# Implementing multi-month scripting (MMS) for ART refills in Nigeria

Consultation on differentiated ART delivery in WCA

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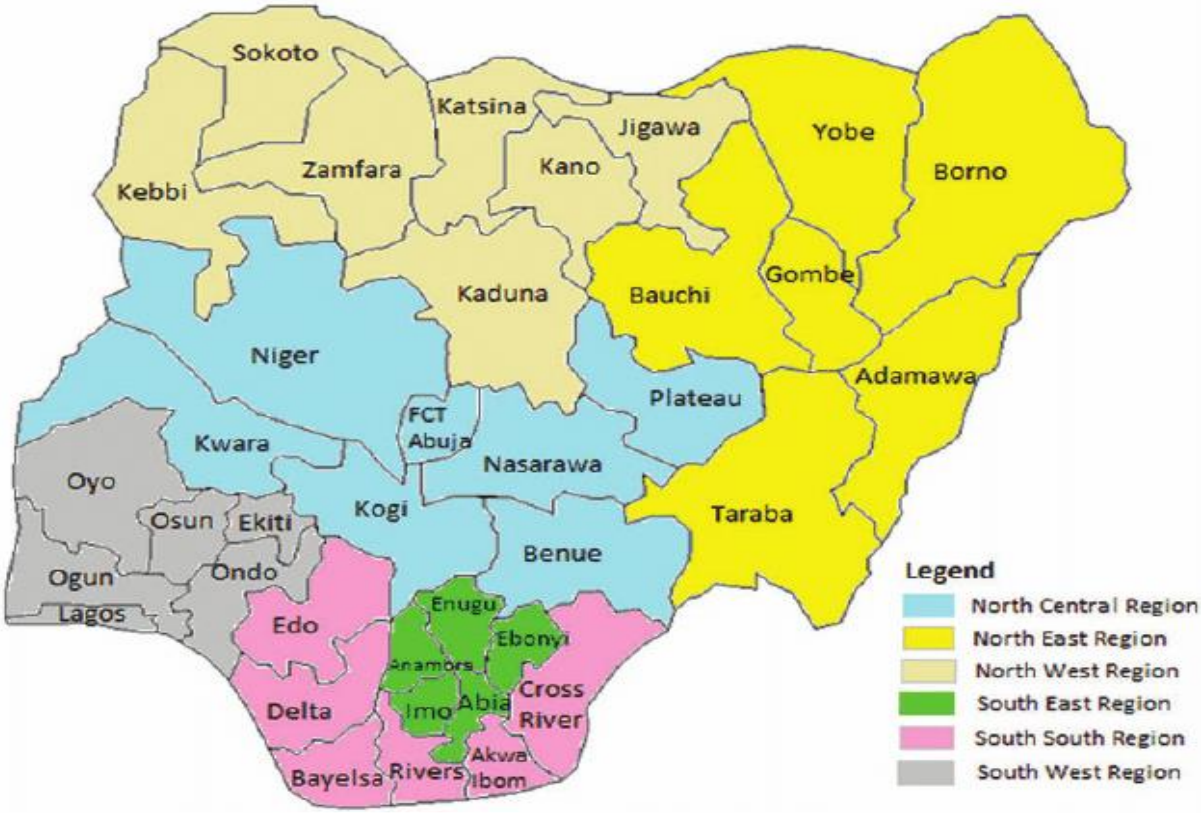
# Background on Nigeria

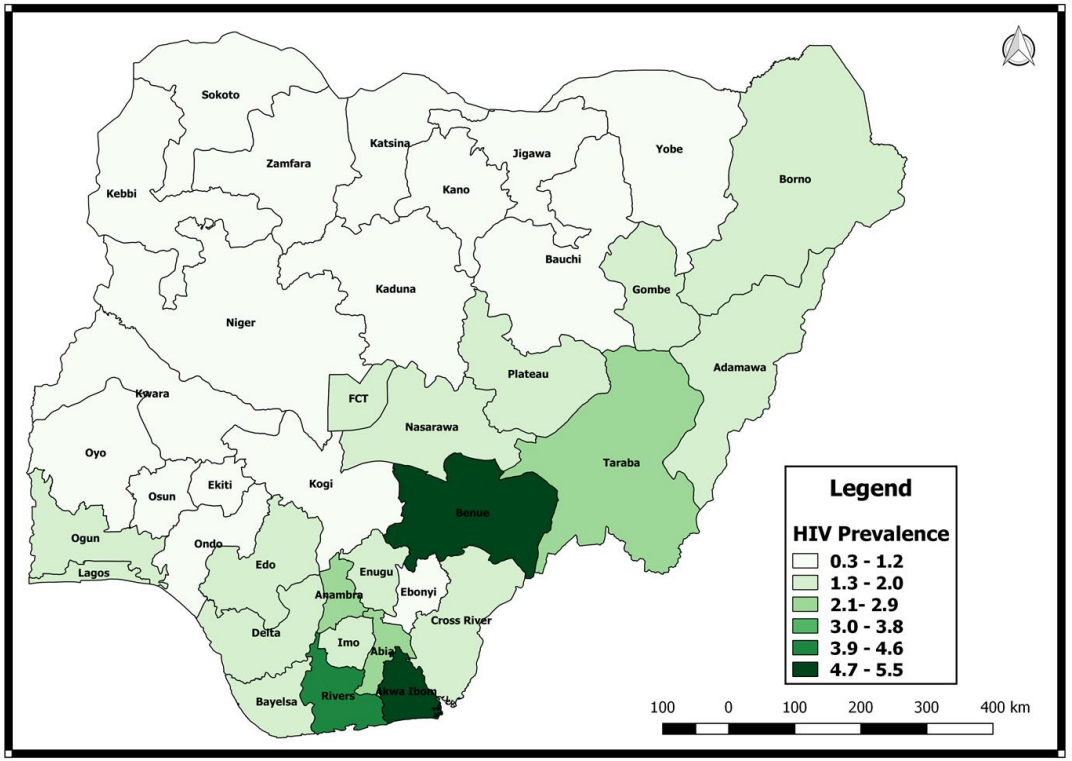



- Population >193 million
- Total area of 923,768 km$^2$
- Federal Republic – 3 tired government system

# HIV in Nigeria

- 1.9 million PLHIV
- 37% access and coverage of HIV testing services
- 47% ART treatment coverage (31% -children under 15yrs)
- 42% viral suppression
- HIV services supported at 4767 health facilities:
  - 1423 ART
  - 3344 PMTCT

National HIV prevalence 15-49 years = 1.4%



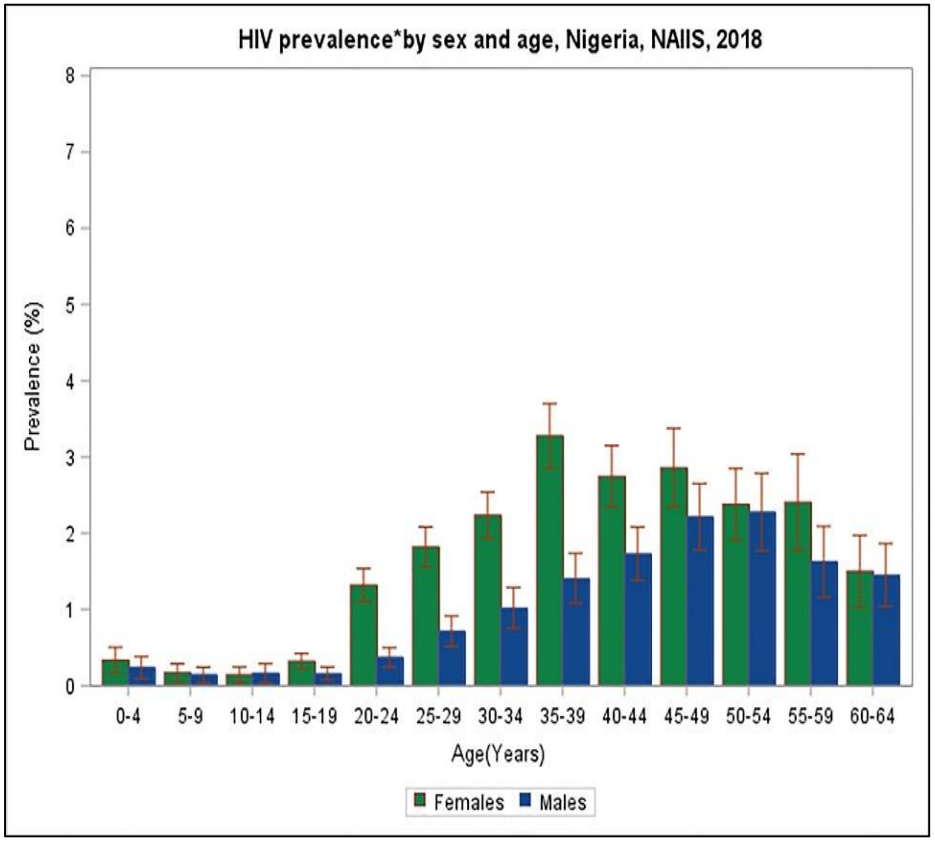

NAIIS PREVALENCE DATA (2018)

# HIV in Nigeria

## Viral Load

- 42% viral suppression
  - women 45%
  - men 35%
- VL adopted for ART monitoring
- Suboptimal coverage
  - Operational inefficiencies
  - Demand creation insufficient
  - PCR lab equipment downtime
  - Poor result turnaround time

## Prevalence Disaggregated



# Challenges

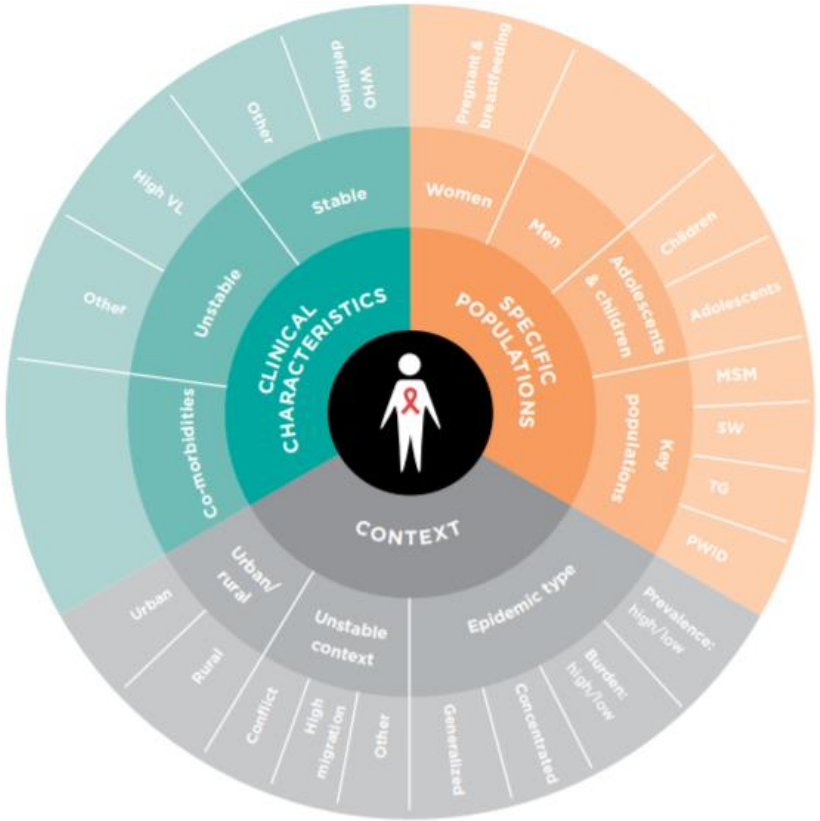
- Undiagnosed PLHIV Unmet Need of 1m (800,00 adults)
- Poor retention especially in males and adolescents
- Frequent clinic visits by stable PLHIV (monthly or every other month)
  - Overcrowding
  - Long wait times
  - Human resource healthcare constraints and fatigue
  - Lower quality of care
  - Poor storage infrastructure across health facilities
  - Inefficiencies in the health systems, insecurity, mobile and hard to reach populations

# Intervention

- MMS began in Nigeria, September 2017 with 102 PEPFAR supported sites nationwide
- Site selection based on a client load >2,000 but later reduced to >1,000 during scale up in May 2018.
- Eligible clients on ARVs >1 year were stable and on first line regimens:
  - TDF/3TC/EFV 300/300/600mg
  - AZT/3TC/NVP 300/150/200mg
  - TDF/3TC/DTG 300/300/50mg (from Nov 2018)
- All clients on MMS visited the clinic once in three months for both clinical consultation and medication pick-up
  - Modified and individualized based on prevailing circumstances*

# Who is intervention aimed at?

- Clinically stable clients
  - On ART for at least one year
  - Adherent
  - No opportunistic infections
  - Have no ADR that require regular monitoring
  - Evidence of treatment success - two consecutive viral load measurements <1,000 copies/ul
- Stable key populations*

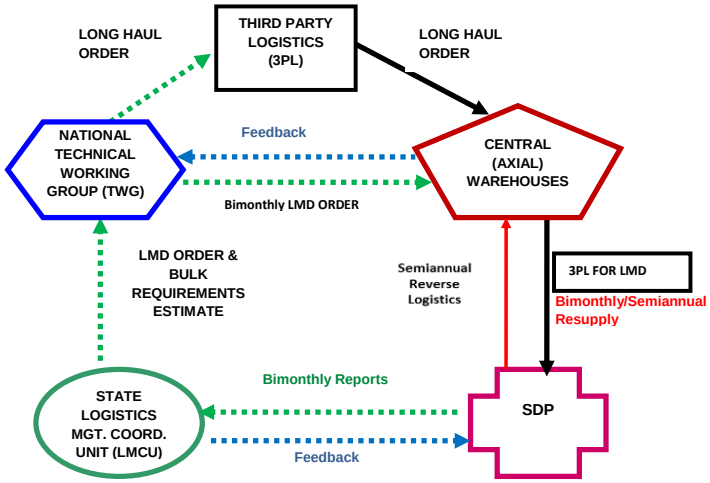


# Building blocks of Intervention

| | ART refills | Clinical consultation |
|---|---|---|
| WHEN | Mix (3,4, 6 months) | 3, 6 months |
| WHERE | Facility / community Pharmacies | Facility |
| WHO | Pharmacist (hospital / community), dispensers | Clinician / Nurse / Adherence counsellors |
| WHAT | ARV / TPT / OI drugs | Viral load / TB Screening |

# Intervention supply chain design and implementation steps

- Assess HF storage space
- Product identification
- Current inventory control system (forced ordering 2 – 4 Min – Max) adapted
- Agile data management
- Data monitoring and triangulation to meet requirement
- Replenishments driven by demand (dispensed-to-user) data




| Facility Type | Resupply Period |
|---|---|
| Low Volume PMTCT Sites | Every 6 Months |
| ART & High Volume PMTCT Sites | Every 2 Months |

# Outcomes and impact (1)

- 180 out of 192 selected facilities implemented MMS and MMD for the same client as at June 2018 targeting about 113,802 clients`*
- IP data = 117,059 clients on both MMS and fast tracking (73.3%) out of 159,776 clients
- Health System
  - Less crowded clinics
  - Less fatigue as workload is significantly decreased
  - Shorter wait times to see a healthcare provider
  - Higher standard of care

# Outcomes and impact (2)

- Client
  - Reduction in travel cost
  - Reduction in time spend
  - Patient's adherence to medication remains stable
  - Shorter wait times
  - Overall satisfaction with facility experience
  - Improved retention


University of Benin Teaching Hospital (UBTH) is one of the sites implementing MMS where survey data were collected.

# Scale up/Sustainability

- Policy review (including dispensing protocol) ongoing to consolidate existing DSD models
- MMS/MMD to be scaled up to as many sites as can accommodate
- Staggered scale up from 3 MMD to between 4 and 6 MMD for eligible clients
- Patient-centered DSD models will improve identification, coverage and retention of men and adolescents on ART

# Lessons learned

- Need to define protocol for 4 & 6 MMD including logistics reporting
- Use of dispensed to user data to drive resupply
- Defining stable patients with rapid changes in regimen is challenging*
- Community involvement to enhance client adherence
- Client appointment scheduling needs to be well-structured to reduce periodic congestion
- Continuous strengthening of service provider capacities in effective commodity management