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# Strategic HIV Service Prioritization for Impact in a Changing Financial Context

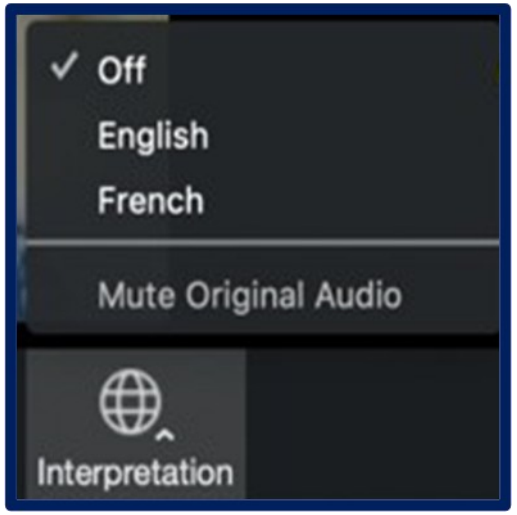
## From Prioritization to Sustainability

Tuesday, September 30, 2025

# Welcome/Bienvenue

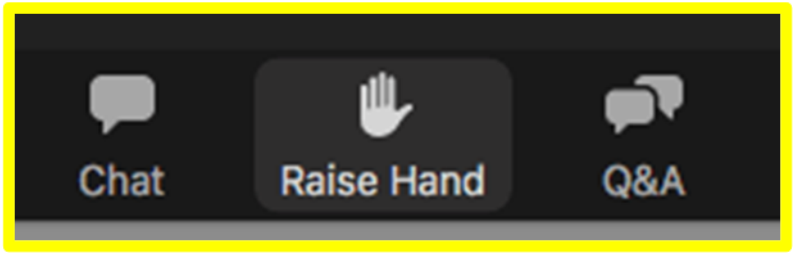
**Dr. Maureen Syowai**
Program Director
CQUIN & HIVE
ICAP in Kenya

- Be sure you have selected the language of your choice using the “Interpretation” menu on the bottom of your screen.
- Assurez-vous d’avoir sélectionné la langue de votre choix à l’aide du menu <<Interprétation>> en bas de votre écran Zoom.



# Housekeeping

- 90-minute webinar with framing presentations followed by a panel discussion with Q&A
- Please type questions in the Q&A box located on the toolbar at the bottom of your screen
- If you would prefer to speak, please use the “raise hand” function on the toolbar and we will unmute you so that you have control of your microphone
- If you are a French or English speaker, please ask your question in your language of choice and the interpreters will translate as needed
- Slides and recordings will be available on the CQUIN website (cquin.icap.columbia.edu)



# Agenda

1. **Introductory Remarks**: Maureen Syowai, ICAP in Kenya
2. **Framing Remarks:** Findings from the preliminary analysis of HIV service prioritization across CQUIN member countries – Onyekachi Ukaejiofo, ICAP/CQUIN
3. **Country Spotlight:**
    - Nigeria: Jonathan Modugu - NASCP, Ministry of Health, Nigeria
    - Kenya: Newton Omale - NASCOP, Ministry of Health, Kenya
4. **Panel Discussion/Q&A**
5. **Closing Remarks**

# Presenters/Panelists

**Onyekachi Ukaejiofo**
Regional Clinical and QI Advisor ICAP in Nigeria

**Jonathan Modugu**
DSD/AHD/ART Specialist
NASCP, Nigeria

**Newton Omale**
Manager- Partnerships & Grants
NASCOP, Kenya

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# Findings from the preliminary analysis of HIV service prioritization across CQUIN member countries

**Dr. Onyekachi Ukaejiofo**
Regional Clinical and QI Advisor
ICAP in Nigeria

# Outline

- Overview of HIV Service Prioritization
- Tools in Support of HIV Service Prioritization
- Prioritization Findings
- Emerging Themes
- Additional Considerations
- Country Next Steps

# HIV Prioritization: Overview

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# Overview: Why this, why now?

- **Jan 2025**: Executive Stop-Work Order (**SWO**) issued.
- **Feb-present:** Impact: System-wide disruptions
  - **Workforce**: At least 140,000 HRH layoffs/redeployments
  - **Data systems**: Delayed HIV reports; EMR halted
  - **Supply chain**: Forecasting delays; last-mile breaks; sample transport disruptions; ARV stock-out risk
  - **Service delivery**: KP testing paused; HIVST distribution down; rapid ART initiation delayed; 6MMD downgraded to 3MMD to protect ARV stock; VL testing coverage/frequency reduced
- **June 2025**: **Response**
  - CQUIN convened member countries to design resilient minimum HIV service packages through a structured HIV service prioritization exercise.
  - Countries used a 0% & 50% external funding scenario. Of note-countries made these decisions before knowing what their HIV budgets will look like as a proactive approach to sustaining essential HIV services amid fiscal uncertainty.

PRESIDENTIAL ACTIONS

REEVALUATInG AND REALIGNING UNITED STATES FOREIGN AID

The White House January 20, 2025

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered:

Section 1. Purpose. The United States foreign aid industry and bureaucracy are not aligned with American interests and in many cases antithetical to American values. They serve to destabilize world peace by promoting ideas in foreign countries that are directly inverse to harmonious and stable relations internal to and among countries.

Sec. 2. Policy. It is the policy of United States that no further United States foreign assistance shall be disbursed in a manner that is not fully aligned with the foreign policy of the President of the United States.

Sec. 3. (a) *90-day pause in United States foreign development assistance for assessment of programmatic efficiencies and consistency with United States foreign policy.* All department and agency heads with responsibility for United States foreign development assistance programs shall immediately pause new obligations and disbursements of development assistance funds to foreign countries and implementing non-governmental organizations, international organizations, and contractors pending reviews of such programs for programmatic efficiency and consistency with United States foreign policy, to be conducted within 90 days of this order. The Office of Management and Budget (OMB) shall enforce this pause through its apportionment authority.

(b) *Reviews of United States foreign assistance programs.* Reviews of each foreign assistance program shall be ordered by the responsible department and agency heads under guidelines provided by the Secretary of State, in consultation with the Director of OMB.

https://www.whitehouse.gov/presidential-actions/2025/01/reevaluating-and-realigning-united-states-foreign-aid/

# Tools in support of HIV Service Prioritization

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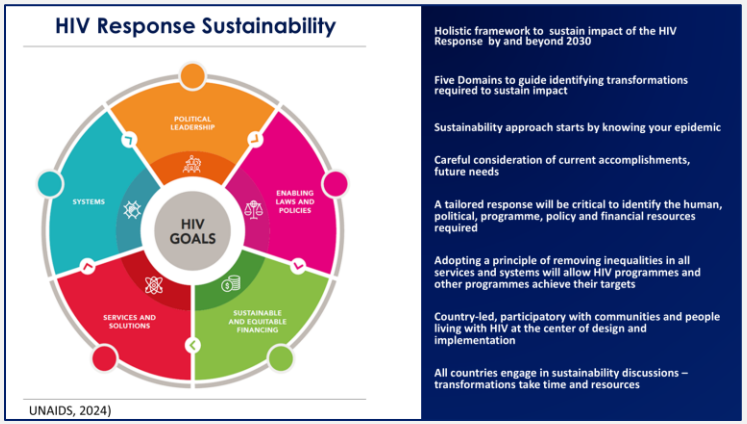
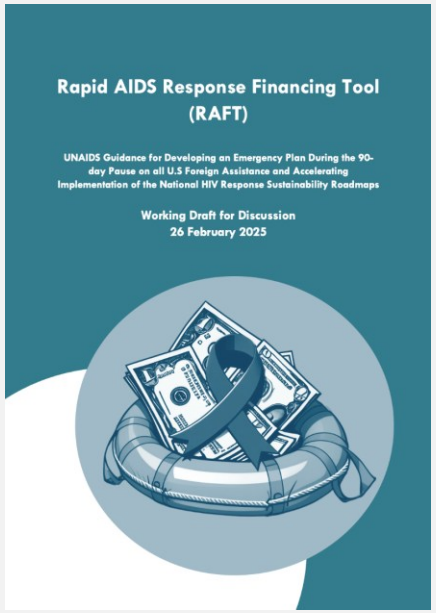
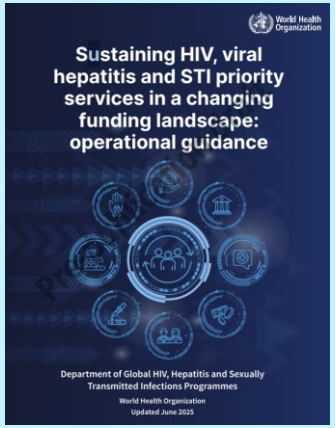
# Global Tools to Support Country Response

## UNAIDS Resources




## WHO operational guidance




## CQUIN Modified TIER Tool

| | HIV TREATMENT SERVICES | With 0% external funding (vs. current year) | | | | |
|---|---|---|---|---|---|---|
| Component | Intervention | Keep or drop | Planned Funding Source (if continuing) % funded by PEPFAR/USG | % funded by GF | % domestic | % funded by other |
| ART continuity | Provide uninterrupted ART treatment to ALL people who are already on ART, all populations and all regimens | | | | | |
| | Provide a minimum of 3MMD for all, unless clinically unwell (including re-engaging clients) with 6MMD preferred for those established on ART (for all over 5-years of age) | | | | | |
| | Conduct an annual quality clinical review if established on ART and virally suppressed with longest scripting period allowed 6-12 months | | | | | |
| | Enroll eligible clients in less-intensive DSD models | | | | | |
| | Sustain individual DSD models based at facilities | | | | | |
| | Sustain individual DSD models for key populations not based at facilities | | | | | |
| | Sustain group DSD models managed by clients | | | | | |
| | Sustain group DSD models for adolescents managed by healthcare workers | | | | | |
| | Susatin individual DSD models not based at facilities | | | | | |
| | Sustain group DSD models managed by healthcare workers | | | | | |
| | Actively support transfer all clients from facilities that are closing to preferred public sector facility with same day continuation of ART, minimum 3MMD, offer less-intensive DSD model without required transfer documentation | | | | | |
| Continuity OI prophylaxis | Provide cotrimoxazole prophylaxis to adults Stage 3 and 4 or CD4 <350. Note recommendation when to stop | | | | | |
| | Provide cotrimoxazole tp adults in settings where malaria and/or severe bacterial infections are highly prevalent, co-trimoxazole prophylaxis should beinitiated regardless of CD4 cell count or WHO stage; Note recommendation when to stop | | | | | |
| | Provide cotrimoxazole to patients living with HIV and TB | | | | | |
| | Provide cotrimoxazole to children living with HIV; Note recommendation on when to stop | | | | | |
| | Provide cotrimoxazole to HIV exposed infants; Note recommendation when to stop | | | | | |
| | Provide secondary fluconazole prophylaxis (maintenance); Note recommendation on when to stop | | | | | |
| ART initiation (and re-initiation) | Initiate children under 5 years | | | | | |
| | Initiate pregnant and breastfeeding women | | | | | |
| | Initiate those with clinical signs and symptoms of HIV/AIDS or CD4<200 if known (AHD) | | | | | |
| | Initiate all people testing positive for HIV (new and re-engaging) and transferring | | | | | |
| | Initiate all people testing positive for HIV - stage 3 or 4 or if CD4 known or baseline CD4 (CD4 nadir) below 200/350/500 | | | | | |
| | Initiate all people testing positive for HIV - stage 1 or 2 or if CD4 known or baseline CD4 (CD4 nadir) above 200/350/500 | | | | | |
| Viral load monitoring | Provide VL testing for those presenting with signs and symptoms of treatment failure | | | | | |
| | Provide VL testing clients with a previously elevated viral load (VL>1000 copies/ml), perform viral load after 3 months | | | | | |
| | Provide first viral load to ensure result is available by 6 months on ART enabling earlier DSD | | | | | |

## Global Fund Reprioritization

### GC7 Reprioritization
### and revision of grant activities

The Global Fund is working with Country Coordinating Mechanisms (CCMs) and Principal Recipients (PRs) to reprioritize grant activities in Grant Cycle 7 (GC7) to safeguard and enable lifesaving interventions.

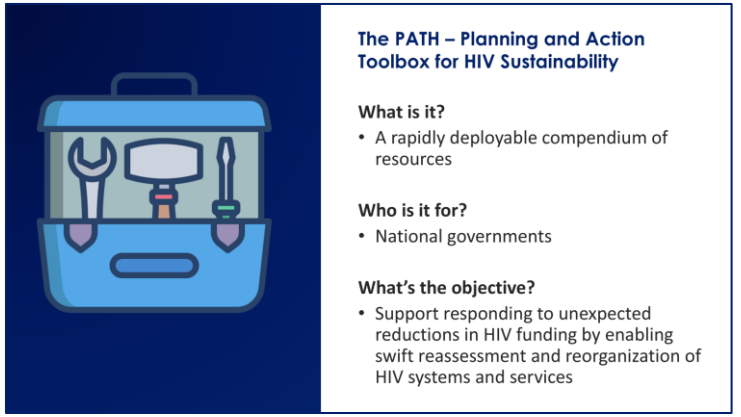
Due to the current challenging funding landscape for global health, GC7 allocations are being reduced to adjust to this new reality, requiring PRs to go through grant reprioritization and revision exercises. Some countries may need to reprioritize beyond Global Fund grants, planning health programs holistically. Reprioritization decisions must be made considering all sources of funding available: domestic and external.

These decisions are an opportunity to build momentum on integration, cost effectiveness and sustainability of HIV, TB and malaria programs, in support of countries' primary health care services and health and community systems.

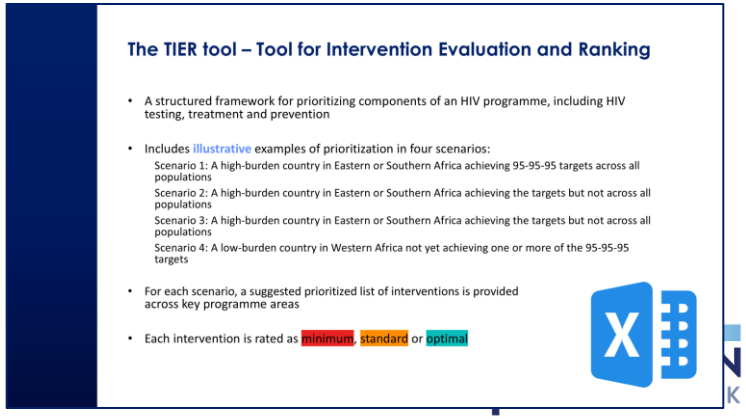
GC7 reprioritization and revisions will build a solid foundation for Grant Cycle 8.

To ensure meaningful stakeholder engagement in this process, the Global Fund is encouraging CCMs to plan meetings with all members to discuss reprioritization.

## The PATHS: The Planning and Action Toolbox for HIV Sustainability




## The IAS TIER tool: Tool for Intervention Evaluation and Ranking



# Method

**Prioritization Resources**:

- UNAIDS Resources: UNAIDS Sustainability Road Map and UNAIDS Rapid AIDS Response Financing Tool (RAFT)
- WHO Operational Guide: Prioritizing the HIV package of care aligned to the national context
- Global Fund GC7 Grant Reprioritization resources
- IAS PATHS: The Planning and Action Toolbox for HIV Sustainability
- IAS TIER tool: Tool for Intervention Evaluation and Ranking
- CQUIN-modified TIER tool
- ICAP list of streamlined M&E indicators and prioritization worksheet

**Funding Scenario approach**: Mainly two external funding scenarios - 0% and 50%

**HIV Service Interventions**: Service interventions across prevention, testing, and treatment

**Decision categories:**

- Keep (no change): maintain scope, cadence, and platform
- Keep (modify): defined adjustments such as cadence of lab tests
- Drop: discontinue the service
- Not applicable: not in national scope / not offered

# Network Country Participation

**Network Participation**

- Submitted outcomes - **16 countries**
- Completed prioritization, but yet to submit the findings - **3 countries**
- Not yet conducted prioritization - **2 countries**

**External funding scenario selection:**

- 14 out of 16 countries completed the 0% scenario (exceptions: Kenya and Liberia)
- 14 out of 16 countries completed a scenario with ≥50% scenario (exceptions: South Africa and Zambia)

# Prioritization Analysis

- **Data submission and review:** Country submissions were systematically collated, cleaned for consistency, deduplicated to remove overlaps, and validated for accuracy.
- **Gap identification:** Any missing entries were flagged to preserve transparency and highlight areas requiring follow-up/clarification.
- **Visualizations:** The analysis was visualized and summarized through multiple lenses to support interpretation.

# Prioritization Findings

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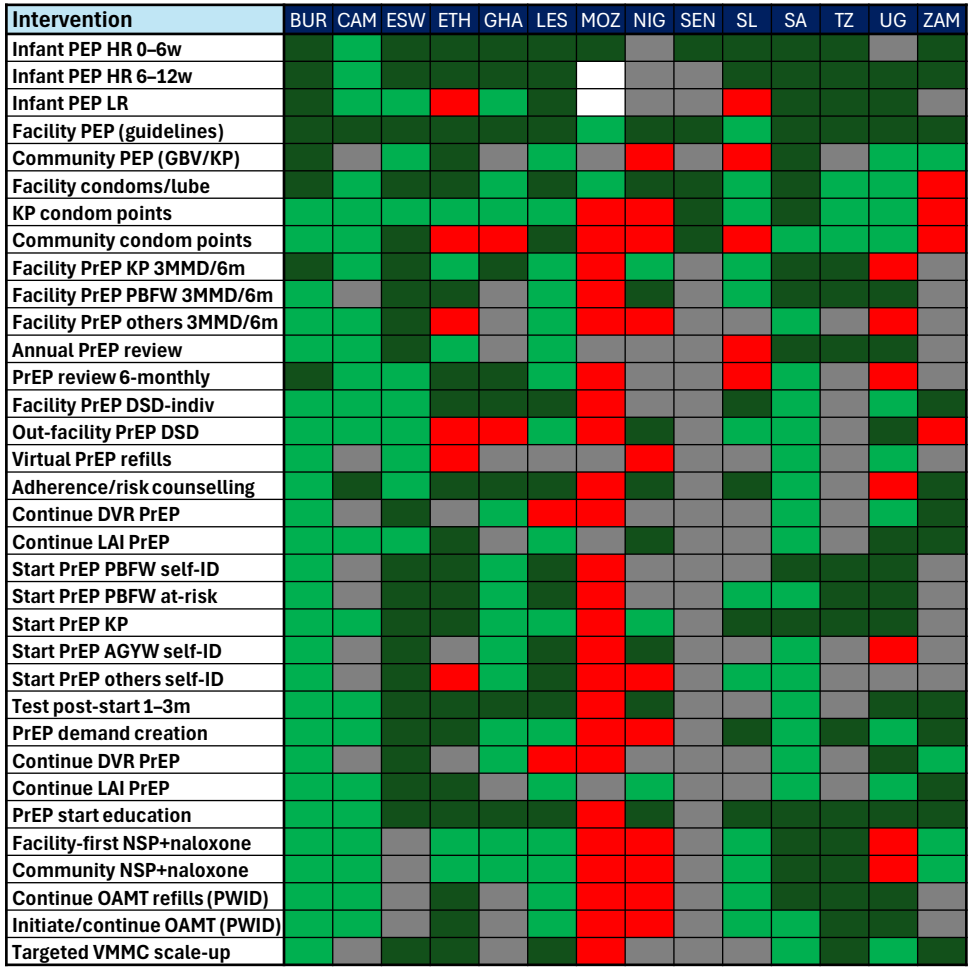
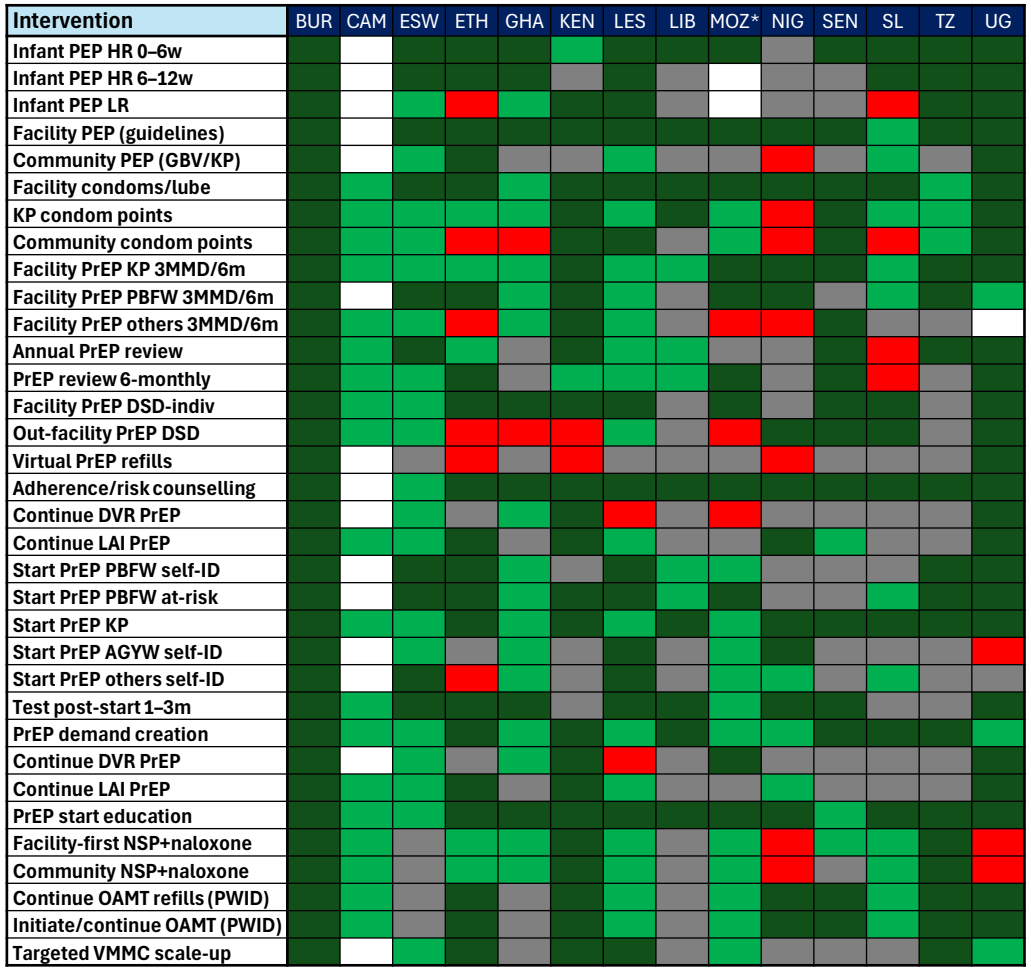
# Results: All countries- Prevention

**External Funding Scenario: 0% (N=14)**




**External Funding Scenario: ≥50% (N=14)**




In both external funding scenarios, countries show confidence in maintaining **prevention** services. Most countries reported few deprioritized prevention services, except for one country.

| |
|---|
| Keep (No Change) |
| Keep (Modify) |
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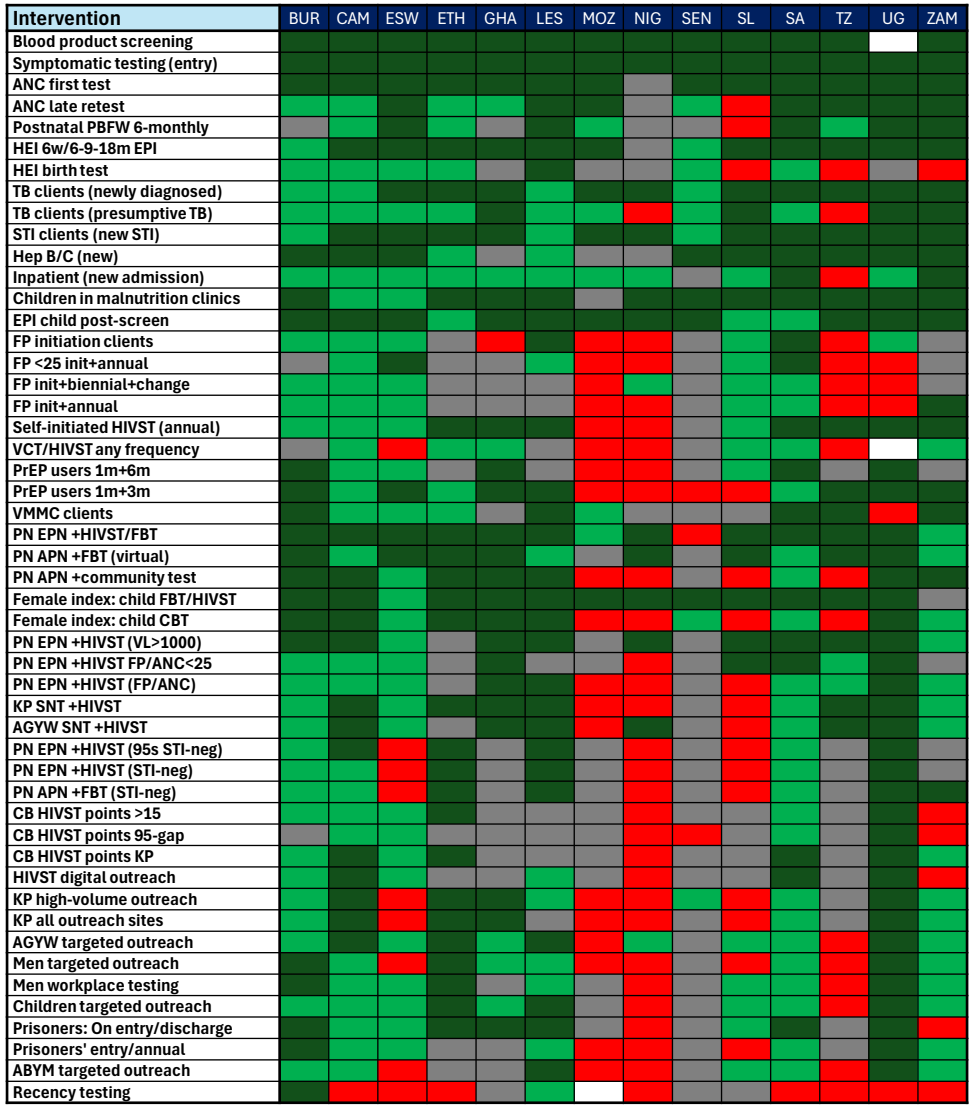
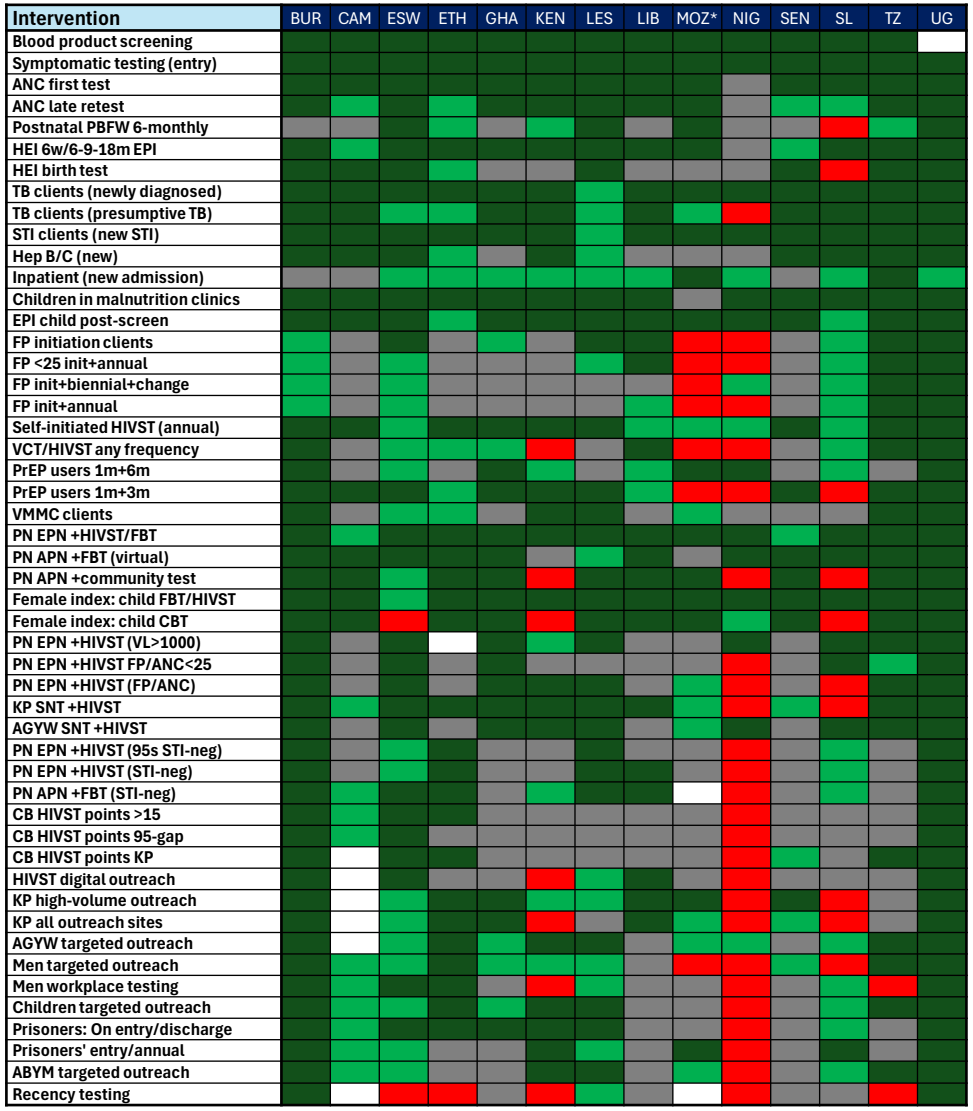
| Not applicable |
| Missing Data |

# Results: All countries- Testing

**External Funding Scenario: 0% (N=14)**




**External Funding Scenario: ≥50% (N=14)**




In both external funding scenarios, countries express confidence in maintaining **testing** services. Most countries reported only a few deprioritized prevention services, except for two countries in 0% external funding scenario.

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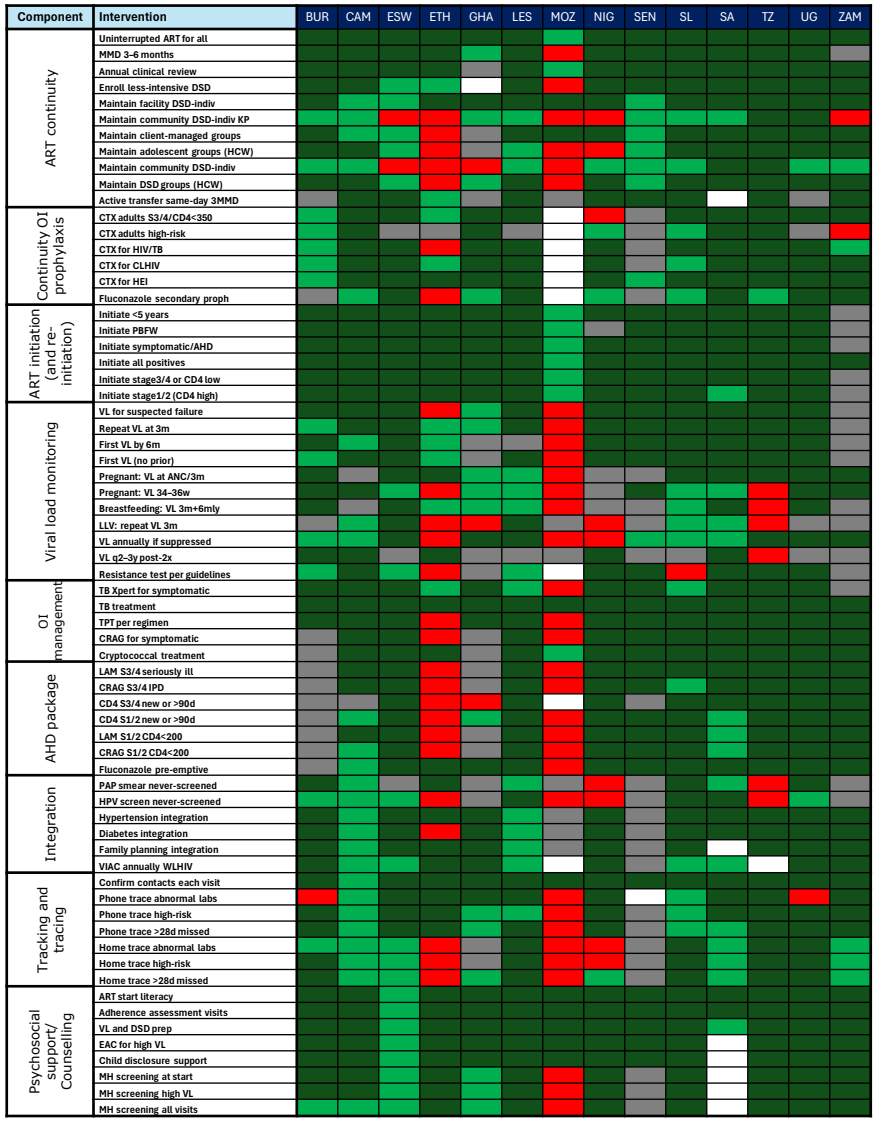
# Results: All countries- Treatment

**External Funding Scenario: 0% (N=14)**

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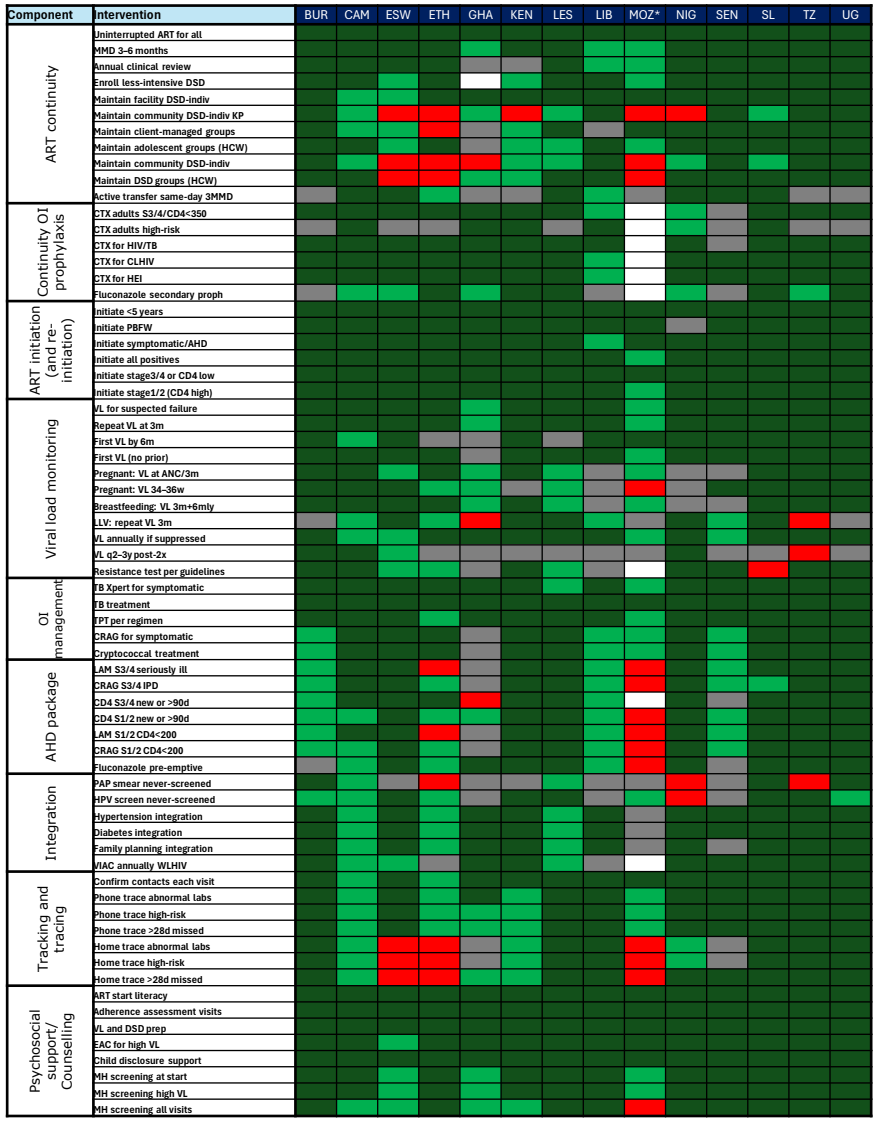


Countries have the most confidence in sustaining **Treatment** services, as shown by more dark green indicators in both funding scenarios compared to prevention or testing. De-prioritized treatment services remain limited, except in two countries under the 0% external funding scenario.

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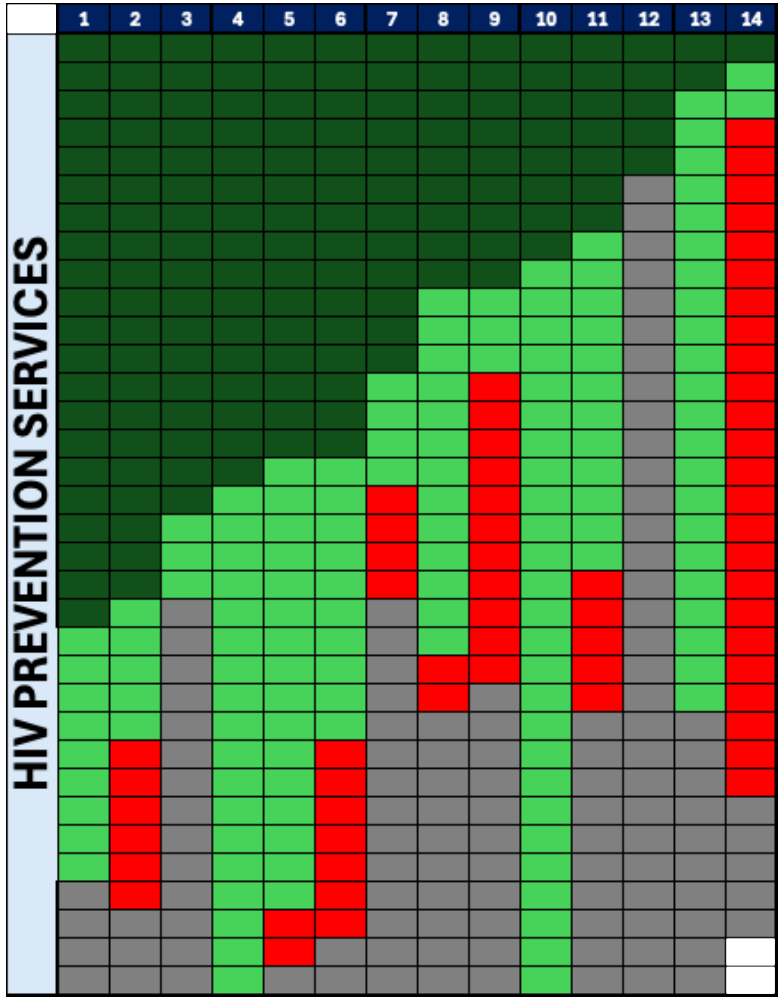
# Distribution of outcomes by domain- Prevention

**External Funding Scenario: 0% (N=14)**

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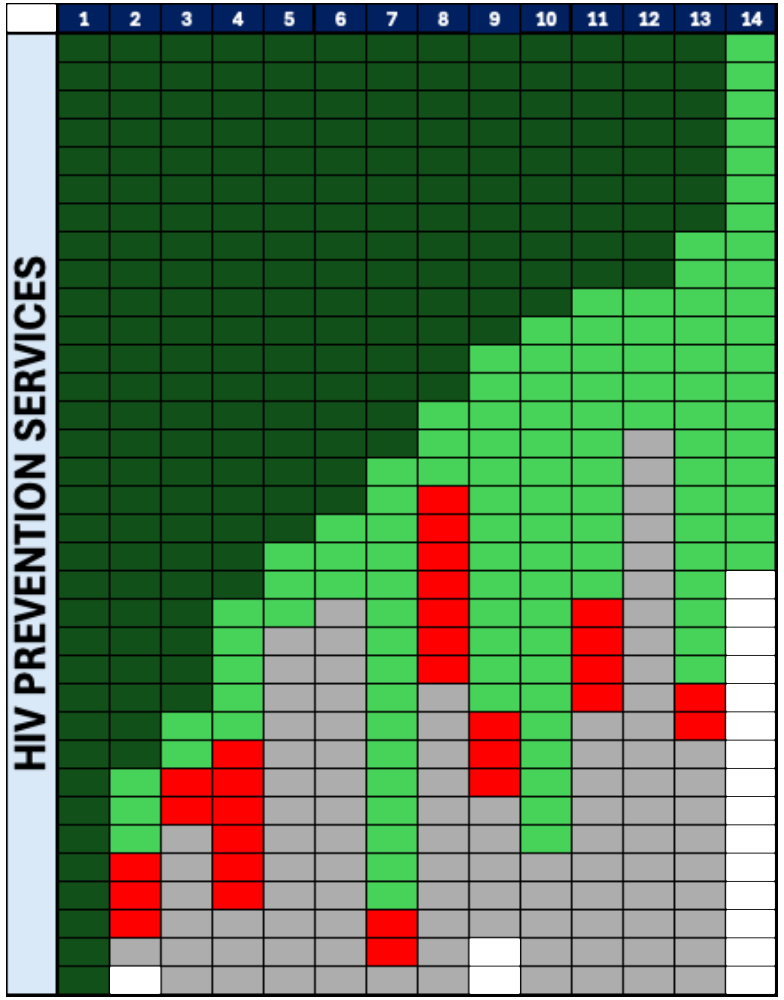
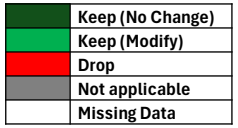



- **Funding Stability:** Countries plan to keep prevention services despite a lack of external funding.
- **Impact of More Funding:** More services are prioritized as funding grows to 50% and beyond.
- **Deprioritized (Dropped) Services:** The count of deprioritized prevention services drops by 52% with higher funding ≥50%.

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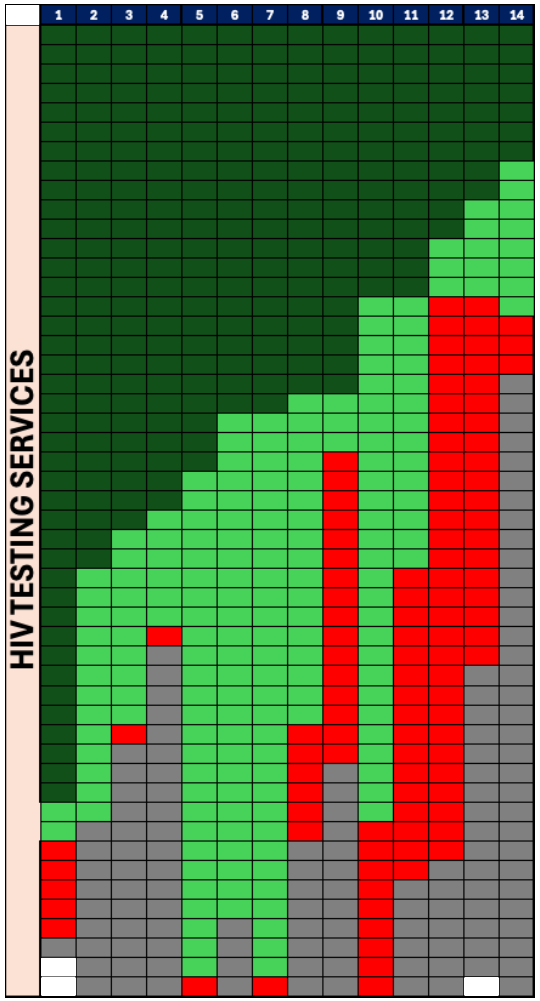
# Distribution of outcomes by domain- Testing

**External Funding Scenario: 0% (N=14)**

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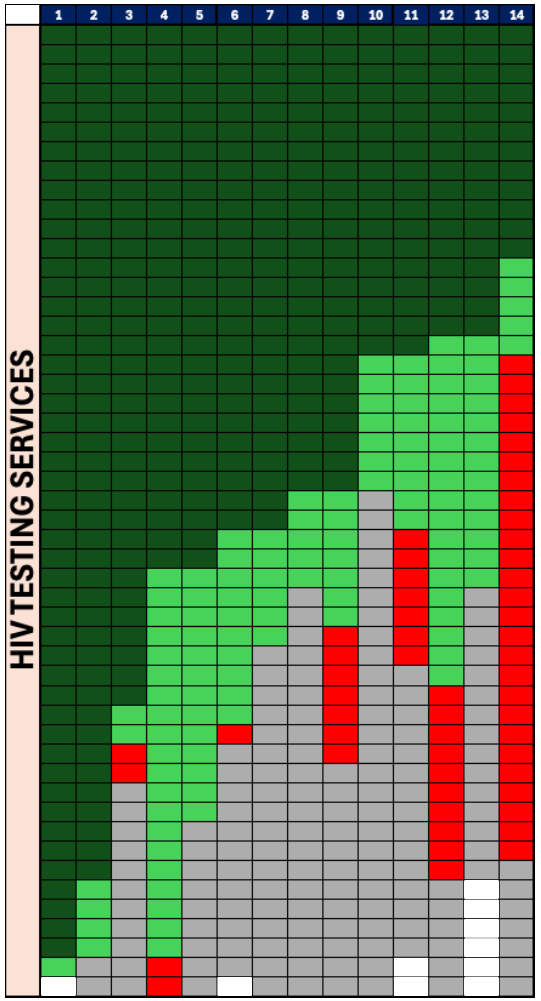


- **Prioritization:** Most countries kept testing services a priority.
- **Increased Funding:** A 50% external funding boost led to more testing services being prioritized.
- **Deprioritized (Dropped) Services:** Deprioritized testing services fell by 49% with increased funding.

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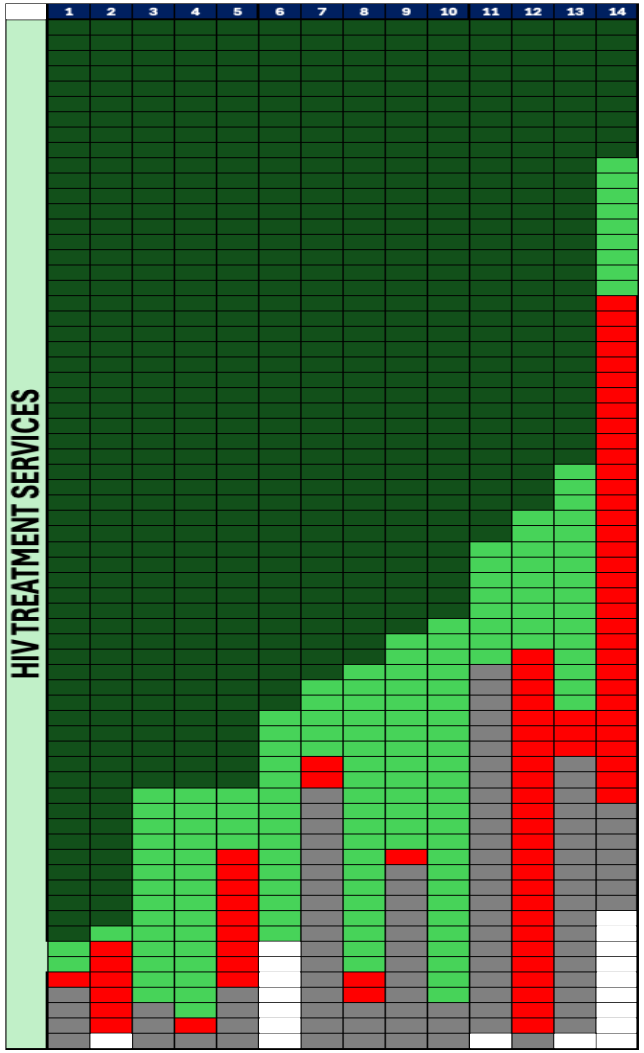
# Distribution of outcomes by domain- Treatment

**External Funding Scenario: 0% (N=14)**

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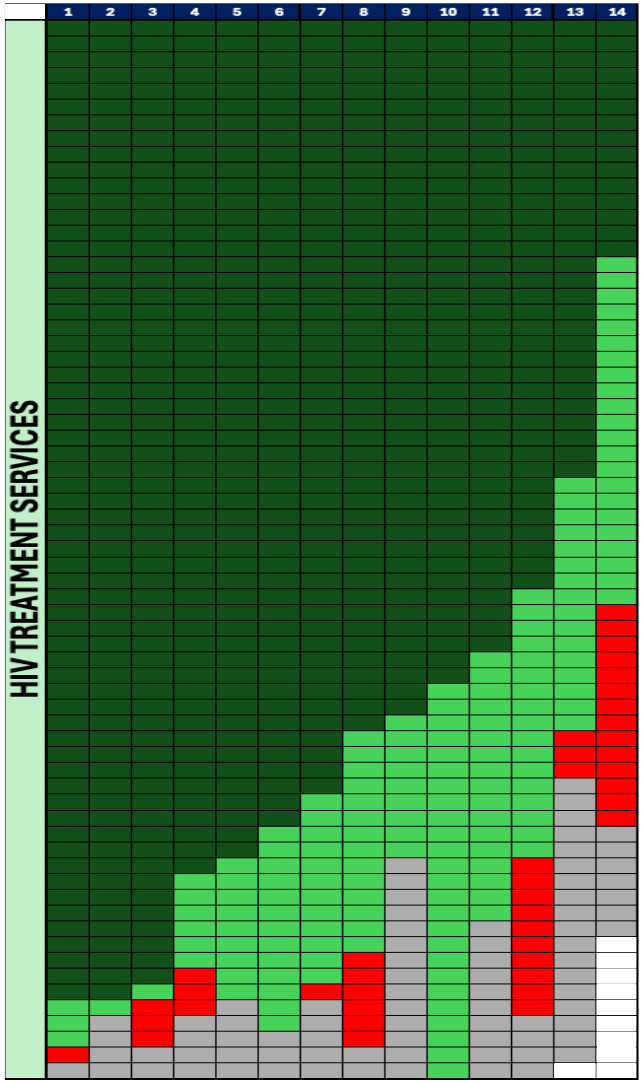


- **Treatment is the most protected domain in all funding scenarios**.
- **Deprioritized (Dropped) Services:** The count of deprioritized treatment services dropped by half (82 to 41) with higher funding ≥50%.

| |
|---|
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| Keep (Modify) |
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| Missing Data |

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# Prevention: What Countries Are Prioritizing


## Top 5 interventions prioritized by countries (0%/50%)

1. Facility-based PEP: 12/12
2. Infant prophylaxis (high-risk, 6w): 11/11
3. PrEP education & risk-reduction at initiation: 10/11
4. Infant prophylaxis (high-risk, 6–12w): 10/8
5. Adherence/ Risk counselling: 7/12

## Top 5 de-prioritized interventions (0%/50%)

1. Community condom points (all populations): 6/ 4
2. Out-Facility PrEP DSD: 4/4
3. Facility PrEP others 3MMD/6m: 4/3
4. Community NSP+naloxone: 3/2
5. Facility-first NSP+naloxone: 3/2

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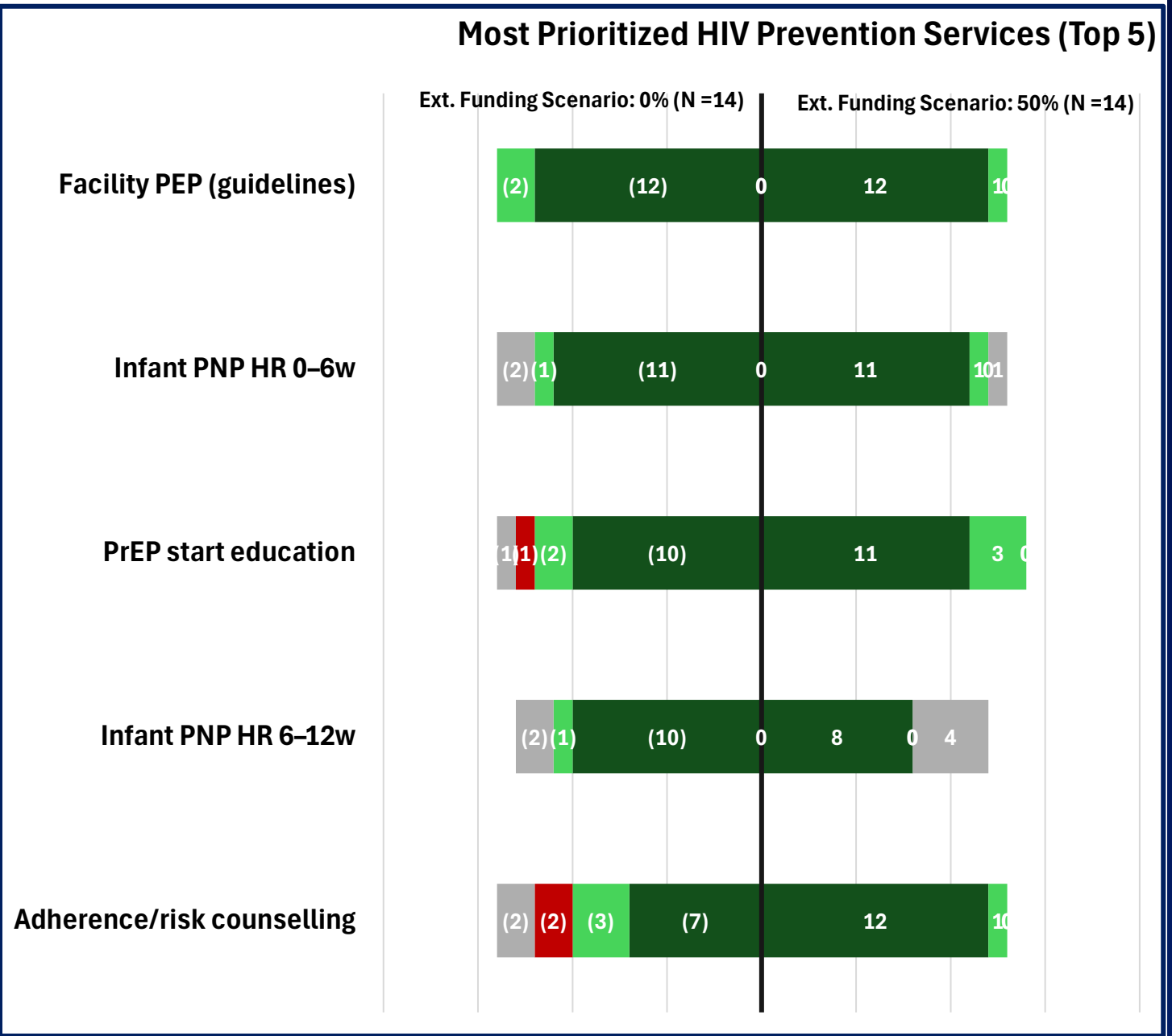
# Prevention: What Countries Are Prioritizing

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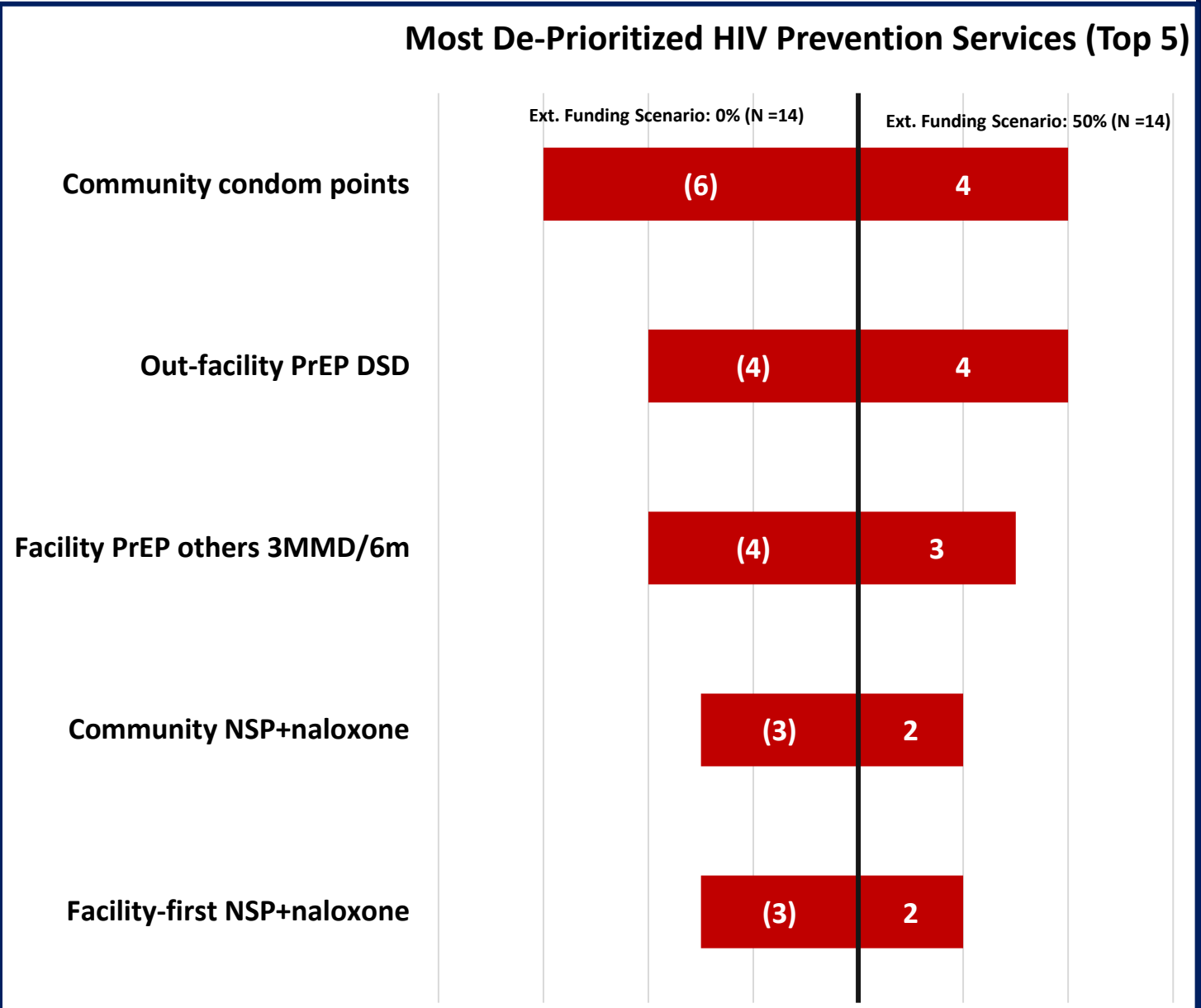


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# Testing: What Countries Are Prioritizing


## Top 6 Testing Services prioritized (0% / 50%)

1. Symptomatic testing (all entry points): 14 / 14
2. ANC first test: 13 / 13
3. Blood product screening: 13 / 13 (UG missing at 0%)
4. Female index: child testing (FBT/HIVST): 12 / 13
5. EPI child post-screen: 11 / 12
6. STI Clients (New STI): 11 / 13

## Frequently de-prioritized (0% / 50%)

1. Recency testing: 8 / 5
2. Men targeted outreach: 5 / 3
3. PN APN +community test: 4 / 3
4. PrEP users 1m+3m: 4 / 3
5. Female index: child community testing (CBT): 4 / 3
6. KP all outreach sites: 4 / 3

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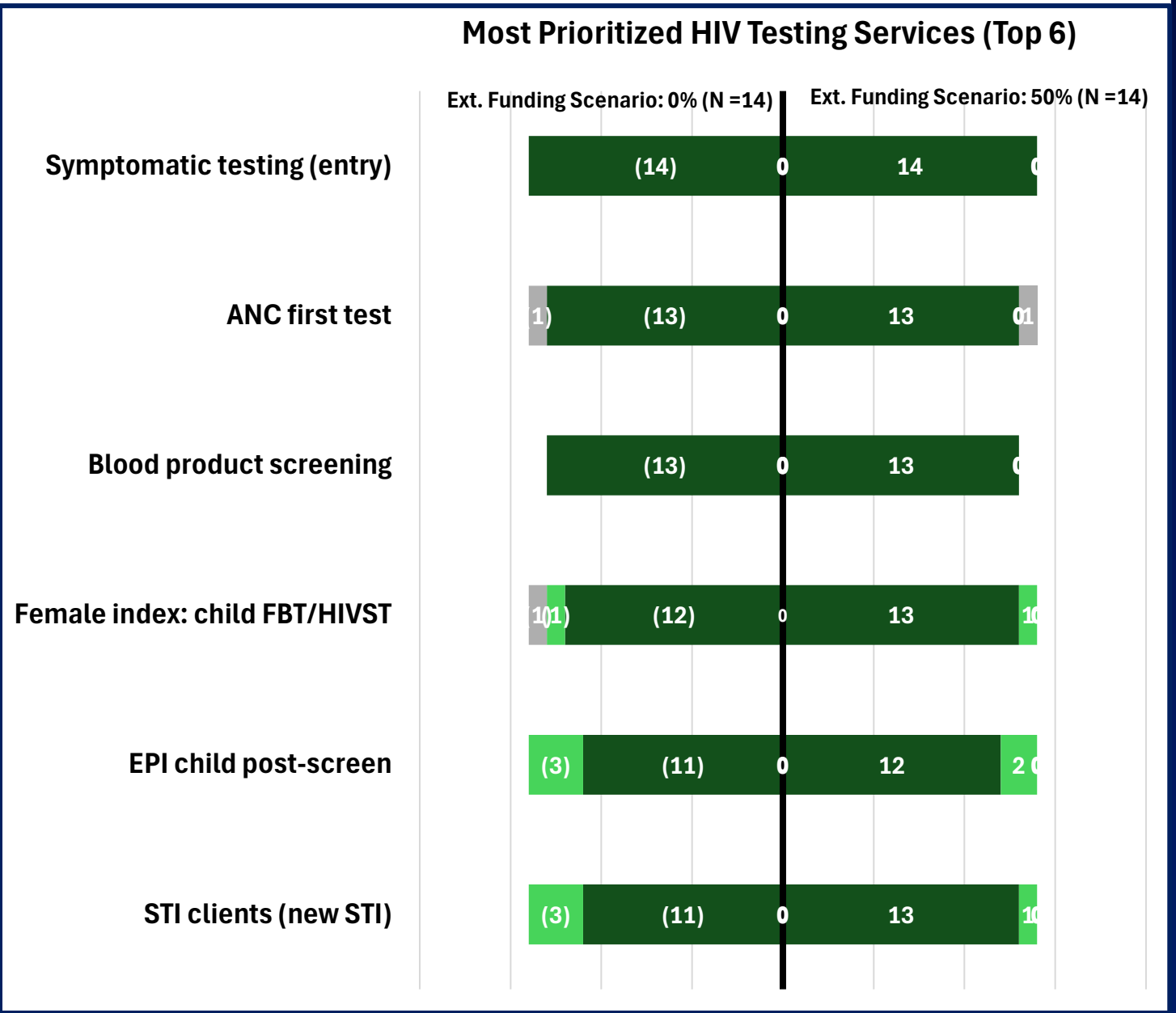
# Testing: What Countries Are Prioritizing

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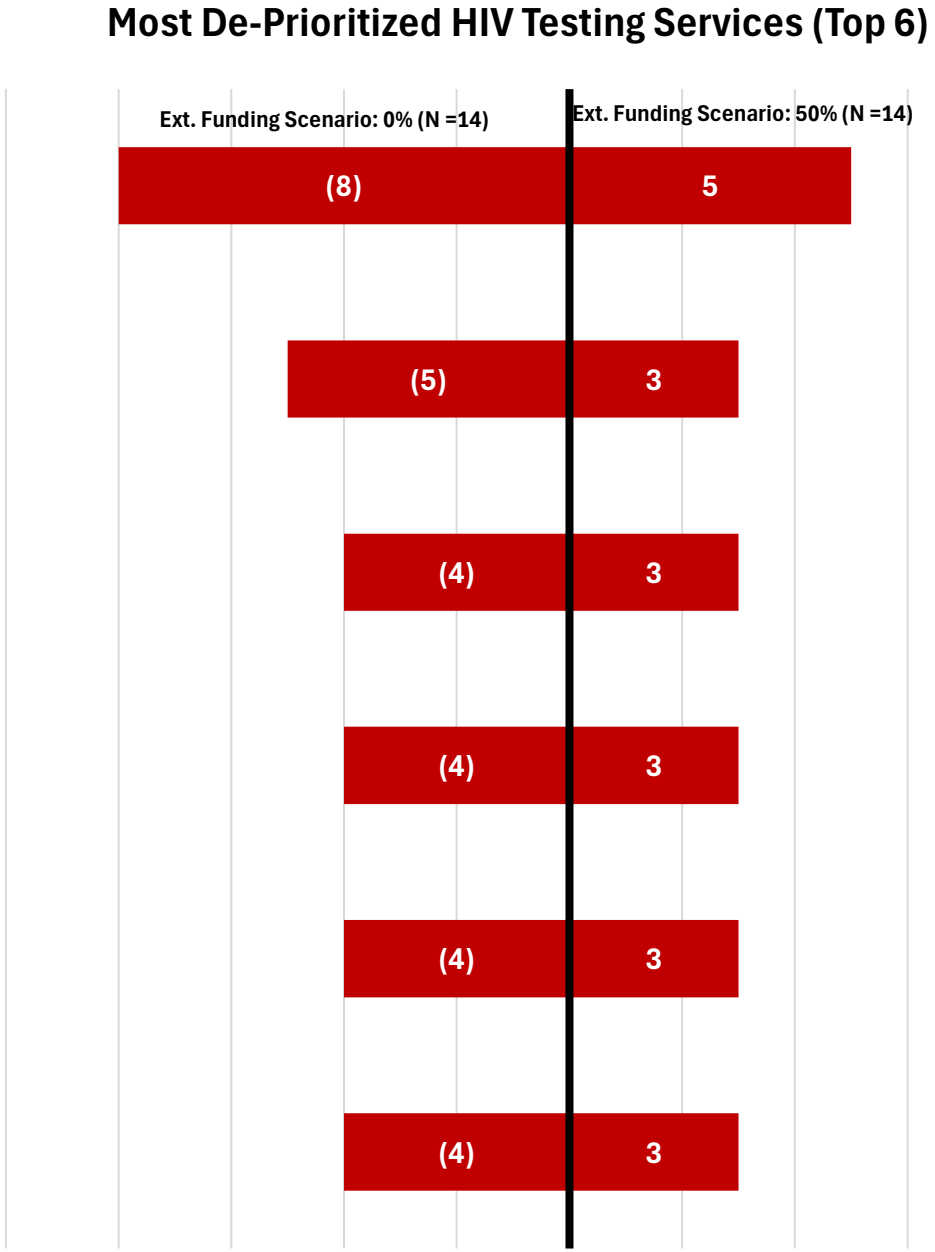
# Testing: What Countries Are De-Prioritizing




**Top 6 Testing Services prioritized (0% / 50%)**

1. Symptomatic testing (all entry points): 14 / 14
2. ANC first test: 13 / 13
3. Blood product screening: 13 / 13 (UG missing at 0%)
4. Female index: child testing (FBT/HIVST): 12 / 13
5. EPI child post-screen: 11 / 12
6. STI Clients (New STI): 11 / 13

**Frequently de-prioritized (0% / 50%)**

1. Recency testing: 8 / 5
2. Men targeted outreach: 5 / 3
3. PN APN +community test: 4 / 3
4. PrEP users 1m+3m: 4 / 3
5. Female index: child community testing (CBT): 4 / 3
6. KP all outreach sites: 4 / 3

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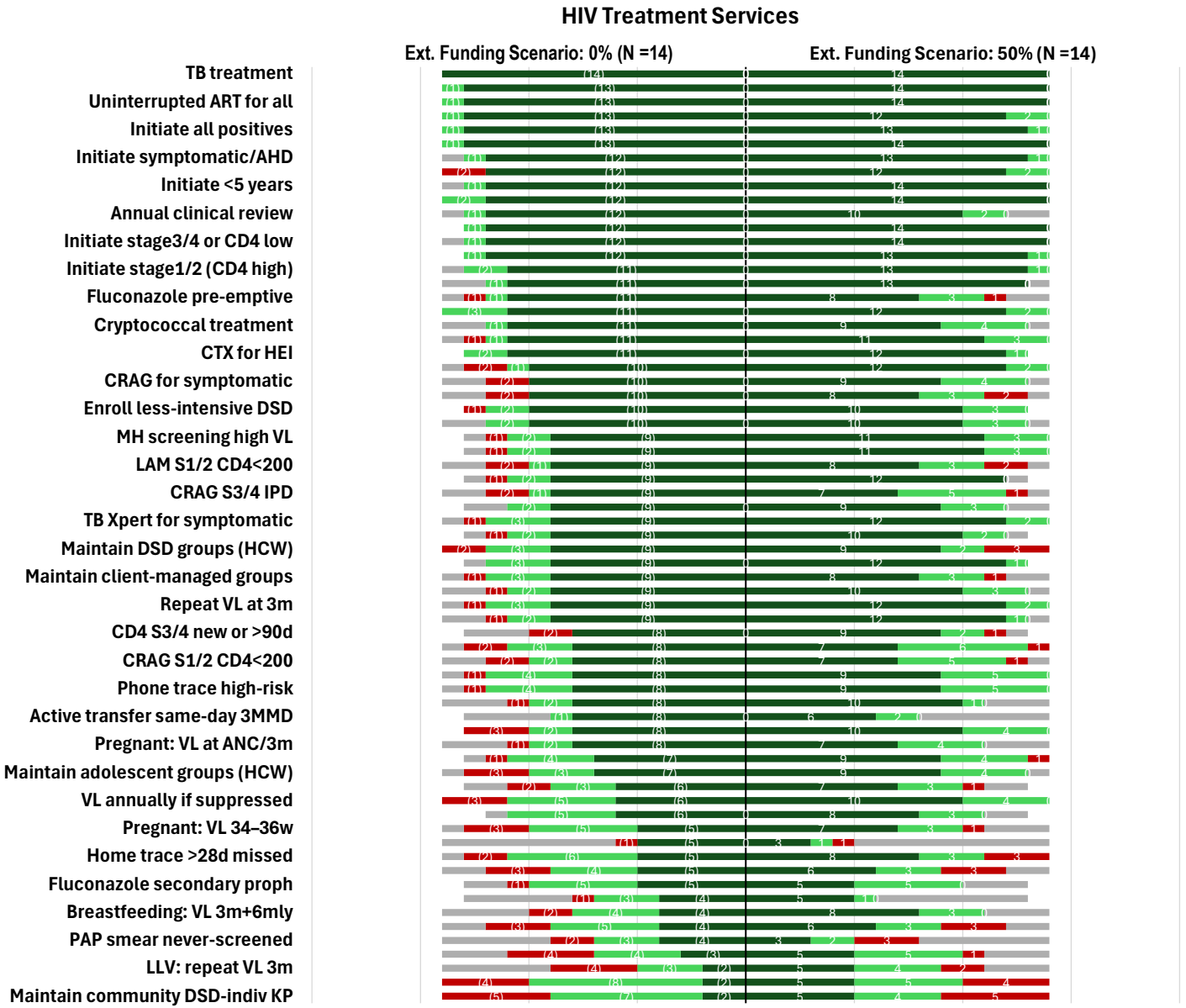
# Treatment: What Countries Are Prioritizing




## Top 6 Treatment Services prioritized (0% / 50%)

1. TB treatment: 14 / 14
2. Adherence assessments (review visits): 13 / 14
3. ART start literacy: 13 / 14
4. Uninterrupted ART for all: 13 / 14
5. Initiate all positives (incl. re-engaging): 13 / 13
6. Confirm contacts each visit: 13 / 12

## Frequently de-prioritized Services (0% / 50%)

1. Maintain community DSD-indiv (KP): 5 / 5
2. Maintain community DSD-indiv (all): 4 / 4
3. LLV: repeat VL at 3 months: 4 / 2
4. HPV screen (never-screened): 4 / 1
5. Home trace high-risk: 3 / 3
6. Home trace abnormal labs: 3 / 3

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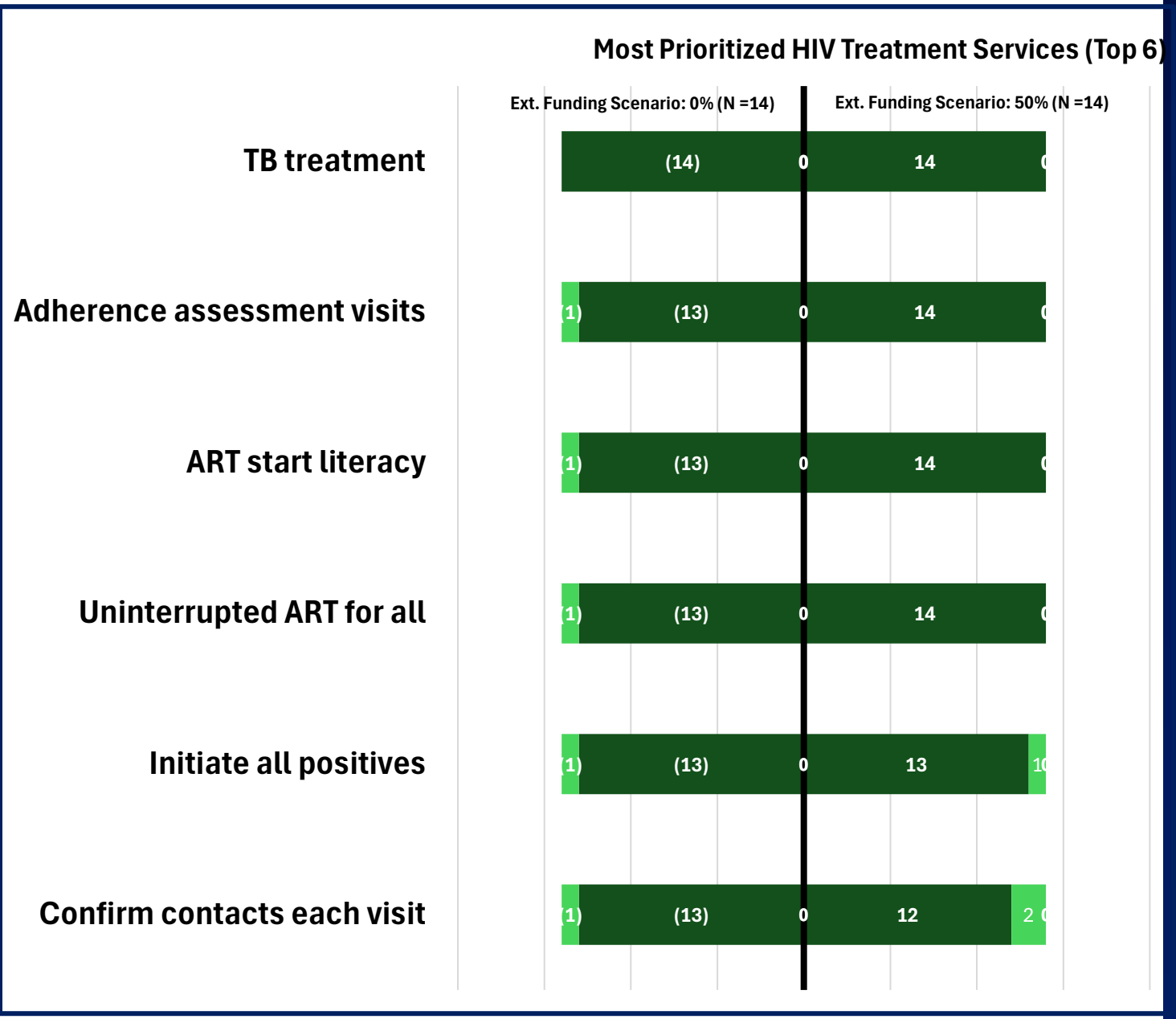
# Treatment: What Countries Are Prioritizing

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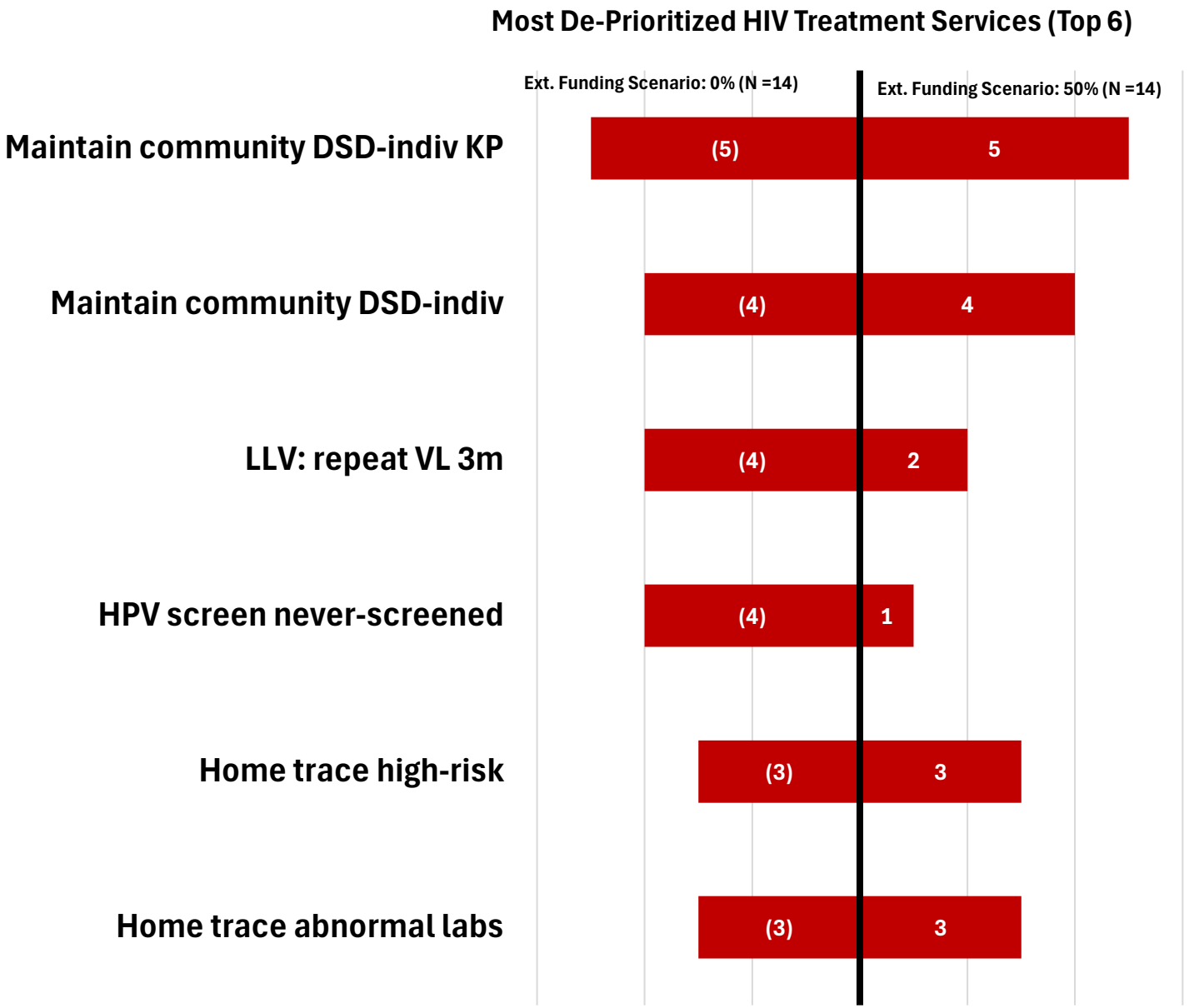


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5. Home trace high-risk: 3 / 3
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# Focus Areas: KP


## Top 5 most Deprioritized KP services in 0% and 50% External Funding Scenarios:

1. Treatment: Maintain community DSD-indiv KP: 5 / 3
2. Testing: KP high-volume outreach: 4 / 4
3. Testing: KP all outreach sites: 4 / 3
4. Testing: KP SNT +HIVST: 3 / 4
5. Prevention: Facility-first NSP+naloxone: 3 / 3

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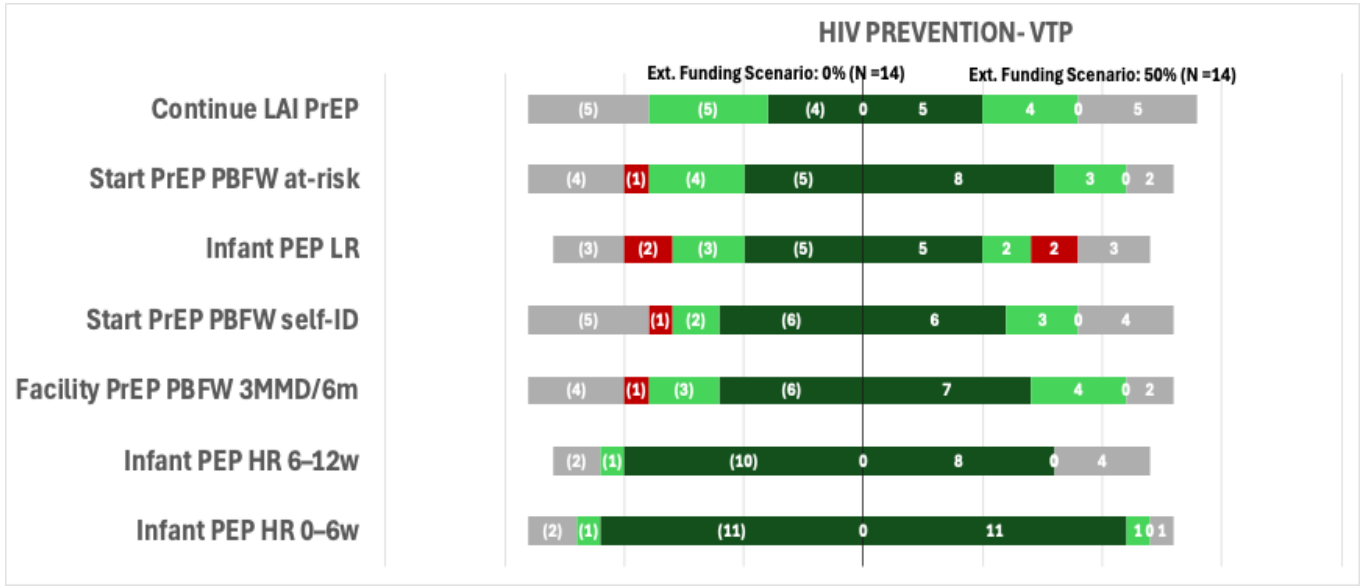
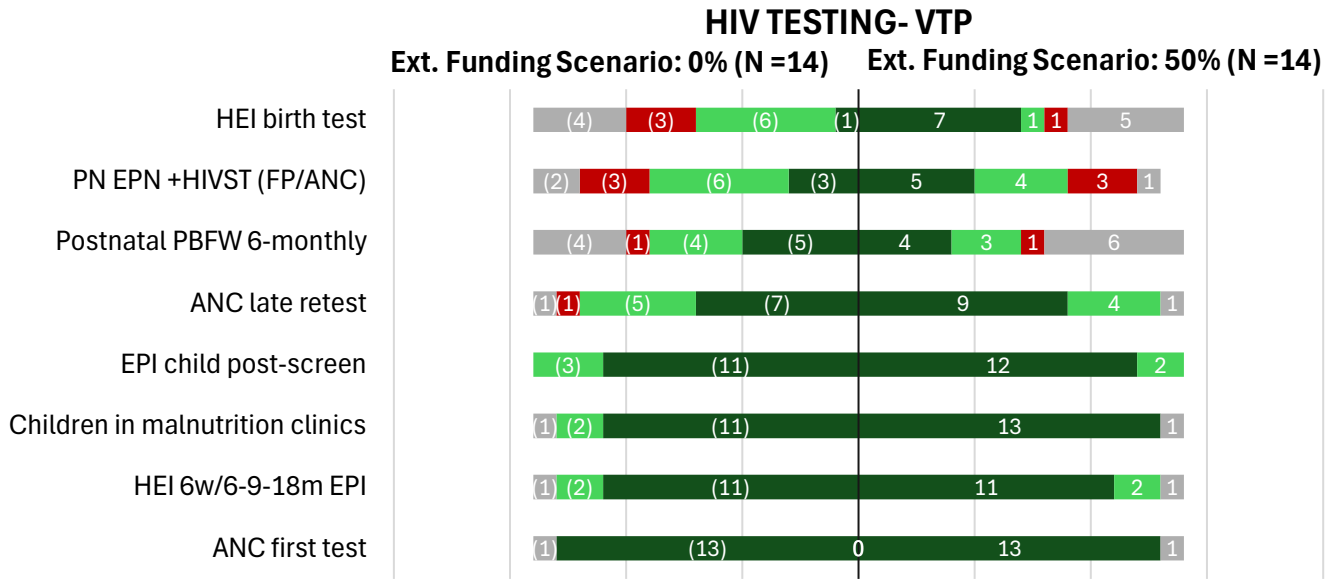
# Focus Areas: VTP




## Deprioritized VT Prevention services in 0%/ 50% scenarios:

1. Infant prophylaxis (AZT or NVP); Low risk 2 / 2

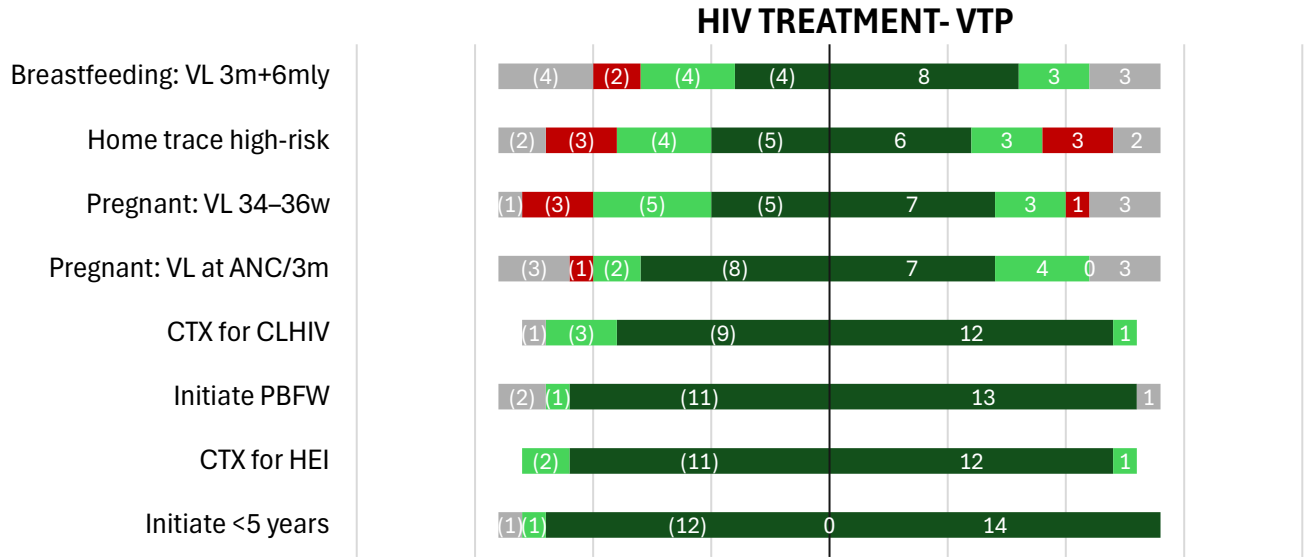
## Deprioritized VT Testing services in 0%/ 50% scenarios:

1. New family planning/ANC client all: Sexual partner testing utilizing enhanced passive notification with HIVST kit/s provision: 3 / 3
2. HIV exposed infants additional birth testing: 3 / 1

## Deprioritized VT Treatment services in 0%/ 50% scenarios:

1. Conduct home tracing if not response to phone calls: those with active OIs, (re)started ART stage 4, CD4 <200, children and adolescents, pregnant and breastfeeding women: 3 / 3
2. For all pregnant women: Provide VL testing at 34-36 weeks of pregnancy (or latest delivery): 3 / 1

# Focus Areas: VTP (contd)




## Deprioritized VT Prevention services in 0%/ 50% scenarios:

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## Deprioritized VT Testing services in 0%/ 50% scenarios:

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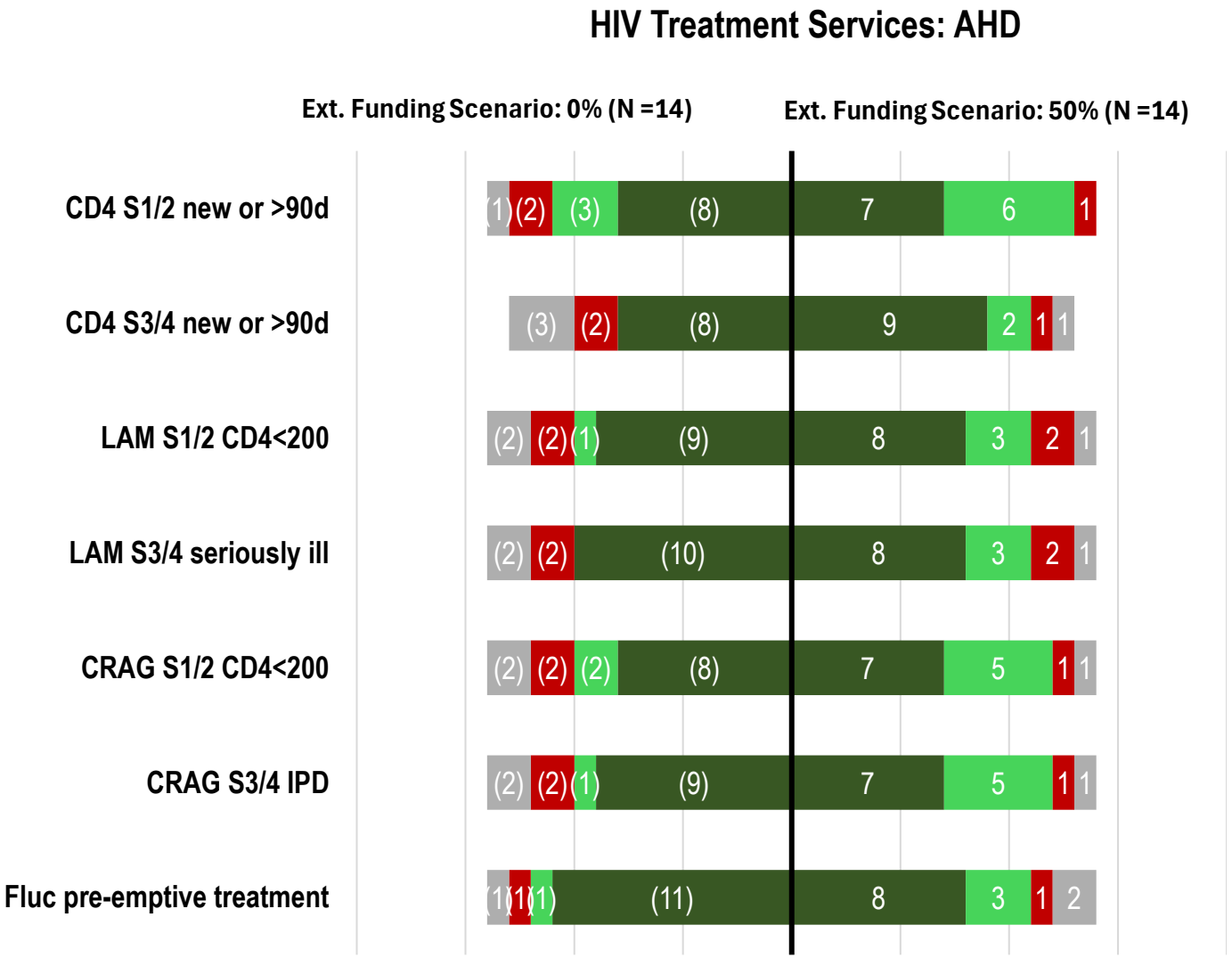
## Deprioritized VT Treatment services in 0%/ 50% scenarios:

1. Conduct home tracing if not response to phone calls: those with active OIs, (re)started ART stage 4, CD4 <200, children and adolescents, pregnant and breastfeeding women: 3 / 3
2. For all pregnant women: Provide VL testing at 34-36 weeks of pregnancy (or latest delivery): 3 / 1

# Focus Areas: AHD




## Deprioritized AHD services (0%/ 50%):

1. Conduct LAM for those with Stage 1 and 2 CD4 <200: 2 / 2
2. Provide LAM for those with Stage 3,4, seriously unwell IPD: 2 / 2
3. Conduct CD4 testing for those with Stage 3 and 4 (newly diagnosed and more than 90 days late) : 2 / 1
4. Conduct CRAG for those with Stage 1 and 2 CD4 <200: 2 / 1
5. Conduct CD4 testing for those with Stage 1 and 2 (newly diagnosed and more than 90 days late) : 2 / 1
6. Provide CRAG for those with Stage 3, 4, IPD: 2 / 1
7. Provide fluconazole for pre-emptive treatment : 1/ 1

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# Results: All countries- M&E Indicator Prioritization

| | | | 0% External Funding Scenario. n=14 | | | | | | | | | | | | | | 50% External Funding Scenario. n=14 | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| # | Program Area | Indicator | MAL | MOZ | ESW | SL | LIB | KEN | TZ | LES | GHA | BUR | UG | ZAM | NIG | ETH | MAL | MOZ | ESW | SL | LIB | KEN | TZ | LES | GHA | BUR | UG | ZAM | NIG | ETH |
| 1 | **VTP** | Ist ANC attendance | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 | | Ist ANC testing | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 | | 1st ANC HIV+ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4 | | 1st ANC Known HIV+ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5 | | HEI 1st EID | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6 | | HEI final outcome | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7 | | HEI ARV prophylaxis | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8 | **HTS** | HTS_TST | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9 | | HTS_POS | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10 | | HTS_TST by modality | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11 | | HTS_POS by modality | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12 | **ART** | TX_NEW | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13 | | TX_NEW by CD4 count | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14 | | TX_CURR by MMD | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15 | | Interuption in Treatment [IIT] | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16 | | AIDS-related mortality | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 | **VL** | VL results received | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18 | | VL results <1,000 C/ml | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19 | **TB** | TB diagnosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20 | | Initiated on TPT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21 | | Completed TPT | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22 | **HIV Prevention** | PrEP_NEW | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23 | | Received PrEP | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24 | | Received PEP | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25 | | Received condoms | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| *Key* | |
|---|---|
| Keep | |
| Keep [But Modify] | |
| Drop | |
| N/A | |
| Not Prioritised | |

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# Country Updates

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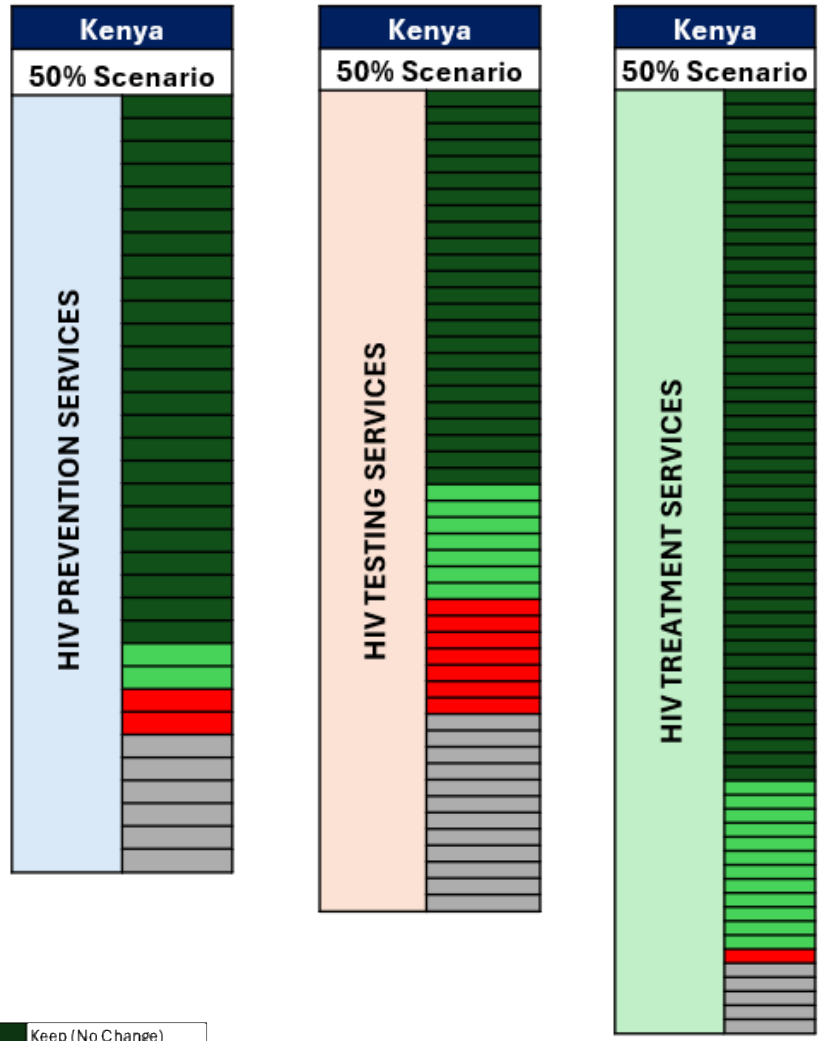
# Kenya




## Deprioritized Prevention services in a 50% external funding scenario:

1. Individual out-of-facility PrEP maintenance (through existing and maintained out-of-facility DSD treatment locations), including refill collection and HIVST
2. Provide PrEP refills through virtual delivery models

## Deprioritized Testing services in a 50% external funding scenario:

1. Self-initiated VCT/HIVST collection available (limit to annual/specific risk exposure)
2. Newly diagnosed client: Sexual partner testing utilizing provider-assisted notification for facility-based testing (consider centralized/virtual notification and HIVST collection at ART DSD points)
3. Newly diagnosed female client: Biological children, facility-based testing, or HIVST by caregiver
4. Key populations: Community-based HIVST collection points after self-managed HTS virtual registration (limited to annual)
5. Key populations: High-volume outreach points and drop-in centres run by community-based organizations
6. Men: Targeted outreach HTS (congregant settings - transport hubs, bars)
7. ABYM: Targeted outreach HTS (educational facilities, youth centres)

## Deprioritized Treatment services in a 50% external funding scenario:

1. Sustain individual DSD models for key populations not based at facilities

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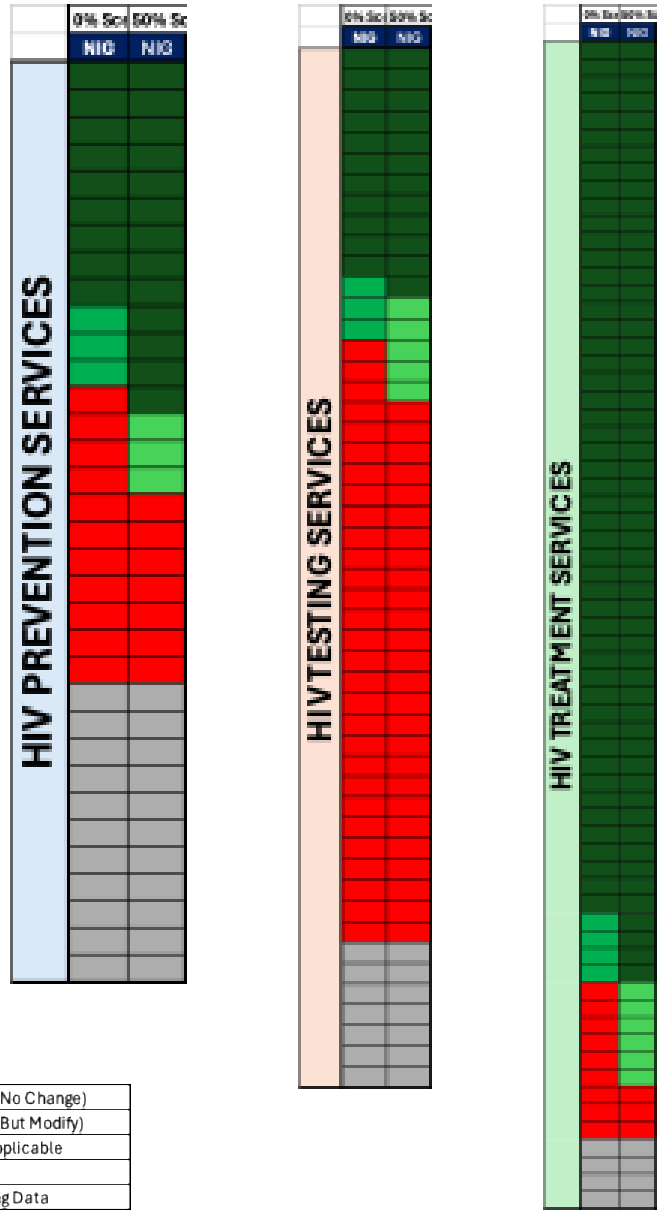
# Nigeria




## Deprioritized Prevention services in 0% and 50% external funding scenarios:

1. Community-based PEP availability - GBV services, maintained community-based KP services
2. Community collection points for condom (and lubricant) for key populations
3. Community collection points for condom (and lubricant) for all populations
4. Facility based oral PrEP maintenance for other populations with regular use - minimum 3MMD with testing every 6 months (including with HIVTST)
5. Provide PrEP refills through virtual delivery models
6. Sterile needles, syringes and naloxone for collection in the following order: facility-based services, existing maintained out-of-facility DSD collection points or KP services
7. Sterile needles and syringes and naloxone in the following order: Community locations where community members can collect and distribute, community outreach locations

## Deprioritized Testing services in 0% and 50% external funding scenarios:

Testing interventions were deprioritized at both funding scenarios

## Deprioritized Treatment services in 0% and 50% external funding scenarios:

1. Sustain individual DSD models for key populations not based at facilities
2. Conduct PAP smear for those who have never been screened
3. Provide HPV screening for those who have never been screened

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# Emerging themes

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# What We Are Seeing

**Prevention**

- Community condom pickup points halted
- Facility oral PrEP maintenance for some populations deprioritized
- Sterile needles, syringes, and naloxone access both in the facility and community for PWID are deprioritized.

**Testing**

- Index testing for sexual partners/biological children with community components reduced.
- Family Planning-based case finding scaled down.
- HIVST distribution declines (facility, community, KP).
- KP outreach/DICs paused in several countries.
- Male ABYM/men appear underserved.
- Recency testing broadly deprioritized

**Treatment**

- Deprioritized community-based DSD models (KP, individual, HCW-managed).
- Scaling back of active tracking/tracing - abnormal VL, AHD/Stage 4, missed appointments.

## Potential Implications

**Prevention:** Deprioritizing condom and PrEP use while leaving sterile needles, syringes, and naloxone unaddressed increases the risk of new infections and mortality in priority groups (KP/PWID), undermining prevention efforts.

**Testing:** Case finding may shift toward symptomatic/ANC/EPI entry points; risk of missing males and KP, and fewer low-contact case detection opportunities through HIVST- late diagnosis of HIV

**Treatment:** As community DSD and tracing decrease, expect higher IIT, lower retention, and reduced VL suppression, especially among KP, Men, and ABYM, and highly mobile clients.

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# Additional Considerations

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# Additional Considerations

1. **Costing**: What is the unit cost for each "Prioritized/ modified" service?
2. **Targets**: How do changes influence progress toward 95-95-95 and Epidemic control?
3. **Operationalization**: What are the exact components of the modified packages (Frequency, coverage, population, processes..)?
4. **Implementation readiness**: What are your plans and timelines to update training curricula, SOPs, M&E tools, and national guidelines?
5. **Quality**: How will service quality be assured/monitored post-changes (HSQA/SQA alignment)?
6. **Dissemination**: How and when will changes be communicated (providers, community, partners)?



Key Population Friendly Services Quality Management Toolkit | CQUIN

Access link

# Country Next Steps

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# Next Steps

- **Reassess and Refine Prioritization Decisions:** Conduct a targeted review and adjustment of HIV service interventions and M&E indicators and align with the current national HIV response funding landscape (both domestic allocations and external donor contributions).
- **Sustain Strategic Engagement with Donors and Implementing Partners (IPs):** Facilitate ongoing dialogue with donors and IPs to harmonize their technical and financial support with the nationally endorsed prioritized services, indicators and frameworks.
- **Operationalize Prioritized Interventions:**
    - **Strengthen HRH Capacity** - orient health workers to the national prioritization decisions to ensure coherence across facility, district, and national levels. Equip them with the necessary tools and resources.
    - **Monitor Implementation Trends** to **Safeguard Treatment Continuity** - track progress against the prioritized indicators, flag service delivery gaps, and proactively address disruptions, especially those affecting continuity of treatment and retention in care.
    - **Review and Strengthen System Adaptations to Support Prioritized Services and Indicators:** Assess and address necessary adjustments in health systems including HMIS, and supply chain management to ensure they are responsive to and capable of sustaining the prioritized HIV services and indicators.

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# Thank You!

# HIV Service Prioritization: Nigeria

Dr. Jonathan Modugu
NASCP- Ministry of Health, Nigeria

# Outline

01 Background

02 Global Changes to the Funding Landscape

03 HIV Service Prioritization Findings

04 Special Considerations

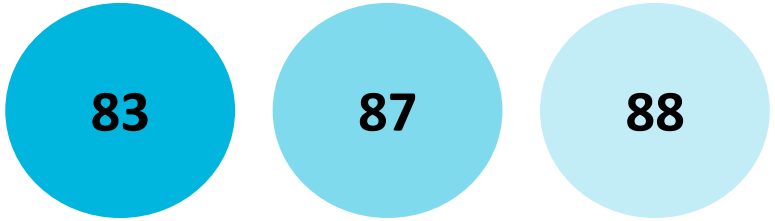
05 Next steps

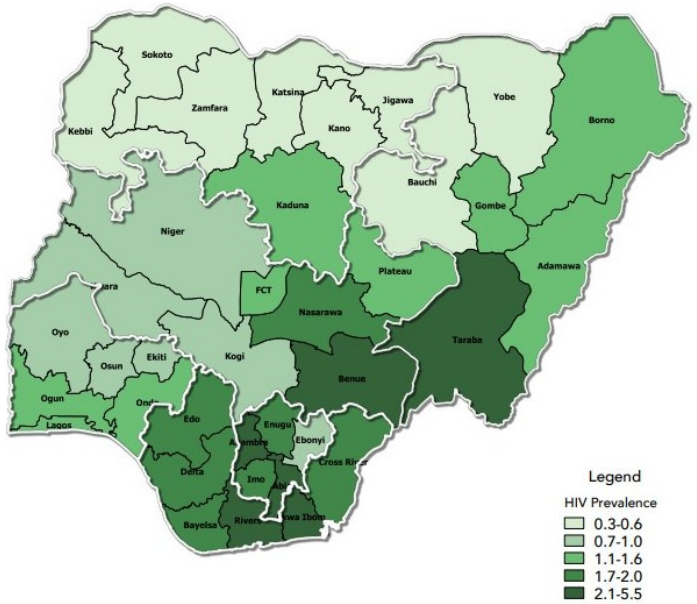
# Background: Country Profile

- Nigeria has an estimated population of **218 million**, with an HIV prevalence rate of **1.3%** (NAIIS 2018).
- Approximately **2 million** people are living with HIV, with about **1.7 million** currently receiving antiretroviral therapy (ART).
- More than **2,000** healthcare facilities provide comprehensive ART services nationwide.

**Progress to 95-95-95 target: Total Population**


**Progress to 95-95-95 target: (CLHIV)**



# Nigeria's Immediate Response to the Funding Pause

- Established AIDS, TB and Malaria (ATM) TWG, led by the Health Minister, with an ongoing technical analysis team.
- Developed immediate and long-term action plans (one-month to three-year action plans).
- Prioritized essential services for uninterrupted care.
- Committed N4.8B initially and secured $200M for local manufacturing.
- Guided State AIDS Programme Coordinators (SAPCs) on gap mitigation and engaged medical directors to sustain services.
- Strengthened client linkage and retention through hub-and-spoke analysis.
- Temporarily capped multi-month dispensing (MMD) at three months post-SWO.

# Prioritization Planning and Meeting (1)

In response to the Stop Work Order and declining donor support, Nigeria authorized the HIV service prioritization exercise to ensure sustainability and continuity of essential care.

- Secured approval from NASCP leadership for pre-prioritization strategy.
- Invitations extended to government MDAs, donors, implementing partners and community leaders.
- Meeting supported by CQUIN and held on the 11th of August 2025

# Prioritization Planning and Meeting (2)

| | HIV TREATMENT SERVICES | With 0% external funding (vs. current year) | | | | |
|---|---|---|---|---|---|---|
| Component | Intervention | Keep or drop | Planned Funding Source (if continuing) | | | |
| | | | % funded by PEPFAR/USG | % funded by GF | % domestic | % funded by other |
| ART continuity | Provide uninterrupted ART treatment to ALL people who are already on ART, all populations and all regimens | | | | | |
| | Provide a minimum of 3MMD for all, unless clinically unwell (including re-engaging clients) with 6MMD preferred for those established on ART (for all over 5-years of age) | | | | | |
| | Conduct an annual quality clinical review if established on ART and virally suppressed with longest scripting period allowed 6-12 months | | | | | |
| | Enroll eligible clients in less-intensive DSD models | | | | | |
| | Sustain individual DSD models based at facilities | | | | | |
| | Sustain individual DSD models for key populations not based at facilities | | | | | |
| | Sustain group DSD models managed by clients | | | | | |
| | Sustain group DSD models for adolescents managed by healthcare workers | | | | | |
| | Susatin individual DSD models not based at facilities | | | | | |
| | Sustain group DSD models managed by healthcare workers | | | | | |
| | Actively support transfer all clients from facilities that are closing to preferred public sector facility with same day continuation of ART, minimum 3MMD, offer less-intensive DSD model without required transfer documentation | | | | | |
| Continuity OI prophylaxis | Provide cotrimoxazole prophylaxis to adults Stage 3 and 4 or CD4 <350. Note recommendation when to stop | | | | | |
| | Provide cotrimoxazole tp adults in settings where malaria and/or severe bacterial infections are highly prevalent, co-trimoxazole prophylaxis should beinitiated regardless of CD4 cell count or WHO stage; Note recommendation when to stop | | | | | |
| | Provide cotrimoxazole to patients living with HIV and TB | | | | | |
| | Provide cotrimoxazole to children living with HIV; Note recommendation on when to stop | | | | | |
| | Provide cotrimoxazole to HIV exposed infants; Note recommendation when to stop | | | | | |
| | Provide secondary fluconazole prophylaxis (maintenance); Note recommendation on when to stop | | | | | |
| ART initiation (and re-initiation) | Initiate children under 5 years | | | | | |
| | Initiate pregnant and breastfeeding women | | | | | |
| | Initiate those with clinical signs and symptoms of HIV/AIDS or CD4<200 if known (AHD) | | | | | |
| | Initiate all people testing positive for HIV (new and re-engaging) and transferring | | | | | |
| | Initiate all people testing positive for HIV - stage 3 or 4 or if CD4 known or baseline CD4 (CD4 nadir) below 200/350/500 | | | | | |
| | Initiate all people testing positive for HIV - stage 1 or 2 or if CD4 known or baseline CD4 (CD4 nadir) above 200/350/500 | | | | | |
| Viral load monitoring | Provide VL testing for those presenting with signs and symptoms of treatment failure | | | | | |
| | Provide VL testing clients with a previously elevated viral load (VL>1000 copies/ml), perform viral load after 3 months | | | | | |
| | Provide first viral load to ensure result is available **by** 6 months on ART enabling earlier DSD | | | | | |

- ***Key stakeholders:*** over 30 key and relevant stakeholders were in attendance for the session.
  - NASCP (Head, TCS, PMTCT Lead, M&E Lead),
  - The Nigerian Primary Healthcare Development Agency (NPHCDA),
  - National Agency for the Control of AIDS (NACA)
  - Donor agencies: US CDC, US Department of State
  - Implementing partners, and technical support organizations: APIN, IHVN, SFH, ICAP, PATA, M2M, ECEWS, CHAI, EGPAF.
- ***Prioritization Processes*:**
  - Integrated VTP and Treatment arms to streamline and prioritize activities.
  - Focused on cost-effective services to preserve previous gains.
  - Utilized the **CQUIN-modified TIER** tool for the exercise.

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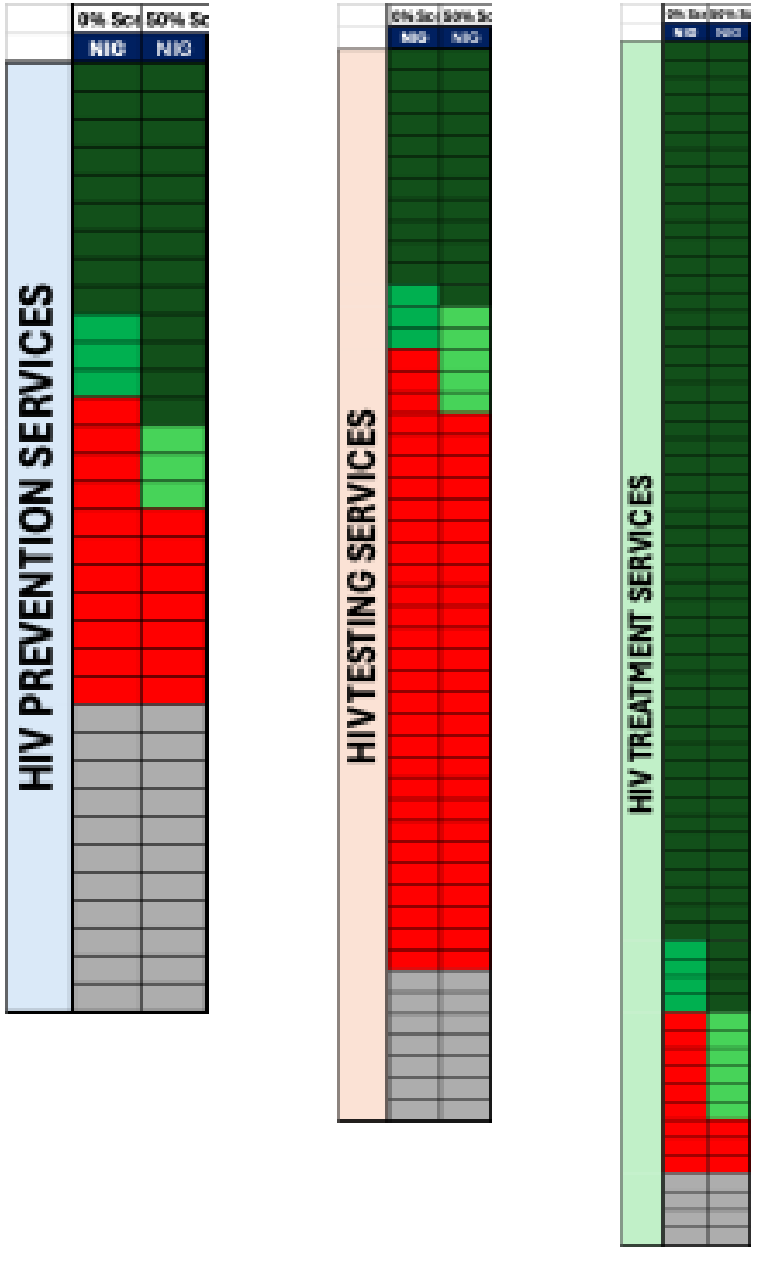
# Nigeria




## Deprioritized Prevention services in 0% and 50% external funding scenarios:

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5. Provide PrEP refills throught virtual delivery models
6. Sterile needles, syringes and naloxone for collection in the following order: facility-based services, existing maintained out-of-facility DSD collection points or KP services
7. Sterile needles and syringes and naloxone in the following order: Community locations where community members can collect and distribute, community outreach locations

## Deprioritized Testing services in 0% and 50% external funding scenarios:

1. A total of 26 out of 50 testing interventions were deprioritized at both funding scenarios

## Deprioritized Treatment services in 0% and 50% external funding scenarios:

1. Sustain individual DSD models for key populations not based at facilities
2. Conduct PAP smear for those who have never been screened
3. Provide HPV screening for those who have never been screened

# Overview of the HIV Services Prioritization Outcomes

**Prevention:**

- Prevention services had major modifications.
- PrEP/PEP/Condoms deemed essential
- KP services deprioritised

**Testing**

- Testing services also had major changes,
- Testing at multiple entry points at facilities, Testing for PBFW and children non-negotiable.
- Many outreach services deprioritised, to be implemented as funding permits.

**Treatment**

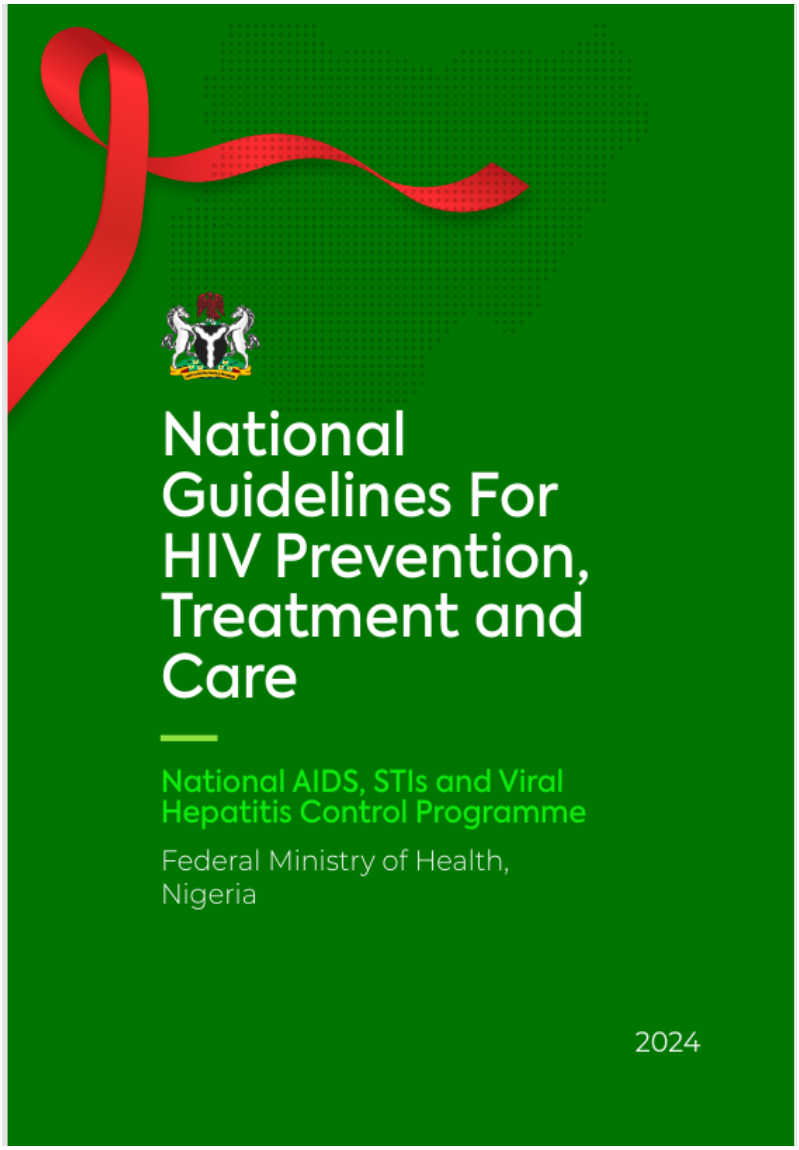
- Minimal changes to our Treatment services.
- ART commodities for all populations are non-negotiable, in particular for pregnant and breastfeeding women.
- Major changes for KP typologies.

# Challenges

- Scheduling conflicts prevented participation from Ministry of Finance representatives.
- Absence of finalized financial data limited the precision of prioritization decisions.
- Recipients of Care (RoC) were not adequately represented at the meeting.
- The prioritized activities, provisional at this stage, are expected to sustain Nigeria's achievements and further advance progress toward epidemic control.

# Other Considerations

- We are exploring the use of the National Health Insurance Scheme to expand coverage for HIV services.
- We are also integrating other health services, such as Sexual and Reproductive Health and Rights (SRHR) and Gender-Based Violence (GBV) services, to enhance comprehensive care.
- Nigeria has completed its review of Monitoring and Evaluation (M&E) tools ahead of the meeting, with the goal of streamlining data collection across the HIV programme.
- There is an ongoing effort to register Recipients of Care (RoCs) under the National Health Insurance Scheme, with a focus on the Basic Health Care Provision Fund.
- Implementation of pooled funding and joint procurement mechanisms for AIDS, Tuberculosis (TB), and Malaria (ATM).
- State governments have initiated procurement of select commodities. We aim to expand this approach, thereby freeing resources to support additional services.



# Next Steps

- Feedback and continuous engagement with the RoC community.
- Dissemination to frontline HCWs.
- Piloting of the revised M&E tools.
- Strengthen ongoing integration efforts.

# Conclusion

- This process is one we intend to revisit periodically as the funding landscape evolves.
- Advocacy to state governments on taking ownership of their HIV programmes is ongoing, with some progress seen in a few states.
- Stakeholders at all levels remain engaged in this ongoing process.
- Community is actively involved in ongoing efforts to prioritize and integrate services.
- Nigeria has accelerated its Integration activities - Instituted a Joint AIDS, TB, and Malaria TWG.
- ICAP is supporting Nigeria with TA in its NCD and FP integration efforts into HIV services
- Joint Pediatric TWG meeting bringing together AIDS, TB, Malaria, and Nutrition just completed with support from ICAP.
- Integrated SRHR/communicable diseases are being piloted with support from GF.

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# Kenya: Strategic HIV Service Prioritization for Impact in a Changing Financial Context

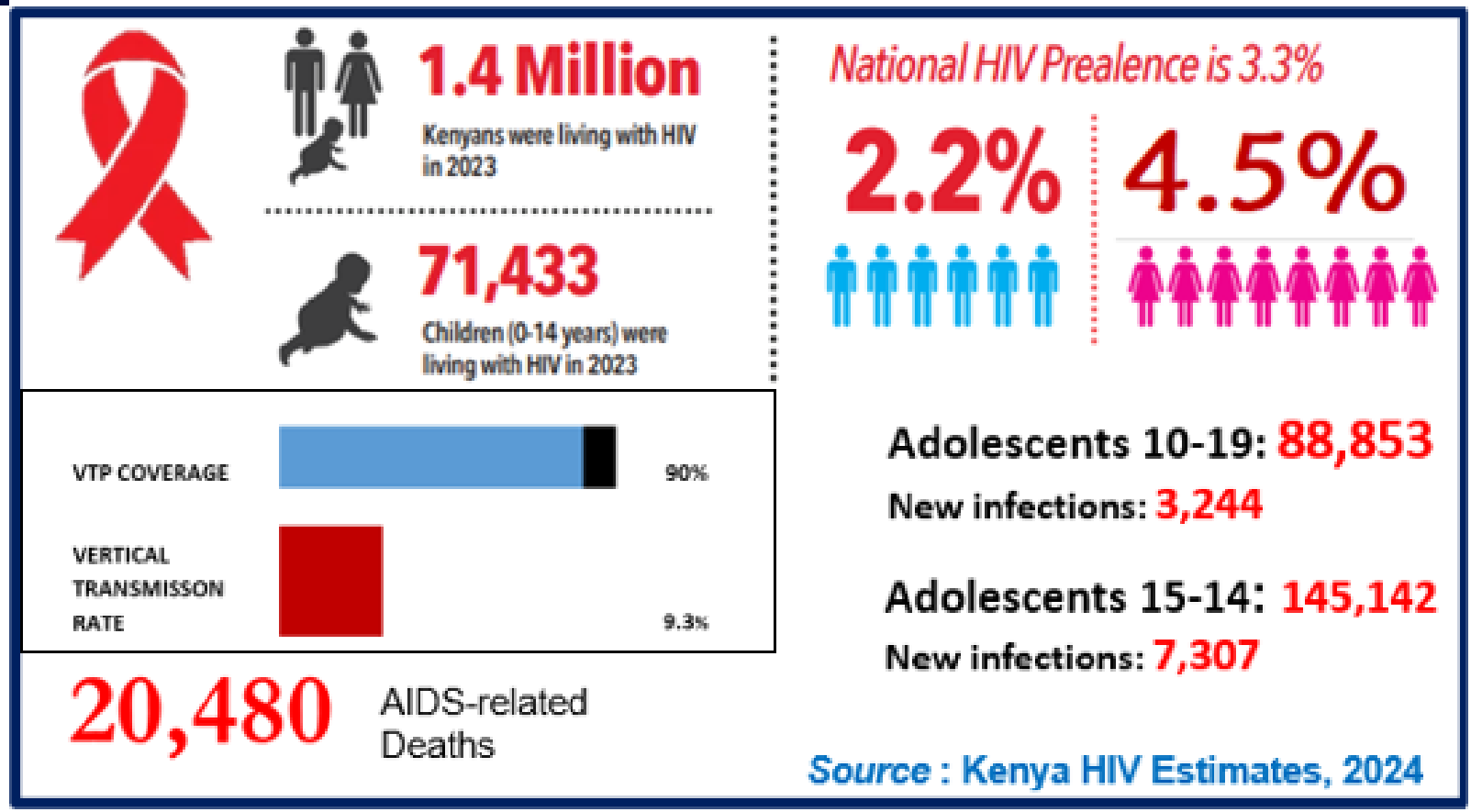
**Dr. Newton Omale**
NASCOP, Ministry of Health
Kenya

# Outline

# Kenya's HIV Epidemiological Context

## Kenya has the 7th Largest Treatment Program in the World

| No. | Country | No. of PLHIV |
|---|---|---|
| 1. | South Africa | 7.8M |
| 2. | India | 2.3M |
| 3. | Mozambique | 2.1M |
| 4. | Tanzania | 1.7M |
| 5. | Nigeria | 1.7M |
| 6. | Zambia | 1.5M |
| 7. | Kenya | 1.4M |
| 8 | Uganda | 1.4M |



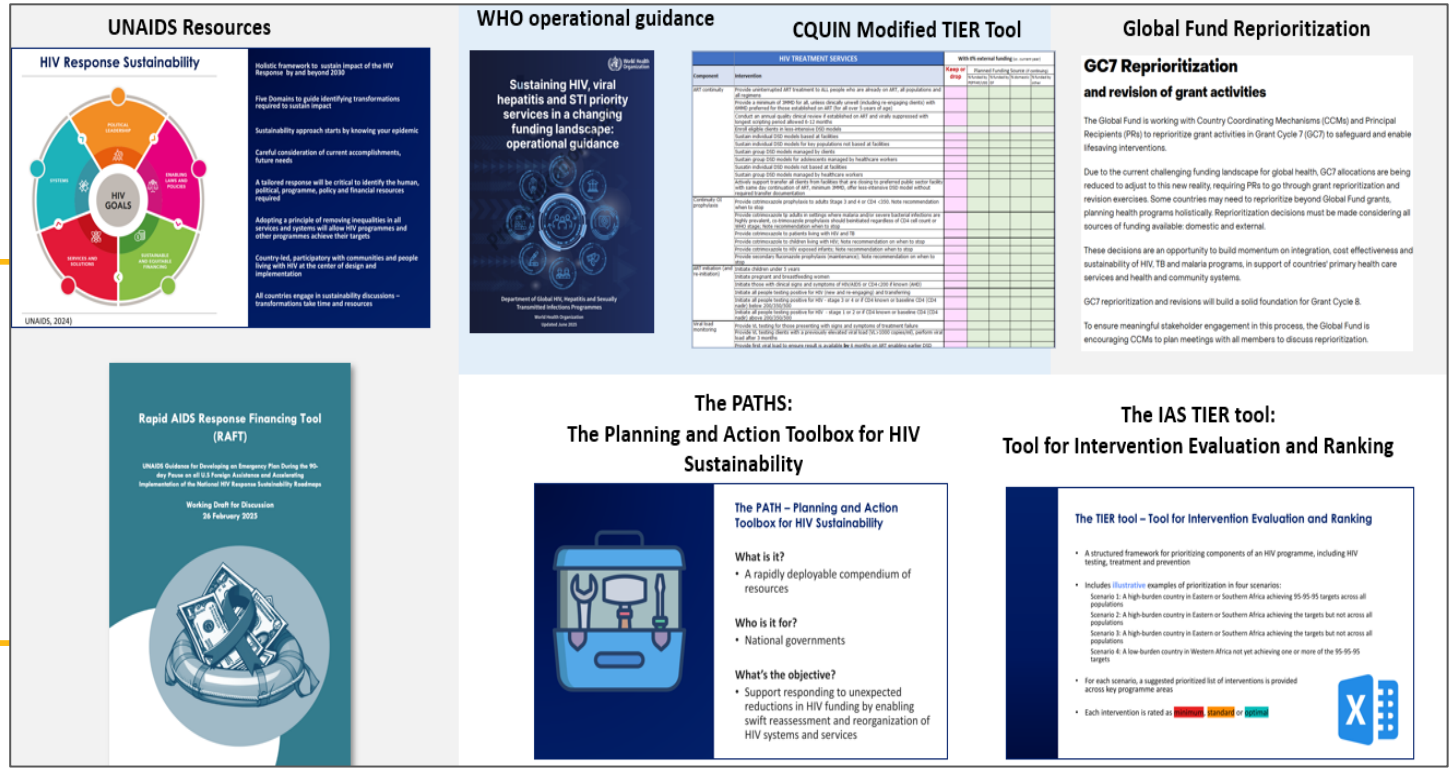

*Kenya is committed to achieving the 95-95-95 UNAIDS targets by 2030 and ending AIDS in children by 2027, as part of its effort to achieve HIV epidemic control*

# Why Prioritization?

Global Fund and PEPFAR/GHSD resource shifts

Need to protect life-saving services

**Objective:** Define Minimum Package of Services (MPS)



# Prioritization Process

**Tool:** CQUIN TIER (Treatment, Testing, Prevention)

**Scenario modeled:** 50% funding cut

**Stakeholders:** MoH, NASCOP, NSDCC, Donors, IPs, CSOs, Communities

**Output**: Prioritized Roadmap

| | HIV TREATMENT SERVICES | With 50% external funding (vs. current year) | | | | |
|---|---|---|---|---|---|---|
| Component | Intervention | Keep or drop | Planned Funding Source (if contin | | | |
| | | | % funded by PEPFAR/USG | % funded by GF | % domestic | % oth |
| | Provide uninterrupted ART treatment to ALL people who are already on ART, all populations and all regimens | Keep (no change) | 40% | 40% | 20% | |
| | Provide a minimum of 3MMD for all, unless clinically unwell (including re-engaging clients) with 6MMD preferred for those established on ART (for all over 5-years of age) | Keep (no change) | | | | |
| | Conduct an annual quality clinical review if established on ART and virally suppressed with longest scripting period allowed 6-12 months | Not applicable | | | | |
| | Enroll eligible clients in less-intensive DSD models | Keep (but modify, provide details | | | 100% | |
| | Sustain individual DSD models based at facilities | Keep (no change) | | | 100% | |
| | Sustain individual DSD models for key populations not based at facilities | Drop | | | | |

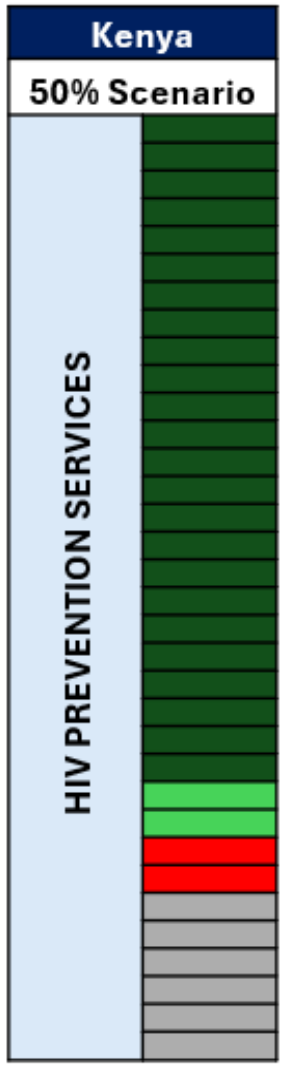
OVERVIEW - Read this | TESTING | TREATMENT | PREVENTION

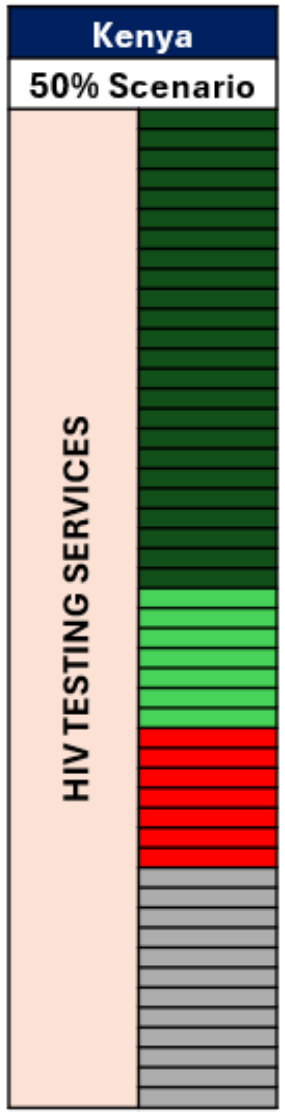
CQUIN prioritization worksheet for HIV reporting indicators

| | |
|---|---|
| Country | Kenya |
| Date | 24.July.2025 |

| Program area | CQUIN priority (1=high; 2=lower) | Indicators, by sex and age group and pregnant/breastfeeding status (where applicable): | With 50% external funding (vs. current year) Keep or drop | Notes |
|---|---|---|---|---|
| VTP | 1 | No. **pregnant women attending first ANC visit** during the month | change) | |
| | 1 | No. **pregnant women** attending first ANC visit **tested for HIV** during the month | change) | |
| | 1 | No. **pregnant women** attending first ANC visit **tested HIV positive** during the month | change) | |
| | 1 | No. **pregnant women** attending first ANC visit during the month already **known to be HIV-positive** | change) | |
| | 1 | No. **HIV-exposed infants** receiving a first virological **HIV test within two months** of age | change) | |
| | 1 | **Final HIV status of infants** at 18 months or cessation of BF | change) | |
| | 2 | No. **HIV-exposed infants who were started on ARV prophylaxis at birth** | change) | |
| | | *[Add any additional indicators for prioritization]* | | |
| HTS | 1 | No. people **tested for HIV** and received the result during the month | change) | |
| | 1 | No. people **tested HIV positive** and received the result during the month | change) | |
| | 2 | No. people **tested for HIV** and received the result during the month, **disaggregated by modality** | Drop | |
| | 2 | No. people tested **HIV positive** and received the result during the month, **disaggregated by** | Drop | |
| | | *[Add any additional indicators for prioritization]* | | |
| ART | 1 | No. people who **initiated ART** during the month | change) | |
| | 2 | No. people who **initiated ART** during the month, **disaggregated by CD4 +/- 200 cells/µL** | change) | Reported through EMR |
| | 1 | No. people **currently on ART** (Active on ART) by the end of the month *disaggregated by **MMD** (<3, 3-5, 6+mo) | Keep (no change) | Reported through EMR |
| | 1 | No. people on ART who experienced **interruption in treatment** this month | change) | Reported through EMR |
| | 1 | No. people on ART who died this month | Not applicable | |
| | | *[Add any additional indicators for prioritization]* | | |
| VL | 1 | No. **VL results received** during the month | Not applicable | |
| | | No. of PLHIV eligible and had a VL during the month (added) | change) | NDWH |
| | 1 | No. **VL results <1000 copies/ml** received during the month | change) | EID/VL and NDWH |

# HIV Service Prioritization





**Key**

| | |
|---|---|
| | Keep (No Change) |
| | Keep (But Modify) |
| | Not applicable |
| | Drop |
| | Missing Data |

**Deprioritized Prevention services in a 50% external funding scenario:**

1. Individual out-of-facility PrEP maintenance (through existing and maintained out-of-facility DSD treatment locations), including refill collection and HIVST
2. Provide PrEP refills through virtual delivery models

**Deprioritized Testing services in a 50% external funding scenario:**

1. Self-initiated VCT/HIVST collection available (limit to annual/specific risk exposure)
2. Newly diagnosed client: Sexual partner testing utilizing provider-assisted notification for facility-based testing (consider centralized/virtual notification and HIVST collection at ART DSD points)
3. Newly diagnosed female client: Biological children, facility-based testing, or HIVST by caregiver
4. Key populations: Community-based HIVST collection points after self-managed HTS virtual registration (limited to annual)
5. Key populations: High-volume outreach points and drop-in centres run by community-based organizations
6. Men: Targeted outreach HTS (congregant settings - transport hubs, bars)
7. ABYM: Targeted outreach HTS (educational facilities, youth centres)

**Deprioritized Treatment services in a 50% external funding scenario:**

1. Sustain individual DSD models for key populations not based at facilities

# HIV M&E indicators Prioritization

| # | Program Area | Indicator | KEN 50% |
|---|---|---|---|
| 1 | VTP | Ist ANC attendance | |
| 2 | | Ist ANC testing | |
| 3 | | 1st ANC HIV+ | |
| 4 | | 1st ANC Known HIV+ | |
| 5 | | HEI 1st EID | |
| 6 | | HEI final outcome | |
| 7 | | HEI ARV prophylaxis | |
| 8 | HTS | HTS_TST | |
| 9 | | HTS_POS | |
| 10 | | HTS_TST by modality | |
| 11 | | HTS_POS by modality | |
| 12 | ART | TX_NEW | |
| 13 | | TX_NEW by CD4 count | |
| 14 | | TX_CURR by MMD | |
| 15 | | Interuption in Treatment [IIT] | |
| 16 | | AIDS-related mortality | |
| 17 | VL | VL results received | |
| 18 | | VL results <1,000 C/ml | |
| 19 | TB | TB diagnosis | |
| 20 | | Initiated on TPT | |
| 21 | | Completed TPT | |
| 22 | HIV Prevention | PrEP_NEW | |
| 23 | | Received PrEP | |
| 24 | | Received PEP | |
| 25 | | Received condoms | |

Key

| | |
|---|---|
| | Keep (No Change) |
| | Keep (But Modify) |
| | Not applicable |
| | Drop |
| | Missing Data |

## M&E Indicator Prioritization at 50% External Funding Scenario

### Deprioritized M&E in a 50% external funding scenario:

1) No. people on ART who died this month
2) No. VL results received during the month
3) No. people received condoms this month (disaggregated by HIV status)

### Dropped M&E in a 50% external funding scenario:

1) No. people tested for HIV and received the result during the month, disaggregated by modality
2) No. people tested HIV positive and received the result during the month, disaggregated by modality
3) No. of people newly enrolled on ART who initiated TPT during the previous reporting period and completed TPT

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# Key Prioritization Outcomes

Treatment: sustain facility DSD models and modify KP & Community DSD models , scale up CPM model

Testing: targeted outreach + HIVST at select sites

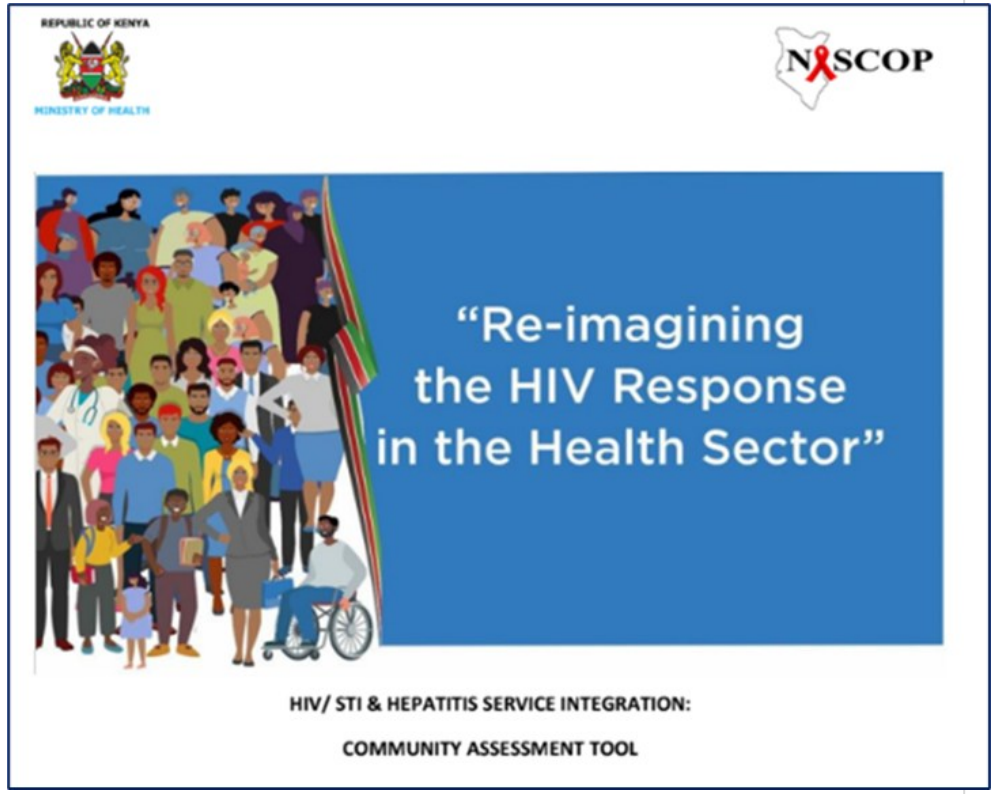
Prevention: limited PrEP refills, DREAMS paused & VMMC available but at a fee, new PrEP Operational Plan

M&E: retained ART/VL indicators; some HTS/TPT indicators deprioritized

# Next Steps in Prioritization

- Update MPS with confirmed GF & PEPFAR/GHSD resources
- Incorporate community & county input
- Anchor within Social Health Insurance Fund/UHC for sustainability

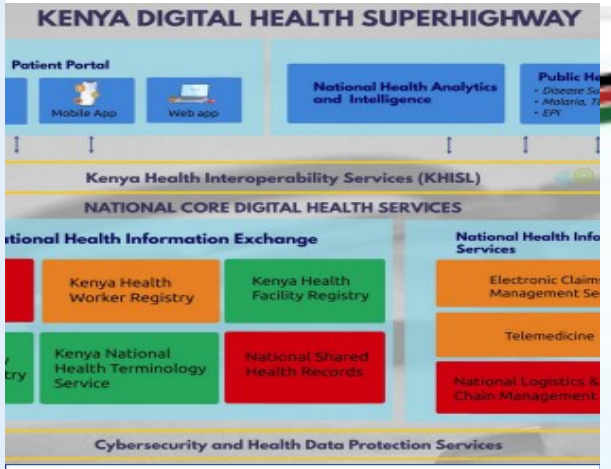
# Integration Milestones and Approach




- Kenya held the first **HIV Integration Summit** in June 2024.
- **Baseline Integration Assessment** & TA completed in 25 counties.
- **Objective:** Ensure continuity of care, optimize available resources and deliver sustainable, dignified, and people-centered services.
- **Approach:** Tailored approach rather than a one-size-fits-all model
- **Consensus**: Integrate HIV, STI, and Hepatitis services into the broader health system-Guidelines under development

# Integration Assessment Findings

- **Community:** Stigma/privacy concerns, SHA enrollment sensitization
- **HRH:** 35k PEPFAR staff; county absorption ongoing
- **Laboratory:** Multi-disease testing using GeneXpert/PCR
- **Data Systems:** Move toward digital health superhighway
- **HPT:** Health products and technologies





# HIV Financing: Integration of HIV Services into PHC

- Leveraging on the Country UHC agenda, including the packaging of HIV services with SHA
- Support enrollment of RoCs into SHA to enhance access to services
- Strengthen PHC Networks to bridge the community-facility interface enhancing access to healthcare

SHA | Social Health Authority

MINISTRY OF HEALTH
REPUBLIC OF KENYA

**Brief**

March, 2025

**ARVs Ziko, Usikose Zako**

The Ministry of Health, through the National AIDS & STI Control Program, would like to assure all recipients of care that we have sufficient stocks of ARVs both for prevention and treatment at the ART sites. ARVs should therefore be taken daily without skipping doses or sharing.

Recipients of care are also advised not to refill ARVs before their due dates for fear of running out.

In case of any further clarification and clinical support, please contact 0726460000.

#ARVsZiko

NASCOP


# Integration Next Steps

- Test and adopt integration models – CCC, OPD, NCD
- Cost the MPS for HIV
- Expand molecular diagnostics & point-of-care testing
- Institutionalize HIV financing into SHA/UHC
- Build HRH capacity: mentorship, ECHO, MoH Academy
- Scale community pharmacy model & engagement
- HIVST and PrEP


# Closing

- **Prioritization = continuity amid constrained resources (with continued community engagement)**
- **Integration = sustainability, efficiency, dignity**
- **Kenya is on track for epidemic control with smart choices**

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# Q&A/Discussion

## Moderators

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*Next CQUIN webinar in October 2025*

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