Trend of Mean HIV Positives diagnosed during active index testing vs passive index testing periods

Abstract 12 Figure 2 Trend of Mean HIV Positives diagnosed during active index testing vs passive index

suboptimal with significant performance gaps in the Malawi Defence Force health facilities. We adopted active index testing in 7 facilities aiming at addressing the performance gap.

Objectives We sought to assess impact of index testing on overall HIV yield and explore factors associated with progress of active index testing.

Methods We conducted bottleneck analysis using problem tree analysis to identify root cause for low HIV yield performance. Using Plan Do Study Act (PDSA) approach, index testing was implemented using HIV diagnostic assistants (HDAs) for six months. Index testing program data was collected by testing modality weekly and run charts were plotted to study performance of HIV yield pre, during and post active index testing periods. In-depth interviews were also conducted with 10 HDAs from 7 facilities involved in the project to understand factors associated with index testing performance.

Results The mean HIV yield during passive index testing was 34.4 (6%yield) and 26 (5% yield) for the October-December 2018 and July-September 2019 quarters respectively. Active index testing mean yields were 103.1(13% yield) and 118 (14% yield) for January-March and April-June 2019 quarters respectively. There was a significant rise in mean yield from 34.4(6%) to 103.1(13% yield) when index testing was implemented. There was a significant drop in mean yield from 118(14% yield) to 26 (5% yield) when active index testing was stopped. Table 1 provision of operational support for index testing implementation and dedicated monitoring of index testing activities (figures 1 and 2) through weekly data reviews were cited as the contributors to the index testing performances.

Conclusions Active index testing is a plausible approach towards accelerated HIV case finding and linkage into care.

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TRIALISTS VIEWS ON SUSTAINING, SPREADING AND SCALING-UP QUALITY IMPROVEMENT INTERVENTIONS

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Background Quality Improvement (QI) evaluations rarely consider how a successful intervention can be sustained, nor how to spread or scale to other locations. A survey of authors of randomized trials of diabetes QI interventions included in an ongoing systematic review found that 78% of trials reported improved quality of care, but 40% of these trials were not sustained.

Objectives To explore why and how the effective interventions were sustained, spread or scaled.

Methods A qualitative approach was used, focusing on case examples. Diabetes QI program trial authors were purposefully sampled and recruited for interviews. Authors were eligible if they had completed the survey, agreed to follow-up, and had a completed a diabetes QI trial they deemed 'effective'. Snowball sampling was used if the participant indicated someone could provide a different perspective on the same trial. Interviews were transcribed verbatim. Inductive thematic analysis was conducted to identify barriers and facilitators to sustainability, spread, and/or scale of the QI program, using case examples to show trajectories across projects and people.

Results Eleven of 44 eligible trialists participated. Four reported that the intervention was 'sustained' and nine were 'spread,' however interviews highlighted that these terms were interpreted differently over time. Participant stories highlighted the trajectories of how projects evolved and how research careers adapted to increase impact. Three interacting themes were identified: i) understanding the concepts of implementation, sustainability, spread and scale; ii) having the appropriate competencies; and iii) the need for individual, organisational and system capacity.

Conclusions Trialists need to think beyond local effectiveness to achieve population-level impact. Early consideration of whether an intervention is feasible and sustainable once research funding ends is necessary to plan for sustainability, spread and/or scale of effective QI programs. The competencies required for these goals are distinct from those required to implement or evaluate QI programs.

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THE COMMUNITY TRANSFORMATION MAP: TRACKING AND PLANNING COALITION-LEAD COMMUNITY CHANGE

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Background Coalitions are promising structures for tackling health inequities. Supporting community health calls for self-administered tools where coalitions can measure their capabilities, determine priorities, set goals, and assess progress. Maturity models map detailed, sequential stages of idealized progress. The Community Transformation Map (CTM) is maturity model where users self-assess and chart a trajectory for improvement. We describe the development, application, and evaluation of the CTM, a collaborative planning tool developed within the 100 Million Healthier Lives community transformation initiative.

Objectives We will (1) describe the theoretical and methodological basis for the CTM, (2) present CTM content,