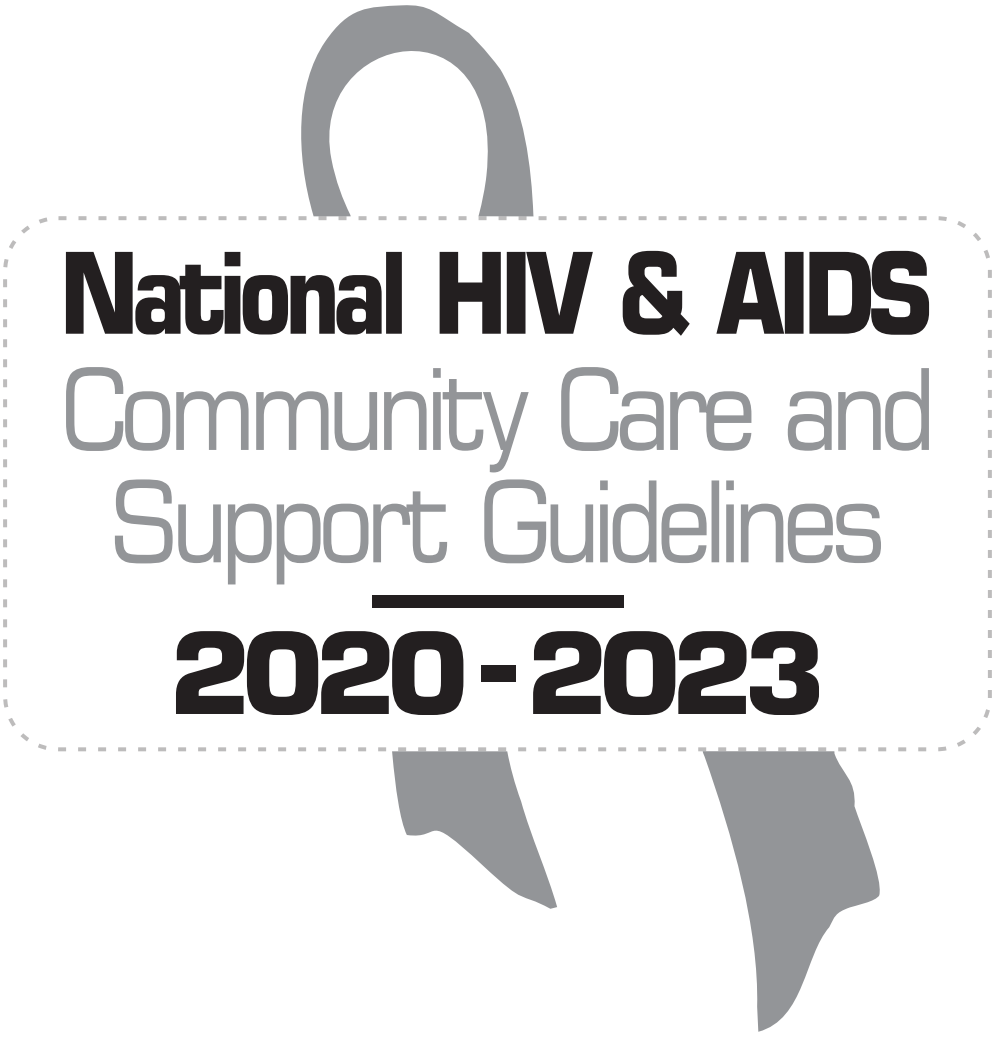
FEDERAL GOVERNMENT OF NIGERIA

National HIV & AIDS Community Care and Support Guidelines 2020-2023



National HIV & AIDS
Community Care and Support Guidelines
2020 - 2023

NACA: National HIV/AIDS Community, Care and Support Guidelines (2020-2023)

FOREWORD

Nigeria is making significant progress in her fight as a nation against the spread of HIV/AIDS. This is revealed in the findings of the Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS, 2018), which reported a lower HIV prevalence among the general population at 1.4% in 2018 compared with the 3.4% reported in 2012. The report showed that almost half of People Living with HIV (PLHIV) in Nigeria have achieved viral suppression. However, until Nigeria becomes an AIDS- free nation, with zero new infection and zero AIDS-related stigma and discrimination, all hands will continue to be on deck.

The first national guidelines for HIV and AIDS Palliative Care was developed in 2006 and was reviewed and revised in 2014 to provide guidance for the design, implementation, monitoring and evaluation of care and support services. A lot has happened globally since the last revision to the care and support services for PLHIV and People Affected by AIDS (PABA). These changes range from the expanding comorbidities of ageing HIV populations, diverse medical, social and economic needs of PLHIV at various stages of life, to the spotlight on the mental health of PLHIV and increasing realization of the importance of community led care and support service delivery. All these are redefining the way care and support services are delivered to beneficiaries across communities and nations of the world.

A rapid appraisal of the 2014 National Guidelines on HIV and AIDS Care and Support was done and gaps identified include among others, the absence of well-defined continuum of care that adequately provides for community level of care and support, absence of linkages to community and state social safety nets protection for PLHIV and PABA, weak non-discriminatory response system and early detection and counseling on mental health disorders for PLHIV and PABA. Additionally, the care and support needs of Key Populations were not elaborated. All these gaps have been addressed in this document.

NACA recognizes and acknowledges the support and partnership of Federal Ministry of Health, Global Fund, PEPFAR, UNAIDS, PLHIV and CSOs in the development of the Guidelines. I commend the use of the guidelines to relevant stakeholders in planning and implementation of care and support services.

Dr Gambo Aliyu
Director General,
National Agency for the Control of AIDS (NACA) 2020

PREFACE

Since the diagnosis of the first case of HIV in Nigeria in 1986, there has been enormous progress in HIV prevention, treatment and care. The recently concluded Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) 2018 reveals that Nigeria is now the 4th most burdened/HIV prevalent country in the world. The HIV prevalence among adults 15-64 years is 1.4% while it is 0.2% among children 0-14 years.

As of 2013, 3.6 million Nigerians were estimated to be living with HIV. The NAIIS 2018 report revealed that Viral Load Suppression (VLS) among people living with HIV ranged from 44.5% among 15-64 years to 55% among males aged 55-64 years and 54.8% among females age 45-54 years. VLS is a measure of the quality of services PLHIV are receiving and a key indicator of the country's journey to ending HIV transmission.

The advent of anti-retroviral drugs caused a paradigm shift in the way HIV and AIDS is perceived and with about 78% of the PLHIV in Nigeria on ART and other care and support services. A first attempt at organizing the care and support services in the country was in 2006 with the development of the National Guidelines for HIV and AIDS Palliative Care. This was revised in 2014 in order to provide well-defined national standard package of services for care and support as well as address significant gaps in the coordination and implementation/service delivery.

This second review of the National Guidelines on Care and Support for PLHIV became necessary to incorporate emerging issues from global, regional and national care and support programmes. Best practices suggests that people living with HIV should have access to consistently high-quality care services. The review was done in partnership with various stakeholders including implementing partners, networks of PLHIV, key and vulnerable populations and PABA, community based associations/organizations, care providers and individuals living with HIV. The document is made up of nine chapters addressing important issues in the care of people living with HIV with focus on the delivery of quality services in the care and support of PLHIV (including adolescents and young people living with HIV), key and vulnerable populations and PABA.

I encourage all to put the needs of PLHIV at the centre of service packages and programme design and delivery to reduce morbidity and enable PLHIV, key and vulnerable populations and PABAs served and live life to the full. In that regard, the implementation of the guidelines by all stakeholders in Nigeria will be a major step towards achieving the global goal of ending AIDS by 2030.

Alex Ogundipe, B. Pharm, MPH
Director, Community Prevention and Care Services, NACA

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We extend special appreciation to all officers of government of Ministries, Department and Agencies as well as development partners, the implementing partners, Civil Society Organizations (CSOs) including Association of Orphans and Vulnerable Children (OVC) Organizations in Nigeria (AONN) for providing time, technical support and knowledge information that was put together to develop the document.

Specific appreciation goes to the consultant for the development of the Guideline, Dr. Bisayo Odetoyinbo for the hard work and resilience she displayed throughout the conduct of the assignment. On behalf of the technical team for the assignment, I also appreciate Pastor Marcus Williams of AONN and Dr Abdulmalik Jibril, Lecturer and Consultant Psychiatrist, University of Ibadan, Ibadan Nigeria for their resourcefulness throughout the entire process that birthed the document.

Sincere appreciation goes to the Network of People Living with HIV in Nigeria (NEPWHAN), Association of Women Living with HIV/AIDS in Nigeria (ASWHAN), Association of Positive Youths Living with HIV in Nigeria (APYIN), Nigeria Network of Religious Leaders Living with or Personally Affected by HIV and AIDS (NINERELA+), Key Populations Secretariat, persons with disabilities and other groups of individuals who participated in the development of the guidelines for their very enlightening contributions at all the consultations including technical, review and validation meetings that produced the document on schedule.

We sincerely thank everybody who contributed significantly to the achievement of the successful development of the guidelines.

Dr. 'Yinka Falola-Anoemuah
Deputy Director and Head
Gender, Human Rights and Care Support Services
NACA

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
AONN	Association of Orphans and Vulnerable Children (OVC) Organizations in Nigeria
APYIN	Association of Positive Youth Living with HIV in Nigeria
ART	Antiretroviral Therapy
ARV	Anti-Retroviral
ASWHAN	Association of Women Living with HIV and AIDS in Nigeria
BBFSW	Brothel-Based Female Sex Workers
BF	Breast Feeding
BMI	Body Mass Index
BMS	Breast Milk Substitutes
CBO	Community Based Organization
CD4	Cluster of Differentiation 4
CHEW	Community Health Extension Worker
CHO	Community Health Officer
CITC	Community initiated Testing and Counselling
CPT	Cotrimoxazole Preventive Therapy
DOT	Directly Observed Treatment
DQA	Data Quality Assurance
DSDM	Differentiated Service Delivery Model
EE	Economic Empowerment
FBO	Faith-Based Organization
FMOH	Federal Ministry of Health
FP	Family Planning
FSW	Female Sex Workers
GBV	Gender Based Violence
GHR-SRT	Gender and Human Rights State Response Team
GON	Government of Nigeria
HAART	Highly Active Antiretroviral Therapy
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
HRBA	Human Rights-Based Approach
HTS	HIV Testing Services
IGA	Income Generation Activities
IMAI	Integrated Management of Adolescent and Adult Illness
IPTP	Intermittent Preventative Treatment in Pregnancy
IPV	Intimate Partner Violence
KAP	Key Affected Population
KP	Key Populations
LACA	Local Action Committee on AIDS
LGA	Local Government Area
LLITN	Long Lasting Insecticide Treated Nets
LMIS	Logistics Management Information System
MARP	Most at Risk Populations
M&E	Monitoring and Evaluation

MH	Mental Health
MSM	Men who have Sex with Men
MTCT	Mother- to- Child Transmission of HIV
MUAC	Mid-Upper Arm Circumference
NACA	National Agency for the Control of AIDS
NBBFSW	Non Brothel-Based Female Sex Workers
NDHIS	National District Health Information System
NEPWHAN	Network of People Living with HIV and AIDS
NOMIS	National OVC Management Information System
NGO	Non-governmental Organization
OIs	Opportunistic Infections
OR	Operational Research
OVC	Orphans and Vulnerable Children
PABA	People Affected by AIDS
PrEP	Pre- Exposure Prophylaxis
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PHDP	Positive Health Dignity Prevention
PITC	Provider initiated Testing and Counselling
PLHIV	People Living with HIV AND AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PPP	Public Private Partnership
PWD	Persons with Disability
PWID	People Who Inject Drugs
RH	Reproductive Health
SACA	State Agency for the Control of AIDS
SLAs	Savings and Loans Associations
SMEDAN	Small and Medium Enterprises Development Agency of Nigeria
SOP	Standard Operating Procedure
STIs	Sexually Transmitted Infections
VLS	Viral Load Suppression
VSLAs	Village Savings and Loans Associations
WASH	Water Sanitation and Hygiene

CONCEPTS AND TERMINOLOGIES

An important element of high-quality care is appropriate use of clear and unambiguous terminology. For the purpose of this document, definitions stated here are from the UNAIDS 2015 Terminology Guidelines unless otherwise stated

Adherence: Adherence to medicines is defined as the extent to which the patient's action matches the agreed recommendations. Non-adherence may limit the benefits of medicines, resulting in lack of improvement, or deterioration, in health and the emergence of drug resistant strains of HIV. *
Adherence support: Mechanisms and interventions that help patients match the agreed recommendations, allowing them to take the correct dose of the correct drug at the correct time. *

Antiretroviral therapy (ART, ARVs): Drugs, usually taken in combination with one another, that suppress the activity of HIV by inhibiting viral replication. *
CD4 cells: The class of white blood cells known as CD4 T-helper lymphocytes, which are the target cells for HIV and subsequent damage. *

CD4 count: The number of CD4 T-helper lymphocytes in the blood. Someone without HIV normally has a count between 500 and 1200 cells/mm^3. *

Community Response: Is the collective efforts of community-led activities in response to HIV. These activities are not limited to service delivery and can also include the following: advocacy by civil society and community networks for policies, programming and investments that meet the needs of communities; participation by civil society in monitoring and reporting on progress made in delivering the national HIV response; and work by community systems on addressing inequalities and social drivers that are barriers to universal access. Service delivery by community systems could include community-led HIV testing and counseling; peer-to-peer adherence support; home-based care; delivery of harm reduction services and service delivery by community networks to key populations and active TB case detection and referral.

Community Systems: Are "community-led structures and mechanisms used by communities, through which community members and community-based organizations and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities". Community systems can be informal and small-scale, or they can be extensive networks of organizations.

Concordant Couple: In the case of HIV infected individuals who are married, when both the couple is seropositive, they are referred to as a concordant couple. ***
Discordant Couple: In the case of HIV infected individuals who are married,

when either of the couple is seropositive for HIV virus and the other is negative, they are referred to as a discordant couple. ***Continuum of Care: The provision of comprehensive care from the hospital to the home, which ensures the pooling together of medical and social services within the community and the creation of linkages between community care initiatives and all other levels of the health care system. **(Adapted)

Counselling is an interpersonal, dynamic communication process between a client and a trained counsellor (who is bound by a code of ethics and practice) that tries to resolve personal, social or psychological problems and difficulties. In the context of an HIV diagnosis, counselling aims to encourage the client to explore important personal issues, identify ways of coping with anxiety and stress, and plan for the future (such as keeping healthy, adhering to treatment and preventing transmission). When counselling in the context of a negative HIV test result, the focus is exploring the client's motivation, options and skills to stay HIV-negative

Disclosure: Defined as the act of informing another person or persons of the HIV-positive status of an individual. Disclosure may be done by the clients themselves or with the help of another person such as a counselor. ***

Discrimination: Refers to any form of arbitrary distinction, exclusion, or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group—in the case of AIDS, a person's confirmed or suspected HIV-positive status—irrespective of whether or not there is any justification for these measures.

HIV Testing Services (HTS): Embrace the full range of services that should be provided together with HIV testing. HIV testing should be undertaken within the framework of the 5Cs of HTS: consent, confidentiality, counseling, correct test results and connection/linkage to prevention, care and treatment.

Human Rights-Based Approach (HRBA): Is a conceptual framework for the HIV response that is grounded in international human rights norms and principles, both in terms of process (e.g. right to participation, equality and accountability) and outcome (e.g. rights to health, life and scientific progress). HRBA addresses discriminatory practices and unjust distributions of power that impede progress in the HIV response by strengthening the capacities of rights-holders to claim their rights and the ability of duty-bearers to meet their obligations.

Key Populations are groups that are key to the epidemic and key to the response. They include gay men and other men who have sex with men, sex workers and their clients, transgender people, people who inject drugs and prisoners and other incarcerated people. These populations often suffer from punitive laws or stigmatizing policies and they are among the most likely to be exposed to HIV. The key population groups in Nigeria are Men who have sex with Men (MSM), People Who Inject Drugs (PWID) and Female Sex Workers (FSW). Young key populations refers to young people aged 15 to 24

years who are members of key populations, such as young people living with HIV, young gay men and other men who have sex with men, young transgender people, young people who inject drugs and young people (18 years and older) who sell sex. Young key populations often have needs that are unique, and their meaningful participation is critical to a successful HIV response. Key populations are distinct from vulnerable populations, which are subject to societal pressures or social circumstances that may make them more vulnerable to exposure to infections, including HIV.

'Late' and 'very late' HIV diagnosis: A CD4 cell count below 350 cells/mm^3 at time of diagnosis of HIV. Very late diagnosis is either clinical presentation of AIDS at time of HIV diagnosis or a CD4 cell count less than 200 cells/mm^3. *

Mental Health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community****

Morbidity and comorbidity: Morbidity is the state of being unhealthy and/or having a particular disease. Comorbidity refers to the presence of all the diseases and health problems that may exist in an individual patient, in addition to HIV. *

Network: Collaboration between service providers to ensure that people living with HIV have equity of access to appropriate care. The network will vary depending on prevalence, cost and complexity of condition. It may involve two local services working together and be based regionally or nationally. *

Onward transmission: When a virus/infection is passed on from one individual to another. *

Opportunistic infection (OI): An infection that usually occurs in a person who has a compromised immune system. Their occurrence in the context of HIV infection usually indicates that the person needs to start ART. Many are AIDS-defining. *

Palliative Care: An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. ***

Post-exposure prophylaxis (PEP): Immediate HIV therapy (started within 72 hours of exposure), usually given for 4 weeks, following a high-risk HIV exposure. The aim is to reduce the risk of acquiring HIV*.

Pre-exposure prophylaxis (PrEP): Anti-HIV medication taken by people who

are HIV negative to lower their risk of acquiring HIV. It usually involves taking drugs on a daily basis. *

Prophylaxis: Treatment that is given to prevent the occurrence of an infection. *

Self-stigma: Refers to feelings of hatred, shame and blame towards oneself. Individuals may believe that they may be judged by others and may refuse to disclose their HIV status for fear of possible negative reactions from family and friend. ***

Social protection: Defined as "all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance social status and rights of the marginalized; with the overall objective of reducing the economic and social vulnerability of the poor, vulnerable and marginalized groups". Social protection is more than cash and social transfers; it encompasses economic, health and employment assistance to reduce inequality, exclusion and barriers to accessing HIV prevention, treatment, care and support services.

Stigma: Described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others, such as when certain attributes are seized upon within particular cultures or settings and defined as discreditable or unworthy. When stigma is acted upon, the result is discrimination.

Test and Treat: Test and treat is sometimes used as a way of referring to voluntary HIV testing and the offer of antiretroviral therapy after diagnosis, irrespective of WHO clinical stage or CD4 cell count. The voluntary nature of both testing and treatment should be emphasized to ensure that individual autonomy is respected.

TB/HIV Co-infection: TB is the leading HIV-associated opportunistic infection in low- and middle- income countries, and it is a leading cause of death globally among people living with HIV. The term HIV-associated tuberculosis or HIV-associated TB should be used, rather than the shorthand HIV/TB, in order to distinguish such instances from tuberculosis per se. The main strategies to reduce the burden of HIV in TB patients are HIV testing (for people whose HIV status is unknown) and the provision of antiretroviral therapy and cotrimoxazole preventive therapy (CPT) (for people living with HIV). The main activities to reduce TB among people living with HIV are regular screening for TB among people in HIV care and the provision of isoniazid preventive therapy (IPT) and ART to HIV-positive people without active TB who meet eligibility criteria.

Treatment as Prevention (TasP): An HIV prevention intervention where treating an HIV- positive person with antiretroviral medication is used to reduce the risk of transmission of the virus to a negative partner. *

Tertiary care: Specialized consultative care, usually on referral from primary or secondary medical care personnel, by specialists working in a centre that has personnel and facilities for special investigation and treatment. *

Transition: The purposeful, planned movement of adolescents and young adults with chronic physical and mental conditions from child-centred to adult-oriented health care systems. *

Viral load: The quantity and activity of HIV in an individual's blood, usually measured by a test that determines the number of copies/mL*

Viral rebound: Confirmed measurable HIV viral load, usually of more than 200 copies/mL, after previously reaching viral suppression on therapy. *

Vertical transmission: Also known as 'mother-to-child' transmission. The transmission of an infection or other disease from a woman to her child. 'Vertical transmission' is a more inclusive term, and acknowledges the role of the father/male sexual partner. *

**British Standards of Care for PLHIV (2018); **Pakistan national Guidelines for Community and Home-Based Care (2015); ***India Operational Guidelines for Care and Support Centers (2013); ****WHO Promoting mental health: concepts, emerging evidence, practice (Report, 2005).*

EXECUTIVE SUMMARY

The National HIV and AIDS Community Care and Support Guidelines defines the minimum standard of care including medical, psychosocial and economic for PLHIV, PABA and key and vulnerable populations. It contains information on care and support services to be accessed by PLHIV (including adolescents and young people living with HIV), key and vulnerable populations and PABA at facility, community and household level. The guidelines are relevant to all service providers as it provides information on what is required as well as indicators to measure performance at the end of a chapter. The document is made up of nine chapters covering the range of care needed by PLHIV, PABA, key populations and other vulnerable groups.

Chapter 1 presents a general overview of the status of HIV/AIDS in Nigeria as well as a situational analysis of care and support services in Nigeria. Report of the SWOT analysis of the 2014 Guidelines was also included. Conceptual frameworks on the continuum of care for PLHIV using integrated approaches such as the bidirectional H-H and Spoke Model, Integrated Chronic Disease Model, Differentiated Service delivery Model and stepwise approach to linkage, adherence and retention in care were all explained in chapter 2.

Chapter 3 deals with delivery of care and support services, and clearly describes in details the component services of a comprehensive package of care and support services. The tripartite need of PLHIV (including adolescents and young people living with HIV), key and vulnerable populations and PABA which includes medical, psychosocial and economic were explained in details with emphasis on mental health, role of religious leaders etc. It outlines services that should be on offer at health facilities and those that ought to be provided at the community level. In addition, this chapter defines the minimum package of Care and Support services that should be offered to PLHIV in the facility and in the community and also services for vulnerable children

The focus of chapter 4 is on provision and retention in care of PLHIV across the life course. It recognizes the diverse needs of people living with HIV at various stages in their lives and thus highlights what is needed for linkage, adherence and retention in care at each stage. It covers services to be provided for children, adolescents, youths, adults, aged as well as key and vulnerable populations. Chapter 5 defines Positive Health Dignity and Prevention and prescribes its minimum package of interventions for PLHIV. It touches on participation of PLHIV in their care, self-management and peer support, health promotion, access to treatment, sexual and reproductive health, prevention of transmission of HIV and AIDS and STIs, protection of human rights including stigma and discrimination reduction and response, gender equality, socioeconomic support and empowerment of PLHIV.

Chapter 6 focuses on the nutrition of the person living with HIV and AIDS and aptly describes the relationship between nutrition and HIV and AIDS. It

speaks to the goals of nutrition counseling and recommends nutrient requirements for the PLHIV. Chapter 7 addresses the management of mental health conditions of PLHIV. It recognizes the need for early detection of mental disorder in PLHIV, PABA, key populations and other vulnerable groups as well as what services are required.

Chapter 8 describes policy and programming for HIV/AIDS Care and Support and focuses on governance, administration and resourcing for Care and Support. It outlines the specific roles of key stakeholders including government, NGOs, and service providers in ensuring compliance with guidelines, provision of services, and effective monitoring and evaluation. Chapter 9 is on monitoring and evaluation of care and support programmes with the overall purpose of measuring programme results at all levels and guide towards achieving goals and strategic objectives.

CHAPTER 1: INTRODUCTION

1.1 Overview of HIV and AIDS in Nigeria

Globally, HIV and AIDS continue to be an important public health issue. In 2019, statistics revealed that 38million people were living with HIV made up of 36.2 million adults and 1.8 million children aged 0-14 years; 1.7 million people newly infected with key populations and their sexual partners accounting for 62% of the new infections. Also, 690,000people died of AIDS-related illnesses across the globe while 25.4 million PLHIV are accessing antiretroviral therapy.[1] In 2017, Nigeria had an estimated 210,000 total new infections, of which 36,000 were among children while 150,000 lives were lost prematurely to AIDS and its complications.[2] Estimates from the reports of the Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) carried out in 2018 revealed that total estimated 1.9 million persons are living with HIV in Nigeria while an estimated 47% of the total number of people living with HIV are on treatment with an unmet need of about 1.0 million people.[3]

Various global efforts and advocacy continued to place HIV and AIDS on the priority agenda of many nations. The fast track report of UNAIDS targets achievement of 90:90:90 by 2020 and 95:95:95 by 2030 advocating that the epidemic can be reduced if 95% of people living with HIV know their status, 95% of those diagnosed receive treatment and 95% of those receiving Anti-Retroviral Drugs are virally suppressed.[4] The goal of the Revised National HIV and AIDS Strategic Framework (NSF) 2019-2021 which took on board the findings from the NAIIS and also supersedes the NSF 2017-2021 which is to fast-track the national response towards ending AIDS in Nigeria by 2030 also resonates with this. It is also to be noted that this target can be achieved if the care and support system at the community level is well strengthened.

In 1986, Nigeria's first official case of Acquired Immune Deficiency Syndrome (AIDS) was recorded and since then, there has been a gradual shift from HIV and AIDS being a myth to a reality of a serious health problem that needs to, and can be managed. Various surveys were carried out over the years to monitor the trends of HIV infections. From the results of the surveys, the emerging picture in the pattern, trend and level of HIV infection over the years showed a great diversity and can be described as complex. It showed a general epidemic affecting the general population and concentrated epidemic affecting key and vulnerable populations as well as geographic and gender variations. Findings from the National HIV Sero prevalence Sentinel Survey (NHSS) among pregnant women attending antenatal care showed an increase from 1.8% in 1999 and peaked at 5.8% in 2001 and then dropped to 5.0% in 2003 and continued the further decline over a period to 3.0% in 2014.[5]

[1] (UNAIDS, 2020)
[2] (NACA, 2019 (A))
[3] ibid
[4] (UNAIDS, 2014)
[5] (NACA, 2018)

The Integrated Biological and Behavioral Surveillance Survey (IBBSS) 2014 also reported a general decline in HIV prevalence across the studied groups between 2010 and 2014 although it is still to be noted that the prevalence rates among the key population groups is still higher than the national prevalence rate. The prevalence rate dropped from 4.2% to 3.2% among People Who Inject Drugs (PWID), and the same trend was also observed among Brothel-Based Female Sex Workers (BBFSW) and Non Brothel-Based Female Sex Workers (NBBFSW) from 27.4% and 21.1% respectively to 19.4% and 8.6%. Prevalence rate among Men who have Sex with Men (MSM) however increased from 17.2% in 2010 to 22.9% in 2014.[6,7].The findings from the National HIV and AIDS and Reproductive Health Survey (NARHS) among the general population also followed a pattern of decline from 3.6% in 2007 to 3.4% in 2012. The concerted efforts of stakeholders at stabilizing the epidemic and reversing it are thus evident.

However, the recently concluded NAIIS changed the narratives of the national HIV and AIDS response (in terms of prevention, treatment and care) and provided baseline data upon which subsequent response going forward can be hinged on along with other surveys especially among key and vulnerable populations. Such surveys include National guidelines for implementation of HIV prevention programmes for FSW and MSM in Nigeria as well as Situation and Needs Assessment of HIV and AIDS, Drug use and related health services in prisons and borstal institutions in Nigeria.

Acclaimed as the largest ever population-based HIV survey, the NAIIS findings reveals that the current national prevalence of HIV is estimated at 1.4% (15-49 years).[8] The HIV prevalence among adults, 15-49 years is 1.4% and 15-64 years is 1.5% while it is 0.2% among children 0-14 years. The HIV prevalence among people in prison is 2.8%, which is double that of the general population.[9]

It is however evident that women and girls are still more affected as the HIV prevalence for females in the age bracket of 15-64years is 1.9% compared to 1.1% among the male counterparts. While the South-South zone has the highest prevalence of 3.3%, the North West had the least prevalence rate of 0.6%.[10] The distribution of HIV burden across age bands indicates 12% of persons living with HIV are between the ages of 0-14 years while 75% are between 15-49 years and 13% are 50 years and above. Adolescents (10-19 years) account for 8% of persons living with HIV.[11] Nigeria has moved from the 2nd to 4th position in the global HIV prevalence rate.

Of importance also are the key population groups (FSW, MSM and PWID) and their partners who are estimated to constitute 3.4% of the adult population

[6] (FMOH, 2010)
[7] (FMOH, 2014)
[8] (NACA, 2019 (A))
[9] UNODC, 2019)
[10] (NACA, 2019 (B))
[11] (NACA, 2019 (A))

and they together contribute 40% of new infections. Female Sex Workers, their clients and client partners alone contribute roughly 20% of new infections of which three-fourths may be attributable to brothel-based FSW. Also, PWID and MSM and their partners respectively contribute about 9% and 10% of the annual new infections.[12] The implication of the high prevalence rates among key populations is that more attention needs to be paid to the structural and legal barriers fuelling infections among these groups if the success achieved is to be sustained. Not only was there a reduction in the HIV prevalence among the general population, findings from the survey also revealed that significant Viral Load Suppression (VLS) was achieved among people living with HIV. In general, it was reported that almost half of PLHIV in Nigeria achieved viral suppression. VLS among PLHIV 15-64 years is 44.5%. It is however highest among males age 55-64 years at 55.0% and the highest among females aged 45-54 years at 54.3%. The VLS gender disparity between females and males was greatest among those age 25-34 years, with females' age 25-34 years having VLS of 40.0% compared to males in the same age group -20.3%. Geographically, the highest VLS was achieved in the North Central (65.6%) while the lowest with 33.7% VLS was in the South-South zone.[13]

Also, it has been established that TB is the leading cause of death among people living with HIV and AIDS and it is one of the top ten causes of death worldwide.[14] Nigeria is among the high TB, TB/HIV and DR-TB countries globally and ranks 7th among the 30 high TB burden countries globally and number two in Africa accounting for 4% of the estimated incidence cases globally with a TB incidence rate of 219/100,000 population and mortality rate of 39/100,000 respectively.[15] The estimated incidence of TB among HIV positive patients is 34/100,000 population and mortality among HIV positive TB patients is 21/100,000 population.[16] Also, the proportion of HIV positives newly enrolled in care on preventive treatment increased from 29% in 2016 to 39% in 2017.[17] The need therefore to intensify effective TB/HIV integration especially at the community level for active case findings of the two diseases and make referrals where needed cannot be overemphasized.

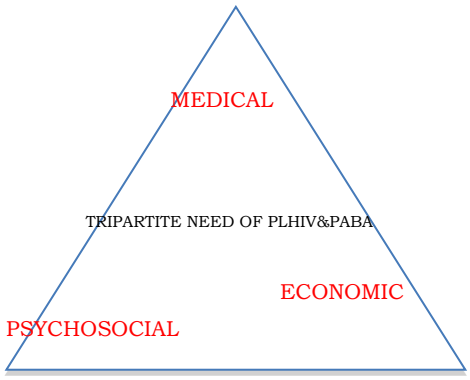
However, in line with the vision of the National Strategic Framework (NSF) of an AIDS-free Nigeria, with zero new infection, zero AIDS-related stigma and discrimination, more still needs to be done especially among the key populations who are disproportionately affected by the epidemic in order to meet global expectations of ending AIDS in 2030.

[12] ibid
[13] (NACA, 2019 (B))
[14] (WHO, 2018)
[15] (FMOH, 2017)
[16] (NACA, 2019 (A))
[17] ibid

1.2 Situational Analysis of HIV and AIDS Community Care and Support in Nigeria

The advent of anti-retroviral drugs caused a major paradigm shift in the way HIV was perceived since the first identification in 1986. Before the introduction of Antiretroviral Treatment (ART), HIV and AIDS was perceived as a mysterious fatal illness and death sentence that has to be managed with palliative care being provided. Stigma and discrimination were deeply entrenched since HIV and AIDS was considered a taboo. With significant advances in ART and consequent improvement on medical outcomes, the perception changed to a chronic disease that can be managed with more people on treatment, increase life expectancy, and more demand for care and support services

In 2006, National Guidelines for HIV and AIDS Palliative Care was developed and this provided direction for care and support interventions for CSOs and Networks providing care and support services. The need for a national guideline with a broader outlook with well-defined national standard package for care and support services coupled with significant gaps in coordination and implementation/ service delivery of the 2006 palliative care guidelines led to the development of a National Guidelines on HIV and AIDS Care and Support in 2014. The goal of the 2014 guidelines is to provide guidance for the design, implementation, monitoring and evaluation of care and support services.



However, the increasing comorbidities of an ageing HIV population as well as other socio-economic factors bring other challenges to the provision of quality care that has to be addressed. Living with HIV requires lifelong adjustments and management. The need to take cognizance of the diverse needs of people living with HIV at various stages of life in care and support service delivery is also becoming more evident. The medical, economic and psychosocial (tripartite need) challenges associated with HIV and AIDS impact on the provision of care. The combination of new HIV infections, increased life expectancy for people living with HIV, greater use of antiretroviral drugs and healthcare services, and changing comorbidities is redefining the way care and support services are delivered.

The continuum of care needed by people living with HIV and AIDS starts from the time they first receive diagnosis through to positive living (including dealing with HIV stigma, strong self-management skills, education and engagement in peer support, participation in decisions about all aspects of treatment and care, service design and delivery). It is also worthy of note that the HIV and AIDS response is fast losing sight of the community end of the response both in policy and implementation especially as regards care and support services. Most of the National Guidelines on Prevention, Treatment

and Care tend to focus majorly on the medical services. Adherence to treatment can be strengthened with efficient community care and support system.

Aside medical needs, other needs of PLHIV (including adolescents and young people living with HIV), key and vulnerable populations and PABA include psychological, nutritional, educational, spiritual, economic and legal; most of these services are provided by community-based structures and individuals including Community Based Organizations (CBOs), Faith Based Organizations (FBOs), networks, schools, community members and families. More often than not, it is the same community structures that will ensure the continuity of care provided to the PLHIV client at the health facility through the continuum of care, if properly coordinated

Though given different names such as (by different HIV implementers) Peer Educators/Counselors, Adherence Counselors, Mentor Mothers, Volunteers, Client Tracking Person and Home-based Care Providers, Community Health Influencers, Promoters and Services (CHIPS), these community structures and members target PLHIV including children, adolescents and young people, pregnant women, PWID, PWD, FSW, MSM and the chronically ill within the community.

They also assist in:

1. Early case identification through testing and counseling and consequent enrollment.
2. Retention of clients in treatment
3. Tracking loss to follow up clients.
4. Referral and networking
5. Identification of other important co-morbidity such as TB

HIV community care and support services must therefore evolve to meet the challenges of the varying needs of a changing population of people living with HIV in form of quality care that promotes the mental, emotional, cognitive and socio-economic well-being of people living with HIV, Adolescents and Young People Living with HIV (AYPLHIV), key populations and other vulnerable groups as well as people affected by HIV. In view of the changing nature of care and support and in line with best global practices, the development of the new National HIV and AIDS Community Care and Support Guidelines included the review of the 2014 Guidelines in order to understand the status of HIV and AIDS community care and support programming and inform the development of one that would address the current programming needs.

1.3 Report of the Review of 2014 National Guidelines on Care and Support

A rapid appraisal of the implementation status of the 2014 National Guidelines on HIV and AIDS Care and Support was carried out during the development process of the new guideline. The aim was to elicit information from state and non-state actors on the adequacy and ease of implementation

of the guideline. It also aimed at identifying emerging issues and current strategies in the delivery of HIV and AIDS community care and support services. This will help to build on the strengths, challenges, opportunities and threats inherent in the guideline as a new guideline is been developed.
A desk review of the 2014 guideline was also carried out and some of the identified gaps in the community care and support components of the national HIV and AIDS programme are:

- Operational definition of concepts and terminologies to guide implementation not clearly set out
- The continuum of care does not adequately explain community level of care and support as well as linkage to social protection nets for PLHIV, PABA and other vulnerable populations
- No clearly defined anti-discrimination response system
- No clear guidelines to address human rights and legal environment
- Care and Support needs of Key Populations not elaborated
- Mental Health Disorders (MHD)-Early Detection and Counseling completely left out
- Non integration of TB and HIV collaborative services at the community level
- No national training manual for community structures on Income Generating Activities (IGA)
- Indicators do not cover all the aspects of care and support services for PLHIV, PABA and other vulnerable populations

A set of checklists was developed to measure the adequacy and ease of implementation along with a SWOT analysis. Stakeholders working in the area of community care and support services and with attention to national coverage filled the checklists. Respondents include state actors such as Federal Ministry of Women Affairs, State Ministries of Women Affairs (Benue and Akwa Ibom), Benue State Agency for the Control of AIDS; Implementing Partners, Networks and Non-governmental organizations including Institute of Human Virology, Nigeria (IHVN), APIN Public Health Initiatives, ASWHAN, AONN, APYIN, NINERELA+ and Center for Health, Education, Economic Rehabilitation and Social Security (CHEERS). Figures 1:1 and 1: 2 give the summary of the adequacy and ease of implementation of the 2014 Care and Support Guideline.

From Figure 1.1, virtually all the topics in the document were deemed to be necessary except supportive services and eligibility for HIV and AIDS for the fact that they were not clearly explained and has also been taken care of in other areas. However, the contents, though necessary were deemed inadequate for all the chapters. However, the chapters on Nutrition and PHDP were to a large extent, adjudged to be adequately covered. Some of the concerns raised include non-delineation of PLHIV by age cohorts especially adolescents and youths; no clear guide on linkage of PLHIV, PABA and other vulnerable populations to government agencies for the much needed economic support; mental health of PLHIV and PABA not properly explored; community roles and interventions were not clearly articulated; lack of clear guidelines on the roles of government agencies involved in care and support

of PLHIV and PABA especially non-medical needs; missing indicators on non-health sector care and support as well as reporting lines and operational definitions for terms used.

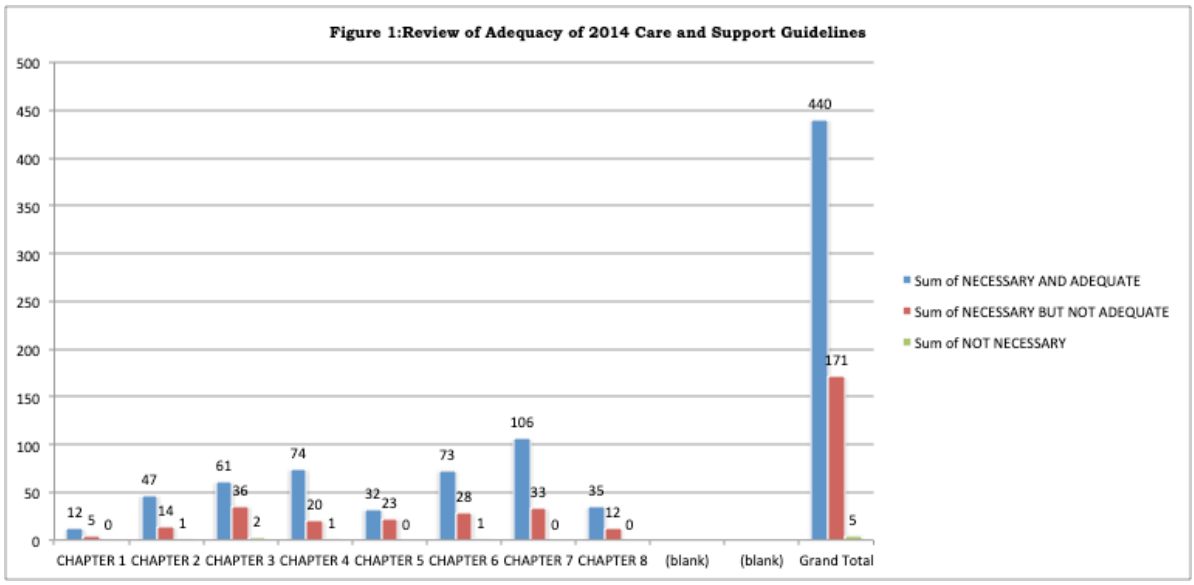


Figure 1 1: Review of Adequacy of 2014 Care and Support Guidelines

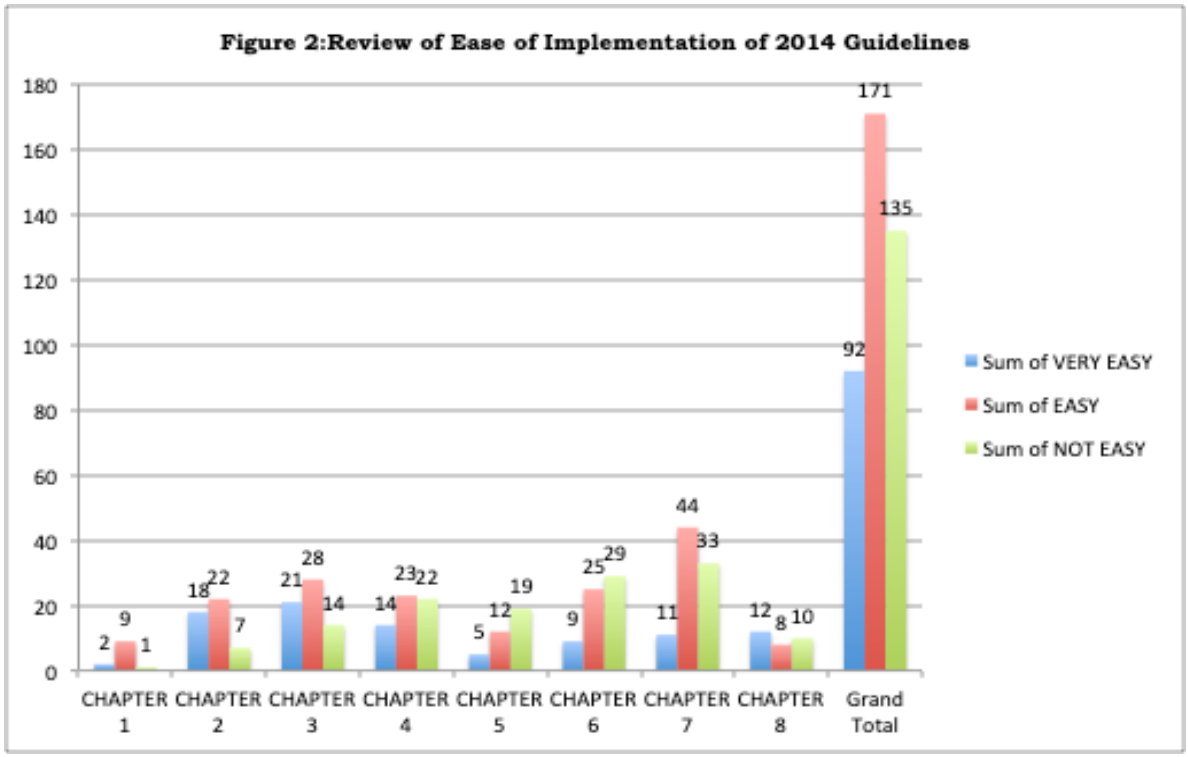


Figure 1 2: Review of Ease of Implementation of 2014 Care and Support Guidelines

With regards to ease of implementation, some of the issues raised include lack of coordination and synergy among and within state and non-state actors; poor structures and lack of capacity at the Local Government Area (LGA) makes cascading of policies and other issues from federal and states

difficult; data housed mostly with Implementing Partners and not government makes data flow and reporting difficult; lack of funding for economic empowerment; lack of proper response mechanism linking federal to community on issues of human rights violation (stigma and discrimination, gender based violence etc.) and lack of capacity for measuring impacts (Figure 1:2).

Table 1. 1: SWOT Analysis of the 2014 Care and Support Guidelines

STRENGTHS • The simplicity of the language to the understanding of a non-literate person • The inclusion of nutritional provisions which has long been neglected • Inclusion of PHDP is good • Availability of a national reference document that provides general guide on care and support • It addresses the contextual issues of the population concerned • It covers the necessary domains to some extent	**WEAKNESSES** • Issues peculiar to adolescents and youths are subsumed under people living with HIV/AIDS • The policies are not cascaded down at the local level • A lot of blanket statements as regards the government agency responsible for oversight functions • Guideline lacks information on current government programmes that can be leveraged on for care and support • Specific targets/indicators were not listed/identified • Issues around some key components such as; mental health, TB, nutrition, health insurance scheme and education were not clearly stated • No provisions for intermittent review of the document to know the level of its implementation (e.g. midterm review, etc.) • Poor data sharing with actors • Donor dependency
OPPORTUNITIES • Community level support • Provides capacity building opportunities for service providers in the community • Availability of stakeholders such as NACA, SACAs, IPs, MDAs, NGOs, FBOs, CBOs, etc • Defined Policy Guidelines on Care and Support	**THREATS** • Some content out of date • Document might be seen as a repetition of other guidelines • Non budgetary releases, non-counterpart funding • Displacement due to natural disasters and communal crisis (flooding, farmers/herders clash) • Economic recession/high level of poverty/ high rate of unemployment

The SWOT Analysis of the 2014 Care and Support guideline is presented in Table 1:1

Some of the general recommendations for the new direction for HIV and AIDS community care and support programme include:

- Provision for Midterm Review of HIV and AIDS Community Care and Support Guidelines
- Provision for periodic interface of all actors to share experiences of achievements, best practices, challenges and bottlenecks in community care and support services with clear fixed periods and Terms of Reference (TOR) for Technical Working Group (TWG) meetings
- A practical and implementable response mechanism on stigma and discrimination should be clearly described.

- Clear guidelines on the role of various government agencies at all the levels
- Integration of TB and HIV at the community level

Based on this report and in line with emerging issues and best international contemporary practices in care and support services, some of the new infusions in this new guideline include integrated approach to care and support services for a continuum of care that provides the link between facility, community and households as well as taking care of comorbidities associated with HIV such as TB etc. (The Bi-directional H-H and Spoke Model of Care); Care and Support for PLHIV across life course based on linkage, adherence and retention in care of various age cohorts including children, adolescents, youths, adults, the aged, Key and Vulnerable populations and People living with Disabilities; management of mental health conditions in HIV and AIDS and antidiscrimination response system that provides a link between the state and the community.

1.4 Aims of the Guidelines

The National HIV and AIDS Community Care and Support Guidelines defines the minimum standards of care required for People living with HIV (PLHIV), People affected by HIV (PABA) and other key and vulnerable populations. Implementation of the standards is expected to lead to quality life and well-being of PLHIV, PABA, Key Populations and other vulnerable groups. The guidelines aim to inform:

- ✓ PLHIV and AYPLHIV about the expected standards along the continuum of care (including medical, psychosocial and economic)
- ✓ PABA about the expected standards along the continuum of care (including medical, psychosocial and economic)
- ✓ Key and Vulnerable Populations (such as FSW, MSM, PWID, PWD, IDP, and pregnant mothers) about the expected standards along the continuum of care (including medical, psychosocial and economic)
- ✓ Service Providers at all levels of minimum standards of care that PLHIV, AYPLHIV, Key Populations, PABA and other vulnerable groups are expected to receive

1.5 Scope of the Guidelines

This is the second review of the National Guidelines on Care and Support for PLHIV. Emerging issues in the global and national care and support programme necessitated the review and it is done in line with identified international best practices. The review is done in partnership with various stakeholders including partners, networks of PLHIV and PABA, community associations, care providers and people living with HIV. The document is made up of nine chapters addressing important issues for the community care of people living with HIV with focus on the delivery of equitable, high-quality services on the care and support of PLHIV, AYPLHIV, Key Populations, PABA and other vulnerable groups.

1.6 Guiding Principles of HIV and AIDS Community Care and Support

The overarching principles that underpin all aspects of these guidelines are:

1. HIV and AIDS is a chronic condition that requires a multi-disciplinary approach and multi-sectoral collaboration in its management; with attention on the non-health sector and psychosocial and economic determinants of health
2. Care and Support of PLHIV, AYPLHIV, PABA, Key Populations and other vulnerable groups should be holistic within the continuum of care
3. PLHIV, AYPLHIV, PABA, Key Populations and other vulnerable groups should be provided with equitable and non-discriminatory care (regardless of age, gender, religion, physical ability and sexual orientation) across all health and social care settings.
4. Meaningful and greater involvement of PLHIV, AYPLHIV, PABA, Key populations and other vulnerable groups in the design, implementation and evaluation of community care and support services
5. Effective referral, linkage and network support systems including the use of peers as case managers.
6. All information (especially disclosure of status) collected for any purpose (surveillance, monitoring or research) should be kept with high confidentiality and in line with ethical standards
7. Coordinating mechanisms for community care and support should include and position the communities delivering and accessing services in leadership roles to ensure ownership and sustainability
8. Economic empowerment of PLHIV, AYPLHIV, PABA, Key Populations and other vulnerable groups via sustainable employment opportunities, skills acquisition, income generating and livelihood activities should be prioritized.

CHAPTER 2: CONCEPTUAL FRAMEWORKS FOR CONTINUUM OF CARE IN HIV AND AIDS COMMUNITY CARE AND SUPPORT SERVICES

2.1 Introduction

Continuum of Care refers to the provision of comprehensive care from the hospital to the home, which ensures the pooling together of medical and social services within the community and the creation of linkages between community care initiatives and all other levels of the health care system. More often than not, the emphasis is on the medical aspect with the HIV care continuum viewed as a progression from testing to HIV diagnosis and linkage into care, retention in care, adherence to ART, and, ultimately, suppression of the virus. People living with HIV need to be seen as an entity with consideration given to the psychosocial and economic determinants of their health; hence, the viral load becoming undetectable should not be seen as the end game but a milestone in a patient-centered approach.

For care and support services, comprehensive continuum of care involves care that promotes the mental, emotional and cognitive well-being of people living with HIV and AIDS. Well-being is a consideration of the broader quality of life issues for people living with HIV and AIDS; such include the psychosocial and economic determinants of their health and not just treatment for viral suppression, physical health and increased longevity. The emphasis here is on the more holistic sense of self-worth and happiness that contributes to quality of life for individuals and communities. Improving and maintaining well-being for people living with HIV clearly brings individual benefits, including greater happiness, social participation, self-worth, improved physical health, greater resilience in the face of adverse events, and more opportunities to contribute to society. A model that forges close working links between primary care, secondary care, mental health services, social care, legal services, peer support and voluntary sector agencies are required to maximize well-being.

2.2 Integrated Approach to Care and Support Services

At the heart of any integrated approach to treatment, care and support of HIV and AIDS is the identification of ways of enhancing service coordination among all the players so that services are accessible, appropriate and effective. Comprehensive and quality HIV care and support services should be at three levels, namely facility, community and household. Patients should have access to care at all the three levels, and an effective referral system needs to be put in place for seamless transfer of care from and within the levels. Figure 2:1 is a graphic representation of such integrated approach.

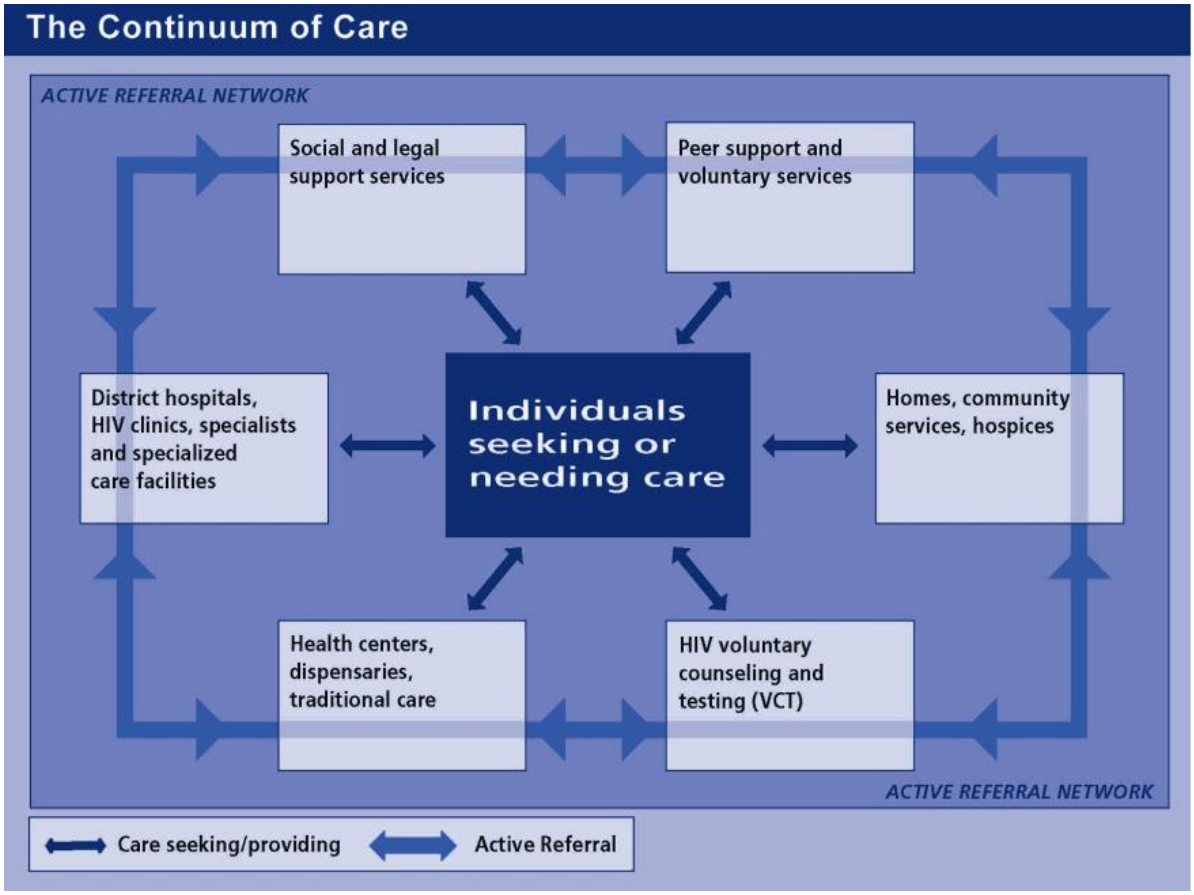


Figure 2. 1: Continuum of Care for Care and Support Services (Source: National Guideline on Palliative Care, Federal Ministry of Health (2006)]

2.2.1 Integrated Cluster System (The Hub and Spoke Model)

The Hub and Spoke Model is a method of organization involving the establishment of a main hub, which receives the heaviest resource investments with most array of services, complemented by spokes, which offer more limited service arrays at sites distributed across the target location/community. In the hub and spoke model, there are different parts of the wheel with different roles, but in the end, everyone is on the same wheel that is spinning. In cases where spoke-to-hub access proves impractical, additional hubs can be developed, creating a multi-hub network.

In a multi hub network, a central hub, controls the entire system, but the lower level hubs also have levels of autonomy in service delivery within their scope. For efficiency however, there has to be a strong communication and referral among and within the hubs and spokes without which the entire model will be disoriented. The hub and spoke model is often used to describe the relationship between different levels of the health care delivery system in the delivery of HIV and AIDS services especially ART where the Tertiary Health centres usually serve as the hubs in the model but with established linkages with several secondary facilities. The secondary facilities serve as spokes from the tertiary facilities and at the same time serve as hubs for the primary level of care. **Figure 2:2** is a graphic representation of The Hub and Spoke model

portraying a continuum of care that links the facility to the community and households for community care and support services. In the **bidirectional hub-hub & spoke model**, which is adopted for the community care and support programmes, there are multi hubs with the main hub as the Ministry of Women Affairs and Social Development or any organ/institution playing that role in each state and its organs at the Federal, State and LGA level.

The MWA&SD as the main/central hub has the function of coordinating the whole system given their mandate as a ministry, which includes among others:

- Mobilization of women, children, the aged, Persons with Disabilities (PWDs), People Living with HIV (PLHIV), and other vulnerable populations to participate fully in the social, economic and political development of the country
- Promotion and protection of the rights of vulnerable populations by upholding various international conventions such as the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), the Child Rights Act, the Persons with Disabilities Act, the Aged Bill, the National Policy on Gender, the Violence Against Persons Prohibition Act (VAPPA), the HIV/AIDS Anti-Discrimination Act.
- Provision of psychosocial services to members of the public through mediation in family crisis between husbands and wives through family casework, children and parents' problems in juvenile case work, kindred casework, handles teenage and out of wedlock pregnancies.
- Registration and supervision of Community Based Organizations, Non-Governmental Organizations and Community Development Associations.
- Provision of social welfare perspectives to issues in secondary schools.
- Offering of counseling services to the members of the public.
- Establishment of shelter for vulnerable children and survivors of Gender-Based Violence (GBV)

Other hubs are health facilities, gender centres, TB Community Care Centres, security agencies, SMEs and community improvement centres. The spokes are the support groups, networks, CBOs, FBOs among others. Roles of each hub is given below:

Health Facility: As a hub, it has the function of providing health care services to the general population, PLHIV, AYPLHIV, Key Populations and other vulnerable groups. It also serves as health care coordinating Hub to spokes via referral services for GBV/non-health related cases. Services provided include:

- Health care service delivery and referral receptor points (centers for rehabilitative care of GBV survivors)
- Offering of counseling services (including counseling on mental health disorders) to health care seeking clients
- Conduct need based community health outreaches and research in collaboration with spokes (CSOs, CBO, FBOs)

- Provides coordination of TB DOTS Centres
- Screening for early detection and Referral for mental illness among PLHIV, AYPLHIV, Key populations and other vulnerable groups.

Gender Centre: Provides pre and post GBV care services to general population including adolescent girls, young women and adolescent boys as well as PLHIV, AYPLHIV, Key Populations and other vulnerable groups. It also serves as a coordinating care Hub to spokes via referral services for GBV related cases. In summary, gender centers provide:

- Pre and Post GBV care service delivery and referral receptor points (centres for rehabilitative care of GBV survivors)
- Offering of counseling services to GBV survivors / care seeking clients
- Conduct need based community GBV responses and research in collaboration with spokes (CSOs, CBO, FBOs)
- Follow up on referred cases including legal issues

Security Agencies: As a hub, the function is to provide protection response care services to general population and PLHIV within communities. It also serves as a coordinating care Hub to spokes via referral services for investigation of suspected cases of violation of rights and prevention of crimes within the community. Services provided include:

- Arrest of suspects, investigation of crimes including stigma and discrimination against PLHIV, AYPLHIV, key and vulnerable populations and PABA.
- Provision of community security for general population including PLHIV, AYPLHIV, PABA as well as key and other vulnerable populations
- Conduct need-based community GBV prevention seminars for responses and research in collaboration with spokes (CSOs, CBO, FBOs)

SMEs: These are small and medium scale enterprises (Hubs) ventures that work in collaboration with spokes to provide job opportunities, livelihood programmes and capacity building for general population and PLHIV and referral points on non-SME-related matters to other Hubs or spokes as the need arises. Other services include:

- Provision of jobs, business opportunities to beneficiaries
- Provision of trade specific skill acquisition opportunities and livelihood programmes for PLHIV, AYPLHIV, PABA, key and other vulnerable populations that is sustainable.
- Support the conduct of need-based community protection responses and research in collaboration with spokes (CSOs, CBO, FBOs)

Community Improvement Centres (CICs): As a hub, their function is to provide oversight function to community-based HIV/AIDS response services. It focuses on strengthening existing community response structures for HIV/AIDS prevention services. It also serves as coordinating care Hub to spokes via referral services for non-related needs-based services. Other services include:

- Monitoring of community HIV/AIDS services and project implementation
- Referral and monitoring of projects to points of care for PLHIV, PABA, key and other vulnerable populations
- Advocate for and support community structures inclusive of project planning and implementation strategies for PLHIV, PABA, key and other vulnerable populations benefits to ensure sustainability
- Conduct need-based community HIV/AIDS, TB, mental health disorders and GBV prevention seminars for responders and research in collaboration with spokes (CSOs, CBO, FBOs)

Ministry of Justice: Provides legal services and legal oversight function to community-based HIV/AIDS prevention response services. It focuses on promoting the rights of key and other vulnerable populations, PLHIV and PABA. It also serves coordinating care Hub to spokes via referral services for non-related need-based services. Their services also include:

- Provision of legal support services to PLHIV, PABA, Key Populations and other vulnerable groups
- Training of other Hubs and spokes on human rights, stigma and discrimination issues
- Prosecute and arbitrate the violation of rights of PLHIV, PABA, Key Populations and other vulnerable groups.
- Support the conduct of needs-based community HIV/AIDS and GBV prevention seminars for responders and research in collaboration with spokes (CSOs, CBO, FBOs)

Community, Social and Religious Groups: This hub provides care and support services to PLHIV, AYPLHIV, Key Populations and PABA on social and religious issues as it relates to PLHIV, AYPLHIV, PABA, key and other vulnerable populations in communities. It also serves as coordinating care Hub to spokes via referral services for non-related needs-based services. Services provided include:

- Provision of Psychosocial support to PLHIV, AYPLHIV, PABA, key and other vulnerable populations
- Provision of effective referrals with the support of Community Improvement Centres
- Day to day monitoring of care and support services for PLHIV, AYPLHIV, PABA, Key Populations and other vulnerable groups in communities among others.
- Support the conduct of researches and impact measuring surveys

Ministry of Education: This Hub main mandate/functions are to initiate and formulate policies. Their services also include:

- The formulation, planning, implementation and coordination of policies, programmes and activities for Early Childhood Care Development Education (ECCDE).
- Working with NGOs and International Development Partners on issues concerning Gender Education (girl/women/boys).

- Provision of functional literacy and continuing education for adult and youths who never had the advantage of formal education or who did not complete their primary education.
- Formulation, co-ordination, supervision and implementation of all policies and programmes targeted at the education of the children with special needs including physically challenged, visually/hearing impaired, albinos, autistics, children Down's syndrome, gifted etc.

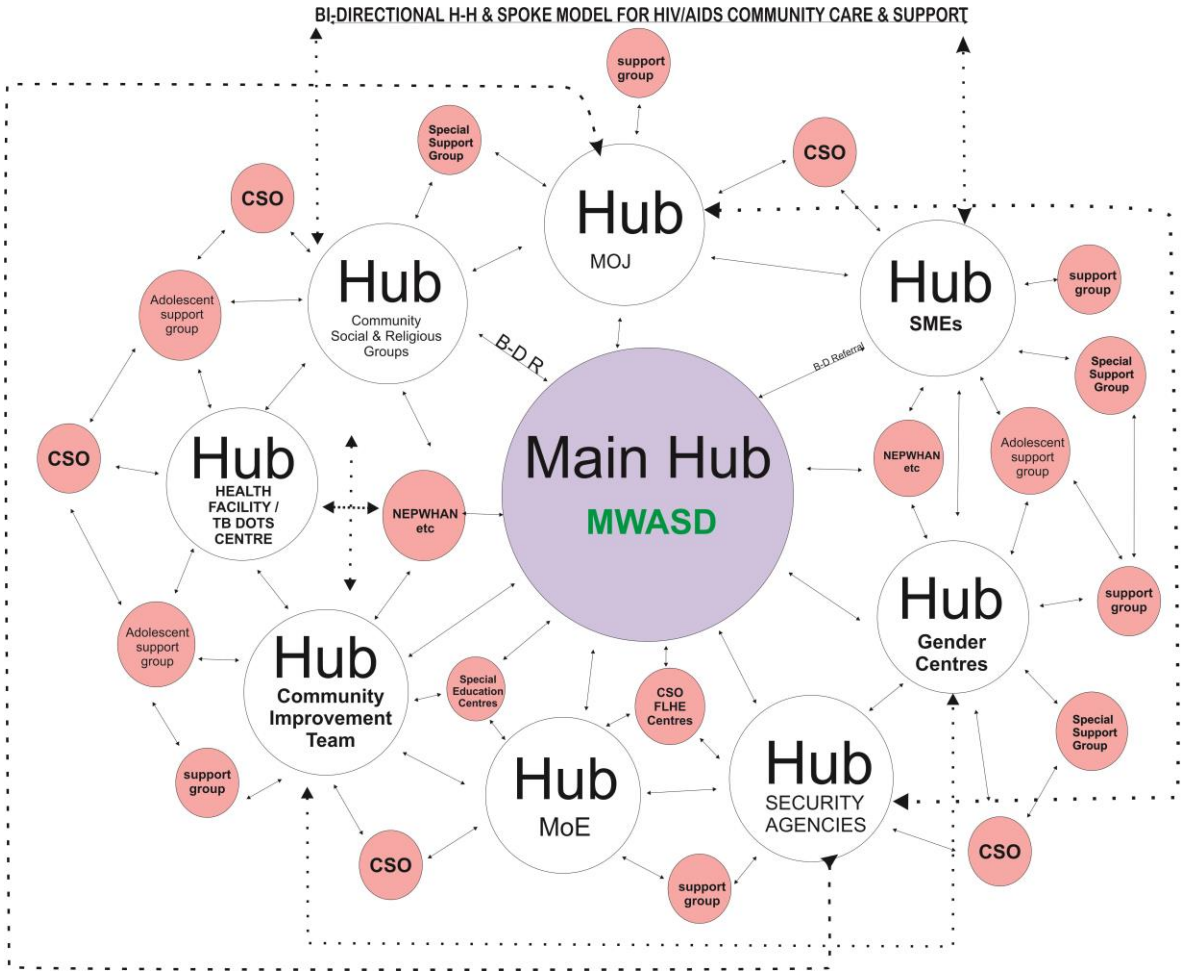


Figure 2. 2: Bi-directional H-H Spoke model for HIV and AIDS Community Care and Support

The Programmatic Flowchart is as shown in Figure 2:3

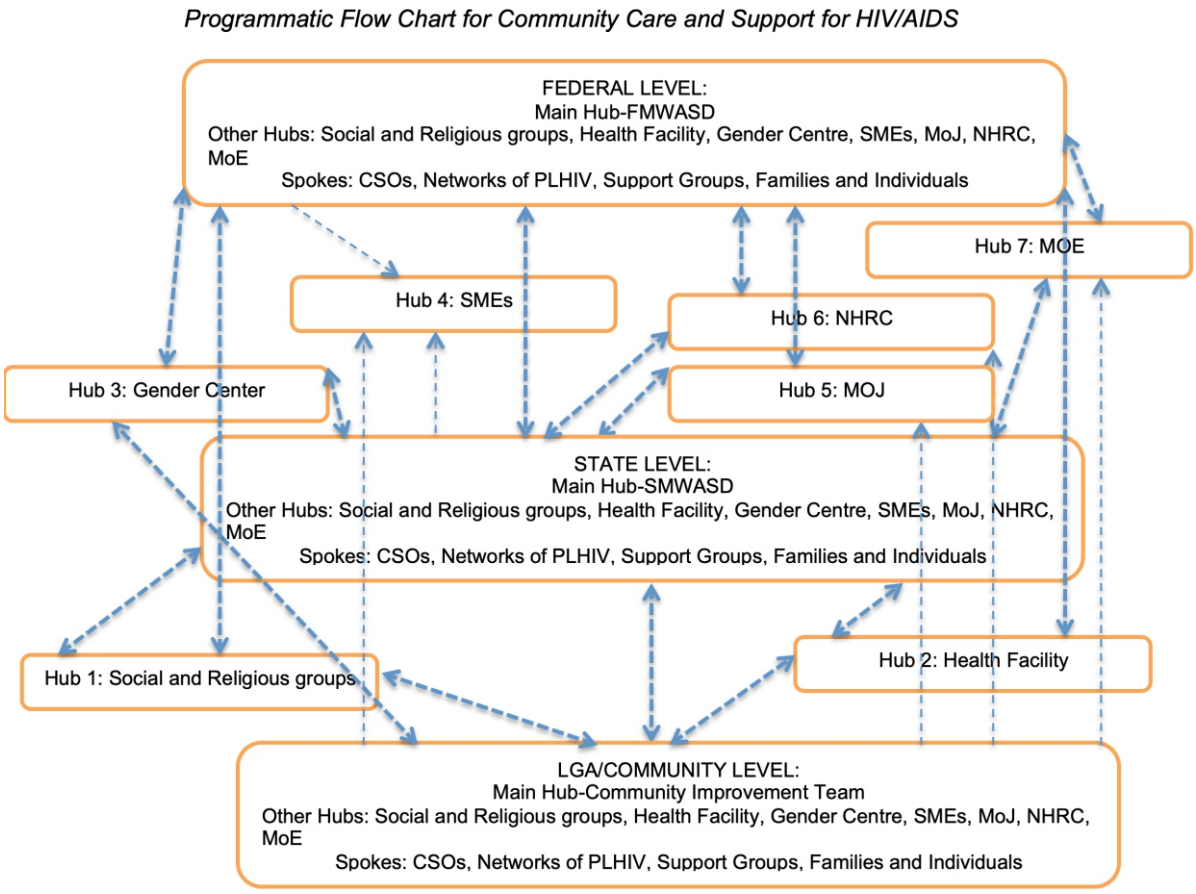


Figure 2. 3: Programmatic Flow Chart for HIV/AIDS Community Care and Support Service

2.2.2 The Integrated Chronic Disease Model (ICDM)

People living with HIV are at increased risk of certain co-infections, particularly TB, hepatitis B and hepatitis C. Risk factors include immunosuppression associated with advanced HIV in the case of TB, as well as shared routes of transmission between HIV and the hepatitis viruses (B and C). It is essential, therefore, that people living with HIV are screened for these co-infections both at initial HIV diagnosis and during follow- up.

ICDM is an approach that strengthens the health system providing integrated prevention, treatment and care for clients with chronic conditions at the PHC level in order to ensure a seamless transition to 'assisted' self-management within the community. The ICDM model addresses chronic communicable diseases, including HIV, TB and MDR-TB, as well as non-communicable diseases including hypertension, diabetes, asthma and mental health illnesses. ICDM is designed to help with early detection of chronic conditions and their appropriate management. The ICDM model offers a 'one-stop shop' approach for all chronic conditions by:

1. Using an integrated counseling model adapted for different conditions to ensure an integrated chronic and service delivery model

2. Training clinical staff to offer integrated consultations to patients with co-morbidities or diverse medical conditions
3. Training community workers in integrated counseling that will enable early detection and referral
4. Establishing clear referral pathway where specialist services are needed

2.2.3 Differentiated Service Delivery Model (DSDM)

Differentiated service delivery is a client-centered approach that simplifies and adapts HIV services along the cascade of care to respond to the preferences and expectations of various groups of PLHIV. It aimed at enhancing the quality of the client experience, putting PLHIV, AYPLHIV, Key Populations, PABA and other vulnerable groups at the centre of the service delivery process while ensuring the health system is functioning in an efficient manner. Different service delivery models are developed to reach a diversity of clients, from those who present well, to those presenting with advanced disease and from unstable to stable clients. Through this approach, the general population, pregnant women, children, adolescents, key populations and vulnerable groups, living in urban or rural settings can all have models of care developed to best fit their needs. Interventions that could help in adherence and should be adopted for care services include but not limited to:

1. Community Adherence (ART) Groups (CAGs) in which stable patients living in the same area organize themselves into groups of 6, taking turns to collect treatment every month for group members. Each member visits the clinic every 6 months for medical check-up (and blood test as needed) and to collect treatment for all group members. In case of problems, patients go back to the clinic (either self-referred or referred by other group members)
2. Fast lane appointments and Chronic Medication Delivery allow stable patients to collect their medication at the pharmacy without waiting. This reduces patients' waiting times and helps reduce congestion at health facilities.
3. Buddy system or peer mentors can help patients to remember the time to take their treatment, remind them when they have to come for follow up and/or accompany them to the facility. The buddy could be an expert patient or a peer from a support group who has been on treatment for some time. It could either be a buddy identified by the patient in which case it can be someone living in the same household or area or the facility can provide among workers if acceptable to patient.
4. The One-Stop-Shop (OSS) Model funded by Global Fund (GF) and PEPFAR is a community-based ART specialized clinic that provides a wide spectrum of HIV prevention, treatment, care and support services for key populations. Due to the peculiarity of key populations, HTS services are provided for them in a "safe space" atmosphere in designated OSS facilities. It provides a friendly, stigma free and recreational facility for key populations which encouraged continuous access to care

The OSS has been described as *an open community space where Key Populations can walk through the door and get free access to health services,*

information, ideas and psychosocial support, all with the help of dedicated professionals.[18] The success rate on ART initiation and consequent viral load suppression is higher among MSM as recorded in the SFH project, which is recommended for KP service provision considering the ever-increasing prevalence among MSM when compared to FSW and PWID.

2.3 Linkages, Adherence and Retention in Care

The outcome of HIV Testing Services (HTS) is only successful if those who are HIV-negative are supported to reduce their risk of acquiring HIV, and if those who are HIV-positive are successfully linked to the continuum of HIV care. Medical, psychosocial and economic interventions will be more effective and sustainable if there is a strong link between facilities and the community structures involved in care and support programmes. The principle of placing communities in leadership roles, delivery and accessing services is critical to ensure ownership and sustainability is entrenched. The fulfillment of these conditions constitutes the continuum of care for PLHIV that ensures proper linkage, adherence and retention in care.

Similarly, person living with HIV is considered a presumptive TB case if he/she presents with cough of any duration. Therefore, there is need to identify them in the community and refer for screening. The mental health of PLHIV especially key populations is also coming to fore and needs to be addressed.

2.3.1 Stepwise Approach to Adherence across the Continuum of Care

Step 1 – Screening to testing: Screening interventions are designed to identify diseases early, thus enabling earlier intervention to reduce mortality and morbidity.

Step 2 – Testing to enrolment in care of patients with confirmed positive results after screening or diagnosis require referral for further investigations or entry into treatment, care and support.

Step 3 –Enrolment in care and initiation to treatment-Preparation for treatment is an important stage in the continuum of care and starts immediately after diagnosis. Initiation to treatment should be done within two weeks of diagnosis. Some diagnosed patients may not be ready to start treatment due to denial or because they are not psychologically ready to adhere to long-term or lifelong treatment. Significant patient attrition occurs at this stage. Hence, peer counseling, follow-up intervention and linkage to support group is recommended.

Step 4 –Treatment initiation to treatment stabilisation (intensive phase)-Following initiation, patients may face a range of challenges – both physical (side effects) and psychological (discouragement, negative thoughts attached to the treatment, etc.). if managed properly, retention in care and treatment adherence results in better clinical

[18] (SFH, 2018)

outcomes and lower healthcare costs by minimising the long-term complications of chronic diseases. For TB and HIV, non-adherence to treatment increases the risk of drug resistance, poor treatment outcomes, and increased infectiousness. Monitoring of patients according to clinical guidelines plays an important role during this phase in evaluating patient adherence to treatment.

Step 5 – Regular reviews for stable patients on treatment (consolidation and maintenance) -Once the patient is stable (according to clinical guidelines monitoring recommendations), after a designated period of time, the healthcare provider must reinforce strategies to maintain the patient at a stable level, through the differentiated service delivery model and community support strategies. Taking treatment and clinical follow-up must be made as convenient as possible for such patients to minimize loss to follow up

Step 6 – Review adherence and treatment for unstable patients on treatment -Patients with poor clinical outcomes, adherence problems (interruption or inconsistency in taking the treatment), those who failed to come for their clinical check and/or treatment collection can be referred to as patients unstable on treatment. These patients are at risk of treatment failure, and require specialized and intensified support from the community structure.

2.3.2 Barriers to Linkages, Adherence and Retention in Care

Barriers to linkages, adherence and retention in care could either be patient related or provider related (Table 2:1)

Table 2. 1: Barriers to Linkages, Adherence and Retention in Care

Patient-related barriers to linkage, adherence and retention in care	
Cognitive	Knowledge and understanding of the result, the disease, the treatment options, the importance of care, the potential side effects, the relationship between adherence and the disease progression and the consequences of discontinuing treatment Perceptions and beliefs about the health system, the health care providers, the efficacy of treatment, alternative/traditional medicines and risky behaviors
Affective	Depression, anxiety, denial, lack of motivation, non-disclosure, reduction of self-worth, fear of violence, stigma and/or abandonment
Behavioral	Forgetfulness, Alcohol and drug consumption, experience with medication and side effects, missed appointments (this could be for a number of reasons, including stigma, disinterest, denial, financial constraints, transport issues etc.)
Medical	Pill burden and regimen complexity, treatment adverse effects, medication toxicities or cross-interaction with other drugs, medication palatability
Socio-demographic	Age (younger), sex (male), socio-economic status (employment status, level of education, available income for transport, lost wages when attending the clinic, etc.), stigma and non-disclosure of status (own or offspring)
Family/social support	Lack of social support, lack of community involvement in treatment programmes, dependency on partner

Provider-related barriers to linkage, adherence and retention in care	
Intervention quality	Poor patient–provider communication, inadequate health education, lack of assessment and understanding of the patient's reasons for non-adherence, weaknesses in monitoring adherence or identifying patients at risk, inadequate consultation or contact-time, poor management of pain, symptoms and medication side effects
Behavioral	Attitude of healthcare providers towards patients, level of engagement and empathy towards patients
Training	Inadequate training of staff in disclosure of status, educating and supporting patients in adherence (delivery of test result and explanation of significance), limited capacity to screen and identify mental illnesses
Structural -related barriers to linkage, adherence and retention in care	
Organizational	Distance to the clinic, long waiting time, lack of integration and of coordination between services, medicine shortages and stock out, inflexible clinic hours
Intervention quality	Lack of tools to guide the healthcare workers on ways to support patients' adherence, lack of confidentiality, inconvenient linkage to care, delayed treatment initiation, inadequate assessment of treatment adaptation needed, poor tracing system, inadequate resources and laboratory services, poor management and support of healthcare workers

Source: South Africa Adherence Guidelines for HIV, TB and NCDs, 2016

CHAPTER 3: HIV AND AIDS COMMUNITY CARE AND SUPPORT SERVICES

3.1 Introduction

Health and social services should be accessible to everyone living with and/or affected by HIV and AIDS. Care and Support interventions required by PLHIV, AYPLHIV, Key Populations, PABA and other vulnerable groups vary from one individual to the other and are determined by the specific needs of the individual at any point in time. The range of services provided to PLHIV, PABA and other key and vulnerable populations should include medical, psychosocial and economic wellbeing.

3.2 HIV and AIDS Care and Support Settings

The main settings for HIV and AIDS Care and Support services are:

- Health facilities
- Communities (CBOs, FBOs, Support groups etc.)
- Households
- Work place

3.3 Providers of Care and Support Services

Care and support for PLHIV, PABA, key and other vulnerable population is the responsibility of every individual. Good-quality care should focus on the person and not only their illness. Person-centred care sees the person as an individual and considers their desires, values, family situations, social circumstances, and lifestyles. In so doing, needs and preferences can be responded to in humane and holistic ways, and people seeking care are seen as participants.

Government and its agencies have a major role in creating an enabling environment for provision of meaningful care and support services to PLHIV, PABA, key and other vulnerable populations. Specific organs of government that have these responsibilities include: - the Federal and State Ministries of Health, National Agency for the Control of HIV/AIDS (NACA), State Agency for the Control of HIV/ AIDS (SACA), Ministry of Women Affairs and Social Development, Local Action Committee on AIDS (LACA), relevant Line Ministries such as Labour, Education, Agriculture, Youth and Sports and Justice. Other agencies include Small and Medium Enterprises Development Agency of Nigeria (SMEDAN), Industrial Training Fund (ITF), National Human Rights Commission (NHRC)etc.

Health facilities and health workers have a primary role of caring for the PLHIV, PABA, key and other vulnerable populations who require care and support to overcome health issues associated with HIV and AIDS infection. All categories of Health care workers play important role in caring for the PLHIV, PABA, key and other vulnerable populations.

Non-health workers also play a critical role in caring for PLHIV and are found in different sectors of the society; they include PLHIV, family and community members, persons and groups involved in the protection of rights of PLHIV and law enforcement agencies.

Family members and PLHIV play essential roles in providing community and home-based care, which include:

- management of minor ailments,
- treatment
- psychological support
- financial support
- knowledge and information management support
- support to access care and other support services.

In broad terms, providers of care and support services are categorized into individuals, community support organizations, non-governmental organizations and governmental organizations. The role each of them play will be determined by the specific needs of PLHIV, AYPLHIV, PABA, key and other vulnerable populations

3.4 Eligibility for HIV and AIDS Care and Support

All persons living with HIV and AIDS including women, children, adolescents, youths and their families are eligible for care and support services throughout the entire duration of HIV and AIDS disease from the time of diagnosis. The type of care and support services they receive will depend on the clinical, psychosocial and economic impact of the disease on the individual.

Families of persons living with HIV and AIDS are eligible for Care and Support services, to cope with the stress that results from close association with persons living with HIV and AIDS such as stigma and discrimination, loss of income, impoverishment and the emotional burden of caring for the PLHIV, PABA, key and other vulnerable populations.

Caregivers who may not necessarily be family members are equally eligible for care and support services to deal with stress, doubts, safety concerns, fears, and burnout associated with HIV and AIDS infection. Finally, members of communities are also eligible for care and support services that deal with fears, myths and misconceptions that fuel stigma and discrimination.

3.5 Components of HIV and AIDS Care and Support

Programming and Relevant Interventions.

The basic needs of PLHIV, PABA, key and other vulnerable populations reflect the multidimensional nature of the impact of HIV and AIDS on an individual and these needs fall within three main domains: medical, psychosocial and economic.

3.5.1 Medical Services

Medical care for PLHIV refers to those services that have a direct bearing on the health of the individual and inclusive of laboratory and clinical management of HIV and AIDS and its medical complications. These services include:

1. HIV testing and counseling
2. Early detection and screening of mental health disorders and referral where appropriate
3. Preventive interventions
4. Literacy on viral load request, understanding of viral suppression and virally unsuppressed; and undetectable equals untransmittable (U=U)
5. Prevention of opportunistic Infections (OIs) including tuberculosis, fungal infections; use of Cotrimoxazole
6. Prevention of Mother to Child Transmission of HIV (PMTCT)
7. Prevention of selected vaccine, preventable diseases including hepatitis B, pneumococcal influenza, and yellow fever
8. Universal safety precautions
9. Post-exposure prophylaxis (and pre-exposure prophylaxis)
10. Management of HIV and AIDS related illnesses (including Opportunistic Infections, Sexually Transmitted Illnesses (STIs), cancer related illnesses and Tuberculosis control)
11. Antiretroviral Therapy
12. Family Planning
13. Nutritional support
14. Health education/promotion including healthy living; water sanitation and hygiene; prevention of malaria, among others
15. Support systems such as laboratory investigations and drug management systems

3.5.2 Psychological/Psychosocial Services

These services consist of a broad range of interventions that cater primarily to the emotional/mental, psychological and spiritual wellbeing of PLHIV, PABA, key and other vulnerable populations. They include

1. Counseling (couple counseling, adherence counseling, tele counseling and spiritual counseling).
2. Initial and follow up counseling for emotional and spiritual needs, disclosure and partner notification services
3. Community support services including support groups, peer groups, community or volunteer outreaches, caregivers' forum, kids/youth club meetings and spiritual support
4. Support for caregivers

3.5.2.1 Mental Health

Though mental health is an integral part of psychosocial services, the understanding of the concept and administration is still vague. Mental Health of PLHIV is fast becoming a major concern that needs to be addressed.

Considering the importance therefore, it is treated separately in this guideline. In a recent assessment of the mental health system in Nigeria funded by WHO, the findings include lack of information on the mental health service in Nigeria and non-existence of family and patient associations focusing on mental health issues among others.[19]

Furthermore, of importance is the bi-directional relationship between HIV and mental health. That PLHIV are more prone to mental health conditions is well documented in literature.[20],[21],[22] For instance, depression as a mental disorder has been identified as both a risk factor and a consequence of HIV infection.[23] Anxiety and depression increase the morbidity of HIV by poor adherence to treatment while early identification and effective management of mental health disorders is associated with improved antiretroviral adherence and improved quality of life in PLHIV.[24],[25],[26] It has also been demonstrated that depressive symptoms in women with HIV are associated with disease progression[27]

In PLHIV, AYPLHIV, key populations including young key populations, contributory factors for depression include comorbidities; coping with the prospects of illness and death, neurobiological changes related to persistent central nervous system (CNS) infections due to HIV, social stigma, sexual dysfunction, and side effects of ART.[28],[29] A successful HIV/AIDS intervention programme must therefore include the assessment of mental disorders and their appropriate management as part of the normative care and support service.

3.5.2.1.1. Assessment, Referral and Care in Mental Health

For the assessment, referral and mental healthcare for people living with HIV, AYPLHIV, key populations, PABA and other vulnerable groups, the following is recommended:

- It should be integrated into the normal health care routine- a holistic and integrated primary mental healthcare approach
- Health care workers should screen routinely for Common Mental Disorders (CMDs) during clinic visits because patients rarely volunteer information about their mental state
- HIV/AIDS counselors trained in counseling skills at the facility and community can provide front-line initial mental healthcare service. Mental disorders encompass a continuum from mild distress to frank

[19] (WHO and MOH, 2006)
[20] (Egbe, et. al 2017)
[21] (Oladeji et. Al, 2017)
[22] (Bing et.al, 2001)
[23] (Meade and Sikkema 2005)
[24] (Suprakash et. al, 2016)
[25] (Omonefe Seb-Akahomen, 2018)
[26] (Hinkin et.al., 2002)
[27] (Jeannette R. Ickovics, et al., 2001)
[28] (Schuster et. Al. 2012)
[29] (Phillips et. Al., 2004)

clinical conditions, and some HIV counselors may already possess the skills to manage the milder emotional problems

- Available tools for assessment include the Patient Health Questionnaire (PHQ-9 or PHQ-2).
- The PHQ2 contain the first 2 items on the PHQ-9 and can be adapted for use. The purpose of the PHQ-2 is to screen for depression in a "first-step" approach and a positive response should either lead to the use of PHQ-9 or/and consequent referral to a specialist/specialized services if concerns are noted.

  The adaptation will require a **YES** or **NO** to the following two questions:

  1. Over the past month, have you felt down, depressed or helpless?
  2. Over the past month, have you felt little interest or pleasure in doing things? These two questions can be incorporated into the normal routine screening of patients.
- The PHQ-9 and other screening questions for other MHDs are in Appendix C.

3.5.3 Religion

Religion has been identified as a major tool in linkage, adherence and retention in care of PLHIV, PABA, key and other vulnerable populations. With every Nigerian belonging to one religion or the other, faith platforms provide a wide network for care and support of PLHIV, PABA, key and other vulnerable populations. The Imam in the Mosque, and the pastor in the church, all have roles to play in care and support for PLHIV, PABA, key and other vulnerable populations. When faith congregations, especially the leaders understand care and support for the PLHIV, PABA, key and other vulnerable populations, it will influence major key issues like stigma reduction, promotion of social safety schemes for PLHIV, AYPLHIV, PABA, key and other vulnerable populations as well as help PLHIV, PABA, key and other vulnerable populations in their congregation to understand the need for adherence to ART than seek spiritual healing. Faith congregation can have support groups that provide care and support for PLHIV, PABA, key and other vulnerable populations.

3.5.3.1 Role of Religious Leaders in Care and Support

1. Encourage members to undergo screening and to accept treatment and care when infected
2. Trained religious leaders can help to provide the right information that will increase acceptance of status for PLHIV, AYPLHIV, PABA, key and other vulnerable populations
3. Trained religious leaders on counseling for PLHIV, AYPLHIV, PABA, key and other vulnerable populations can provide counseling and also create awareness during religious activities.
4. Faith leaders can be used as counsellors and champions of stigma reduction for PLHIV, PABA, key and other vulnerable populations.
5. Provision of psychosocial and spiritual support
6. Support groups for PLHIV, AYPLHIV, PABA, key and other vulnerable

populations formed on basis of faith to bring together the members
7. Faith congregation can help to promote uptake of available health services for PLHIV, AYPLHIV, PABA, key and other vulnerable populations especially adherence and adherence counselling.
8. Faith congregation can provide home-based care for PLHIV, PABA, key and other vulnerable populations.
9. The faith platforms can partner with philanthropists to create economic empowerment opportunities for their members living with HIV.

3.5.3.2 Disclosure, Partner Notification Service in Religious Setting

All patients should be supported for disclosure and partner notification. The faith platforms can be used to support process around status disclosure and partner notification services. Trained religious leaders can create demand for HTS for young people and adults by including HTS in their youth fellowships and other young people's programmes. The religious leaders can also help to facilitate the process of status disclosure and status acceptance, by reducing stigma and through counseling; help members disclose their status as most would prefer to listen to their priest, pastor or Imam than the counselor tester in the clinic.

3.5.4 Economic Empowerment and Sustainable Livelihood

PLHIV, AYPLHIV, Key Populations, PABA and other vulnerable groups should have access to interventions that empower them to cope with the economic challenges of HIV and AIDS. These interventions include:

1. Skills acquisition
2. Income generating activities
3. Access to basic education and literacy programmes
4. Advocacy for employment opportunities for those qualified
5. Linkage to existing social protection services
6. Providing financial support for economic empowerment such as Bank of Industries (BOI), Village Savings and Loans Association (VSLA), Small and Medium Enterprises Development Agency of Nigeria (SMEDAN) etc.
7. Social welfare schemes that improve access to nutritional support, housing and medical services
8. Access to affordable health insurance
9. Interface with entrepreneurs including Association of Small-Scale Industries (NASSI) in Nigeria with Chapter across the States to mentor and assist PLHIV, AYPLHIV, PABA, key and other vulnerable populations to establish small businesses
10. Ensure that being HIV positive does not lead to loss of job
11. Involvement of trade unions to promote their participation and strengthen their engagement with the PLHIV, PABA, key and other vulnerable populations
12. Creation of employment opportunities and also through linkage to micro-credit and other resource mobilization agencies.
13. Advocacy to community stakeholders to provide farm lands for

cultivation.

14. Linkage to Ministry of Agriculture to provide agro-investment opportunities for interested PLHIV, PABA, key and other vulnerable populations
15. Linkage to the various Household Uplifting Programmes as well as other Social Safety Nets initiatives coordinated by the Social Investment Programmes Office under the Vice President's Office including palliatives during health emergencies such as COVID-19.

Other important elements of community care and support service are:

3.5.5 Human Rights and Legal Environment

Stigma, discrimination and human rights violations against PLHIV especially key populations and other vulnerable groups represent some of the most significant barriers to entire continuum of care including medical, psychosocial, economic domains in linkage, adherence and retention in care. It is the duty of all to ensure that the human rights of PLHIV are respected and protected and that they are treated with dignity and respect in their families and communities. This can be achieved through legal and policy reforms especially where it concerns key populations, enforcement of the 2014 HIV and AIDS (Anti-Discrimination) Act, access to justice by PLHIV and documentations of offenders to serve as deterrents. Some of the key points to note are:

1. Addressing stigma and discrimination at health facilities, care centres, communities and workplaces
2. Addressing issues of confidentiality and individual rights to disclosure
3. Promoting equal access to care regardless of gender, age, ethnicity or religion.
4. Succession planning
5. Schemes for mitigation of stigma, discrimination and social exclusion
6. Greater Involvement of people living with HIV through meaningful participation in programme design and implementation
7. Taking cognizance of people with special needs especially Persons with Disabilities (PWDs), using braille, sign language, other accessible means of communication and infrastructure
8. Access to legal protection (pro bono services) and enforcement of positive judgment for PLHIV through statutory legal systems
9. Creation of "safe space " for different populations who ordinarily will not access care services from regular points due to cultural and legal barriers. These populations include AYPLHIV, MSM, FSW and PWID

3.6 The Minimum Package of Care and Support interventions for PLHIV

The minimum package of care and support interventions describes the basic unit of interventions every PLHIV should receive at either the facility or community level.

At the facility, the minimum package for PLHIV at each encounter should include:

1. Psychosocial assessment and support including counseling for PLHIV.
2. Linkage to a peer support group and other community-based services where required
3. Cotrimoxazole preventive therapy for all eligible persons
4. Screening for tuberculosis
5. Screening for mental health status
6. Provision of PHDP services (STI and risk assessment, condom education and supply, sexual and reproductive health and family planning referral, adherence counseling, alcohol and substance abuse assessment)
7. Viral load monitoring

At the community level, the minimum package of care should include:

a. HIV counseling and when possible, testing
b. HIV testing services for sexual partners and index testing for other members of the household
c. Provision of supportive services such as psychosocial, nutrition, education, protection, shelter
d. Linkage to social protection schemes for employment opportunities, skill acquisition and income generating activities
e. Referral to a health facility for comprehensive medical assessment and management
f. Referral to relevant bodies based on needs through the Bi directional H-H and Spoke Model of Care.
g. Provision of home-based care (where absolutely necessary)
h. Tracking of defaulters or missed appointment and return loss to follow up (LTFU) back to care.
i. Linkages to OVC programmes and services for children

3.7 The Minimum Package of Care and Support Interventions for PABA

A Person Affected by HIV and AIDS (PABA) may be a person living with, caring for, and/or a dependent of a PLHIV.

All PABA should receive:

a. Appropriate psychosocial support including counseling at each encounter at the facility or the community
b. Referral to appropriate Community Based Organization for socio-economic support
c. Referral to appropriate bodies on violence against children/persons where indicated.
d. Index Case Testing (ICT) for family members

3.8 The Package of Care and Support Interventions for Vulnerable Children

The National Priority Agenda for Vulnerable children in Nigeria (2013-2020) categorized vulnerable children to include:

- Children living in poor households
- Children in need of alternative family care/ deprived of primary

caregivers
- Children with disabilities
- Children living on the street
- Children in need of legal protection
- Children infected or affected by HIV or other chronic illnesses
- Children in 'hard-to-reach' areas
- Children living in households where the breadwinner is living with HIV or other chronic illnesses and are impoverished
- Children living in households with recent deaths of a working age adult (breadwinner)
- Children who are abused or neglected
- Children in exploitative labour
- Trafficked children
- Children in conflict with law
- Children 'on the move' (exploited almajiri, nomadic, militants)
- Children affected by armed conflict
- Socially excluded children

The Priority Agenda is anchored on Nigeria Vision 20:20:20 with the following commitments:

1. All poor and vulnerable children have equitable access to and benefit from comprehensive social protection services
2. All children are safe from abuse, violence, exploitation and neglect
3. Vulnerable children are healthy and well- nourished
4. Vulnerable children have equitable access to and benefit from quality basic education. (ECD, primary, and junior secondary)
5. Vulnerable children have an adequate standard of living conditions.
6. All children have a legal identity.[30]

The National Standards for Improving the Quality of Life of Vulnerable Children in Nigeria identified seven core service delivery areas, which are considered essential components of a comprehensive set of services targeting vulnerable children. Services are provided based on the need and circumstances of the child. The seven service areas include health, food and nutrition, psychosocial support, protection, education and training, shelter and care and household economic strengthening.[31]

[30] (FMWASD, 2013)
[31] (FMWASD, 2014)

3.9 Measurable Outcomes

Targets

- 90% of PLHIV access care and support services by 2023.
- 90% of individuals (HIV infected or affected) with complete referrals
- 90% of reported cases of discrimination that receive legal support services by 2023.

Indicators

- (Number and) % of PLHIV (disaggregated by age and sex) receiving community-based care and support services
- (Number and) % of individuals (disaggregated by age and sex) (HIV infected or affected) referred with complete referrals
- (Number and) % of reported cases of discrimination that receive legal support services (disaggregated by age and sex)
- (Number and or %) of PLHIV that received support for partner notification (disaggregated by age and sex)
- (Number and or %) of PLHIV/PABA linked to available social protection services

CHAPTER 4: PROVISION AND RETENTION IN CARE OF PLHIV ACROSS THE LIFE COURSE

4.1 Introduction

Needs of people living with HIV differs at different stages of life informed by the peculiarities associated with each stage. While there is a need to note the peculiarities of each cohort, quality care will also make provision for smooth transition from one stage of life to the other. It has also been noted that addressing HIV and mental health together with a life cycle approach is a win-win.

4.2 Linkage, Adherence and Retention in Care among Children

Good adherence means that children must take their medications every day as they are prescribed without missing doses.

4.2.1 Adherence Issues in children

Early Infant Diagnosis (EID) of children exposed to HIV during pregnancy, labor and delivery, and breastfeeding requires the collection of dried blood spot (DBS) samples. DBS is a form of bio-sampling where blood samples are blotted and dried on a filter paper, and then transferred to a designated specialized laboratory for analysis. Adherence in children is more challenging as children rely on a responsible parent/caregiver for clinic visits, investigations, medication and other services. Where the mother is also HIV positive; the child may be affected by the mother's compromised health therefore a secondary back-up informed caregiver may need to be involved in the care of the child. Changes in pediatric dosages as the child grows can also affect adherence.

Socioeconomic status of the caregiver, family cultural beliefs and practices, the HIV status of the parents and caregivers and the relationship between the caregiver and the child are some of the other issues that could hinder adherence in children. For adherence success, it requires commitment and knowledge on the part of the child and primary caregiver. Appropriate disclosure can also improve adherence. Peer support groups are particularly beneficial.

4.2.2 Procedure for Retention in Care

The following could be considered for adherence and retention-in-care of children:

1. Establish parent/caregiver readiness to start treatment
2. Disclose child's status and need for lifelong treatment to responsible parents/caregiver

3. The decision to inform the child of his/her HIV status should be viewed as mandatory and be age appropriate. It is important that disclosure follows a planned process and to understand that there are levels of disclosure over time. The process of disclosure is cyclical, it needs to be repeated as new information or deeper levels of information are shared with the child.
4. Five to seven years are earliest recommended ages for disclosure, and all should be disclosed by age 12.[32]
5. Service providers should ensure age specific services to children living with HIV and transition planning.
6. The service provider/caregivers should know when to track for next ART refill and viral load testing
7. Parent/caregiver understands importance of clinic visits
8. The caregiver/parent should be empowered to know when it is due and demand for viral load testing and ART refill
9. Identify responsible person for daily drug administration/clinic attendance.
10. Family centred approach is recommended which should include testing of other family members, including all children, and enrollment of the mother in ART.
11. Conduct demonstration sessions on drug dosages and administration with family members/caregiver or designated persons.
12. Adherence counselor always on hand to visit family and ensure adherence.
13. Strategies must be reviewed regularly to meet the changing needs of the growing child. e.g. balancing clinic visit and school attendance.
14. Participation of parents/caregivers in existing support groups in the community

4.3 *Linkage, Adherence and Retention in Care among Adolescents and Youths*

The Nigerian National Youth Policy defines youth as anyone between the ages of 18 and 35 years. The World Health Organization (WHO) defined adolescents to include individuals aged 10–19 years; youth within 15-24 years bracket while young people are defined as individuals within the 10-24years bracket and all young people aged 20–24 years.[33] This age cohorts are at most risk for HIV and common mental disorders. Young people and adolescents living with HIV have complex medical and psychosocial needs. It is a period of emotional and personal growth such as puberty and neurocognitive development. High rates of mental health difficulties, suicide risk and unplanned pregnancies have been reported in young adults and adolescents living with HIV compared to their peers. In a recent study, it was reported that 20-40% of FSW began selling sex before the age of 18.[34]

[32] (FMOH, 2014)
[33] (NACA, 2016)
[34] (NACA, 2020)

4.3. 1 Adherence Issues in Adolescents and Youth

Adolescence is a transitioning stage from childhood to adulthood. More change occurs during adolescence than any other stage in life except in infancy. It is a period of physical and sexual growth accompanied by restlessness at times. Peers are more preferred than parents, as they become standards and models of behavior. They are preoccupied with themselves and have a yearning to be accepted and independent. Young adults and adolescents living with HIV may even be more vulnerable due to complex social circumstances such as stigma related with chronic illness, challenges of parental authority, physical ill health, mental health difficulties, and substance misuse.

It is a period that needs purposeful and planned processes to address the medical, psychosocial, educational/vocational and economic need of adolescents and youths living with HIV as they move from child-oriented care to adult oriented care. If access to HIV care and additional support that is accessible and young-person friendly is not made available, adherence to ART may be difficult.

There should be services addressing the need for comprehensive sexual and reproductive health and rights for this age group. These services can be accessed through youth-friendly centres as well as in health care facilities. The special needs of young FSW, MSM as well as FSW and MSM with disability should also be taken into consideration through purposeful planning and outreach.

4.3.2 Procedure for Retention in Care

Peer support and good mentorship are strong factors in helping adolescents and young adults with adherence and other related issues. When young adults and adolescents living with HIV meet other young people in similar circumstances, it boosts their confidence and self-esteem, and allows a safe space to discuss HIV and eliminate isolation. Some of the steps for retention of young people in care are:

1. Dedicated adolescents and youth friendly services/clinics
2. Screening and early detection of any mental disorders such as depression, suicidal ideation and appropriate referral
3. Adequate support from caregiver, family, and friends
4. Disclosure:
    a. Beneficial and early disclosure leads to increased participation in their treatment.
    b. Extra support needed for disclosure of HIV status to sexual partners and forming healthy relationships. (A mentor or close peer from support groups could be of help)

5. Treatment literacy:
    - Information should be given proactively, in appropriate simple and understandable language

- Involve adolescents when discussing treatment options
- Adolescents are curious and should be provided with comprehensive and detailed information
- Lack of readiness and refusal is exhibited if they are not convinced or properly informed
- Use real life examples to illustrate issues as adolescents often think in concrete terms
- Explain to adolescents what to expect while on therapy and how to manage potential positive and negative side effects and adherence problems.
- Empower adolescents to request for viral load testing as a means of tracking viral suppression

✓ Mentorship/Support Programme should allow:

- Positive approach to treatment that nurtures the adolescent's belief in their success
- Exploring with the adolescents challenges they experience in taking the drugs and work out strategies to address them
- Adolescents to discuss and disclose their problems
- Familiarity with people responding well to similar therapies so as to encourage the adolescents and youths to adhere to treatment.
- The adolescents and youths to identify a treatment supporter
- Peer-led mentorship approach for provision of services

4.4 Linkage, Adherence and Retention in Care among Adults

Adults refer to persons between 25 and 64 years and this spans the peak ages of reproduction and employment. Most people in this age bracket are diagnosed in adulthood.

4.4.1 Adherence Issues in Adults

Education, training and employment are key determinants of health and well-being for people in this category. Heightened vulnerabilities and lack of adherence among this group could be due to one or more of a number of different factors including late diagnosis, long duration of HIV, unemployment, underemployment, lack of any income generating activity, poor housing, stigma, drug and alcohol dependency and mental issues such as anxiety and depression. Also, most people in these age groups are sexually active and would need support to have healthy and fulfilling sex lives through emphasis on the role of Treatment as Prevention (TasP) in reducing transmission risk. Furthermore, there are other barriers to adherence such as transportation fees to clinic, user fees, co-morbidity and negative provider attitude.

4.4.2 Procedure for Retention in Care

1. Impact of lack of employment, Income Generating Activities (IGA) and skills on PLHIV at various stages such as HIV diagnosis, ART commencement and co-infection diagnosis or treatment should be examined and proper referral made where necessary.
2. Providing support to help PLHIV maintain adequate income, housing and social support.
3. Advocate for zero tolerance to discrimination against PLHIV in workplace and service delivery settings.
4. Advocate to policy makers, gatekeepers, law enforcement and judiciary for zero tolerance to discrimination against PLHIV, PABA and other vulnerable populations in the community.
5. Screening and early detection of mental disorders such as anxiety, depression and appropriate referral
6. Services should be structured in order to minimise time loss from their means of livelihood/employment when PLHIV, PABA, key and other vulnerable populations have to seek healthcare services and other support.
7. Providing information on partner management (including testing, PrEP), contraception, sexually transmitted infection screening and treatment, pre-conception planning, assisted conception, antenatal services, and psychosocial services are all critical
8. It may be important to tailor ART to co-medications such as menopause hormone therapy.
9. Peer support groups are beneficial
10. HIV services should form part of health insurance packages for sustainability and retention in care.

4.5 Linkage, Adherence and Retention in Care among Aged People

The aged people are considered to be persons from 65 years and above. Older age is a significant consideration in the provision of HIV care because of increasing number of people ageing with HIV as a direct result of treatment efficacy. Although access to ART has greatly increased life expectancy for people living with HIV, it is essential that palliative care continued to be provided for those who may face life-threatening illnesses such as cancer, heart and kidney failure, those whose HIV is not responding to treatment, or for those ageing with HIV who need good end-of-life care. HIV treatment has improved so much that the focus has shifted away from end of life care provided mostly in the communities.

4.5.1. Adherence Issues in Aged People

Issues of health and well-being related to ageing intersect with those of HIV and may give rise to increased complexity in clinical and service delivery. There is considerable complexity relating to comorbidities and their relationship to ageing, particularly in the areas of cardiovascular disease, osteoporosis, menopause and dementia. There is also the issue of drug–drug

interactions seen in the possible co-effects of HIV medications and medications used in ageing- related health conditions. Palliative care in form of home-based care seems to have gone into extinction and will need to be resuscitated with proper guidelines on how it should be provided to optimize quality of life and relieve distress in the face of serious and advanced illness.

4.5.2 Procedure for Retention in Care

- ✓ Screening and early detection of mental disorders such as dementia and appropriate referral
- ✓ People with life-threatening illness should have access to palliative care to relieve unnecessary distress.
- ✓ Home-based care for those with life-threatening illness (depending on choice) should also be readily available

4.6 Linkage, Adherence and Retention in Care Among Key and Vulnerable Populations

Key and vulnerable populations, by the virtue of their circumstances and in some cases, associated behavior, are different from other people and have different needs. This group includes Female Sex Workers (FSW), People Who Inject Drug (PWID), Men who Have Sex with Men (MSM), Persons with Disabilities (PWDs), Internally Displaced Persons (IDPs) and pregnant mothers.

4.6.1 Adherence issues for Key and Vulnerable Populations

Issues around stigma and discrimination heightened fear of disclosure of status as well as prevent some from accessing treatment and care and support services. Socio-cultural and institutional barriers are also major issues in linkage and adherence to care and support especially MSM, FSW and PWID. The need to integrate mental health and substance use interventions in prevention, treatment and care and support of key populations is crucial. Report indicates that more than half of the people who inject drugs are living with viral hepatitis C and 1 in 8 are living with HIV while alcohol consumption associated with HIV risk and HIV/AIDS mortality in 2016 is 33,000 (3.3%) deaths. [35]Also, physical barriers, limited access to written materials are issues that affect people with disability (PWD). Internally Displaced Persons (IDPs) live in shelters that are not conducive with little or no access to health and non-health services as well as in conditions that fuels gender-based violence. For pregnant women, issues such as morning sickness, postpartum depression and childcare challenges are also critical.

[35] (Martineau, 2019)

4.6.2 Procedure for Retention in Care

- Focused counseling to address the different needs of different clientele in health facilities, one-stop shops and community. The capacity of health workers, peer and other service providers needs to be built along this line
- Screening and early detection of mental disorders such as HIV Associated Neurocognitive Disorders (HAND) and disorder due to alcohol and substance use and appropriate referral
- Meaningful participation of these groups in meetings
- Formation of Specific Support groups and identification of peer mentors among them
- Provision of prevention services including PrEP as an option for those at high risks.
- Provision of adherence support by peers and health workers
- Empowerment of this group to request for viral load testing
- Community based-support through the use of home-based care provider or the use of mobile phones for follow up.
- Communication materials accessible in format adaptable to different groups
- Inclusion in information, education and communication materials for the general population on prevention technologies (including use of water-based lubricant) and on transmission routes (including anal sex)
- Outreach interventions to propose a comprehensive package of care especially for those due to severe stigmatization and socio-cultural barriers might not be willing to go to facility.
- Use of peers as case managers
- Creation of safe space for key populations through the adoption of OSS nationally especially in “hotspots”

4.7 Measurable Outcomes

Targets
90% PLHIV (disaggregated by age and sex) receive adherence support

Indicators
(Number and) % of PLHIV (disaggregated by age and sex) received adherence support
(Number and %) of PLHIV (disaggregated by age and sex) retained on treatment
(Number and) % of PLHIV children and adolescents (0-19yrs), disaggregated by age and sex who received adherence support

CHAPTER 5: POSITIVE HEALTH DIGNITY AND PREVENTION (PHDP)

5.1 Introduction

Positive Health Dignity and Prevention (PHDP) is defined as a set of actions that help people living with HIV and AIDS to live longer and healthier lives. PHDP emphasizes the importance of placing persons living with HIV and AIDS at the centre of managing their health and well-being. It is about improving and maintaining the dignity of the individual living with HIV, supporting and enhancing the physical, mental, emotional and sexual health of PLHIV. The primary goal of PHDP is to improve the dignity, quality and length of life of PLHIV. HIV and AIDS services need to include PLHIV in the conception, design and implementation of the services meant for them. PHDP highlights PLHIV as key players in the solution to the long-standing challenge of preventing HIV and AIDS transmission.

5.2 Core Values and Principles

- PLHIV should be leaders in the design, programming, implementation, research, monitoring and evaluation of all programmes and policies affecting them
- Human rights approach is the foundation of Positive Health, Dignity and Prevention
- Preventing HIV and AIDS transmission is a shared responsibility of all individuals irrespective of HIV and AIDS status
- Sexual and reproductive health and rights should be recognized and exercised by everyone regardless of HIV and AIDS status
- PLHIV should be enabled to optimize self-management and access peer-support opportunities to promote their physical and mental health, and overall well-being.

5.3 Components of the Key Elements of Positive Health, Dignity, and Prevention

- ✓ Participation of PLHIV in their care
- ✓ Self-Management and Peer Support
- ✓ Health Promotion and Access
- ✓ Sexual and reproductive health and rights
- ✓ Prevention of new infections
- ✓ Provision of Human Rights services including stigma and discrimination reduction
- ✓ Promotion of Gender equality
- ✓ Provision of Social and economic support

5.3.1 Participation of PLHIV in their care

PLHIV. AYPLHIV, Key Populations and other vulnerable groups should be actively involved in decisions about their own health and social care. There should be due recognition that they are also part of the clinical, social care and service workforce. As such, they should be actively involved in the design, planning, delivery and review of these services. They should be able to provide feedback, ranging from comment on individual consultations to input into service design, delivery and performance review at Local, State and National levels.

However, ensuring active engagement in decision-making may require support and capacity building for networks of PLHIV, AYPLHIV, Key Populations, other vulnerable groups and their members. In essence, participation entails:

1. Meaningful involvement of networks of PLHIV, AYPLHIV, Key populations including young key populations and other vulnerable groups
2. Meaningful involvement of PLHIV including AYPLHIV, Key populations and other vulnerable groups
3. Capacity building of networks of PLHIV, AYPLHIV, Key populations including young key populations and other vulnerable groups
4. PLHIV, AYPLHIV, Key populations including young key populations and other vulnerable groups leadership development
5. PLHIV, AYPLHIV, Key populations including young key populations and other vulnerable groups legal, rights and health literacy
6. Training as volunteers or ad-hoc staff as peer counselors, community mobilizers so as to enhance linkages and referral between facility and community
7. Some of the advantages of meaningful participation of PLHIV, AYPLHIV, Key Populations including young key populations and other vulnerable groups in their care and retention in care are:
    1. Physical and psychological readiness for treatment
    2. Concerns about taking ART or using specific ARV drugs, including potential or actual adverse effects are addressed
    3. Confidence in the ability to adhere to ART and the importance of adherence
    4. Understanding of other treatments and medications, particularly on how these may interact with HIV and ART
    5. Increase access to certain socio-economic, cultural or practical factors such as, (e.g. income, access to housing, faith, reduce intimate partner violence/abuse, stigma and acceptance of their condition) that gives rise to positive impact on adherence
    6. Confidence in talking to medical staff about HIV and other health/mental issues and talking to others about HIV status
    7. Improved health and wellbeing

5.3.2 Self-Management and Peer Support

Self-management involves PLHIV, AYPLHIV, Key populations including young key populations and other vulnerable groups developing an understanding of how their condition affects their lives and how to cope with the clinical, physical, psychological and social challenges it presents. Effective self-management allows them to make the many daily decisions that improve their health-related behaviors and outcomes. When an individual engages with self-management, he/she is able to manage current challenges and prepare for future challenges since living with HIV requires lifelong adjustments and management.

Building capacity to optimally self-manage will require strong networks of peer support. Peer support is a key contributor to optimizing self-management. Peer support is a relationship in which participants see each other as equal partners and where the focus is on mutual learning and growth. A support group is a group of people who come together to share experiences about their common issues, provide peer support for one another, as well as engage their communities to foster convenient environment for their welfare. Strong emphasis should be placed on the advantages of self-management in support groups as it helps members gain confidence, skills and knowledge to better manage their health, with resulting improvements in quality of life and independence.

Support groups are based in the health facility or the community, and can be formed based on some demographics where necessary if positive outcomes will be achieved. It could be on the basis of religion, occupation, age etc.

Types of support group includes but not limited to:

- General Support Groups (Everybody)
- Mother -to -Mother support groups
- Singles/Widows support groups
- Adolescent support groups
- Pregnant Women support groups
- Children support groups
- Discordant couples support groups
- FSW support groups
- Men only support group
- MSM support Group
- PWD support groups
- PWID support groups

General Activities of support groups:

A. Theme based:
    - Basic Health and Hygiene
    - Basic HIV Information
    - Diet and Nutrition
    - Early detection/symptoms of Mental illness

- Home Based Care
- OI Management and co-infection
- Treatment adherence
- Treatment education
- Prevention of transmission
- Social events and livelihoods
- Self-Management

B. Provision of emotional and social support
C. Facilitate experience sharing and learning
D. Proper documentation of all activities

Some activities for key population support groups are:

Female sex workers (FSWs)

- Negotiation for safer sex with clients
- Dealing with children of sex workers
- Overcoming self-perceived stigma and discrimination
- Dealing with substance abuse and harassment
- Dealing with Mental health issues (screening, counseling and referral)
- Response to crisis such as sexual harassment/violence
- Reproductive and sexual health issues and concerns

Men who have Sex with Men (MSM)

- Sexual identity issues and concerns
- Overcoming self-perceived stigma and discrimination
- Dealing with substance abuse and harassment/violence
- Dealing with Mental health issues (screening, counseling and referral)
- Response to crisis such as sexual harassment.

People Who Inject Drugs (PWID)

- Care for PWID and their spouses and children
- Dealing with Mental health issues (screening, counseling and referral)
- Safer injecting and sexual practices.
- Counseling on safe sex
- Co-infection with HIV and Hepatitis B, C and/or STI.

5.3.3 Health Promotion and Access

Access to ART is not the only treatment need that PLHIV have. PLHIV are at increased risk of certain co-infections, particularly TB, hepatitis B and C. Risk factors include immunosuppression associated with advanced HIV in the case of TB, as well as shared routes of transmission between HIV and hepatitis B and C viruses. The mental health of PLHIV is also becoming a front burner issue as studies have established the intersection between HIV and mental disorder. While people with mental health conditions are at greater risk for HIV through unsafe sex, injecting drug use, sexual abuse; HIV treatment can cause an array of neurocognitive disorders and a wide range of mental health related side-effects. It is essential, therefore, that PLHIV are screened for these

co-infections and mental health disorder both at initial HIV diagnosis and during follow- up, according to national guidelines. Those found to be co-infected should be referred to specialist services for appropriate treatment. Some of the expected services are:

- HIV Testing Services (HTS)
- Provider-initiated Testing and Counseling (PITC) and community counseling and testing under conditions of informed consent and confidentiality
- Index Case Testing (ICT)
- Viral load monitoring
- Antiretroviral therapy (ART), including clinical monitoring, adherence support, access, availability and quality assurance
- Access to health care and insurance
- Health education for living well
- Treatment literacy
- Psychosocial wellbeing, including building self-esteem and confidence
- Mental health services
- Preventing disease progression and further infections/prophylaxis for Tuberculosis (TB) and opportunistic infections (OIs)
- Palliative Care

5.3.4 Sexual and Reproductive Health and Rights (SRHR)

SRHR is about supporting PLHIV, AYPLHIV, Key populations including young key populations and other vulnerable groups to establish and maintain healthy sexual and reproductive lives for themselves and their partners. They and their partners require access to appropriate, culturally sensitive and effective information and support about sexual behaviour and minimizing transmission risks; this is particularly needed among key populations who are severely discriminated against. Reproductive decision-making is also an important, yet complex part of the lives of PLHIV. The potential for transmission of HIV through either

unprotected sexual intercourse or vertical transmission complicate the reproductive decisions for PLHIV.

PLHIV require access to services related to the diagnosis and treatment of STIs and other sexual health illnesses, comprehensive sexuality education and counseling; and other services integrated into sexual and reproductive health (SRH) and HIV-related services where and when appropriate. The services must not only be gender- specific and age-responsive but must also address issues of sex and sexuality. AYPLHIV and young key populations must be supported through the provision of appropriate and specific programmes on their sex and sexuality as they transition into adulthood. SRHR interventions that are grounded in principles of gender equality and human rights can lead to improved health status and quality of life. In summary, SRHR services include:

- Sexual and reproductive health care services
- Maternal health

- Family planning
- Prevention and treatment of sexually transmitted infections (STIs), including hepatitis B &C
- Sex and sexuality education and services

5.3.5 Prevention of New Infections

The goal is to reduce the number of transmissions of HIV through the empowerment of PLHIV, AYPLHIV, Key populations including young key populations and other vulnerable groups in accessing treatment and prevention within a context of shared responsibility for transmission and exposure. Unlike the initial response, which focused mainly on the prevention of new infections of HIV through their engagement to prevent HIV transmission to their partners, a more holistic approach is being advocated for. Such include support for sero-discordant couples, Treatment as Prevention, prevention literacy and access to other prevention technologies and treatment. Strategies to achieve this include:

- Transmission literacy
- Harm reduction (drugs and alcohol)
- Prevention of Mother to Child Transmission
- Treatment and Prevention literacy
- Support for sero –discordant couples
- Treatment for prevention
- Differentiated HTS for key populations
- Palliative care

5.3.6 Human Rights including Stigma and Discrimination Reduction

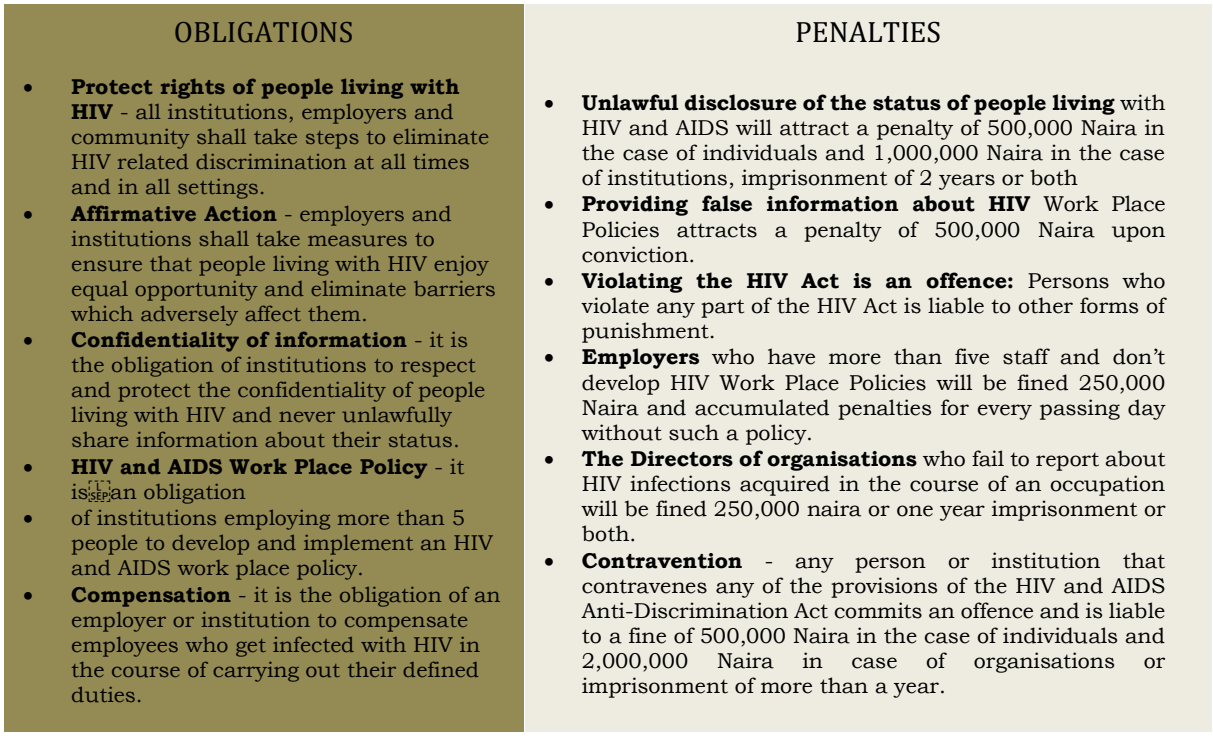
HIV-related stigma is widely reported and feared by PLHIV, AYPLHIV, Key populations including young key populations and other vulnerable groups, and refers to any form of prejudice, negative attitude, discrimination or abuse directed at them because of their status or sexual behavior. Social change must be supported through the empowerment of PLHIV, AYPLHIV, Key populations including young key populations and other vulnerable groups to know their rights, and that there is anti-discrimination act that protect them and be able to confront the stigma, self-stigma and discrimination they face. Human rights violations against PLHIV should be monitored and addressed appropriately, through known functioning redress mechanisms.
Also, each individual's HIV status must be confidential, particularly when HIV-positive. The decision to disclose one's status is the sole responsibility of that individual – he or she alone should decide how, when and to whom to disclose his/her status. In general, PLHIV are to be treated with dignity and respect in their families and communities.

Under Human Rights of PLHIV, PABA, AYPLHIV, Key populations including young key populations and other vulnerable groups, the following are expected:

- Ensuring confidentiality of status

- Safe and voluntary disclosure ("to create an environment of open communication and equality in relationships")
- Autonomy of the individual ("i.e. choice as to when, and if, to initiate ART")
- Legal literacy, advocacy and activism
- Enabling environment, including protective laws
- Shared responsibility

Figure 5:1 is the simplified and popular version of the HIV and AIDS Anti-Discrimination Act (2014)



OBLIGATIONS

- **Protect rights of people living with HIV** - all institutions, employers and community shall take steps to eliminate HIV related discrimination at all times and in all settings.
- **Affirmative Action** - employers and institutions shall take measures to ensure that people living with HIV enjoy equal opportunity and eliminate barriers which adversely affect them.
- **Confidentiality of information** - it is the obligation of institutions to respect and protect the confidentiality of people living with HIV and never unlawfully share information about their status.
- **HIV and AIDS Work Place Policy** - it is an obligation
- of institutions employing more than 5 people to develop and implement an HIV and AIDS work place policy.
- **Compensation** - it is the obligation of an employer or institution to compensate employees who get infected with HIV in the course of carrying out their defined duties.

PENALTIES

- **Unlawful disclosure of the status of people living** with HIV and AIDS will attract a penalty of 500,000 Naira in the case of individuals and 1,000,000 Naira in the case of institutions, imprisonment of 2 years or both
- **Providing false information about HIV** Work Place Policies attracts a penalty of 500,000 Naira upon conviction.
- **Violating the HIV Act is an offence:** Persons who violate any part of the HIV Act is liable to other forms of punishment.
- **Employers** who have more than five staff and don't develop HIV Work Place Policies will be fined 250,000 Naira and accumulated penalties for every passing day without such a policy.
- **The Directors of organisations** who fail to report about HIV infections acquired in the course of an occupation will be fined 250,000 naira or one year imprisonment or both.
- **Contravention** - any person or institution that contravenes any of the provisions of the HIV and AIDS Anti-Discrimination Act commits an offence and is liable to a fine of 500,000 Naira in the case of individuals and 2,000,000 Naira in case of organisations or imprisonment of more than a year.

Figure 5. 1: Popular Version of the HIV and AIDS Anti-Discrimination Act (2014), published in 2016

5.3.7 Gender Equality

Gender Equality means that women and men, girls and boys enjoy the same status in society, have the same entitlements to all human rights, enjoy the same level of respect in the community, can take advantage of the same opportunities to make choices about their lives, and have the same degree of power and maintain order, structures and systems in a community). Gender inequality has been identified as a key driver influencing the vulnerability of women and girls to HIV infection. Women and girls constitute one of the most vulnerable groups to the HIV/AIDS epidemic.

Some of the government interventions at reducing vulnerability to HIV due to harmful gender norms, gender-based violence and unequal power relations are:

- Scaling up of PMTCT

- Accelerated PMTCT programmes at PHC & community levels, and giving attention to MARPs, women, young people, Vulnerable Children (VC).
- Mainstreaming gender issues, women empowerment and male involvement in all efforts of the national HIV response.
- Mobilization of strategic partnership with FBOs, women focused NGOs, traditional rulers, public and private organization through the office of First lady and wives of Governors and LGA Chairmen.
- Integration of reproductive health and HIV services including comprehensive programmes that address gender inequality in a holistic way and cross-examine the socialization of boys and girls at home and school.
- Involvement of male and female gender focused networks including women and girls with disabilities who have been marginalized.
- Ongoing institutionalization of Gender Management System, which will enable a gender responsive functional system at national and sub-national levels and;
- Gender responsive budgeting in HIV/AIDS programming.[36]

For PLHIV, AYPLHIV, PABA and other key and vulnerable populations, addressing issues related to gender equality will mean:

- Addressing stigmatizing attitudes amongst service providers and general public
- Addressing gender-based violence through enforcement of protective laws against Gender Based Violence (GBV) such as the Child's Right Act (2003); Violence Against Persons Prohibition Act (2015) and Trafficking in Persons (Prohibition) Law Enforcement and Administration Act (2015)
- Addressing social and legal drivers of inequality
- Self-empowerment and decision making for PLHIV, AYPLHIV, PABA and other key and vulnerable populations
- Legal literacy for PLHIV, AYPLHIV, PABA and other key and vulnerable populations in particular women
- Referrals to social protection services and support.
- Accessibility of services by key population
- Empowerment for women living with HIV via employment, skill acquisition, income generating activities and joining VSLA because they often bear the burden of care because of their gender.
- Support to caregivers, in particular women caring for families Vulnerable Children (VC) and in households with people living with HIV through household economic strengthening activities
- Mobilization of and support to networks of women living with HIV and key populations

[36] (NACA, 2016)

5.3.8 Social and Economic Support

Employment and economic empowerment for PLHIV, in particular, women, young PLHIV and Key and vulnerable population requires ensuring that they have equitable access to education and employment through focused efforts by various networks of PLHIV in collaboration with relevant sectors. Women and young PLHIV, who are more vulnerable because of their gender and age as well as their HIV status, need support through focused education and employment opportunities, such as facilitating access to micro-financing, retraining opportunities, income generating activities, apprenticeships, job placement, and vocational trainings. Food, livelihood and water security programmes for PLHIV is also critical as they are more susceptible in the absence of these items due to the already compromised immune system.

PLHIV community (including key and vulnerable population) interface with officers from social benefit schemes could be organized once a quarter either at the Local, State or Federal level for mass application, awareness generation and linkage. All indigent PLHIV, AYPLHIV, Key populations including young key populations and other vulnerable groups will be informed well in advance about the event and will also be asked to bring required documents to avail them of the services. These officers will be sensitized on PLHIV issues, and motivated to attend events that provide information about the schemes to PLHIV, as well as facilitate mass applications.

Social support for PABA includes; nutritional, educational, access to health and HIV services, tutorial and psychosocial supports for vulnerable children, and economic empowerment for caregivers. The services that could be accessed here include:

1. Access to comprehensive educational package, skills, training and retraining and employment opportunities for PLHIV, AYPLHIV, Key populations including young key populations and other vulnerable groups.
2. Support of productive financial service linkages including cooperatives for women in particular
3. Access to pension services
4. Linkage to existing social protection services
5. Linkage to social services such as education, health protection etc. for children affected by HIV and AIDS.

5.4 Minimum PHDP Services for PLHIV

PHDP messages and services should be routinely offered to all PLHIV, AYPLHIV, Key populations including young key populations and other vulnerable groups attending Care and Support services in both clinic and community settings. Messages and services should include as a minimum:

- Preventive recommendations (status disclosure, partner testing, safe sex with condom promotion/distribution and alcohol/substance use reduction)
- Adherence assessment, counseling and treatment support

- Screening for mental health status
- Family planning and safe pregnancy counseling
- STI assessment, diagnosis and treatment
- Referral to community-based programmes for relevant non-clinical services
- Infant feeding counseling

5.5 Discrimination Response System (DRS)

Addressing stigma and discrimination is a key aspect of reducing vulnerability as well as fostering quality of life. Efforts by government and partners in ensuring that stigma and discrimination is tackled include the development of laws, action plans and surveys. Interventions cover mapping of laws, policies and services on gender-based violence and its intersections with HIV in Nigeria; National Plan of Action (2017-2022) on removing legal and human rights barriers to HIV and AIDS response in Nigeria; National HIV and AIDS Stigma reduction strategy and the HIV and AIDS Anti-Discrimination Act (2014) as well as other ongoing efforts such as the development of guidelines and manual on access to justice by PLHIV, AYPLHIV, key populations including young key populations and other vulnerable groups

Lately, the Gender and Human Rights State Response Team (GHR-SRT) was cascaded to states in order to support access to justice, HIV services and promotion of human rights of key and vulnerable populations in a coordinated manner in Nigeria. The GHRSRT is composed of representatives from the state Ministries, Departments and Agencies (MDAs), Law Enforcement institutions, UN Agencies, Development and Implementing Partners in the States, Nigerian CSOs/ Networks, the Media, Academia, Private sector and other relevant Experts. The GHRSRT's goal is to support the mainstreaming of gender equality and human rights into the State response as outlined in the HIV and AIDS Policy and National Strategic Framework and Plan (NSF & NSP) and other national guidelines and standards.
Their roles and responsibilities are to:

- Advise relevant stakeholders on how to prevent and remedy Human Rights (HR) violations at all levels in the State
- Domesticate and popularize the HIV and AIDS Anti-Discrimination Act (2014), the State HIV and AIDS Anti-Discrimination laws, Violence Against Persons Act and its equivalent at the state levels
- Promote and facilitate appropriate law reviews and reforms
- Facilitate access to justice for survivors of gender based violence, Human Rights violation or HIV/AIDS related stigma and discrimination
- Provide technical assistance on gender and Human Rights to stakeholders including but not limited to: state MDAs, CSOs and other TWGs for the development and implementation of gender and human rights responsive strategies, policies and plans.
- Promote the conduct of gender analysis and research to inform gender and HR responsive programming in the States.

- Support the conduct of advocacies to policy makers, key influential people, gatekeepers, programme managers and implementers on gender equality and women empowerment, male engagement for inclusiveness and HR.
- Advocate for appropriate allocation of resources in a gender and human rights responsive manner.
- Convene regular meetings to promote the generation of ideas on current and emerging issues, technical input and information sharing at the State level.
- Promote and support gender and human rights responsive monitoring systems at various levels.
- Promote networking and foster relationships amongst gender and HIV and AIDS stakeholders at the state levels.
- Identify, adapt and disseminate tools and training materials for gender and human rights analysis and mainstreaming.
- Conduct trainings for relevant stakeholders on mainstreaming gender and HR issues.
- Review, update and disseminate existing directories that support gender and HR mainstreaming efforts in the state.
- Develop indicators for monitoring and evaluation of gender and HR mainstreaming efforts including the evaluation of the achievements of gender and HR related NSF objectives.

Most of the abuse, stigma and discrimination however happen within the community and go unreported and undocumented or even redressed. The need to establish an effective and sustainable mechanism to address cases of discrimination faced by PLHIV therefore became imperative. For proper linkage with the community, the Community Improvement Team, which in this case is expected to, consist of members made up of representatives from different clusters/networks of PLHIV (women, men, adolescents, young people, FSW, IDU, PWD) among others including community and religious leaders, law enforcement agencies, LACA etc. can handle such issues at the community level and report to the GHRRC at both local and state level for action.

How to respond to discrimination incident

When a community member informs on one's behalf or on behalf of another member who gets harassed, the member of the Community Improvement Team responding to the information is to get in touch with the affected person by phone or in person to confirm the issue. S/he also will contact other team members to appraise them of the situation. It is important to provide immediate moral support and give the message that the person is not alone in this situation and the person has support. The case should then be forwarded to members of the Gender and Human Rights Response Team (GHR-SRT) at the local and State level for immediate action

5.6 Measurable Outcomes

Targets
90% of PLHIV access PHDP-related services by 2023.

Indicators
(Number and) % of PLHIV (disaggregated by age and sex) provided with 'prevention with positives' services
Number of Key Populations (disaggregated by age, KP type) provided with 'prevention with positives' services
(Number and) % reported GBV cases who received post-GBV care and support services

CHAPTER 6: NUTRITION FOR PEOPLE LIVING WITH HIV AND AIDS

6.1 Introduction

This section of the HIV and AIDS Community Care and Support Guideline focuses on nutrition and specifically addresses the following objectives:

- To provide consistent and evidence-based recommendations for nutritional response to HIV and AIDS
- To assist in improving the nutritional status of PLHIV
- To provide users (service providers, PLHIV, caregivers) evidence-based information on quality nutritional care and support
- To assist in the improvement of the quality of life of PLHIV through maintaining a healthy lifestyle

6.2 The Link between Nutrition and HIV and AIDS

Adequacy of nutritional status enhances the immune system. Figure 6:1 illustrates that a well- nourished person has a stronger immune system for fighting infections and coping with HIV and AIDS.

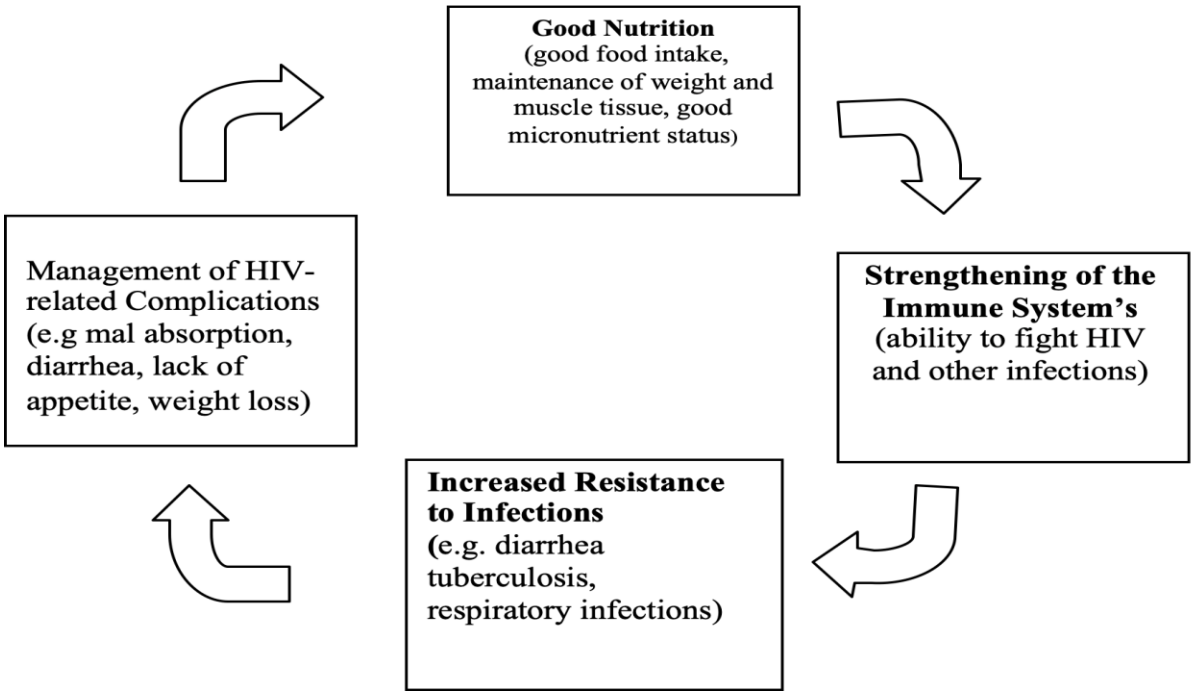


Figure 6. 1: The cycle of good nutrition and resistance to infection in the context of HIV and AIDS (adopted)[37]

[37] (Piwoz and Preble, 2000)

6.3 Nutrition Challenges of PLHIV in Nigeria

Malnutrition is a serious problem that aggravates the spread of HIV and AIDS. HIV and AIDS prevalence in Nigeria is stabilizing but malnutrition is still a problem. While the prevalence of underweight among children aged 0-59 months was 19.9 percent, the prevalence of stunting was 32.0 percent and has remained the largest burden of malnutrition with stagnated rates of above 30 percent since 2014.[38] Stunting indicates a long-term nutritional problem in the country.

Also, the national prevalence of acute malnutrition using MUAC (<221 mm) among Nigerian women in the reproductive age was 6.9 percent with 3.8 percent as severely malnourished (MUAC <214 mm), indicating a stable situation, consistent with previous nutrition survey conducted in 2015.[39] It is clear that malnutrition negatively affects an optimal immune function, thus increasing the susceptibility of victims to high morbidity and mortality. Adults and children living with HIV and AIDS may suffer from loss of appetite, difficulty in eating due to oral infections. It is important therefore, that the provision of quality cares and support for PLHIV, AYPLHIV, Key Populations including young key populations and other vulnerable groups should include nutritional counseling care and support.

The goals of the nutritional counseling care and support for PLHIV should include:

- Improvement of nutritional status
- Ensuring adequate nutrient intake
- Preventing food and water-borne diseases
- Enhancing quality of life and prolong survival

6.4 Recommended Nutrient Requirements Using Local Food Sources

- **Energy giving foods:** yam, cassava, plantain, rice, bread, maize, potatoes (Irish and sweet) and cocoyam etc.
- **Sugars and Sugary Foods:** sugar cane, honey, sweets, jams, marmalade, sugar cakes (Alewa) and cookies etc.
- **Fats and Oils:** palm oil, groundnut oil, cottonseed oil, soybean oil, shea butter and margarine etc.
- **Dietary Fiber:** garden eggs, maize, fruits, vegetables, cassava, yam, sweet potatoes, and cocoyam etc.
- **Body Building Foods (Protein Rich Foods):** Beans, groundnuts, pigeon peas, soya bean, Bambara nuts, meat, eggs, fish and milk (including yoghurt, wara (local cheese) etc.
- **Protective Foods:** jews mallow (ewedu), spinach, water-leaf, bitter-leaf, zogale, ugu, oha, sorrel, cassava leaf, worowo, amunututu, sokoyokoto, ujuju, erimionu, kerenkerem, afang, okazi, mgbolodi,

[38] (FMOH, 2018)
[39] ibid

ayakwa, okro, carrot, green peppers, onions. Avocado pears, local pears (Ube), bananas, guavas, mangoes, oranges, pawpaw, pineapple etc. (Figure 6:2)

Although water is not part of the food groups it is important for life and is necessary every day. Water aids digestion, absorption and transportation of nutrients in the body. It is recommended that a person should drink at least eight glasses (1.5 litres) a day.

There is no single food that contains all the nutrients that the body needs, except breast milk for infants up to six months of age. For a balanced meal, use at least one type of food from each food group.

Figure 6. 2: Available variety of Foods

6.5 Nutritional Care and Support for Children and Adults Living with HIV and AIDS

For Children:

Severe wasting is a common clinical presentation of HIV infection in children. HIV-infected children with severe malnutrition have a higher risk of mortality than uninfected children due to the frequency and severity of OIs including TB. Severe Acute Malnutrition (SAM) is characterized by the presence of any of the following: weight/height z score < -3, a MUAC of < 11.5cm, bilateral oedema in children of 6-59 months of age.[40] No agreed indicators yet for Severe Acute Malnutrition (SAM) for children less than 6 months. Key points to note for children and nutrition

[40] (WHO and UNICEF, 2009)

- Ensure the child receives treatment for the presenting symptoms of clinical conditions
- Ensure increased intake of fluids
- Give multivitamin and mineral supplements as recommended
- Continue regular growth monitoring and adequate nutrition counseling
- Should use anti-retroviral (ARVs) if prescribed
- Ensure that the child completes full course of immunization
- Ensure regular hand washing practices

For adults with HIV and AIDS:

- Eat variety of foods with emphasis on nutrient dense foods
- Eat small meals frequently (especially for a very sick person)
- Use spices for appetite and absorption: ginger, garlic, cardamom, lemon
- Drink clean and safe water
- Observe food safety, improve cooking methods and hygiene principles
- Need to do light exercises/ Be physically active
- Manage stress
- Use prescribed anti-retroviral (ARVs)
- Avoid alcohol, avoid smoking
- Manage specific disease symptoms promptly (e.g., nausea, vomiting, diarrhea and constipation).
- Periodically check their nutritional status (weight, BMI), hemoglobin level should be determined and recorded
- PLHIV found to have weight loss of more than 10% in the last three months, should have their diet intake and history of illness assessed.
- Services of support groups which run specialized nutrition services on supplementary foods should be sought where available and necessary

6.6 Nutritional Care for HIV Positive Pregnant Women/Adolescents

- Family members should support pregnant adolescents and women living with HIV and AIDS and other related diseases to access appropriate health and nutrition services
- They should be given priority at meals to eat enough of the right foods because of increased energy needs due to HIV and pregnancy
- They should not restrict food intake during the last months because of fear of having a big baby or obstructed labor. This is because it can lead not only to Low Birth Weight (LBW), but will lower the mother's immune status with resultant increased risk of illness and death of mother and baby.
- Pregnant HIV-positive women should eat alternative animal foods (in cultures where intake of some sources of animal protein is a taboo) in other to ensure good nutritional status and birth outcomes.

- Those who expend energy on household or agricultural work should also increase their energy intake or reduce workload and have adequate rest.

6.6.1 Safe Food Handling Practices

- Hand washing practices for food handlers before and after food preparation
- Wash and keep food preparation surfaces, utensils, and dishes clean
- Wash all fruits and vegetables, avoid eating raw food, cook foods thoroughly especially meats and chicken.
- Avoid storing cooked food without a fridge; serve all food immediately after preparation
- Drink clean and safe water,
- Do not use bottles with teats to feed children, use cup and spoon instead

6.6.2 Feeding for HIV Exposed Infant

According to the national PMTCT guideline and the Nigerian Infant and Young Child Feeding (IYCF) policy, all HIV positive pregnant women should be on ART throughout their pregnancy and for life. HIV positive breastfeeding mother should not breastfeed their baby for more than 12 months.

6.6.3 Exclusive Breastfeeding

Educate mothers that breast-feeding:

- Gives infants all the nutrients they need, protect infants and children from diseases other than HIV and AIDS and breast milk is easily digestible.
- Increases risk of HIV and AIDS transmission if the mother has a breast infection (e.g. mastitis or cracked and bleeding nipples)

Breastfeeding mothers should:

- Be given information to make breast milk as safe as possible, receive nutrition counseling, be taught good positioning and attachment
- Put the baby to the breast immediately (within an hour) after birth
- Breastfeed exclusively (avoid mixed feeding) until 6 months of age
- Introduce complementary foods after 6 months
- Be taught that infant mouth problems such as mouth ulcers and candidiasis (oral thrush) increase the risk of HIV and AIDS transmission.
- Continue Breastfeeding till one year of age with ARV
- Do not breastfeed when there is wound on the nipple

6.7 Nutritional Care for PLHIV taking Medication or Herbal/Local Remedies

People living with HIV and AIDS take different types of medications including antiretroviral drugs (ARVs) and oftentimes, herbal remedies. These medications can interact with certain nutrients to produce negative side effects or to reduce their efficacy. For example, the drug used for the treatment of tuberculosis (Isoniazid), inhibits metabolism of vitamin B6 and may cause B6 deficiency. The antibiotic tetracycline similarly inhibits the absorption of calcium, zinc, iron and magnesium.

Furthermore, various medications may produce side effects such as taste changes, loss of appetite, vomiting, nausea and diarrhea, which can negatively affect food intake, nutrient absorption and metabolism leading to weight loss. It is note-worthy that some ARVs cause side effects due to their effect on metabolism; in like manner, some food may also have negative side effects on the absorption, utilization, metabolism and excretion of some of the medications. It is therefore important for service providers to be aware of food/drug and nutrient/drug interactions in order to minimize side effects. Key issues to note are:

PLHIV, AYPLHIV, Key Populations including young key populations and other vulnerable groups should:

- Be provided with information on how to prevent food-drug interactions and how to prevent or minimize side effects of medications and herbal remedies. This could be during group health education at adult ARV or PMTCT clinics
- Read widely, note instructions on drug packages
- Be provided with IEC materials that address dietary issues.
- Be informed on where they can get information on food/nutrition and drug.
- Should be counseled to adhere to all instructions with respect to their drugs and food.
- Should receive advice and counseling on drugs to be taken with food and those to be taken on an empty stomach.
- Seek advice early enough from service providers where there is complications and referrals made where necessary
- Timely report of any identified side effect to appropriate service providers

6.8 Nutritional Assessment Counselling And Support (NACS)

Nutritional Assessment, Counseling and Support (NACS) is an essential strategy and component of Care and Support for PLHIV. NACS should be conducted at every setting where Care and Support is provided to PLHIV in the Community or Facility.

In the community, this assessment and necessary interventions should be carried out during home visits, support group meetings and other community outreach activities.

The Facility assessment should be carried out on the clients at each clinic visit at PHC, secondary and tertiary centres. Specialist advice for complicated cases may be sought from dieticians and nutritionists at secondary or tertiary health facilities or at state ministries or local government departments.
Note: Inpatient treatment may be appropriate for patients with severe malnutrition.

6.8.1 Components of NACS

6.8.1.1 Assessment

The counselor should work with the client (PLHIV) to assess the following.
Nutritional status

- Weight, height; and then calculate Body Mass Index (BMI) for adults and mid upper arm circumference (MUAC) for children and pregnant women
    - Use of the height/weight chart for adults or WHO Road to Health chart for children
    - Compare findings with previous records
- General wellbeing and functioning
- Appetite
- Any nutritional or health problems

Dietary Practice

- 24- hour dietary recall of food intake and related problems
- Occurrence of drug/food related interactions
- Clinical (in relevant settings): Clinical assessment for signs of malnutrition

6.8.1.2 Counseling

The key Issues for Nutritional Counseling of PLHIV should be based on the principles of PHDP. They should be provided with information on:

- Good dietary practices including information about food groups, balanced diets, local dietary options etc.
- Positive Health Dignity and Prevention (PHDP) practices including:
    - Water and Sanitation Hygiene (WASH)
    - Food hygiene
    - Safe storage, preparation and preservation of animal products, fruits and vegetables
    - Smoking and alcohol use
    - Opportunistic infection
    - Family planning and child spacing
    - Lifestyle modification including exercise
    - Support group membership
    - Positive mental attitude

- Awareness and prevention of food/drug interactions and how to prevent or minimize side effects of medications and herbal remedies.
  - Note instructions on drug/breast milk substitutes packaging.
  - Consult relevant health professionals when queries arise.
- Attend conferences, seminars, meetings and workshops where issues on HIV and AIDS are being discussed
- PLHIV need IEC materials that address dietary issues

For complicated or specialized dietary issues requiring medical nutrition therapy, please, consult the dietician.

6.8.1.3 Outcomes of Assessment

6.8.1.4 Anthropometric

Categories of anthropometric assessment
- Undernourished/underweight
- Normal
- Overweight (Table 6:1)

Table 6 1: Outcome of Anthropometric Assessment

BMI	<18.5 (Underweight)	18.5 - 24.9 (Normal)	25 – 29.9 (Overweight)	>30 (Obese)	>40 (Morbidly obese)
MUAC (Under 5)	<11.5cm (Underweight)	11.5-12cm (Normal)	>13cm (Overweight)		
MUAC (Pregnant women)	<23cm (Underweight)				

6.8.1 5 Poor Nutritional literacy

Poor Nutritional literacy is defined as the inability to understand the importance of good nutrition in maintaining health.

6.8.1.6 Referral Criteria

PLHIV assessed and identified to be clinically undernourished will meet the following criteria:
- Adult BMI< 18.5
- Children Under 5 (MUAC) <11.5cm
- Pregnant women (MUAC) <23cm

6.9 Nutritional Support for PLHIV

Support includes but not limited to the following:
- Goal setting/Planning
- Food demonstration using locally available food options
- Innovative agricultural practices like kitchen gardens, food banks etc.

- Food rehabilitation using Ready-To-Use therapeutic foods for severe malnutrition, food supplies from CBOs etc.
- Follow up.
- Referral and linkage (in cases of malnutrition, food insecurity: - food not readily available for the family e.g. minimum meal frequency, minimum dietary diversity and minimum acceptable diet)

6.10 Measurable Outcomes

Target
90% of eligible adults and children (PLHIV/PABA) receive nutritional support services

Indicators
Number and) % of malnourished PLHIV who completed referrals and received nutritional support services
(Number and) % of eligible adults and children (PLHIV/PABA) (disaggregated by sex and age) provided with nutritional support services
(Number and) % of eligible pregnant women (PLHIV/PABA) (disaggregated by sex and age) provided with nutritional support services

CHAPTER 7: MANAGEMENT OF MENTAL HEALTH CONDITIONS/ DISORDERS IN HIV AND AIDS

7.1 Introduction

Mental Health is a state of well-being in which every individual realizes his or her own potential and can positively cope with the normal stresses of life. There is evidence that people living with HIV are more likely than the general population to have multiple long-term conditions such as poorer mental health and poorer sexual health due to the impact of living with a stigmatized, chronic medical condition and traumatic life events among others. Five distinct mental health-related issues that are relevant to HIV/AIDS programmes are:

- ✓ Cognitive impairment and dementia due to viral infection of the brain;
- ✓ Depression and anxiety due to the impact of the infection on the person's life;
- ✓ Alcohol and drug use, which contribute to risk behaviours;
- ✓ The psychiatric side-effects of some antiretroviral therapy (notably efavirenz);
- ✓ The social difficulties faced as a result of stigma and discrimination[41]

Findings from Nigeria, indicate that the prevalence of mental health problems among PLHIV range from 21.5% to 59.1%.[42][43][44] Furthermore, Adewuya et al., (2007) demonstrated a much higher prevalence of mental health problems among PLHIV at 59.1%; as compared with 19.5% among controls without HIV and AIDS. Depression is also higher at 28.2% among PLHIV.[45] as compared with 3.1% in the general adult Nigerian population.[46]. Among PLHIV, suicidal ideation and behaviours is also common, with about 15.1% thinking about suicide (ideation); 5.8% had active plans to commit suicide; while 3.9% had made an attempt in the past.[47]

Not only does mental health negatively affect quality of life, it can create a vicious cycle as it can complicate clinical care (e.g. disengagement from healthcare systems, non- adherence to ART), thus, compromising physical health and heightening the risk of onward HIV transmission. Indeed, this is buttressed by Nigerian studies that have shown for example, that PLHIV who also have co-morbid anxiety and depression were 16 times more likely to be poorly adherent with medications, when compared with PLHIV who did not have anxiety and depression.[48] Furthermore, Adejumo et al., (2016) also

[41] (Martineau, 2019)
[42] (Adewuya et al. 2007)
[43] (Olagunju et al. 2013)
[44] (Egbe et al. 2017)
[45] ibid
[46] (Gureje et al. 2010)
[47] (Oladeji, et al., 2017)
[48] (Seb-Akahomen, Lawani, & and James, 2018)

reported a two-fold increased rate of poor adherence among PLHIV with mental health problems, compared with PLHIV without mental health problems.

Two groups of people may present with mental health conditions and HIV infection. These groups are: a) those with pre-existing mental illnesses who become secondarily infected with HIV and b) those who are HIV positive and present with mental health conditions (either directly or indirectly).

7.2 Description of Mental Health Conditions

There are some mental conditions that may be related to the stress of living with HIV and AIDS and these include depression, anxiety and mania. The most common primary mental health complications that can occur at any CD4 level are adjustment disorder, depression, anxiety disorders, as well as mixed depression and anxiety disorders. However, other mental disorders may be secondary to neurological complications of HIV, opportunistic infections or side effects of ARV drugs. They include delirium, HIV Associated Neurocognitive Disorders (HAND), Alcohol and Substance Use disorders may also occur. Some of the commonest conditions are discussed briefly below

7.2.1 Adjustment Disorder

This condition occurs predominantly at the time of HIV diagnosis and includes acute and chronic adaptation responses to diagnosis. These responses may include fear of discrimination and imminent death, guilt over infecting others and suicidal ideation. With the progression of the HIV and AIDS, patients also need to constantly adapt to changes in their lives brought about by each new symptom as well as loss events such as death of an intimate partner or child as a result of an HIV and AIDS related condition. Adjustment disorder can be a major barrier to disclosing test results and hence, restricts access to social support that may potentially protect patients from many other mental health consequences of HIV. Supportive counseling and involvement of support groups is helpful to assist them to cope with adjustment disorder as an acute response.

7.2.2 Depression

Depression is a common mood disorder characterized by low or sad mood, loss of interest or pleasure, feelings of guilt, suicidal thoughts, disturbed sleep, appetite and weight changes, poor attention and concentration, changes in energy level/fatigue and psychomotor disturbances. Major depression is a mental disorder that affects the mind and body and therefore presents with both psychological and physical symptoms. If untreated, depression undermines adherence to medical recommendations, which worsens physical health and survival. In some instances, it can lead to suicide.

Noticeable behavioral changes may include change in treatment adherence, frequent crying or weepy spells for no clear reason, reduced appetite or sleep,

multiple non-specific bodily complaints, feelings of worthlessness, poor attention and concentration, inability to make life/medical care choices (indecision), preoccupation with minor problems, change in functioning, social isolation, interpersonal problems, or initiation/return to substance use. More often than not, the concerned person either does not recognize the situation or fails to admit it and will therefore need help. Indeed, even health workers can easily miss the presence of depression if they do not carefully look for it. Yet, it is very important and may potentially cause death, via suicide, if left untreated.

7.2.3 Anxiety Disorders

Anxiety disorders occur when there are excessive symptoms of fear, panic and worry that are sufficiently severe enough to interfere with a patient's daily functions, interpersonal relationships and also causes marked subjective distress. Even brief episodes of anxiety, such as those occurring during a panic attack may interfere markedly with a patient's life and warrant a diagnosis of an anxiety disorder. Patients with HIV infection may have any of the anxiety disorders, but generalized anxiety disorder, posttraumatic stress disorder, and obsessive – compulsive disorders are particularly common.

The initial high levels of experienced fear accompanying an HIV diagnosis tends to subside with time, and then persist at a lower level. Symptoms of anxiety disorders are both psychological and physical due to physiological arousal. The wide range of physiological manifestations include: sudden difficulty breathing (shortness of breath), chest pain, racing/ pounding heart, dizziness, sweating, dryness of the mouth and gastrointestinal disturbances, which may overlap with symptoms of other common medical disorders. In addition, patients present with fear, worry, insomnia, impaired concentration and memory, diminished appetite, compulsive rituals and avoidance of situations that make them anxious.

General measures that help in the treatment of persons with anxiety disorders include reassurance, psycho education and supportive counseling when the level of anxiety does not interfere significantly with social or occupational functioning. Medications are used when anxiety levels interfere significantly with sleep or daily functioning.

7.2.4. HIV-Related Mania

HIV and AIDS related mania is characterized by elated or irritable moods (either occurring acutely or sub acutely), increased activity and energy regardless of physical status, decreased need for sleep and an exaggerated sense of self-importance (grandiosity or grandiose delusions). Behavioral changes centre on increased activity, disinhibited behaviour - including financial and sexual recklessness, and intrusiveness. The condition occurs with more advanced immunosuppression and is often associated with HIV related cognitive impairments.

7.2.5 Delirium

Delirium is an acute state of disorganized behavior following the effect of the HIV infection on the brain. It is a state of altered consciousness that is marked by fluctuating levels of consciousness, lethargy, anxiety, incoherent or disorganized speech, disorientation and visual hallucinations. The patient may also experience frequent disorientation and struggles to make sense of their surroundings, on account of clouded thinking and diminished awareness. The disturbance tends to fluctuate during the course of the day, often worse in the evenings and night (diurnal variation).

Delirium in HIV infected patients can present with characteristic perceptual disturbances such as visual hallucinations (seeing things that are not there) and illusions (misinterpretation of visual cues, such as mistaking shadows for people). They may also present with impaired psychomotor functions, which may be in the form of decreased activity, increased activity or a mixture of both. The rate of delirium is higher in elderly persons with AIDS. Among children and adolescents, delirium caused by medications may be more common.

7.2.6 HIV-Associated Neurocognitive Disorders (HAND)

HIV Associated Neurocognitive Disorders (HAND) is a chronic neurode-generative disorder characterized by cognitive, motor and behavioral abnormalities. Prior to ART, HAND manifested as a progressive subcortical dementia, which was known as AIDS Dementia Complex (ADC). However, with the advent of ART, the Dementia component only occurs in the most severe cases. Thus, HANDS is an acquired impairment of intellectual/cognitive abilities in a sufficient degree of severity to interfere with social or occupational functioning where memory impairment is a predominant feature. **Affective impairment** is usually in the form of apathy; irritability and sometimes elevation of mood. **Behavioral changes** include psychomotor retardation (slowed speech and response time), personality change and social withdrawal. Common **cognitive changes** include lack of visual spatial memory (misplacing things), poor visual- motor coordination, and difficulty with complex sequencing (difficulty in performing previously learned complex tasks), impaired verbal memory (word finding ability), impaired concentration and attention.

Patients will often show **motor changes** such as unsteady steps, loss of balance due to leg weakness, dropping things, tremors, poor handwriting and decline in motor skills. Seizures, global cognitive deterioration, incontinence, and severe confusion are other common clinical features of late stage HAND. Older age and increased level of immunodeficiency are known risk factors for the development of HAND.
HAND is further sub-categorized based on severity (Frascati Criteria) into three categories:

- Asymptomatic neurocognitive impairment (ANI)
- Mild neurocognitive disorder (MND)
- HIV-associated dementia (HAD)

7.2.7 Alcohol, Substance Use and HIV

People who inject drugs and take alcohol have special clinical needs, which require mental health skills and sensitivity in terms of assessing the patients' risky behaviors and substance use habits. Alcohol dependence and drug use have serious consequences on mental health (may cause depression, psychosis and anxiety disorders); and complicates the management of HIV and AIDS. Lowered immunity and other physical complications of HIV can be associated with alcohol use. Alcohol increases susceptibility to some infections that can occur as complications of AIDS. Infections associated with both alcohol and AIDS include tuberculosis; pneumonia caused by the bacterium Streptococcus pneumonia; and the viral disease Hepatitis C, a leading cause of death among people with HIV. Major mental disorders associated with alcohol and drug use are delirium and dementia amongst others. Conversely, alcohol and substance use lead to disinhibitions and risk-taking behaviors which further puts them at risk of physical and mental harm.

7.3 Screening Measures/Early Diagnosis

People living with HIV should receive care and support that assesses, manages and promotes their mental health needs, in addition to the currently exclusive focus on physical health problems and ART medications. Screening for any of the mental disorders discussed above should be part of the routine check-up just as is done with TB, with prompt referrals of severe cases. However, effective screening cannot be implemented in the community and at the primary care facilities without adequate training and support.

A pragmatic engagement to provide training for primary care health workers and peer support volunteers is to deploy the *World Health Organization's (WHO) Mental Health Gap Action Programme Intervention Guide (mhGAP-IG)* which is an easy, step by step guidelines for screening and providing basic psychosocial interventions for common mental disorders.

The mhGAP-IG has been contextualized for Nigeria[49] and piloted successfully for use in Nigeria for training non-specialists in different parts of the country.[50] An additional strategy to improve screening and detection for mental disorders is to use short screening tools such as the *General Health Questionnaire (GHQ-9); and the Patient Health Questionnaire – 9 items (PHQ-9)* which is included in the appendix. Furthermore, public awareness campaigns to reduce the associated stigma of mental disorders need to be aggressively pursued. Some PLHIV and PABA may have come to accept the mental health sequelae as inevitable, without realizing that there are effective interventions that can improve their emotional wellbeing, and day-to-day functioning.

Similar to the approach mentioned earlier, it is also important to take into cognizance, the peculiar needs of PLHIV, AYPLHIV, key populations, PABA

[49] (Abdulmalik, et al., 2013)
[50] (Gureje et al. 2015)

and other vulnerable groups across the lifespan, with respect to their mental health risk. For instance, the challenges of children, adolescence, young to middle adulthood, older age, and end of life considerations as well as some personal demographics such as gender and religion are all important variables that may be considered and leveraged upon to address their peculiar mental health needs in a way that is most appropriate. The overarching aim of psychosocial support is to optimize mental wellbeing, improve their resilience and coping strategies; while helping them to overcome their vulnerabilities. Those who develop mental health problems should receive screening, early identification and prompt interventions to restore optimal mental wellbeing.

Some of the general questions that can be used to screen for various mental disorders before referral are:

Depression

- Over the past month, have you felt down, depressed or helpless?
- Over the past month, have you felt little interest or pleasure in doing things?

Hypomania/mania

- In the past, have you ever had a period where you felt not just good, but better than good?
- Did this feeling of unusually high energy and a decreased need for sleep go on not for hours or an evening, but for days and days at a time?

Generalized Anxiety Disorder (GAD)

- Would you describe yourself as a chronic worrier? Would others say you are someone who is always worrying about things?
- Do you worry about anything and everything as opposed to just one or two things?
- If so, how long has this been going on?

Obsessive-compulsive disorder

- Do you have any unusual or repetitive thoughts that you know are silly but you simply cannot stop thinking about (for example, being contaminated by germs)?
- Do you feel there are certain rituals you have to do, such as tap your hand a certain way or do things in sets of threes, which takes up a lot of time in the day?

Panic attacks

- Do you have panic attacks or anxiety attacks? By that I mean an attack of anxiety that comes fairly suddenly and is rather uncomfortable and involves feeling a certain number of physical sensations such as heart palpitations, shortness of breath or dizziness.

Agoraphobia

- Do you avoid going certain places because you are fearful of having a panic attack?
- Has this feeling restricted your activities?

Social phobia

- Are you able to go to social situations where you may have to interact with people you don't know well, or is that very daunting for you?
- Can you eat in restaurants in front of others?
- Were you able to give presentations in front of others when you were in school, or can you do it now?
- Do your social fears get in the way of your life?

7.4 Interventions for Mental Health Conditions

Global best practices and the WHO recommend the effective integration of mental health services into routine general health care services for PLHIV, AYPLHIV, key and vulnerable populations and PABA.[51] Thus, at the time of diagnosis, basic supportive counseling and psychosocial support should be routinely provided for all PLHIV and PABA – as part of the standard care provision protocol. Such routine screening include the use of the adapted PHQ-2 with the following questions:

1. Over the past month, have you felt down, depressed or helpless?
2. Over the past month, have you felt little interest or pleasure in doing things?

An answer in the affirmative to the two questions will require further screening and referral for further action if need be. Routine screening and psycho-social support should continue on an on-going basis for PLHIV, AYPLHIV, key and vulnerable populations and PABA. These services should be delivered by workers who have received training on the WHO's mhGAP-IG.

A cascade model of training (using the mhGAP-IG) with supportive supervision and linkage pathways (for both supervision and referrals of complex cases) may be employed to achieve improved access to qualitative and evidence-based interventions for mental health problems affecting PLHIV, PLHIV, AYPLHIV, key and vulnerable populations and PABA.

Psychosocial support may suffice for mild to moderate cases of anxiety, post-traumatic stress disorder, depression and alcohol or substance use disorders. Severe cases that may require use of medications (pharmacological interventions) will need to be referred for psychiatric evaluation and expert care.

Clear referral pathways with effective and defined communication channels should be established between HIV services and those providing specialist

[51] (Freeman, Patel, Collins, & Bertolote, 2005)

mental healthcare, to minimize fragmentation, with the patient included in the communication process, as much as possible.

7.5 Measurable Outcomes

Targets
90% of PLHIV are screened for mental disorders
90% of PLHIV identified with mental disorders receive interventions for mental health

Indicators
(Number and) % of PLHIV screened for mental disorders
(Number and) % of PLHIV identified with mental disorders who completed referral for mental health services
(Number and) % of PLHIV identified with mental disorders that received mental health services

CHAPTER 8: INSTITUTIONAL ARCHITECTURE, SYSTEMS, COORDINATION AND RESOURCING FOR HIV AND AIDS CARE AND SUPPORT

8.1 Introduction

The implementation of HIV and AIDS Care and Support programmes will require effective policy, collaboration and coordinated inputs of a large number of stakeholders including governments at all levels, international and local NGOs, Private sector, associations of PLHIV, Community Based Organizations (CBOs), Faith Based organization (FBOs), Civil Society Organizations (CSOs), families and PLHIV themselves. While there will be multiple stakeholders involved in provision of HIV and AIDS Care and Support programmes, there are agencies that should provide leadership for the coordination of the implementation of Care and Support interventions. While National Agency for the Control of AIDS (NACA) provides the oversight functions at the Federal level, State Agency for the Control of AIDS (SACA) and Local Action Committee on AIDS (LACA) are expected to do the same at states and LGAs respectively. Government has the responsibility for providing policy and guidelines and ensuring compliance.

8.2 Policy, Guidelines and Regulations

- The 2009 National Policy on HIV/AIDS currently under review provided the framework for advancing the national multi-sectoral response to the HIV/AIDS epidemic in Nigeria. Specifically, on care and support of PLHIV, PABA, key and other vulnerable populations, the goal is to promote the survival and improve the quality of life of persons infected and affected by HIV and AIDS by reducing and mitigating the health, social, economic and psychological impact of the epidemic.
- The National Guidelines on HIV and AIDS Care and Support should be used in conjunction with other national guidelines and surveys such as Integrated National Guidelines for HIV Prevention, Treatment and Care; National Guidelines for HIV and AIDS Treatment and Care in Adolescents and Adults, National Guidelines for Nutritional Care and Support for PLHIV in Nigeria, National Guidelines for Implementation of HIV Prevention Programmes for Men who have Sex with Men in Nigeria, National Guidelines for Implementation of HIV Prevention Programmes for Female Sex Workers in Nigeria, National Situation and Needs Assessment of HIV and AIDS, Drug Use and Related Health Services in Nigerian Prisons, Situation and Needs Assessment of HIV and AIDS, Drug Use and Related Health Services in Borstal Institutions in Nigeria and National Guidelines for TB/HIV Co-management among others.

- Government and its partners should ensure widespread dissemination and compliance with the guidelines.
- Government should establish systems for effective public private sector partnership for Care and Support services.
- Government should map all organizations involved in provision of HIV and AIDS Care and Support Services for effective coordination as well as provide minimum standards expected of CBOs providing care and support services.
- All organizations engaged in the provision of HIV and AIDS Care and Support services should be monitored to ensure that services offered are in line with the provisions of the national guidelines for HIV and AIDS Care and Support.
- Government, Faith Based Organizations (FBOs), CBOs and PLHIV support groups should engage community groups and unorthodox medicine practitioners as well as faith healers to limit the proliferation of false claims, inappropriate practices and harmful practices
- Gender and Human Rights State Response Team (GHR-SRT) should mobilize and advocate for the domestication of the HIV/AIDS Anti-Discrimination Act (2014) in all states.
- The Ministry of Labour and Employment should actively monitor and enforce the implementation of the work place policy in both the public and private sectors
- Government should organize in conjunction with PLHIV networks, opportunities for PLHIV to interact with those providing social welfare programmes

8.3 Structures and Systems for Care and Support

- FMWASD, NACA, FMOH, SACA, SMOH, LACA
- Other Ministries, Departments and Agencies (MDAs)
- Health Facilities
- CBOs and FBOs providing care and support services
- Networks of PLHIV, AYPLHIV, Key Populations and other vulnerable groups
- Support Groups
- Communities
- Families
- Individuals

8.4 Leadership, Coordination and Collaboration

Government should exercise overall leadership and oversight for the implementation of HIV and AIDS Care and Support services in Nigeria. Government at all levels should establish and implement mechanisms for effective coordination of Care and Support services. All HIV and AIDS Implementing Agencies especially those engaged in providing funding for international and local NGOs in the country have the responsibility to coordinate the activities of NGOs funded by them in line with national guidelines.

Faith Based Organizations (FBOs) and Community Based Organizations (CBOs) are encouraged to strengthen and work with other existing community structures to ensure effective coordination and implementation of HIV and AIDS care & support services. HIV and AIDS treatment centers and health facilities should strengthen effective linkages with community-based HIV and AIDS Care and Support services as they key into the Bi directional Hub and Spoke model for Care

The community is the closest milieu to the client and for services to have an impact on PLHIV, PABA, AYPLHIV, Key Populations including young key populations and other vulnerable groups, the community has to participate and own the programme. There is also need to engage community stakeholders in the design, implementation, monitoring and evaluation of HIV and AIDS programmes

8.5 Human Capacity Development

- Government should provide necessary support to develop and strengthen human capacity including training, orientation, mentoring, supervision and provision of equipment for the delivery of comprehensive HIV and AIDS Care and Support services.
- The development and review of a national curriculum for training of care providers in HIV and AIDS Care and Support should be the responsibility of Government and it should facilitate the incorporation of HIV/TB education in the curricula of schools from primary to tertiary levels.
- All NGOs, CBOs and FBOs should ensure regular training for HIV and AIDS Care and Support personnel in their service according to the national guidelines.
- PLHIV Support Groups should provide literacy seminars on treatment Care and Support for its members.
- Training and re-training on Advocacy and Resource Mobilization Strategies should be organized for networks of PLHIV, PABA, key and other vulnerable populations

8.6 Resourcing

- Government at all levels and international partner organizations should increase financial commitment to the provision of HIV and AIDS Care and Support services.
- Public Private Partnership (PPP) and donor collaboration should be encouraged to enhance resource mobilization for HIV and AIDS Care and support services.
- Government, private organizations and donor agencies should strengthen capacity of PLHIV support groups to leverage financial resources for the delivery of HIV and AIDS Care and Support service.
- Government should strengthen community and facility level social welfare schemes to respond to the Care and Support needs of indigent

PLHIV, AYPLHIV, Key Populations including young key populations, other vulnerable groups and PABA.

- PLHIV support groups should engage in constructive advocacy for increased government funding for HIV and AIDS Care and Support services.
- Networks of PLHIV, AYPLHIV, Key populations and other vulnerable groups should be trained in various resource mobilization strategies to ensure sustainability.
- Relevant government institutions such as Ministries of Women Affairs and Social Development, Budgets and Planning should prioritize PLHIV, AYPLHIV, Key and Vulnerable Populations welfare in the various social welfare programmes. PLHIV should be mobilized to acquire skills, form SLAs and engage in other income generating activities to boost their economic survival
- Civil society organizations and multi-national organizations should invest in schemes that provide economic empowerment for HIV and AIDS affected households such as income generating activities, cooperative low interest loans to family members and vocational skills acquisition for PLHIV, AYPLHIV, Key populations including young key populations and other vulnerable groups.

8.7 Advocacy, Sensitization and Mass Mobilization

Focused advocacy is essential for successful implementation of HIV and AIDS Care and Support services. Necessary steps should be taken to ensure that at every level of government there is adequate public commitment to the provision of Care and Support for PLHIV, AYPLHIV, Key populations including young key populations and other vulnerable groups.

Government and relevant stakeholders should develop a national advocacy package for HIV and AIDS Care and Support services. A package that addresses issues such as increased public involvement in the Care and Support of PLHIV, implementation of work place policies, community involvement in HIV and AIDS Care and Support services and increased financial commitment to HIV and AIDS Care and Support. This can be done within the 1% that should be allotted by the state government to HIV and AIDS funding.

Government and stakeholders at all levels should plan and implement sensitization and mass mobilization campaigns on HIV and AIDS Care and Support. The objective of this campaign is to increase community awareness of the benefits of Care and Support for the PLHIV.

8.8 Measurable Outcomes

Targets
100% of states should have anti-stigma and discrimination law in place

Indicators
(Number and) % of states with anti-stigma and discrimination law

CHAPTER 9: MONITORING & EVALUATION OF CARE AND SUPPORT SERVICES

9.1 Introduction

Monitoring and Evaluation (M&E) is an essential component of HIV and AIDS care and support activities. The overall purpose of monitoring and evaluation is to measure programme results at all levels and guide toward achieving the goals and strategic objectives. Information obtained through M&E can be used to demonstrate to programme managers and policy makers that programme efforts had measurable effects and inform future programming/planning.

Monitoring is a routine process used to verify step-by-step progress of the programme at various levels to see whether activities are being implemented as planned, ensuring accountability, and identifying successes and challenges related to the intervention activities. It also provides resources for evidence-based planning through timely feedback to relevant authorities. Monitoring is best carried out using well-defined indicators meant to measure the input, process, and outputs of the intervention.

Evaluation is carried out periodically to determine and document the extent to which results are attributable to the intervention, measured through the outcome and impact indicators. It is concerned with identifying reasons for success and failure of a programme. It addresses future options, challenges, strategies and priorities for the continuous process of development.

Monitoring and Evaluation involves the collection, collation, analyzing, report writing and feedback on various thematic activities. The feedback provides information for informed policy development, guidelines and implementation of the programme.

9.2 Responsibility for Monitoring and Evaluation Activities

The Federal Ministry of Women Affairs and Social Development (FMWA&SD) will maintain the central management information system database and provide technical assistance to states ministries of women affairs, LGAs Community Development Departments and CBOs for continuous monitoring of the Community HIV and AIDS care and support programme.

NACA has the responsibility of coordinating the adaptation, development and review of the guidelines, indicators and data capturing tools (DCT) that guide the collection of HIV and AIDS care and support data at various levels. HIV and AIDS care and support data reporting will follow the national data flow

and reporting timelines as stipulated in the National Health Information System Policy.
Process evaluations will be conducted periodically to assess the quality of HIV and AIDS care and support implementation at all levels. The overarching purpose of process evaluation is to guide programmatic implementation and aid in appropriate redirection of human resources and commodities to meet the national targets. Evaluation of the level of implementation and quality of services will focus on the ability of all facilities and CBOs to meet the minimum service delivery and reporting requirements.

Targeted evaluations and other operational research (OR) including complex analysis of the routine care and support data will be used to periodically evaluate the effectiveness of services and intervention outcomes and impact in Nigeria. Some of the areas of interest include but not limited to: -

- HIV and AIDS/TB retention in care,
- HIV and AIDS related stigma and discrimination.
- Economic Empowerment for PLHIV
- Vulnerable Children programme
- State of Home-Based Care/Palliative Care in Nigeria
- Mental Health Management

The focal MDAs for each component in collaboration with other stakeholders and implementing partners will conduct these evaluation activities

9.3 Data Management

9.3.1 Data Collection and Reporting Tools

In order to adequately capture the indicators mentioned above, and monitor the care and support programme, the following DCTs were developed for recording and reporting care and support services.

- National Care and Support Enrollment Form
- National Care and Support Community Screening Checklist
- National Care and Support Service Form
- National Care and Support Service Register
- National Care and Support Summary Form
- VC tools include:
    - Pre-enrolment Register
    - Vulnerable Children Enrolment Card.
    - Child Vulnerability Index (CVI)
    - Child Vulnerability Index (CVI) Form
    - Vulnerable Children Enrolment Register
    - Vulnerable Children Service Form.
    - Vulnerable Children Monthly Service Register
    - Vulnerable Children Referral Form
    - Nigerian Child Status Index (CSI)
    - Committee Activity Tracking Form for Vulnerable Children Response
    - Funds Tracking Form for Vulnerable Children Response

- Vulnerable Children Monthly Summary Form
- LGA Vulnerable Children Monthly Summary Form
- State Vulnerable Children Monthly Summary Form
- National Vulnerable Children Summary Form.
- National Vulnerable Children Organisation Capacity Assessment Tool
- Committee Activity Tracking Summary Form for Vulnerable Children Response
- Funds Tracking State Summary Form for Vulnerable Children Programme
- Funds Tracking National Summary Form for Vulnerable Children Programme
- M&E Supportive Supervision Guide

9.3.2. Data Reporting and Information Flow

Health facilities and CBOs are to summarize all information in the care and support registers into the summary forms at the end of every month. The summary forms will be checked and signed by the supervisor before they are submitted to the M & E Unit of the LGA health office.

The Local Government M & E officer, and the LGA data management team will then enter the data from all the facilities within the LGA into the national database linked to DHIS 2 and the National VC Management Information System (NOMIS). The SMOH and SMWASD will review the data from the LGAs; provide feedback to the LGAs before the database closes.
FMWASD and FMOH will analyze all data from the States, write report and provide feedback to all levels. FMWASD and FMOH should share the reports with implementing partners and other stakeholders at national levels including National Agency for Control of AIDS (NACA). Implementing Partners supporting care and support services at various levels are to key into this information flow and strengthen the LGAs and State monitoring mechanism along with other M&E activities for social and health services across the country.

9.3.3 Supportive Supervision

There will be regular local, state and national M & E supportive supervision for all care and support services along with other components of HIV/AIDS programme in Nigeria. This ensures that data collected on HIV and AIDS care and support programme in Nigeria are valid, consistent, accurate, timely and reliable for informed programme decision-making. A system to periodically monitor the quality of care and support services and data will be developed by all local programmes and monitored by external resource persons (designated as Site Support Supervisors) at the LGAs, State, and National level. A National Care Quality process will be developed to address quality issues.

During each on-site supportive supervision visit, the standardized care and support checklist will be applied to review the services and data collection

process. This in-depth review will ensure identification of inconsistencies in data collection; collation and transmission to the next level of data flow and serve as an opportunity for on-site capacity building process for the service providers.

To ensure the effectiveness of this supportive supervision, relevant cadre of community/health care providers and M & E specialists should be identified and then trained, on how to provide supportive supervision, to care and support sites within their locality. At the state and LGA levels, the State AIDS Programme Coordinator and LGA Department of Health HIV and AIDS Focal Person should be identified as well as the community development officers at the LGA Education and Social Service Department.

9.3.4 Data Quality Assurance

Quality Assurance (QA) is the "systematic monitoring and supervision of various aspects of the care and support service delivery process in order to maximize the probability that standards of quality are being attained". Quality Assurance for generating care and support data includes all the steps needed to regulate the processes of data collection, collation, analysis, and reporting. The main criteria for data quality – validity, timeliness, relevance, completeness, integrity, and precision/accuracy – apply to each step of the data generation process. The final care and support data reported to the national M&E system – will be as good, reliable, and precise as the data management systems that generated the data.

9.4 Knowledge Management

9.4.1 Feedback Mechanisms

Feedback will be provided to all implementing partners and coordination partners to improve care and support services delivery in line with this guideline and feeding into the current NSF. The platforms and processes for providing feedback will include:

9.4.1.1 Review meetings:

The coordinating institution will periodically hold review meeting with implementing partners at the state and national level. At these meetings, implementing partners will present progress report of their work and will be reviewed by key stakeholders.

9.4.1.2 Supportive supervision and data verification visits by national level institutions:

During these visits, feedback on progress in the care and support guideline in line with the NSF implementation will be provided to stakeholders at the national levels and implementing partners. Opportunity of the meeting will be used to possibly address bottlenecks in service delivery and operations.

9.5 Targets and Indicators

Targets

90% of PLHIV access care and support services by 2023.

90% of individuals (HIV infected or affected) with complete referrals

90% of reported cases of discrimination that receive legal support services by 2023

90% of PLHIV be screened for TB by 2023

Indicators

(Number and) % of PLHIV (disaggregated by age and sex) receiving community-based care and support services

(Number and) % of individuals (disaggregated by age and sex) (HIV infected or affected) referred with complete referrals

(Number and) % of reported cases of discrimination that receive legal support services (disaggregated by age and sex)

(Number and or %) of PLHIV that received support for partner notification (disaggregated by age and sex)

Number and or % of PLHIV/PABA linked to available social protection services

(Number and or %) of PLHIV with TB referred for DOT services (disaggregated by age and sex)

Targets

90% PLHIV (disaggregated by age and sex) receive adherence support

Indicators

(Number and) % of PLHIV (disaggregated by age and sex) received adherence support

(Number and %) of PLHIV (disaggregated by age and sex) retained on treatment

Number and) % of PLHIV children and adolescents (0-19yrs), disaggregated by age and sex who received adherence support

Targets

90% of PLHIV access PHDP-related services by 2023.

Indicators

(Number and) % of PLHIV (disaggregated by age and sex) provided with 'prevention with positives' services

Number of Key Populations (disaggregated by age, KP type) provided with 'prevention with positives' services

Number and) % reported GBV cases who received post-GBV care and support services

Target
90% of eligible adults and children (PLHIV/PABA) receive nutritional support services

Indicators
(Number and) % of malnourished PLHIV who completed referrals and received nutritional support services
(Number and) % of eligible adults and children (PLHIV/PABA) (disaggregated by sex and age) provided with nutritional support services
(Number and) % of eligible pregnant women (PLHIV/PABA) (disaggregated by age) provided with nutritional support services

Targets
90% of PLHIV are screened for mental disorders
90% of PLHIV identified with mental disorders receive interventions for mental health

Indicators
(Number and) % of PLHIV screened for mental disorders
(Number and) % of PLHIV identified with mental disorders who completed referral for mental health services
(Number and) % of PLHIV identified with mental disorders that received mental health services

Targets
100% of states should have anti-stigma and discrimination law in place

Indicators
(Number and) % of states with anti-stigma and discrimination law

Targets
90% of PLHIV be screened for TB by 2023

Indicators
(Number and) % of PLHIV screened for TB
(Number and) % of PLHIV identified with TB diseases with referral for DOT services
(Number and) % of PLHIV identified with TB diseases who started and completed TB treatment

9.6 Indicator Matrix

S/N	INDICATOR	DEFINITION (Numerator/Denominator) How is it calculated?	BASELINE What is the current value?	TARGET What is the target value?	DATA SOURCE How will it be measured?	FREQUENCY How often will it be measured?	RESPONSIBLE Who will measure it?	REPORTING Where will it be reported?
1	(Number and) % of PLHIV (disaggregated by age and sex) receiving community-based care and support services	**Percent of PLHIV (>3 years old) who are enrolled in a CB C&S services, disaggregated by type and sex** **Numerator**: Number of PLHIV (> 3 years) receiving community-based C&S disaggregated by sex and type of service **Denominator**: Total number of PLHIV (>3 years old) with access to C&S services, disaggregated by sex **N/D*100/1**	34.6%	90%	Care and Support monitoring tools. Care and support Registers	Monthly	IPs, CSOs, LG and state	Community, LG and State Level
2	(Number and) % of individuals (disaggregated by age and sex) (HIV infected or affected) referred with complete referrals	**Percent of PLHIV and(or) PABA (>3years old) who were referred for and completed referral for CB C&S,** **Numerator:** Percent of PLHIV/PABA(>3 Years old who received at least one CB C&S service disaggregated by sex **Denominator:** Total number of PLHIV/PABA (>3 years old) who are eligible and have access to C&S services, disaggregated by age and sex.	34.6%	90%	Care and Support monitoring tools. Care and support Registers	Monthly	IPs, CSOs, LG and state	Community, LG and State Level

3	(Number and) % of reported cases of discrimination that receive legal support services (disaggregated by age and sex)	**Percentage of demonstrated and(or) documented cases of violence, neglect, discrimination or abuse that have been linked to the GON social welfare and other post violence and child protection services.** **Numerator:** Number of PLHIV/PABA (>3years) with a demonstrated and/or documented case of violence, exploitation or neglect or discrimination who have been successfully referred to Government of Nigeria Social Welfare and other post-violence and child protection services **Denominator:** Number of PLHIV/PABA >3 with a demonstrated and/or documented case of violence, exploitation, discrimination or neglect.	TBD	90%	GBV monitoring tool, GBV register, Referral forms	Monthly	IPs, CSOs, LG and state	Community, LG and State Level
4	(Number and or %) of PLHIV that received support for partner notification (disaggregated by age and sex)	**Percentage of PLHIV (>18 years) on treatment who were linked and completed referral with support for PNS services, disaggregated by age, sex** **Numerator:** Number of PLHIV (>18) who received PNS support Services disaggregated by sex **Denominator:** Number of PLHIV (>18) on treatment	TBD	90%	PNS register, HTS register, referral forms	Monthly	IPs, CSOs, LG and state	Community, LG and State Level

5	Number and or % of PLHIV/PABA linked to available social protection services	**Percentage of PLHIV/PABA who have access to money to pay for unexpected household expenses, school fees and other important expenses through social protection services** **Numerator:** Number of active PLHIV/ PABA HHs that have access to money to pay for unexpected household expenses, school fees and other important expenses through social protection services **Denominator:** Number of HHs of PLHIV/PABA active on treatment.	TBD	90%	Referral forms, VSLA registers, SILC register Cash transfer registers HES registers	Monthly	IPs, CSOs, LG and state	Community, LG and State Level
6	(Number and) % of PLHIV (disaggregated by age and sex) received adherence support	**Percentage of PLHIV on treatment who self-reported [or caregiver - reported] adherent to treatment regimen for the last six months, disaggregated by age, sex** **Numerator**: Number self-reporting adherent to treatment regimen for the last six months**.** **Denominator:** Number of PLHIV on treatment	161,110 (19.3%)	90%	ART Register Adherence Register. Referral forms	Monthly	IPs, CSOs, LG and state	Community, LG and State Level
7	(Number and %) of PLHIV (disaggregated by age and sex) retained on treatment	**Percentage of PLHIV on treatment who are adherent to treatment regimen for the last six months, disaggregated by age, sex** **Numerator:** Number of PLHIV on ART for at least Six months, disaggregated by sex and age **Denominator:** Number of PLHIV Active on ART	161,110 (19.3%)	90%	Adherence register, ART Register. Tracking register.		IPs, CSOs, LG and state	Community, LG and State Level

8	Number and) % of PLHIV children and adolescents (0-19yrs), disaggregated by age and sex who received adherence support	**Percentage of OVC PLHIV (aged 0 -19) that received adherence support services, disaggregated by age and sex** **Numerator:** Number of OVC/PLHIV who received adherence support services disaggregated by age and sex **Denominator**: Number of OVC/PLHIV active on treatment.	1,024,538	90%	Adherence register ART register, Adolescent support group register		IPs, CSOs, LG and state	Community, LG and State Level
9	(Number and) % of PLHIV (disaggregated by age and sex) provided with 'prevention with positives' services	**Percentage of PLHIV on treatment who are provided with positive health and prevention services, disaggregated by age, sex** **Numerator:** Number of PLHIV provided with positive prevention services. **Denominator**: Total number of PLHIV active on ART,	*Male:* 96,293 *Female:* 213,141	90%	PHDP Registers, Referral Registers, Adherence Registers, PSS register,		IPs, CSOs, LG and state	Community, LG and State Level
10	Number of Key Populations (disaggregated by age, KP type) provided with 'prevention with positives' services	**Percentage of KP on treatment who are provided with positive health and prevention services, disaggregated by age, sex** **Numerator:** Number of KP provided with positive prevention services **Denominator:** Total Number of KP PLHIV active of ART	TBD	90%	PHDP Registers, Referral Registers, Adherence Registers, PSS register		IPs, CSOs, LG and state	Community, LG and State Level
11	Number and) % reported GBV cases who received post-GBV care and support services	**Percentage of PLHIV with documented cases of GBV who received post-GBV care and support services based on the minimum package.**	TBD	90%	GBV referral Registers, Referral forms, Post GBV care register		IPs, CSOs, LG and state	Community, LG and State Level

		Numerator: Number of PLHIV who received post GBV care, disaggregated by age , sex and type of services **Denominator:** Total Number of PLHIV with reported GBV Cases.						
12	Number and) % of malnourished PLHIV who completed referrals and received nutritional support services	**Percentage of Malnourished OVC PLHIV (<18years old) identified through quarterly nutrition assessment and linked to the appropriate nutrition services.** **Numerator:** Number of OVCPLHIV who received nutritional support services disaggregated by age and sex **Denominator:** Total number of OVC PLHIV (<18years old) who are eligible for Nutritional Support services	TBD	90%	Referral forms, NACS assessment forms Referral registers	Quarterly	IPs, CSOs, LG and state	Community, LG and State Level
13	(Number and) % of eligible adults and children (PLHIV/PABA) (disaggregated by sex and age) provided with nutritional support services	**Percentage of Malnourished OVC PLHIV/PABA who received at least one nutritional services in a quarter** **Numerator**: Number of PLHIV/PABA provided with Nutritional Services disaggregated by sex, age and service type **Denominator:** Total Number of PLHIV/PABA active on ART eligible for Nutrition Support services.	TBD	90%	Referral forms, NACS assessment forms Referral registers	Quarterly	IPs, CSOs, LG and state	Community, LG and State Level
14	(Number and) % of eligible pregnant women (PLHIV/PABA) (disaggregated by sex	**Percentage of pregnant women (PLHIV/PABA) active on ART who are identified through**	TBD	90%	Referral forms, NACS assessment forms	Quarterly	IPs, CSOs, LG and state	Community, LG and State Level

	and age) provided with nutritional support services	**quarterly nutrition assessment and are linked to nutritional support services.** **Numerator:** Number of Pregnant women (PLHIV/PABA) provided with Nutritional Support Services disaggregated by sex, age and type of service. **Denominator:** Total Number of pregnant women PLHIV/PABA active on ART			Referral registers PMTCT register			
15	(Number and) % of PLHIV screened for mental disorders	**Percentage of PLHIV who are active on ART, were of unknown mental health status and determined to be at risk.** **Numerator:** Number of PLHIV active on ART screened for mental Health disorders, disaggregated by sex and age. **Denominator:** Total Number of PLHIV Active on ART	TBD	90%	Referral forms. Mental Health Check list Referral registers,	Monthly	IPs, CSOs, LG and state	Community, LG and State Level
16	(Number and) % of PLHIV identified with mental disorders who completed referral for mental health services	**Percentage of PLHIV active on ART, who were of unknown mental health status, risked accessed and determined to be at risk and linked to mental health services.** **Numerator:** Number of PLHIV Active on ART who completed referrals for Mental Health disorders, disaggregated by Age and sex **Denominator:** Total Number of PLHIV active on ART Screen for Mental Health disorders	TBD	90%	Referral forms. Mental Health Check list Referral registers,	Monthly	IPs, CSOs, LG and state	Community, LG and State Level

17	(Number and) % of PLHIV identified with mental disorders that received mental health services	**Percentage of PLHIV active on ART, were linked to and received mental health support services.** **Numerator:** Number of PLHIV active on ART who received Mental Health support services disaggregated by sex and age **Denominator:** Total Number of PLHIV active on ART who are at risk of mental health disorder	TBD	90%	Referral forms. Mental Health Check list Referral registers, Service Registers	Monthly	IPs, CSOs, LG and state	Community, LG and State Level
18	**Number and) % of states with anti-stigma and discrimination law**	**Percentage of states with the anti-stigma law.** **Numerator:** Number of state with anti-stigma or discrimination law **Denominator:** Total number of states.	22%	100%	Organizational Development Assessment	Annually	SACA, NACA	State Level and National Level
19	Number and) % of PLHIV screened for TB	**Numerator**: Number of PLHIV screened for TB **Denominator**: Total number of PLHIV in care	Refer to NASCP					
20	Number and) % of PLHIV identified with TB diseases who referral for DOT services	**Numerator:** Number of PLHIV identified with TB disease referral for DOT services **Denominator:** Total number of PLHIV identified with TB	Refer to NASCP					
21	(Number and) % of PLHIV identified with TB diseases who started and completed TB treatment	**Numerator:** Number of PLHIV identified with TB disease who started and completed TB treatment **Denominator:** Total number of PLHIV referral for DOT services	Refer to NASCP					

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Appendices

Appendix A: Development Process

The development process commenced with the engagement of a consultant in 2018 as a result of the need to review the 2014 Care and Support Guideline. The consultant conducted a desk review of related literature along with the current guideline to identify gaps in the current document and best international practices in care and support.

A two-day multi-level stakeholders consultative meeting organized by NACA between the 19th and 20th December 2018 allowed for the sharing of experiences, issues and identified gaps in the 2014 Care and Support Guideline. A roadmap, an outline to guide the writing as well as tools to review the adequacy and ease of use of the 2014 guideline were developed, agreed upon and shared.

The zero draft of the new guideline and report of the assessment of the 2014 Guideline were shared with stakeholders at the stakeholders technical meeting held between 19th -22nd of February, 2019. The draft was reviewed and inputs made and the meeting came up with the first draft of the new guideline. Considering the importance of the bidirectional relationship between HIV and mental health and the need to adequately reflect this in the new guideline, a specialist in mental health from University of Ibadan was also invited to be part of the process.

Two zonal meetings to validate the second draft were organized by NACA. The North zonal validation meeting came up in Kuchikau, Nasarawa state (2nd to 4tt May 2019) while the South zonal meeting came up in Ibadan, Oyo state (7th to 9th May, 2019). A major feature of the meetings is the inputs/presentations on the TIB/HIV intersection and the need to reflect this in the new guidelines especially at the community level. Inputs from the two zones were incorporated and the final draft shared with stakeholders in the community of practice as it affects care and support of PLHIV, AYPHIV, Key populations and other vulnerable groups.

Sequel to this, the need to further reflects the special needs of some cohorts as separate entities for intervention purposes were highlighted by some stakeholders. These include key populations-FSW, MSM and PWID as well as adolescents and young people living with HIV. Also, the reports of some ongoing surveys at the onset of the process, that are critical in interventions for the care and support guidelines were completed. All these were incorporated into the final version that was presented for national validation on the 10th of November 2020.

Appendix B: List of Contributors

S/N	NAME	ORGANIZATION
1.	ALEX OGUNDIPE	NACA
2.	DR. YINKA FALOLA-ANOEMUAH	NACA
3.	DR. FUNKE OKI	NACA
4.	DR. DANIEL NDUKWE	NACA
5.	NWAFOR EMEKA IFEANYI	NACA
6.	ADE'-YUSUF TAIWO ALI	NACA
7.	ROSELINE AKINOLA	NACA
8.	EZINNE OKEY-UCHENDU	NACA
9.	EKOCHE IKEH	NACA
10.	HASIYA BELLO	NACA
11.	DR. OLADELE TOLU	NACA
12.	EMMANUELA ABAKPA	NACA
13.	IYAMU FAVOUR	NACA
14.	MERCY EGEMBA	NACA
15.	AJIBOYE OLUWATOSIN	NACA
16.	ESOR FABIAN	NACA
17.	LAMI TAUHID NDAYAKO	NACA
18.	PRISCILLA ODANGLA	NACA
19.	DR. BISAYO ODETOYINBO	INFLUENCE CONSULTS
20.	RICHARD AMENYAH	UNAIDS
21.	IDOKO REBECCA	BENSACA
22.	VICTORIA B. A. BAAH	KADUNA SACA
23.	OKEKE JOHNBOSCO N.	ANAMBRA SACA
24.	IBILOYE OLUJUWON	APIN
25.	DAVID A. OWOLABI	UNDP
26.	BELLO RUTH NABE	NASARAWA SACA
27.	OBANUBI CHRIS	USAID
28.	ASHANDOBE EMMANUEL	CRS
29.	FRANCA AKOLAWOLE	IHVN
30.	JULIET NYIOR	IHVN
31.	CHIOMA OLEM	WEWE
32.	ADIBE VICTOR	WEWE
33.	OLLEY MOSES	WEWE
34.	DR. GRACE DAFIEL	AONN
35.	DORIS ADA OGBANG	UNAIDS
36.	OLIKO CHRISTIANA	FMWASD
37.	ADEGOKE MICHAEL	FMWASD
38.	AMBER ERINMWINHE	INERELA+
39.	ISAH MOH'D TAKUMA	APYIN
40.	ESTHER JAMES	ASWHAN
41.	ABIYE KALAIWO	USAID
42.	THOMPSON K. C	FMOH
43.	AJOGWU ARINZE E.	INERELA+
44.	OYE TOMORI-ADELEYE	SFH
45.	ABLE O. ONOLA	SFH
46.	UTO T. JAMES	AMHACI
47.	IBRAHIM USMAN	FACA

48.	COLLINS TOBECHUKWU N.	FMWASD
49.	FORTUNE KALIO	APYIN
50.	MARCUS WILLIAMS	AONN LIWOM
51.	EMMANUEL ONOJA A.	NINERELA+
52.	AYOBAMI ADEJUGBE	APIN PHI
53.	EDWARD A, OGIJI	APYIN
54.	HELEN OMUH	IHVN
55.	FARUNA BENEDETTE	ASWHAN
56.	OLADIPO AKINMADE	CRS
57.	IKENNA MGBEDIMMA	CRS
58.	BRIDGET ONYEBUCHI	NASCP
59.	HELEN APHAN	ASWHAN
60.	SEUN OJOMO	ARFH
61.	DR. JIBRIL ABDULMALIK	UCH/UI
62.	PAT UGBENE	SFH
63.	HALIMA MOMODU	SFH
64.	OMOTUNDE ELLEN THOMPSON	OHCSF
65.	UCHE OKORO	FACA
66.	IGBOELINA ONYEKA DONALD	USAID
67.	EMMA NWABUEZE	AHF
68.	Dr. EZE EMMANUEL IYKE	NASCP/FMOH
69.	BLESSING A, DANIEL	CISHAN
70.	JUMOKE IDOWU	ACAEDF
71.	GRACE EDWARD UMODEN	MWASW
72.	DOOSHIMA AGEH	MWASD
73.	DIANA SULE TOMA	NASACA
74.	DR. ODOEMENA OBINNA	CHEERS
75.	KUCHELI WUDIRI	SFH
76.	DORIS ADA OGBANG	UNAIDS
77.	DR. EGI O. C	RH/FMOH
78.	RICHARD AMENYAH	UNAIDS
79.	THOMPSON KOBATA C.	FMOH
80.	OKOCHA ADAEZE	CISHAN
81.	OCHANYA IYAJI-PAUL	APIN PHI
82.	ZUNZKA THOLE	GEDE
83.	OMOWORARE FIYINFOLUMA	ARFH
84.	TESSIE PHILIPS-ONONYE	USAID
85.	DR. OMOKORE OLUSEYI	FMOH
86.	OGUNDEKO OLUWAFUNMILAYO	CRS
87.	STELLA EKEH.	NTBLCP
88.	UMAR BELLO ALKAMMAWA	SOKOTO SACA
89.	DAUDA ADAMU HASKE	ADAMAWA SACA
90.	ABDULRASHEED IBRAHIM DAURA	KATSINA SACA
91.	CHENGE, PAULYN M.	MWASD MKD
92.	SHAIBU W. DANJUMA	KOGI SACA
93.	ABBA SALE IBRAHIM	TARABA SACA
94.	AMINU A. DANWADA	ZAMFARA SACA
95.	LAYIDI JOHNSON	TARABA NEPWHAN
96.	ASSUMPTA REGINALD	ASWHAN
97.	EZINWA NWOKOCHA	ABIA SACA
98.	ADEBARI OLAGUMOKE	NTBLCP/FMOH

99.	DR ADEGBULU ADEDAYO	ONDO SACA
100.	DR FATUGASE KEHINDE	OGUN SACA
101.	DOHERTY CHARLES	EKITI SACA
102.	MIKE ARINZE	DELTA SACA
103.	IFERE OBETEM	CROSS RIVER SACA
104.	OFFIADI OBIANUJU	ENUGU SACA
105.	EMMANUEL BENSON	AKWA IBOM SACA
106.	OLATUNJI GABRIEL O.	OSUN SACA
107.	OYEBAMIJI ABIMBOLA ESTHER	OYO TNLCP
108.	DR NWAOKENNEYA PETER	NASCP/FMOH
109.	DR DURUEKE CHARLES	IMO SACA
110.	EMODI NWAMAKA R.	ANAMBRA STBLCP
111.	OGREGADE KEIMOKUMO E.	BAYELSA SACA
112.	ODERINDE A. A	MWA
113.	MICHAEL ESSIEN	LAGOS SACA
114.	ABDULKAREEM KHADIYAT L.	LSMOH
115.	JAYEOBA OLAWALE C.	ASOHON
116.	OGUNKUNLE OLKAYODE	OYSACA
117.	ALABI M. OYEBUKOLA	OYO STATE NEPWHAN
118.	OBATUNDE OLADAPO	OYO SACA
119.	AYINDE BOLANLE	OYO STATE ASWHAN
120.	FORTUNE KALIO	RIVERS SACA
121.	FLORA OYAKHILOME	EDO SACA
122.	JACOB BUSUYI OWOLABI	AEFU EBONYI STATE
123.	TOYIN ADERIBIGBE	AD
124.	ABDULKAREEM RASHEED LAIDE	LAGOS SASCP

Appendix C: PHQ-9

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 *weeks,* how often have you been bothered by any of the following problems? *(use "/" to indicate your answer)*	Not at all	Several days	More than half the **days**	**Nearly** every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns		
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).		TOTAL:		

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

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PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 □s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 □s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 □s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up □s by column. For every □: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every □ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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Other Screening Questions for different psychiatric disorders:

Depression

- Have you ever had a period where you felt down? Not just for a week or two but for many weeks or, perhaps, months?
- Did you find you had no energy, had no interest in things, and overall had great difficulty functioning?
- Has this ever happened to you before?

Hypomania/mania

- In the past, have you ever had a period where you felt not just good, but better than good?
- Did this feeling of unusually high energy and a decreased need for sleep go on not for hours or an evening, but for days and days at a time?

Dysthymic disorder

- Have you felt down or low but able to function over the last number of years?

Generalized anxiety disorder

- Would you describe yourself as a chronic worrier? Would others say you are someone who is always worrying about things?
- Do you worry about anything and everything as opposed to just one or two things?
- If so, how long has this been going on?

Obsessive-compulsive disorder

- Do you have any unusual or repetitive thoughts that you know are silly but you simply cannot stop thinking about (for example, being contaminated by germs)?
- Do you feel there are certain rituals you have to do, such as tap your hand a certain way or do things in sets of threes, which takes up a lot of time in the day?

Delusions and hallucinations

- Do you have unusual experiences, such as hearing voices that other people cannot hear? What about seeing things that other people cannot see?
- Do you have unusual ideas, such as feeling that the TV or radio has special messages for you?
- Do you have unusual ideas that people you do not even know are plotting to harm or kill you?
- Do you have unusual ideas, such as feeling that you have special powers that no one else has?

Panic attacks

- Do you have panic attacks or anxiety attacks? By that I mean an attack of anxiety that comes fairly suddenly and is rather uncomfortable and involves feeling a certain number of physical sensations such as heart palpitations, shortness of breath or dizziness.

Agoraphobia

- Do you avoid going certain places because you are fearful of having a panic attack? Has this feeling restricted your activities?

Posttraumatic stress disorder

- Do you find it hard to stop thinking about a very difficult event that has happened to you?
- Do you find that you have nightmares related to the event?
- Do you find that you have flashbacks? By that I mean very vivid daydreams or what we may call a "daymare" about the event?
- When something happens that reminds you of the event, does that trigger a very large response in you?
- Do you find that you avoid things that remind you of the event?
- Generally, do you feel anxious since the event and have trouble sleeping or startle easily?
- Do you feel that this event, and the way it has left you feeling, still gets in the way of your life?

Social phobia

- Are you able to go to social situations where you may have to interact with people you don't know well, or is that very daunting for you?
- Can you eat in restaurants in front of others?
- Were you able to give presentations in front of others when you were in school, or can you do it now?
- Do your social fears get in the way of your life?

Borderline personality disorder

- Do you feel you are still searching for your sense of who you are (self-identity)?
- By "sense of who you are," I mean do you have a set of values (what is important to you) that stays constant over time?
- Do you have long-term feelings of sadness?
- Do you have long-term feelings of anger?
- Do you find that your relationships usually get very difficult and end abruptly?
- Have you had thoughts of killing yourself on and off over the years?
- Have you tried to kill yourself in the past?
- Have you had episodes in the past where you tried to hurt yourself, not to kill yourself but simply to cause yourself pain or distract you from something?
- How do you feel after these episodes? (Patients often respond that they feel a sense of release or relief.)

- Do you often feel empty inside?
- Do you find that you can be feeling okay then suddenly feel angry, or you can be feeling okay and suddenly feel sad? Does this happen a lot during the course of a day?
- Do you find that you do things on impulse and then regret it afterwards?

Adapted from: Jon Davine, The art of the brief psychiatric interview in primary care, Psychiatry in Primary Care CAMH, 2011)

For further information please contact:

National Agency for the Control of AIDS
No 3, Ziguinchor Street, off IBB WayBehind Abuja
Electricity Distribution Company, Wuse, Zone 4,
FCT, Abuja, Nigeria