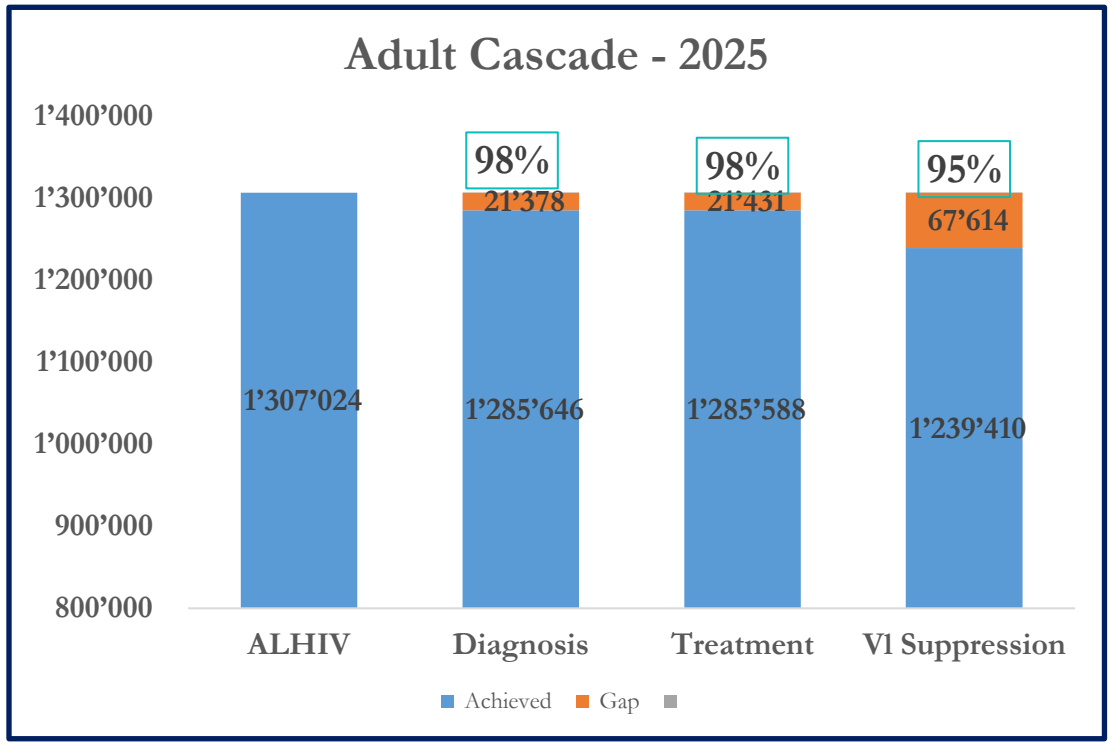
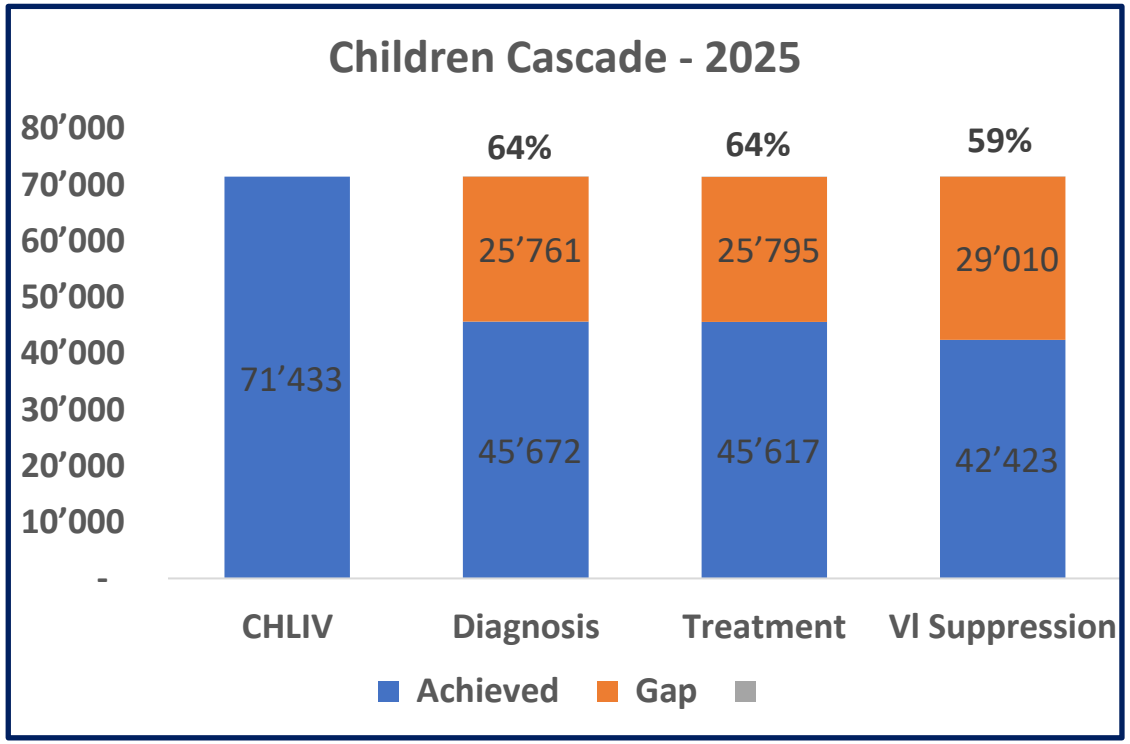
The impact of early viral load

Experience from Kenya

Lazarus Momanyi, NASCOP, Kenya
The future of differentiated HIV services: Prioritize for impact
ICASA 2025

Kenya 95-95-95

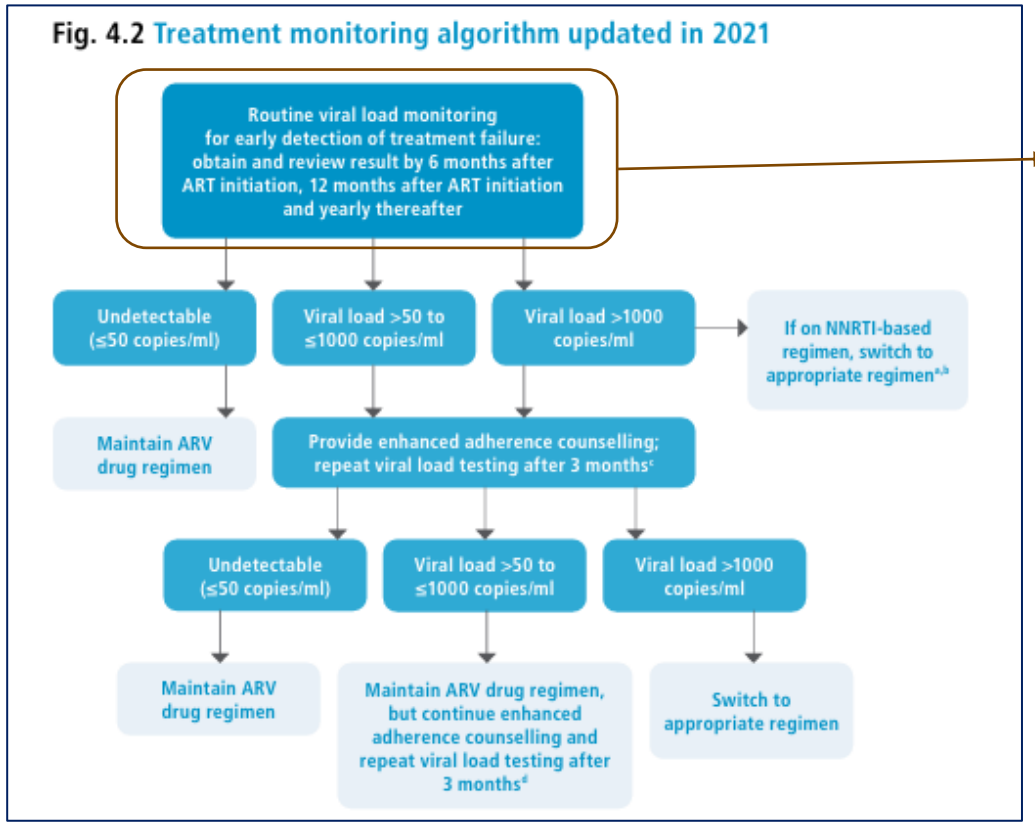




Evolution of Kenya VL Testing

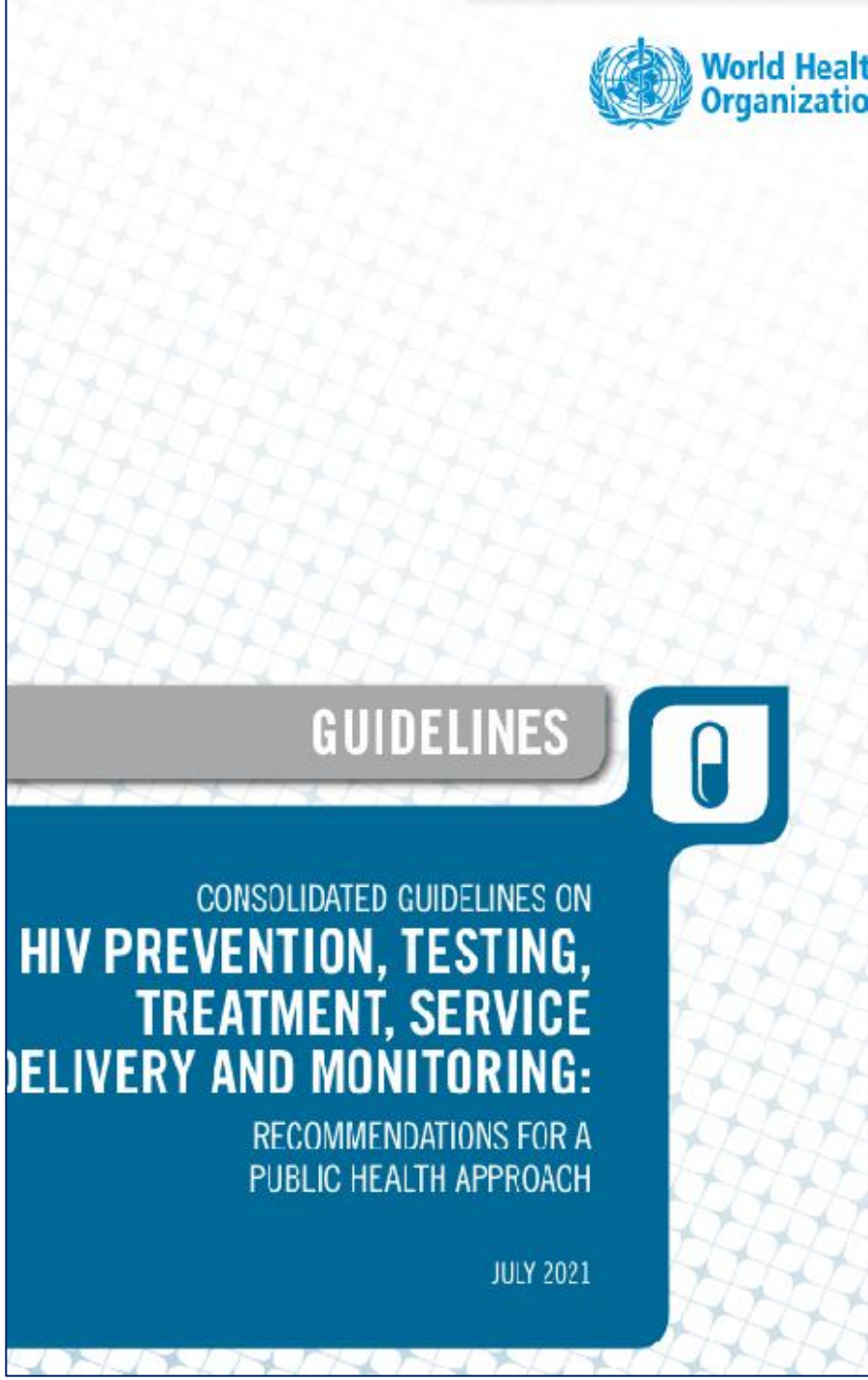
2006-13; Early Foundation	2014-15; Shift to Routine Monitoring	2015-17 Expansion Phase	2018-20;Age Differentiated Monitoring	2020-21 COVID-19 Resilience	2021-Present
• VL introduced; targeted testing • Limited access	• Routine VL adopted • Expansion of national VL Lab capacity	• Sample referral network launch • .500K VL tests by 2027	• New schedule for 0-24, 25+ yrs • Adult suppression >90%	• Reagent redistribution • Prioritization • MMD integration	• Optimization & integration • Dashboard use • Harmonization • Early VL

WHO guidance on viral load



- Routine viral load monitoring can be carried out by **6 months, at 12 months and then every 12** months thereafter if the person is established on ART

*Early VL (≤3 mo.); may be beneficial for rapid identification of poor adherence and/or potential pretreatment drug resistance; risk of unnecessary early switch to 2nd line ART



Kenya guidelines for viral load monitoring

Age/Population	1st VL	Follow Up
0-24 years	After 3 Mo of ART	6 Monthly
25+ Years	After 3 Mo of ART	at 12 Months, then Annually
Pg & BF (New on ART)	After 3 Mo of ART	6 Monthly until cessation of BF
Pg & BF (Already on ART)	At Pg Dx/then at 3 months	6 Monthly until cessation of BF

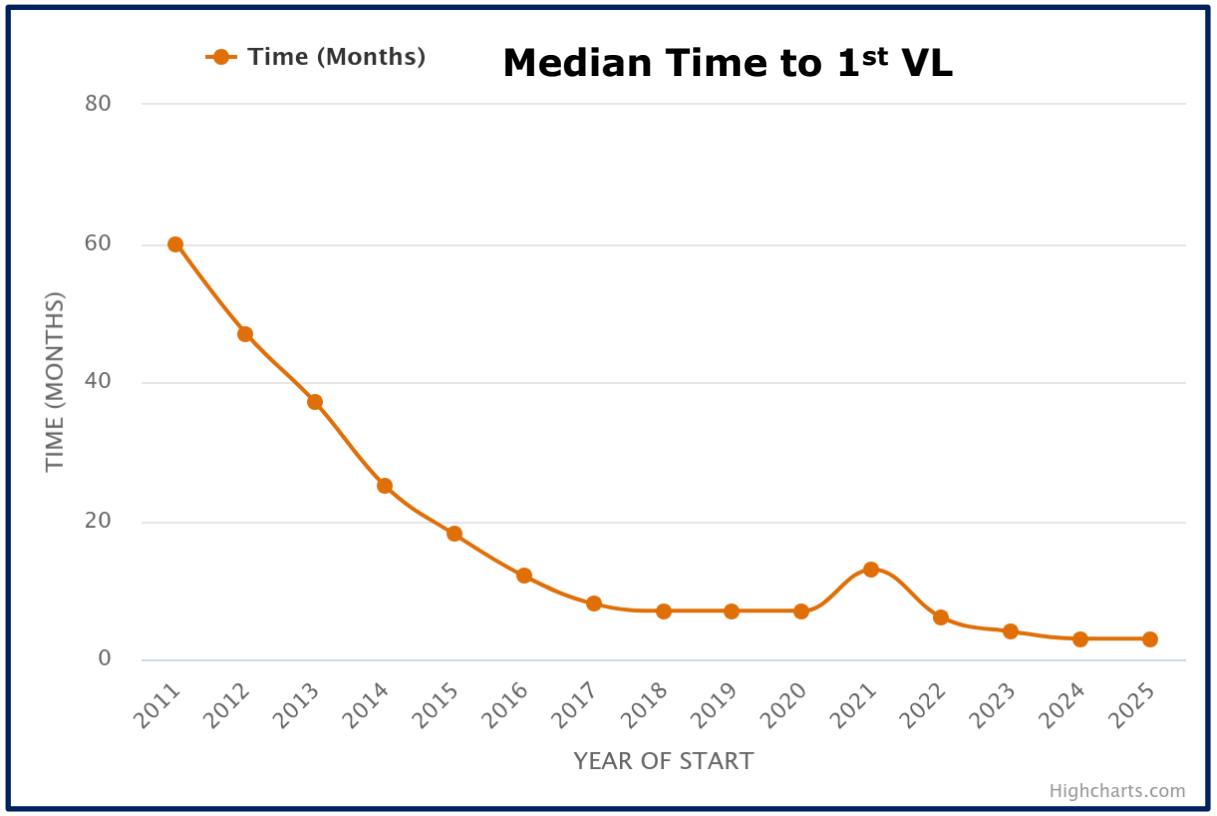
- ROC with unsuppressed VL: Enhanced Adherence Counselling and managed appropriately

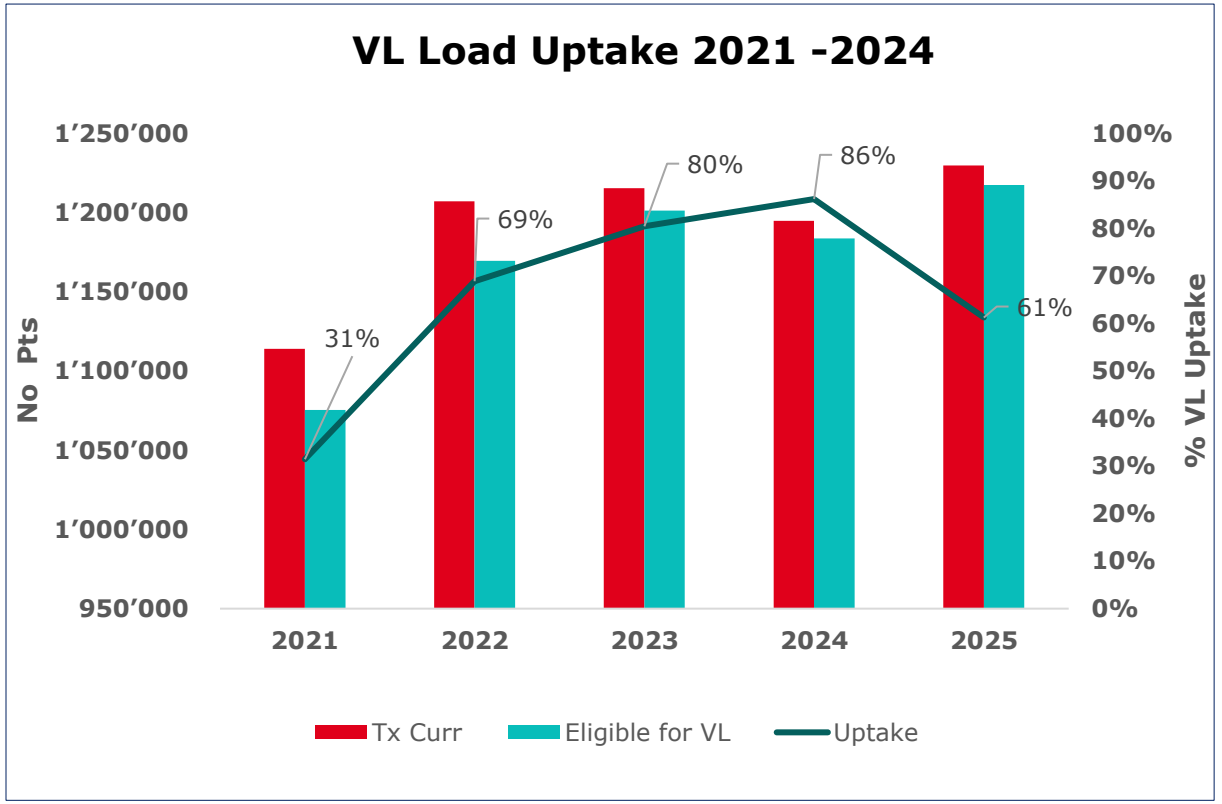
Rationale for performing viral load at month 3 on ART

- Need to harmonise VL monitoring across all populations
- Majority of the ROC at time of guideline revision (2022) were on DTG* - Kenya one of early adopters since 2017
- Early (3 Mo) VL results will allow for early evaluation at 6-month visit - early transition to less intense models for ROC established on ART (as per Kenya national criteria)

** Pooled analysis - after three months of ART, 87% of those receiving DTG-based regimens and compared to 63% of those on NNRTI (WHO)*

Progressive Reduction of Time to 1st VL and Increased Uptake

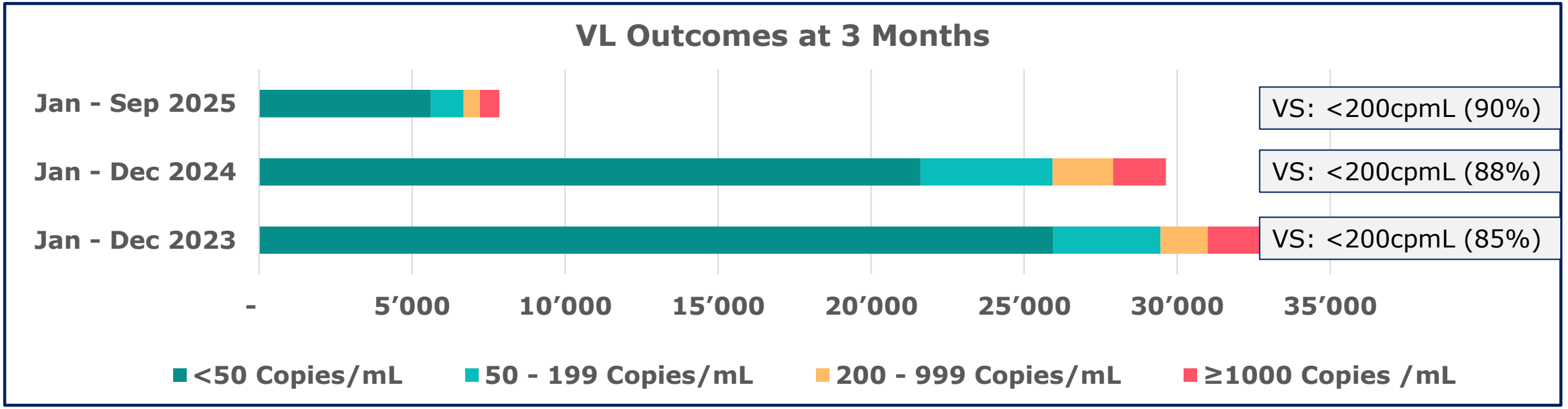




Month 3 viral load: Uptake and timing

Population		Time Period		
		Jan - Dec 2023	Jan - Dec 2024	Jan - Sep 2025
Pg & BF	New on ART	9,009	7,489	4,397
	VL at 3 Mo	3,804	3,172	1,061
	% Uptake	42%	42%	24%
0-14 yrs	New on ART	4,606	3,711	1,938
	VL at 3 Mo	1,595	1,532	372
	% Uptake	35%	41%	19%
15+ yrs	New on ART	82,848	68,287	41,529
	VL at 3 Mo	27,448	24,932	6,421
	% Uptake	33%	37%	15%

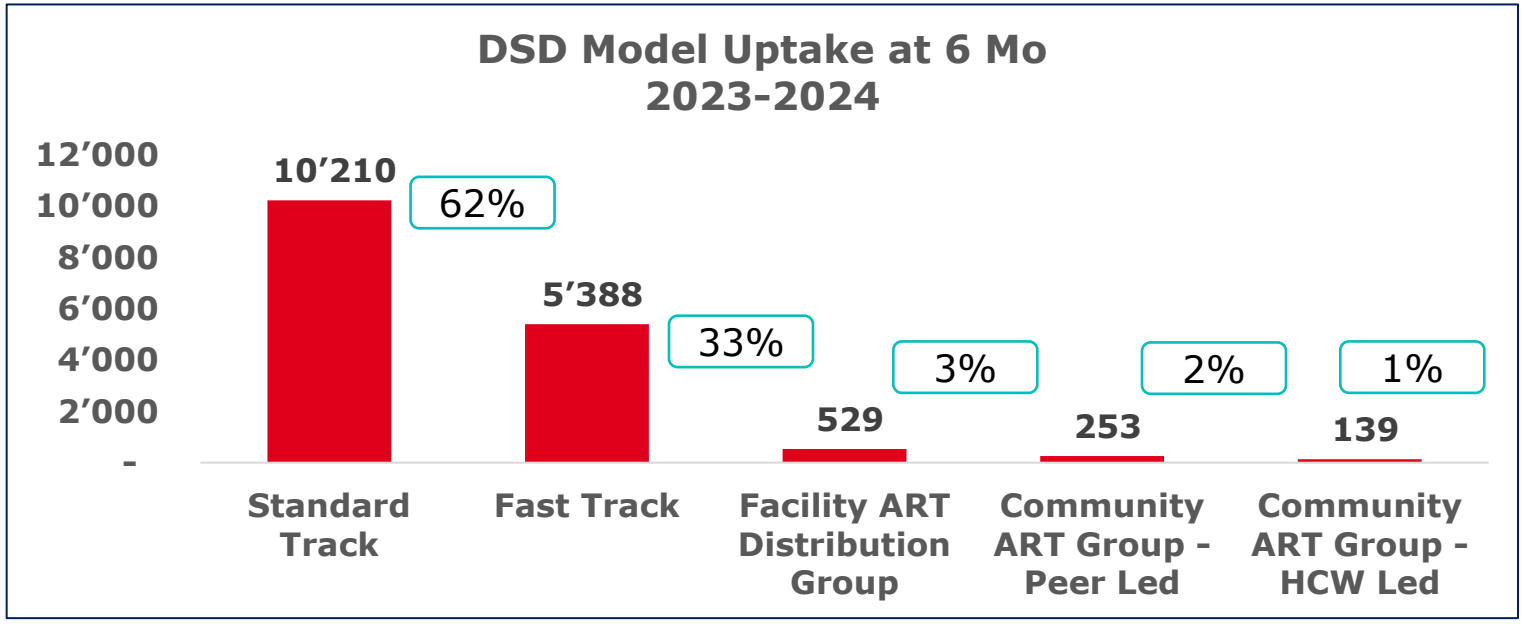
Rates of VL suppression at 3 Mo



Overall Viral Suppression at 3 Months (2023-2025):

- <1000 cp/mL : 93%
- <200 cp/mL : 88%

Timing and uptake of DSD



Possible exclusions from low intense models due to other criteria beyond VL outcomes

REPUBLIC OF KENYA
MINISTRY OF HEALTH

The Implementation of HIV Differentiated Service Delivery in Kenya Using a Quality Improvement Approach, 2024

Operational Manual

June 2024

NASCOP

Perspectives of recipients of care

- VL at 3 Mo is desirable/beneficial:
  - Early access to information on efficacy of ART – motivation for adherence
  - An early transition to DSD reducing intensity of facility visit
  - Enables early messaging for U=U to enhance adherence

IAS

Definition of established on treatment: Should this be changed with earlier VL available?

Pros:

- Favourable VL suppression at 3Mo
- ROC willingness

Cons:

- Considerations: Other considerations for 'established on ART' – duration on ART, satisfactory adherence

Could DSD models be offered earlier than month 6?

Pros:

- Early DSD allows for transition to DSD models reducing burden to system
- Enhanced AHD programs, short TPT regimens allows for prompt OI diagnosis, mx

Cons:

- Closer adherence support /monitoring is critical - time period of high-risk interruption
- Risk of IRIS during this period

Key learning points:

- Early VL is feasible and does not translate to additional VL requirements
- With transition to more efficacious (DTG-based) ART, suppression rates are favourable at 3-month VL
- Early VL allows for early transition to less intense models - increasing ROC convenience and reduced burden to the health system
- Additional support/mentorship is critical to optimise DSD interventions

Way forward

- Dissemination of guidelines 2025: maintained recommendation for VL testing, expansion of 6MMD, introduction of annual clinical follow up
- Stabilising VL testing in current funding landscape through innovation such as multiplexing, POC platforms
- Continued support to HCWs in the integration settings to scale diverse DSD models