Utilization of Viral Load data in Kenya

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Lead Surveillance – Strategic Information

NASCOP

HIV LEARNING NETWORK
The CQUIN Project for Differentiated Service Delivery

The Science & Practice of SCALE-UP

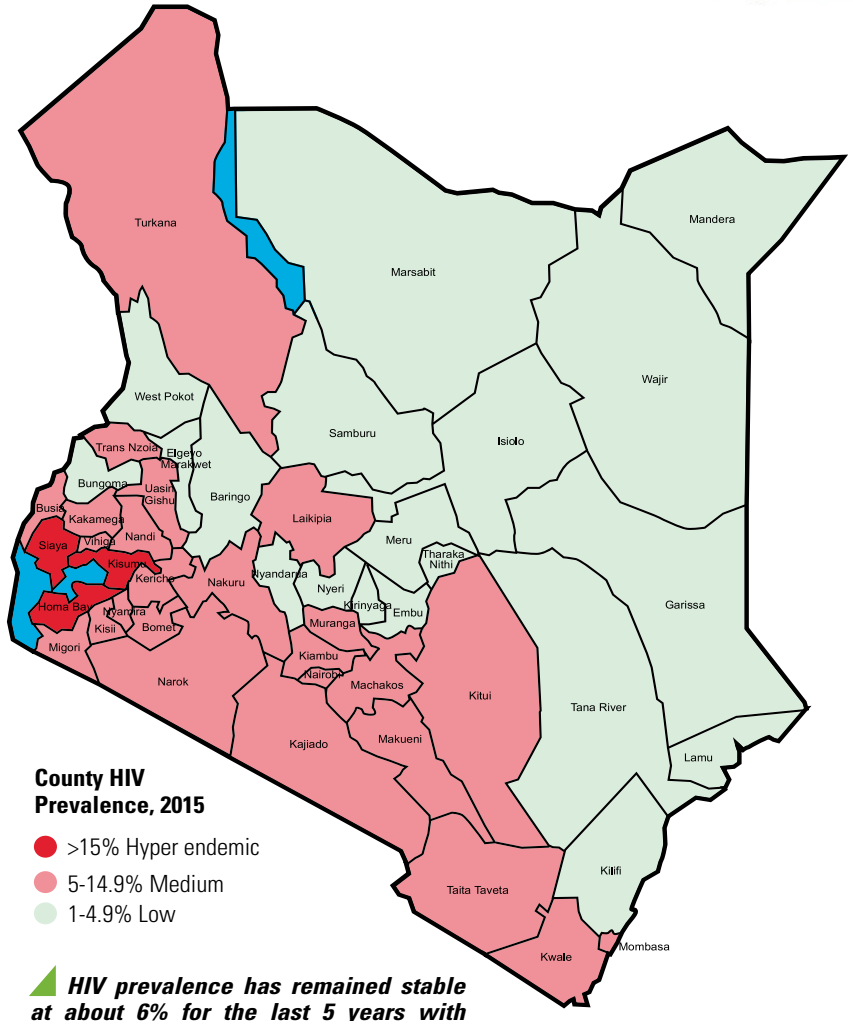
Outline

- Background
- Kenya VL timeline story
- Rationale of the collaborative
- Description of the QI Collaborative
- Findings
- Conclusion

HIV/AIDS Situation in Kenya, 2015

	Children (0-14 years)	15+ years	15+ years	
NUMBER OF PEOPLE LIVING WITH HIV	98,170	775,939 6.3% prevalence	643,598 5.5% prevalence	**1,517,707** 5.9% prevalence
NUMBER OF NEW HIV INFECTIONS	6,613	39,868	31,167	**77,647**
TREATMENT COVERAGE	71,547 77%	826,097 66%		**897,644**
AIDS RELATED DEATHS	5,004 14%	10,681 30%	20,136 59%	**35,821**

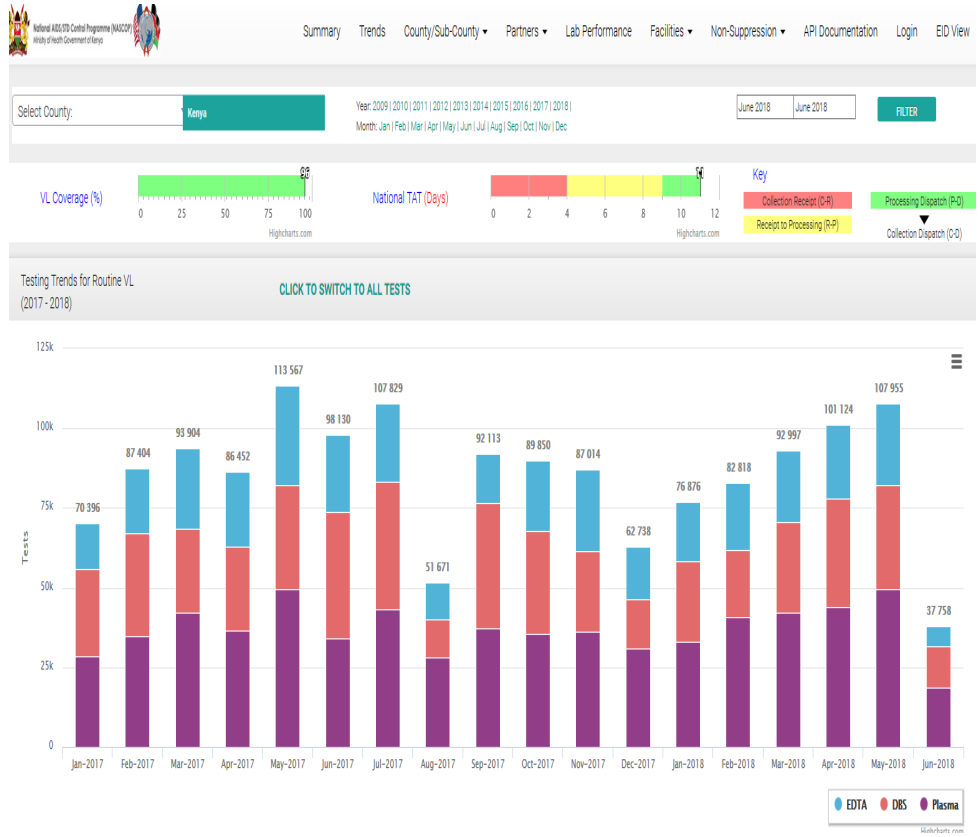
- National estimates released every 2 years;
- last estimates report covers 2015



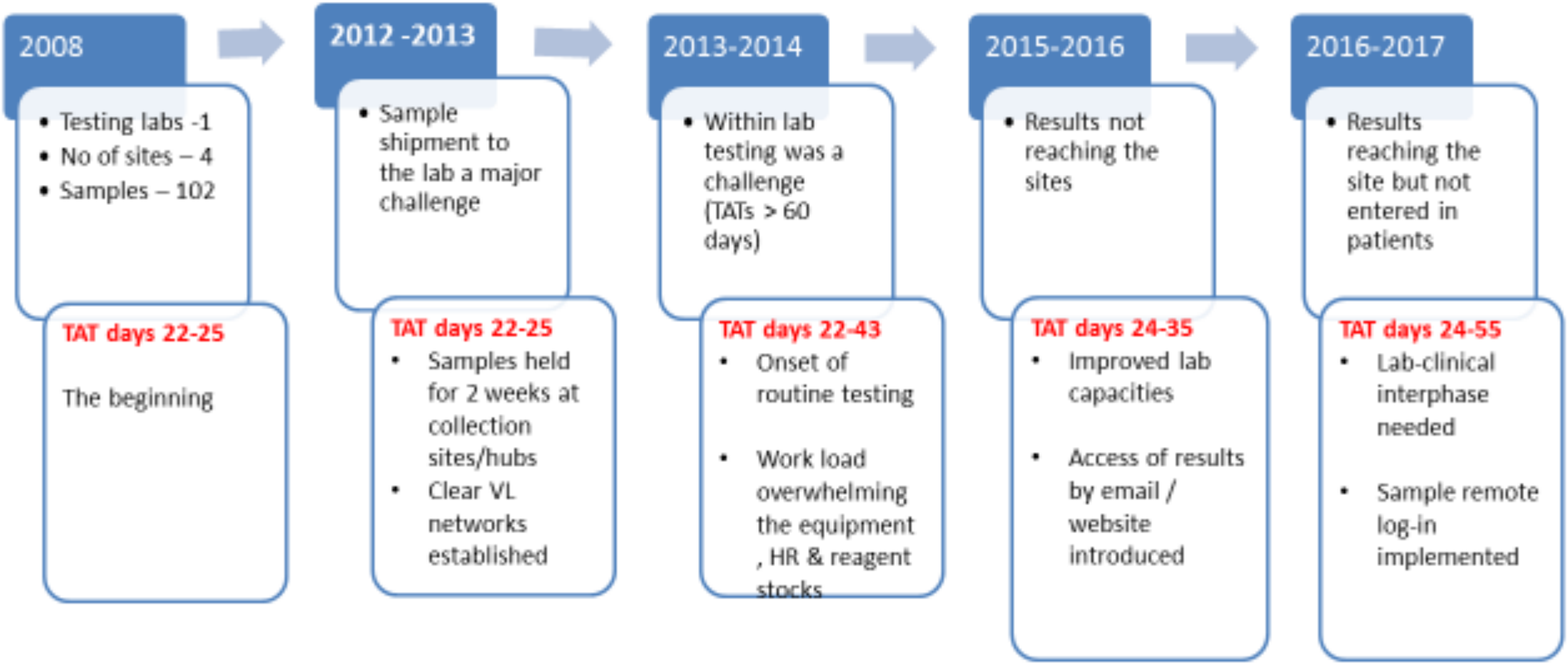
HIV prevalence has remained stable at about 6% for the last 5 years with

Background

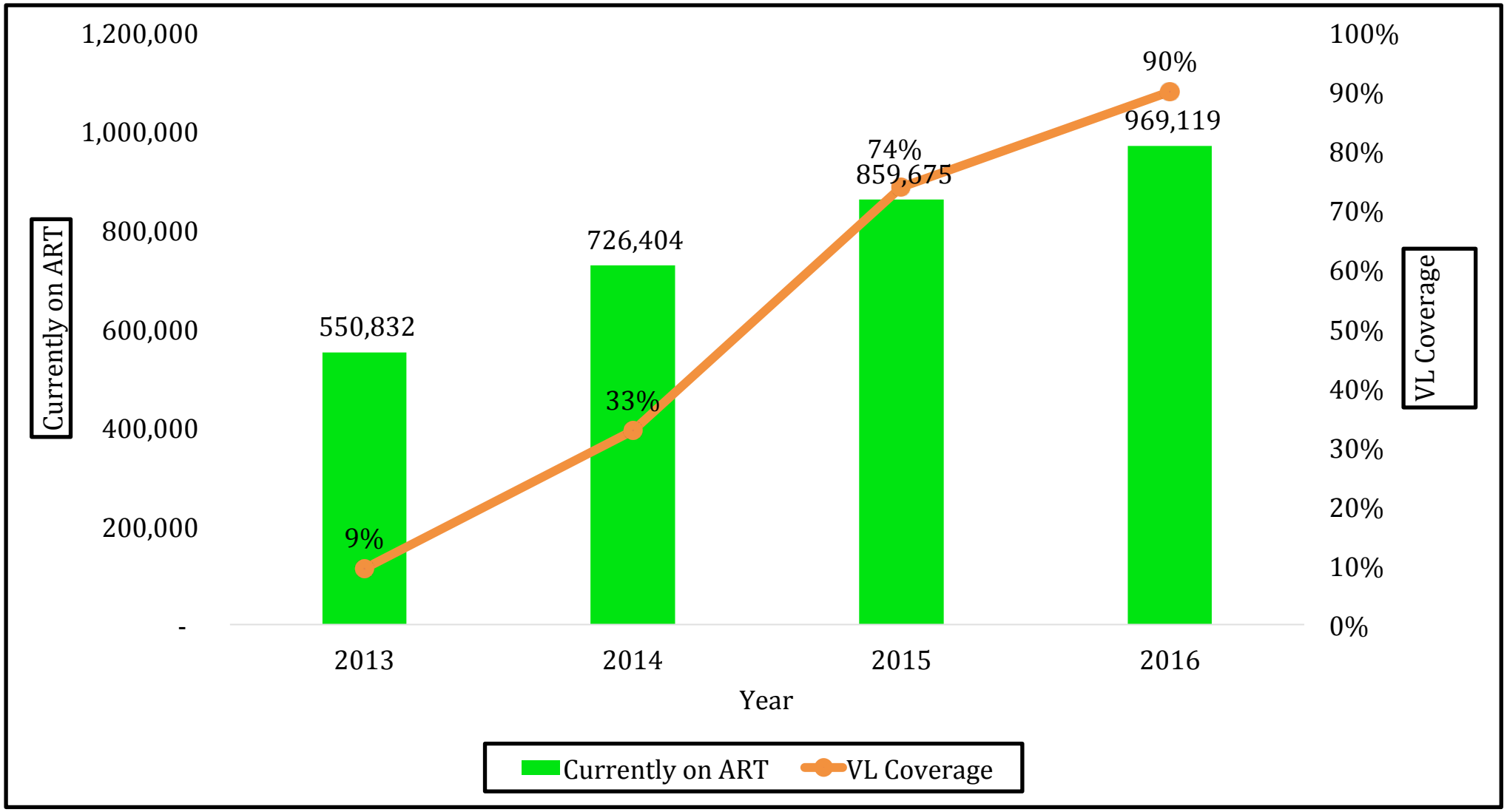
- Kenya Quality Improvement Framework – the national guide to ensure quality HIV services and hence patient outcomes
- The use of QI cycle to determine areas that require strengthening/ improvement and to monitor the same
- The national VL system – overhauled to improve its user friendliness by all stakeholders particularly the counties



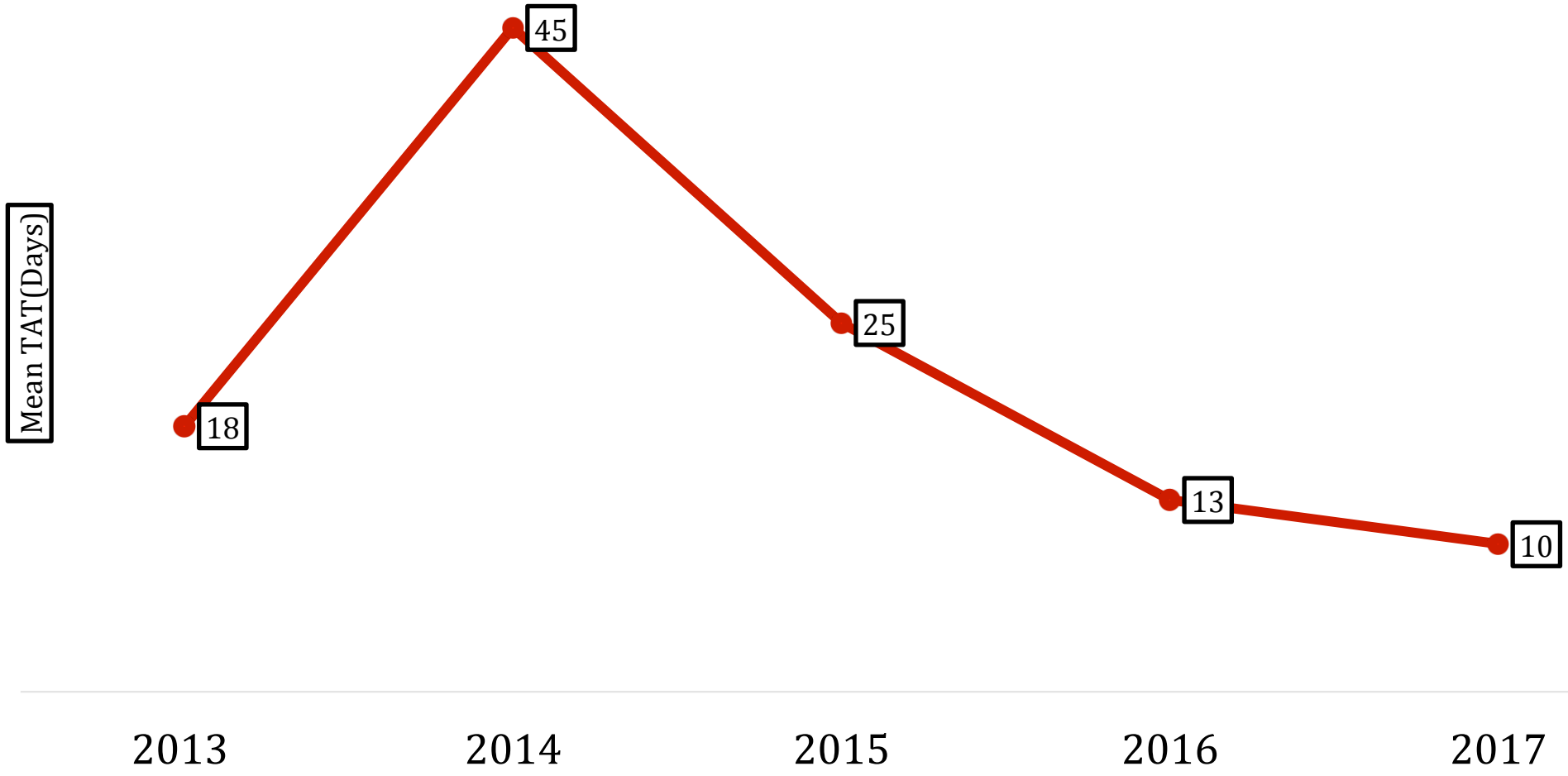
Kenya's Timeline: The VL story



National VL Coverage 2013 to 2017

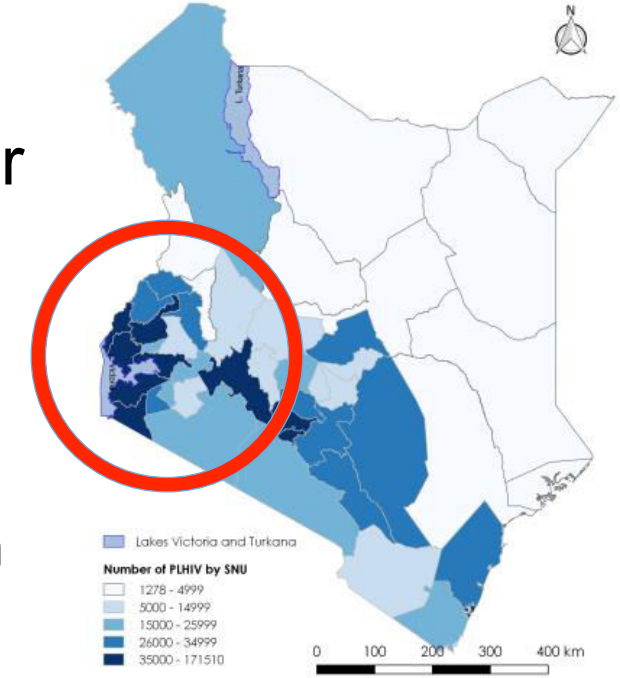


National Viral Load Turn Around Time - 2013 to 2017

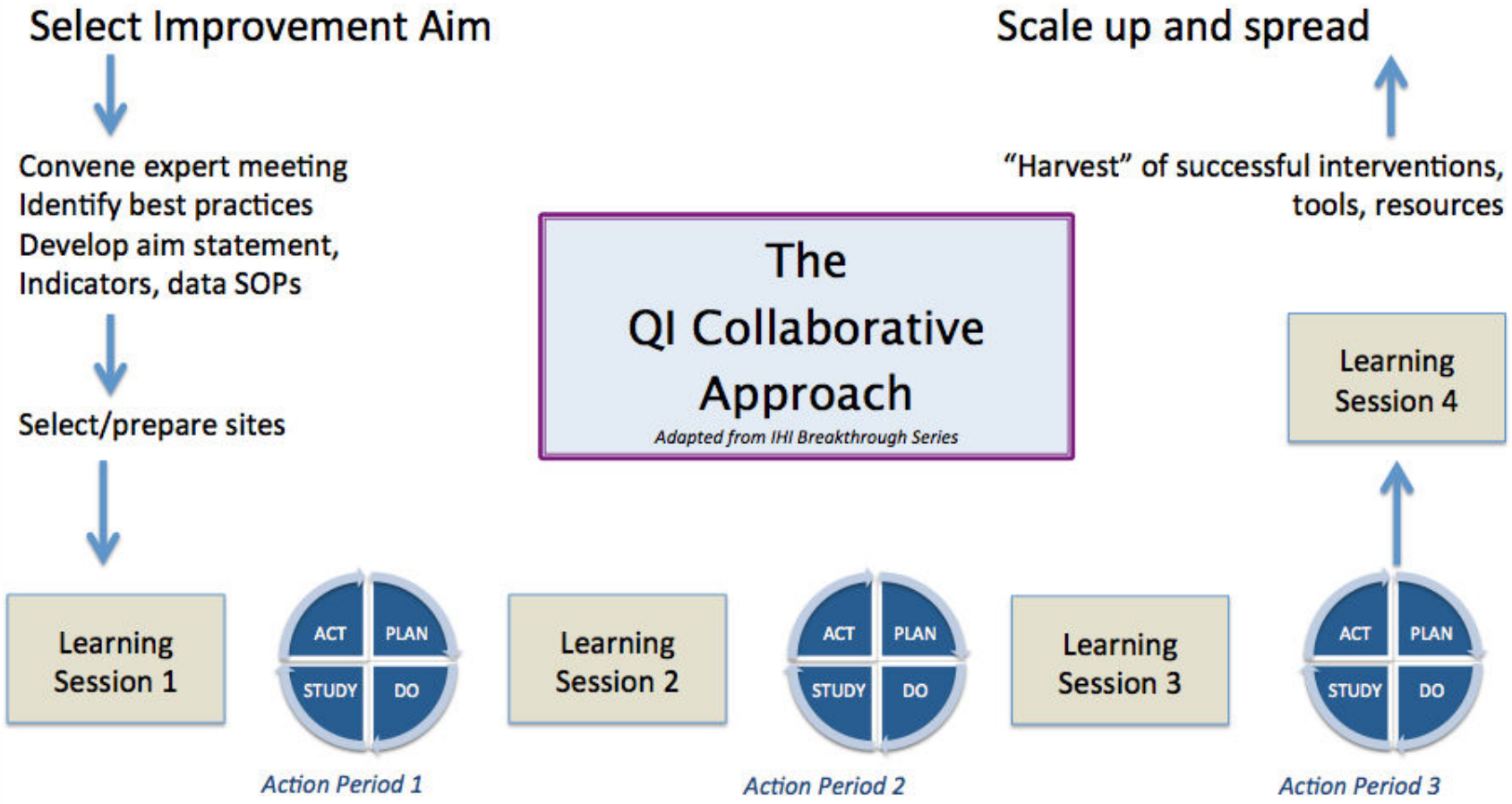


Rationale for the collaborative

- Routine VL testing has been scaled up nationwide
- MOH/NASCOP guidelines recommend the following for clients with unsuppressed VL (UVL):
  - 3 enhanced adherence counseling (EAC) sessions at one-month intervals
  - Repeat VL testing at 3 months
  - If repeat VL remains unsuppressed → change to new ART regimen
- A review at 30 health facilities in Siaya County in 2016-2017 suggested that these guidelines were rarely followed and that utilization of VL results was suboptimal



Using QI Methods to Improve VL Utilization



The QI Collaborative Approach

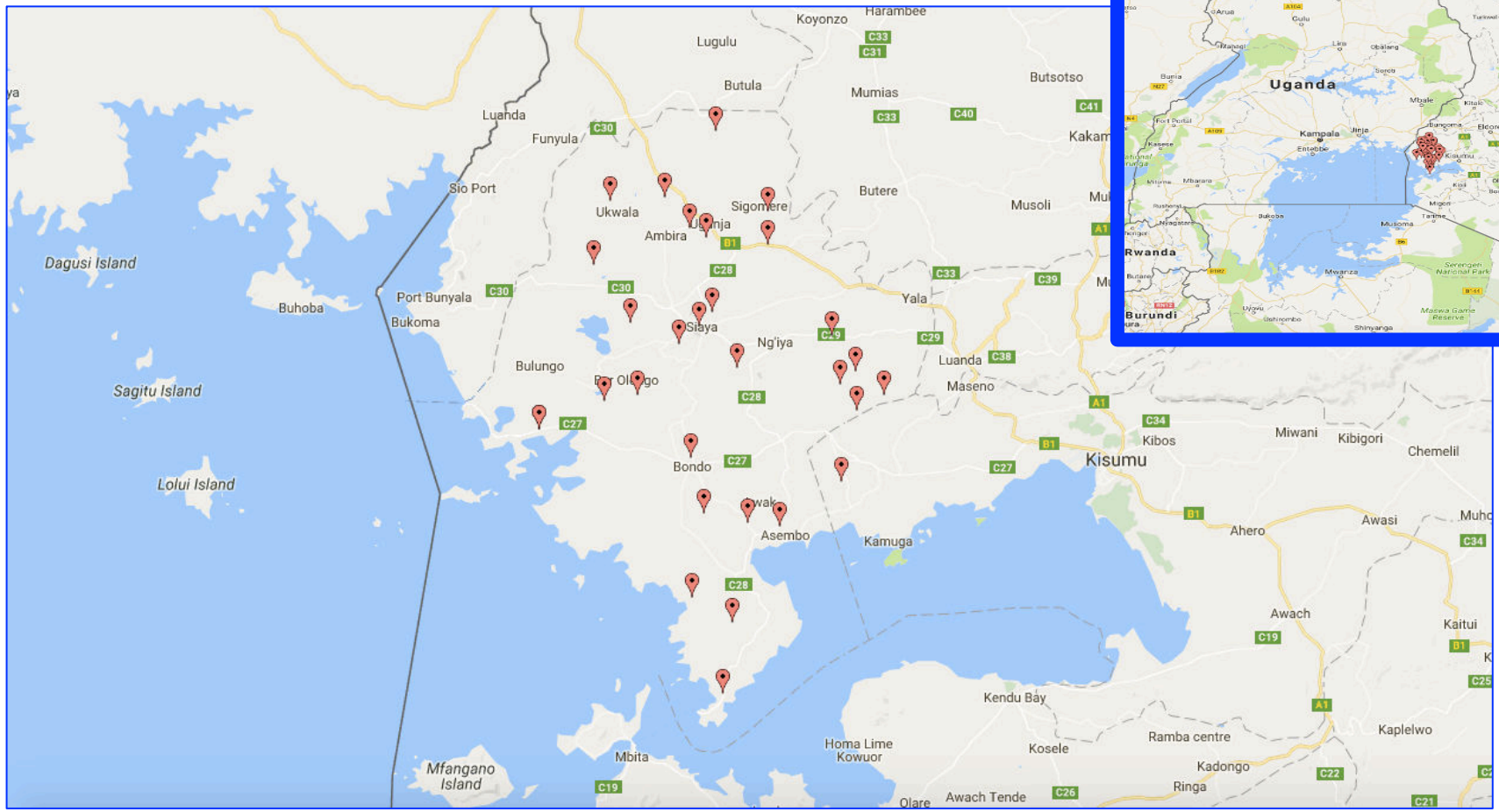
Adapted from IHI Breakthrough Series

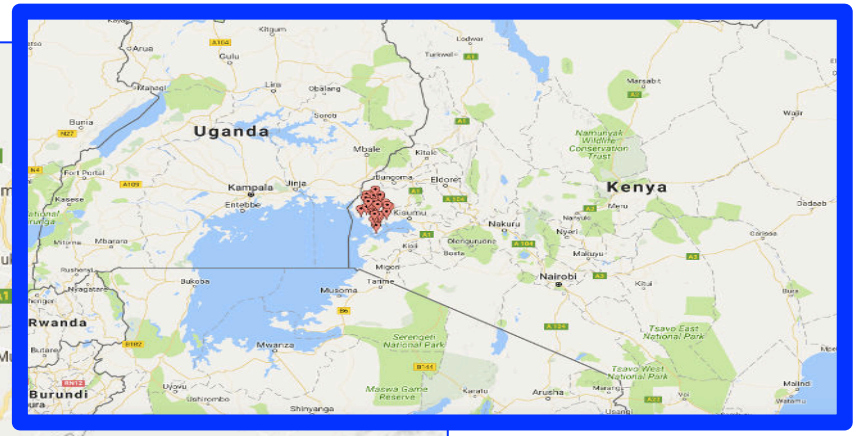
Empowering Health for 15 years

ICAP

Columbia University Mailman School of Public Health

30 High-Volume and High PEPFAR priority Health Facilities in Siaya County, Kenya





QI Collaborative Activities – 1

- **Intensive stakeholder engagement**
  - ICAP, CDC, HRSA, NASCOP, NHRL, Siaya County Health Management Team, site leadership and PEPFAR implementing partners, including CHS and KCCB/KARP
- **Baseline training and project design**
  - ICAP and MOH/NASCOP provided baseline training to QI teams at each site: nurses, physicians, lab technologist, peer educators and counselors
  - The QI teams conducted root cause analyses, identified and prioritized “change ideas” to improve VL utilization, and conducted rapid tests of change using PDSA cycles to identify contextually appropriate interventions

QI Collaborative Activities – 2

- **Monthly/Quarterly supportive supervision visits**
  - ICAP, County Health Management Team, Sub-County HMT and implementing partners supporting the sites make monthly visits to each site
- **Quarterly QIC learning sessions convening all 30 sites**
  - Diffusion of innovation, friendly competition
  - Careful documentation of interventions and outcomes

Common Challenges / Root Cause Analysis

- **Systems challenges**
  - Poor documentation and tracking of VL results
  - Delayed defaulter tracing
  - Poor patient flow within facilities
- **Staffing challenges**
  - Staffing shortages and remuneration challenges for case managers
  - Staff unfamiliar with management of patients with UVL
- **Patient level challenges**
  - Knowledge gap re: meaning / importance of VL suppression
  - Concerns / fears re: second line ART
  - Challenges with adherence and retention

Illustrative Change Ideas -1

Between April 2017 and March 2018, the teams conducted 376 PDSA cycles and tested 35 change ideas, including:

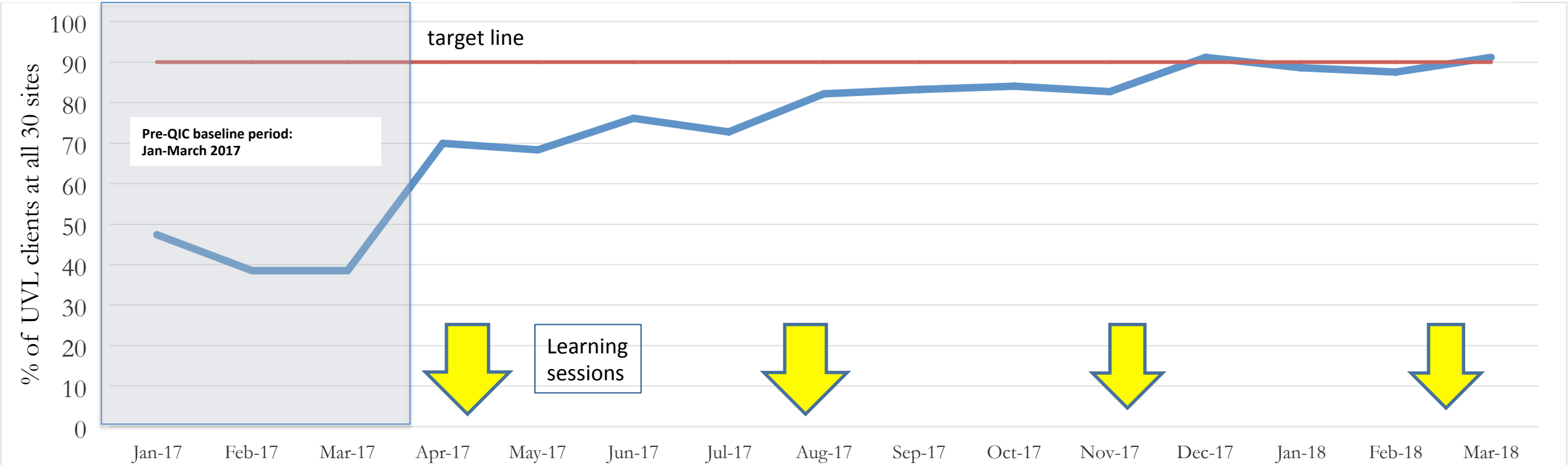
- Develop a “high VL” management SOP
- Color-code files for clients with unsuppressed VL (UVL)
- Appoint a VL focal person to monitor and follow up VL results daily
- Assign case managers to clients with UVL
- Update patient locator information at every visit
- Form UVL support groups for adults, adolescents and children

Illustrative Change Ideas -2

- Appoint 2nd line ART champion to improve client knowledge and dispel myths/misconceptions
- Use the UVL register weekly to identify and trace clients who miss EAC appointments
- Mentor all staff on EAC and management of clients with UVL
- Restructure patient flow to improve real-time documentation on the EAC/high VL register

Progress to Aim 1: Timely Completion of 3 EAC Sessions

Aim 1: Increase the % of clients with unsuppressed VL who complete 3 EAC within 4 months to 90%



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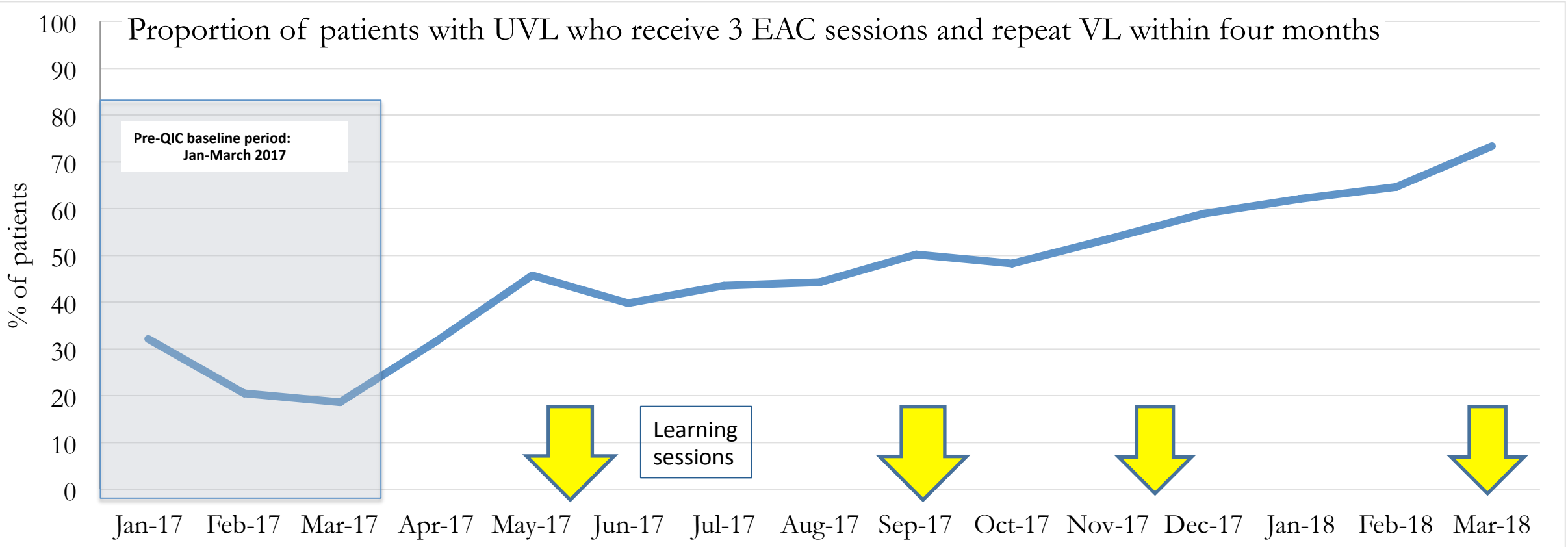
Timely Completion of EAC *and* Repeat VL testing



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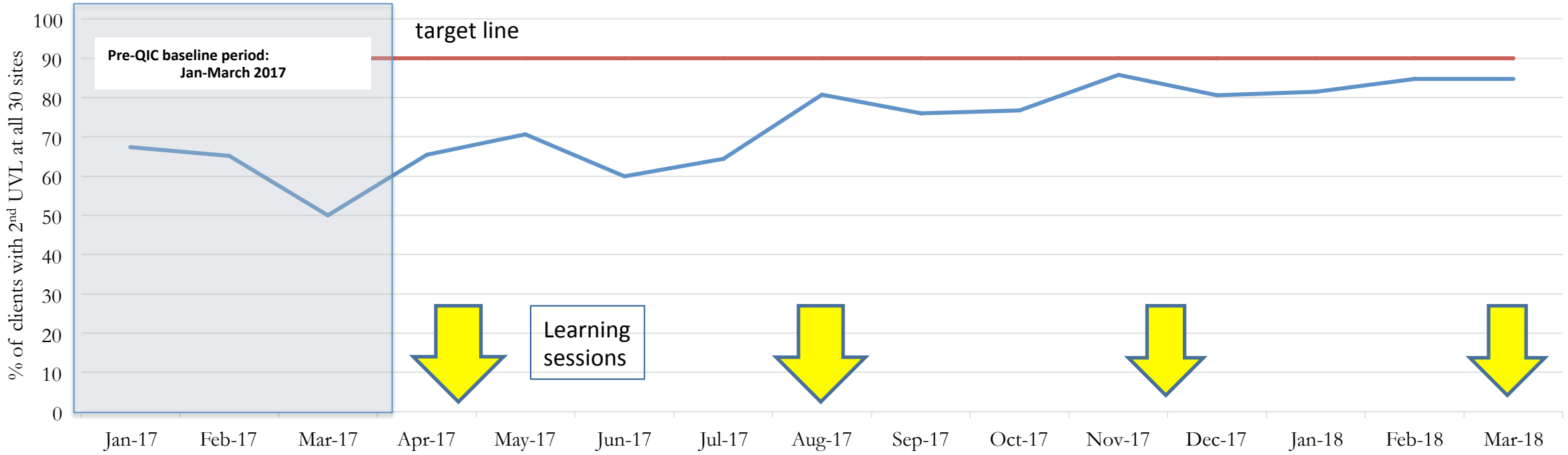
Progress to Aim 2: Timely Switch to Second Line Therapy

Aim 2: Increase the proportion of clients with persistently unsuppressed VL who are switched to 2nd line ART within 4 months to 90%



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Conclusion

- The QIC is still ongoing, but results to date suggest that the use of QI methodology enabled individual health facility teams to identify contextually appropriate interventions
- This has led to improved client case management and has the potential to contribute to achievement of the “third 90” in Siaya county
- Formal dissemination of the QIC and a scale-up plan will be developed

Other considerations

- Patients must achieve viral suppression to be put on the fast track model
- The 6 month TCA harmonized with routine VL schedule
- The regional TWGs supporting clinicians to manage patients
- Call centre (Uliza) provide additional support and follow up for patients with unsuppressed VLs

Acknowledgements