Background

- Youth represent 40% of new HIV infections worldwide.
- Adolescent tailored services are desirable to reach this population.
- In 2015 Kenya’s National AIDS and STD Control Program (INASCOPI) introduced an adolescent package of care (APOC) guidelines, including a checklist to act as a guide to providers.
- This evaluation assessed the impact of APOC on visit adherence, family planning (FP) uptake, and viral load (VL) suppression.
- Females comprised 60% of adolescents.
- VL suppression increased over time, as did APOC checklist utilization.
- Increased APOC checklist utilization was not associated with increased utilization of the APOC checklist.

Methods

- Health care providers were trained on APOC from November 2015-December 2016.
- Random sample of adolescent (9-19 years) encounters (30-40/site/quarter) obtained from electronic medical records following APOC training to audit charts.
- Chart audits were conducted to assess:
  - Availability of adolescent checklist in files
  - Use of the checklist for the selected patient visit
  - Completion of all selected 15 checklist assessments like support groups, Tanner’s staging, reproductive health, drug abuse
  - Utilization score (0-10 scale) was generated from checklist chart audits

Results

- A total of 2,055 clinical encounters for 957 HIV-infected adolescents were analyzed for checklist implementation.
- 2,739 HIV-infected adolescents and 1,372 VL tests for 1,305 adolescents were analyzed for checklist implementation.
- Youth represent 40% of new HIV infections worldwide.
- Gender Male
- Checklist usage
- Quarter (1 – 4) 1.54 (1.09, 2.20), 0.01 0.96 (0.79, 1.17), 0.50 0.87 (0.80, 0.95), <0.01 1.05 (0.99 1.10), 0.12
- Female
- Quarter (1 – 4) 1.46 (1.21, 1.76), <0.01 0.84 (0.77, 0.96), <0.01 1.18 (1.01, 1.38), 0.03 1.50 (1.3, 1.8), <0.01

Conclusions

- Observed increased VL suppression and FP uptake during scale-up of the APOC.
- Factors not ascertained by APOC checklist determine clinical outcomes.
- Possibly he checklist doesn’t represent what the providers/clinics actually do.
- Require better methods for tracking how adolescent services are provided, e.g. post-visit surveys.
- Further investigation for additional APOC elements is needed to assess full implementation and impact of APOC on adolescent treatment outcomes.

Table 1. Implementation of Adolescent Checklist

<table>
<thead>
<tr>
<th>Measure</th>
<th>Q1 (Nov-Dec 2015) n (%)</th>
<th>Q2 (Jan-Mar 2016) n (%)</th>
<th>Q3 (Apr-Jun 2016) n (%)</th>
<th>Q4 (Jul-Sep 2016) n (%)</th>
<th>Test for trend p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checklist available in patient files</td>
<td>156/172 (94.4%)</td>
<td>212/224 (94.6%)</td>
<td>213/238 (90.1%)</td>
<td>232/272 (85.3%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Checklist used in visit</td>
<td>154/175 (88.4%)</td>
<td>209/239 (86.7%)</td>
<td>207/249 (82.2%)</td>
<td>204/296 (72.0%)</td>
<td>0.001</td>
</tr>
<tr>
<td>Checklist completion</td>
<td>105/154 (68.0%)</td>
<td>213/282 (75.6%)</td>
<td>220/292 (81.2%)</td>
<td>240/307 (78.2%)</td>
<td>0.017</td>
</tr>
</tbody>
</table>

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The findings and conclusions in this poster are those of the authors and do not necessarily represent the official position of the Children’s Investment Fund Foundation or Government of Kenya.

Other info

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