

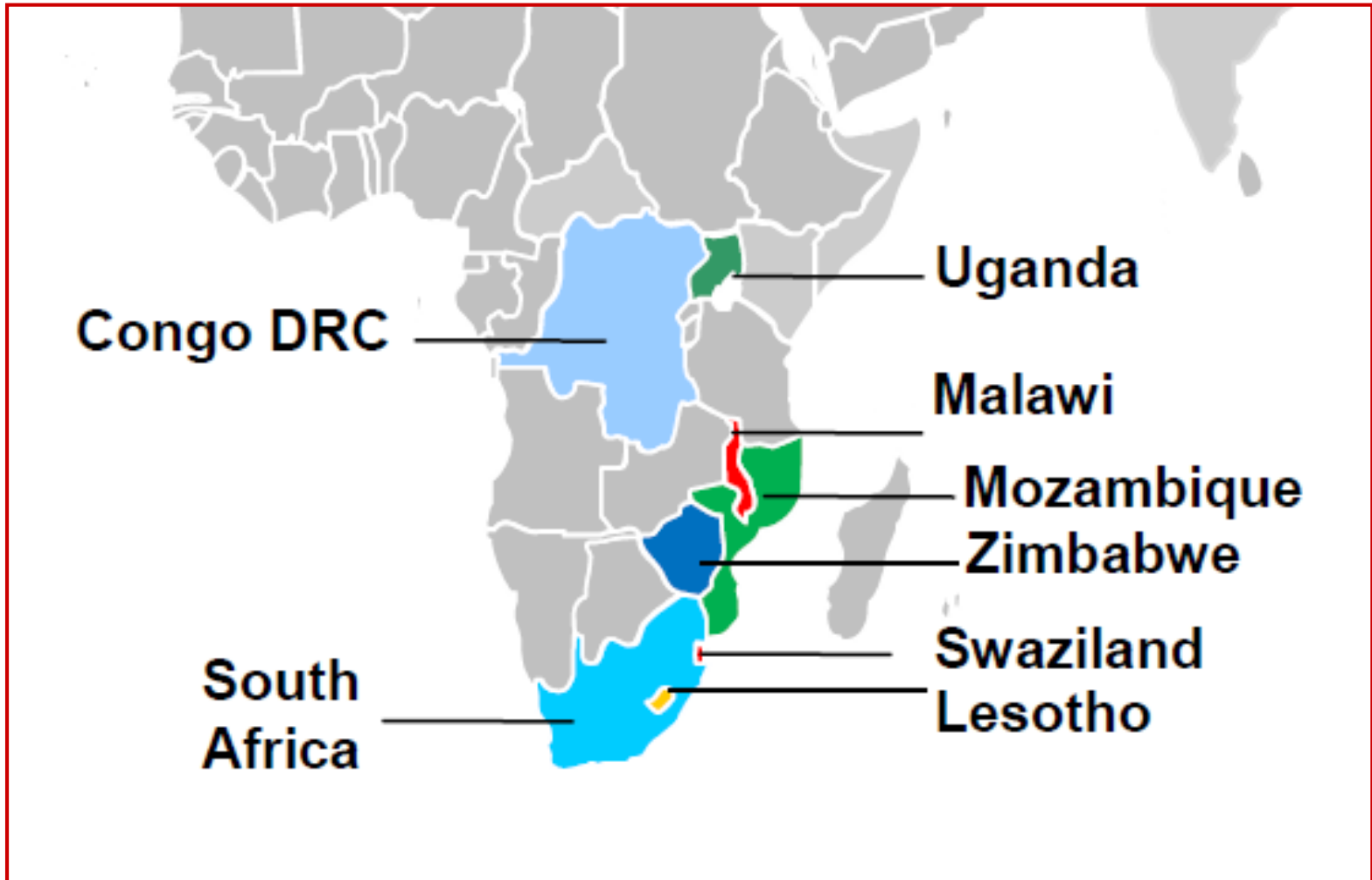
Country Case Studies of MSF Support to Viral Load Scale Up in Sub-Saharan Africa



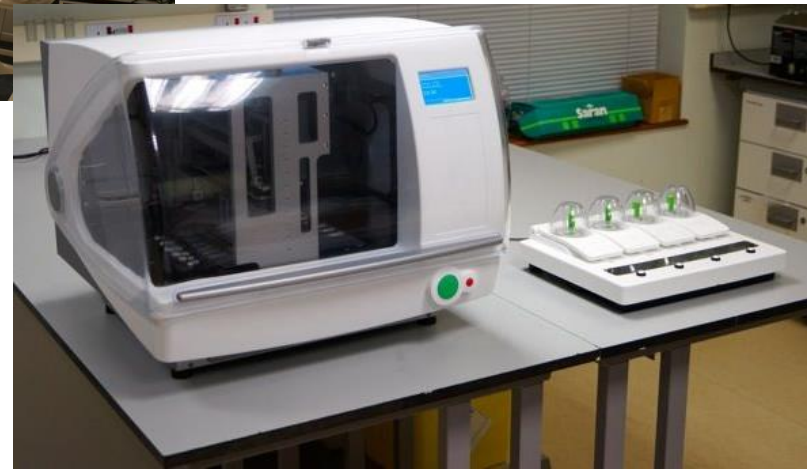
Why do Viral Load?

- Inform the patient
- Simplification of follow-up
 - CAGs, Clubs, Fast-track, Long refills
- Early detection of risk of failure and failure
 - Focus on those in need
- Optimised resource use
 - Targeted CD4

What and where?



Centralised or PoC?



A simple sample

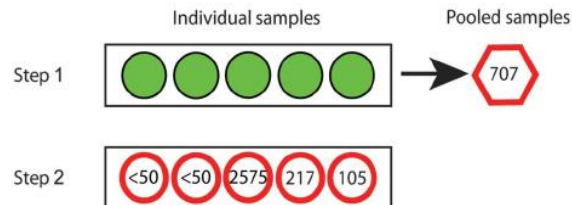
- DBS
 - FP or Venepuncture
 - DPS?



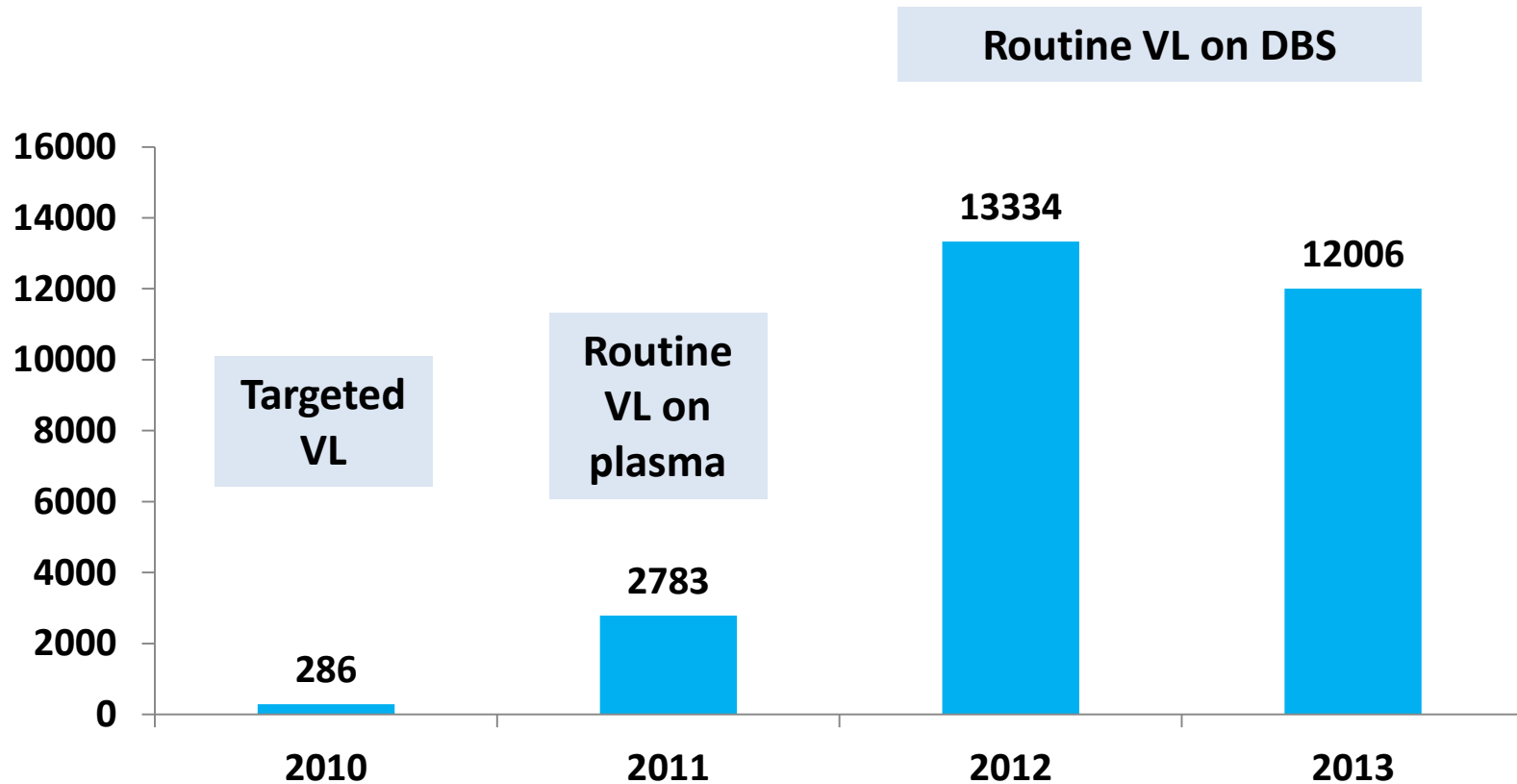
- Task-shifting

- Pooling

- 25-50% less tests

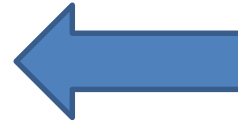
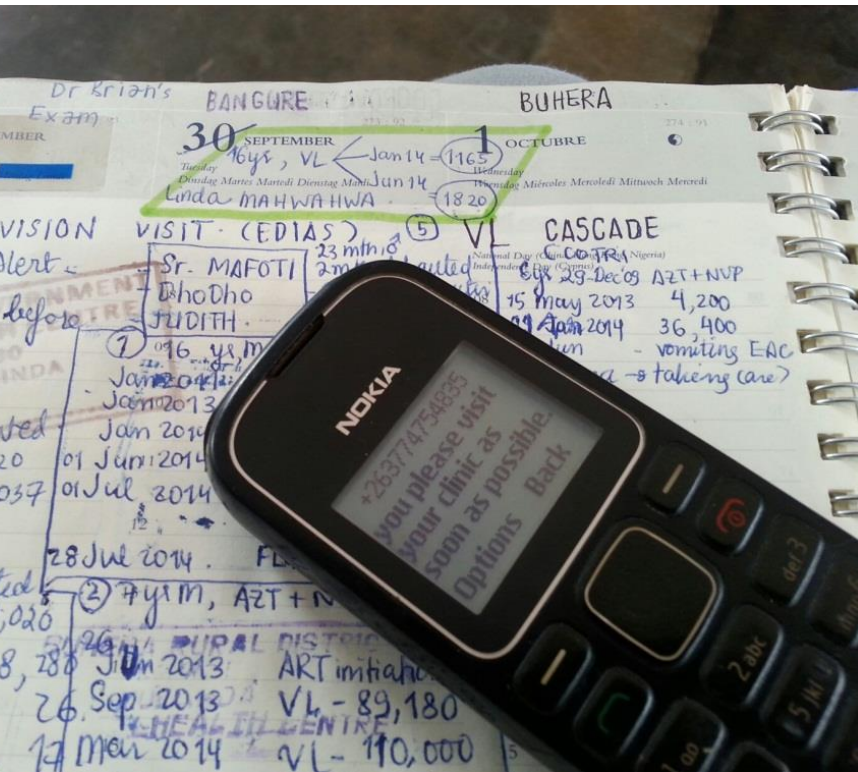


Viral load Scale Up Zimbabwe

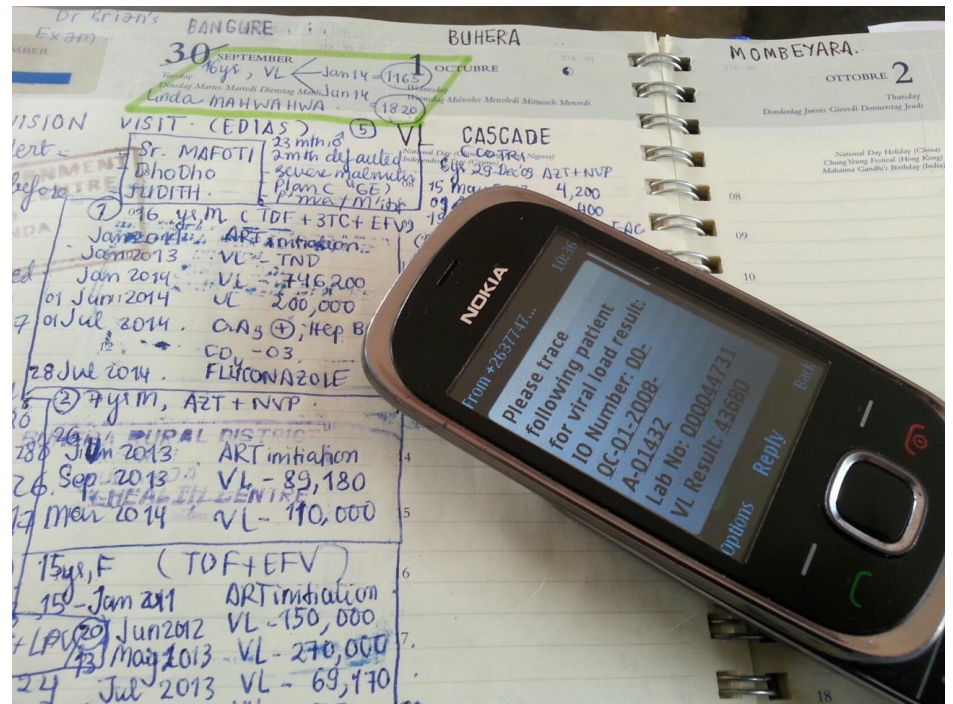


Zimbabwe: 2014 : **92% of cohort had a viral load**

Getting results to the patient



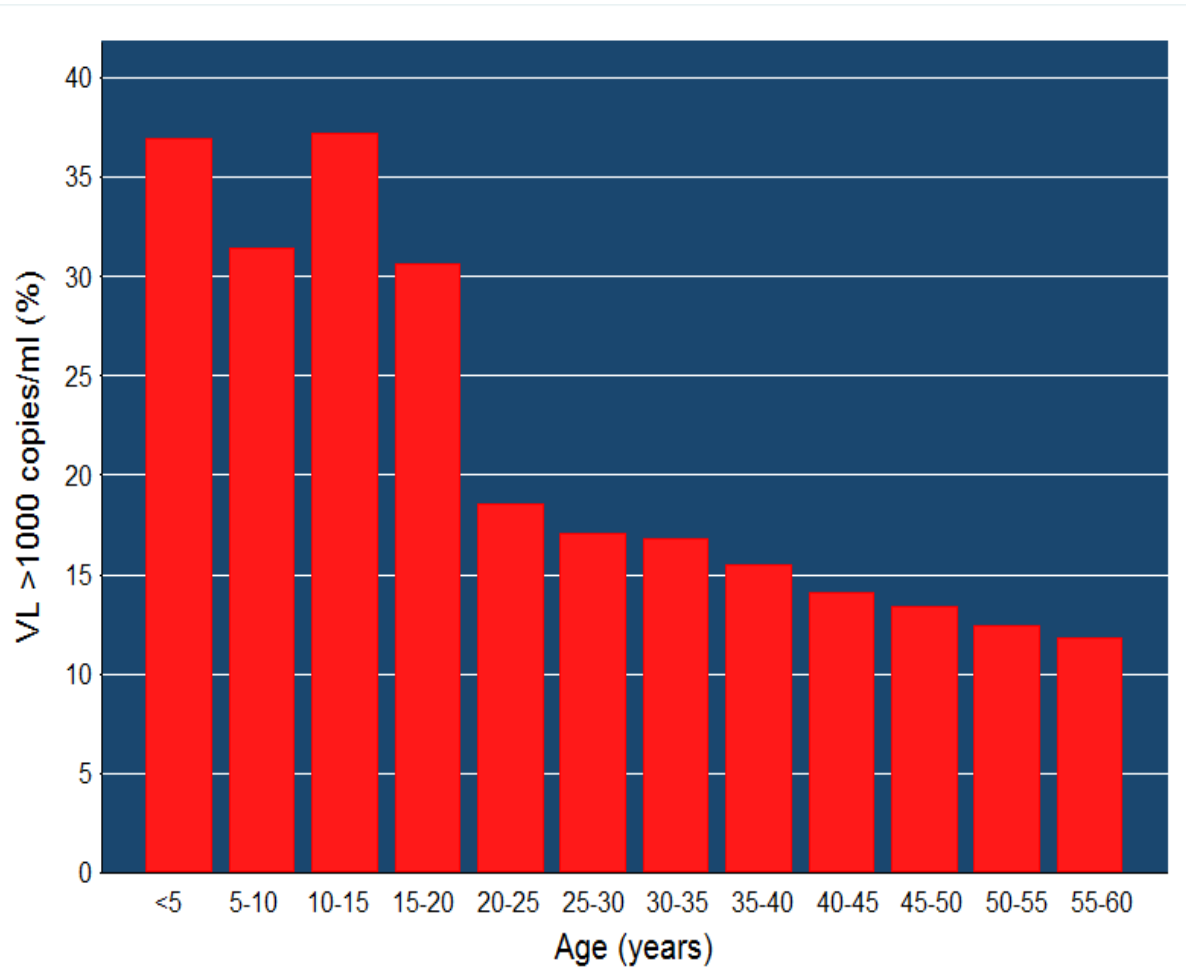
To Patient with VL > 1000



To Clinic for patient with VL > 1000



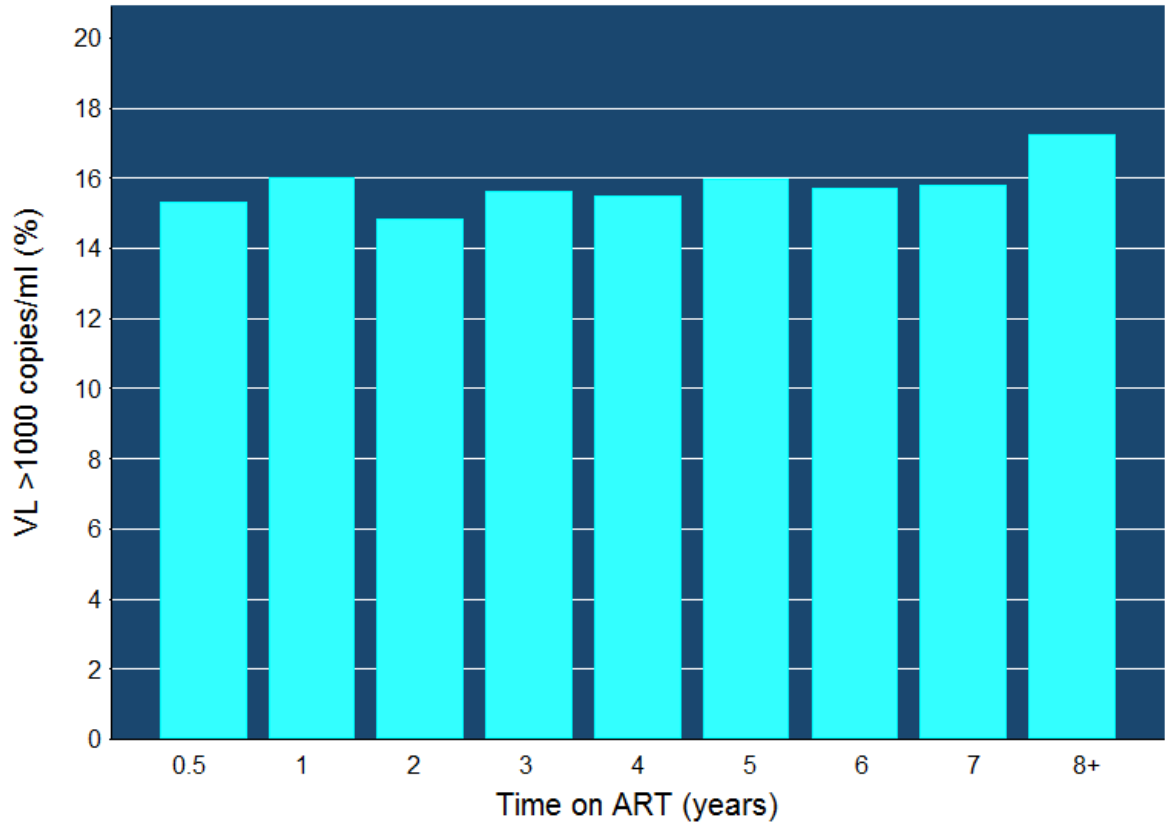
Change in Rates of Viral Load >1000 by Age



➤ Risk is greater in children and adolescents

➤ Risk decreases with age among adults

Viral Load Suppression by Time on Treatment



Rates of VL suppression change little with time

Having the Test is not Enough: The Viral Load Cascade

Number (%) with VL 1 > 1000 copies/ml

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graph TD; A[Number (%) with VL 1 > 1000 copies/ml] --> B[Number (%) completing adherence intervention]; B --> C[Number (%) with VL 2 taken]; C --> D[Number (%) with VL 2 > 1000 copies/ml]; D --> E[Number with VL 2 > 1000 copies/ml switched to second line];
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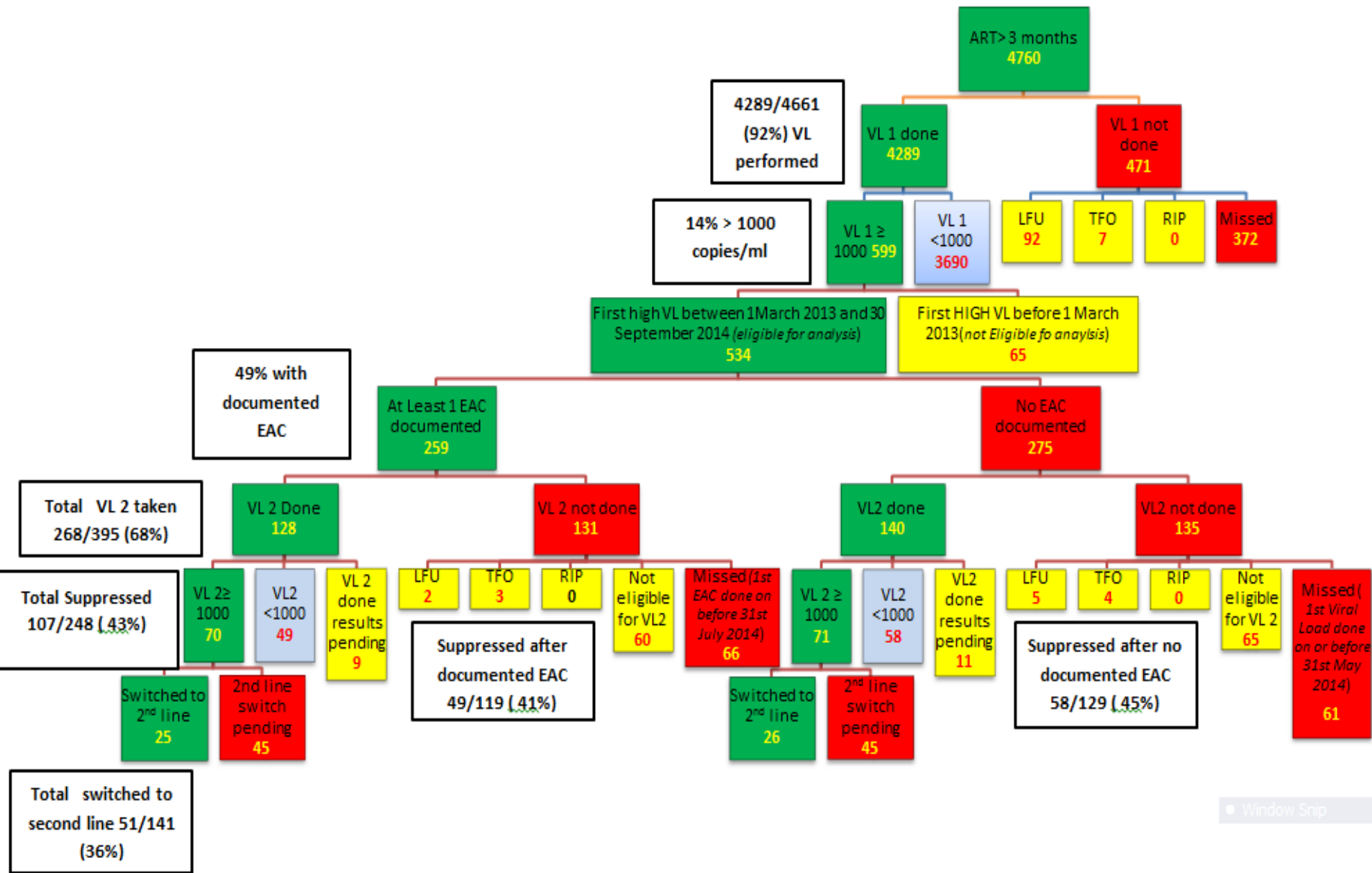
Number (%) completing adherence intervention

Number (%) with VL 2 taken

Number (%) with VL 2 > 1000 copies/ml

Number with VL 2 > 1000 copies/ml switched to second line

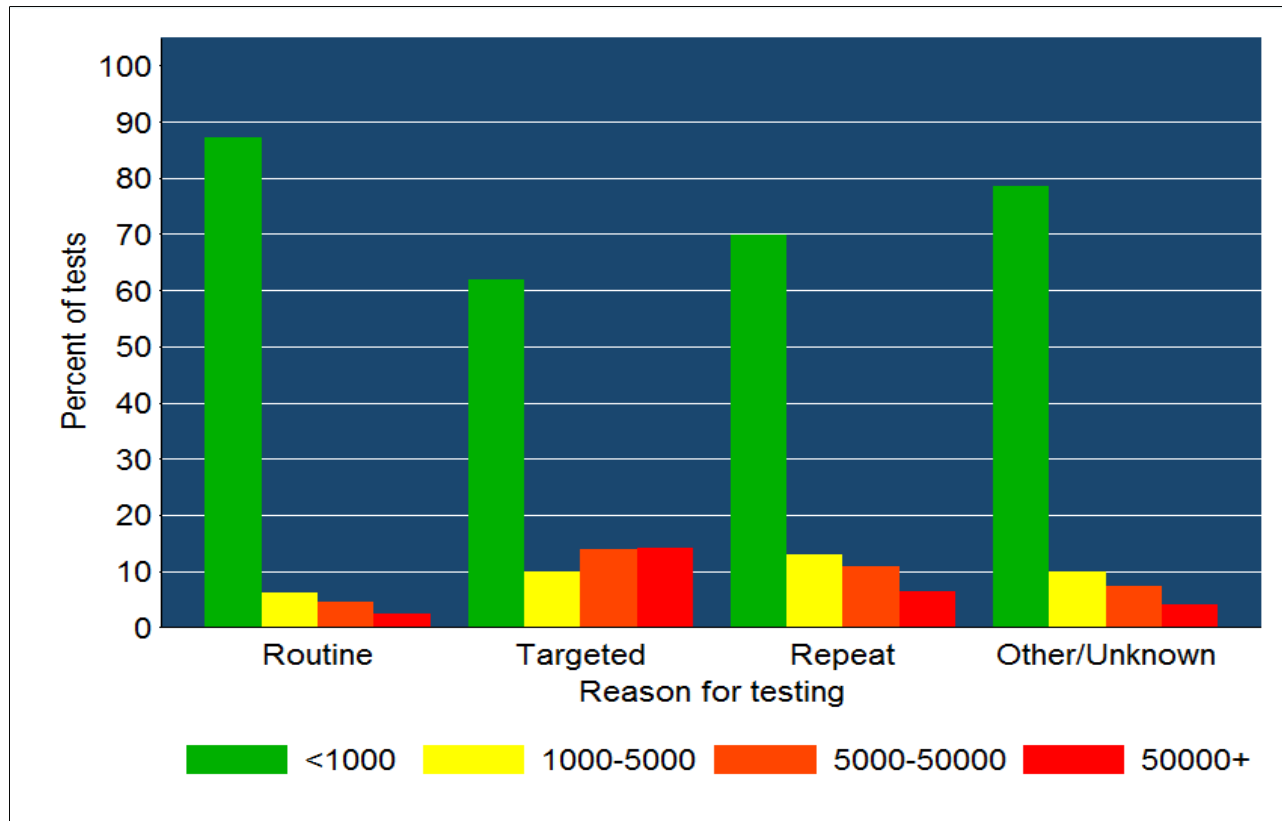
The Viral Load Cascade!



Some early cascades..

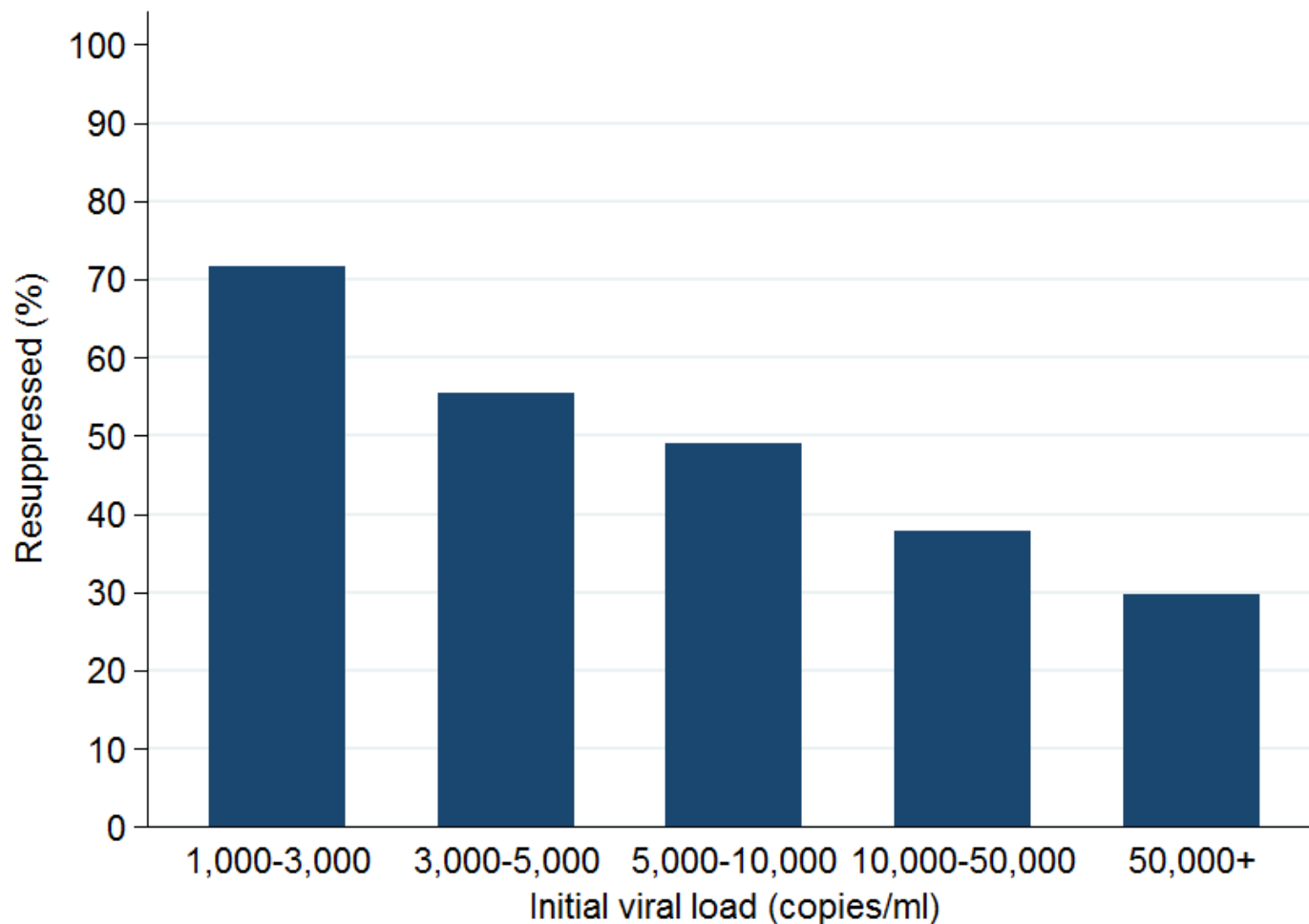
	Kibera	Buhera	Nhlangano	Mavalane
% Routine Viral loads according to protocol	99%	91%	84%	41%
% > 1000 copies/ml	10%	14%	17%	21%
% receiving EAC	100%	43%	73%	-
Second VL taken according to protocol	100%	68%	55%	42%
Median Time 1 st VL to 2 nd VL	96d	158d	-	
Switched to second line if > 1000	74%	52%	14%	

The Problem with Targeted Viral Load



- **Do not switch without a viral load**
- **Targeted VL identified failure.....but too late**

Likelihood of Resuppression



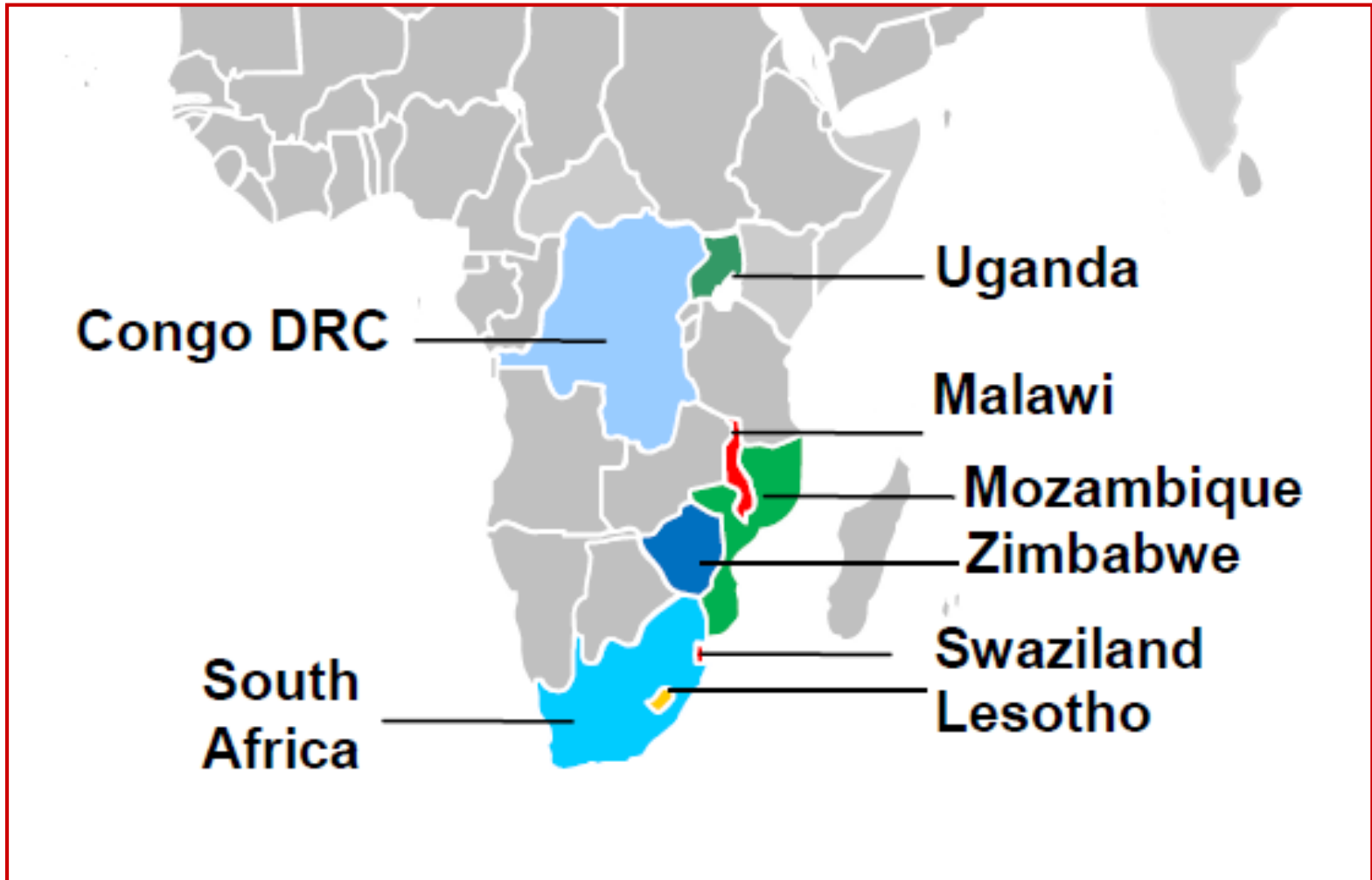
Some Lessons Learned

- Patient and Healthworker misconceptions are common:
 - “my blood test was undetectable so I stopped my drugs”
- Poor M&E systems lead to wasted tests
- Only 30 to 60% of people re-suppress
 - What is optimal EAC package?
 - Role of Genotype and Drug levels?
- Switch to 2nd line has improved but remains low
 - Clinicians need mentorship and training
 - Ongoing adherence problems are frequent
 - Second line committee and lack of decentralised access

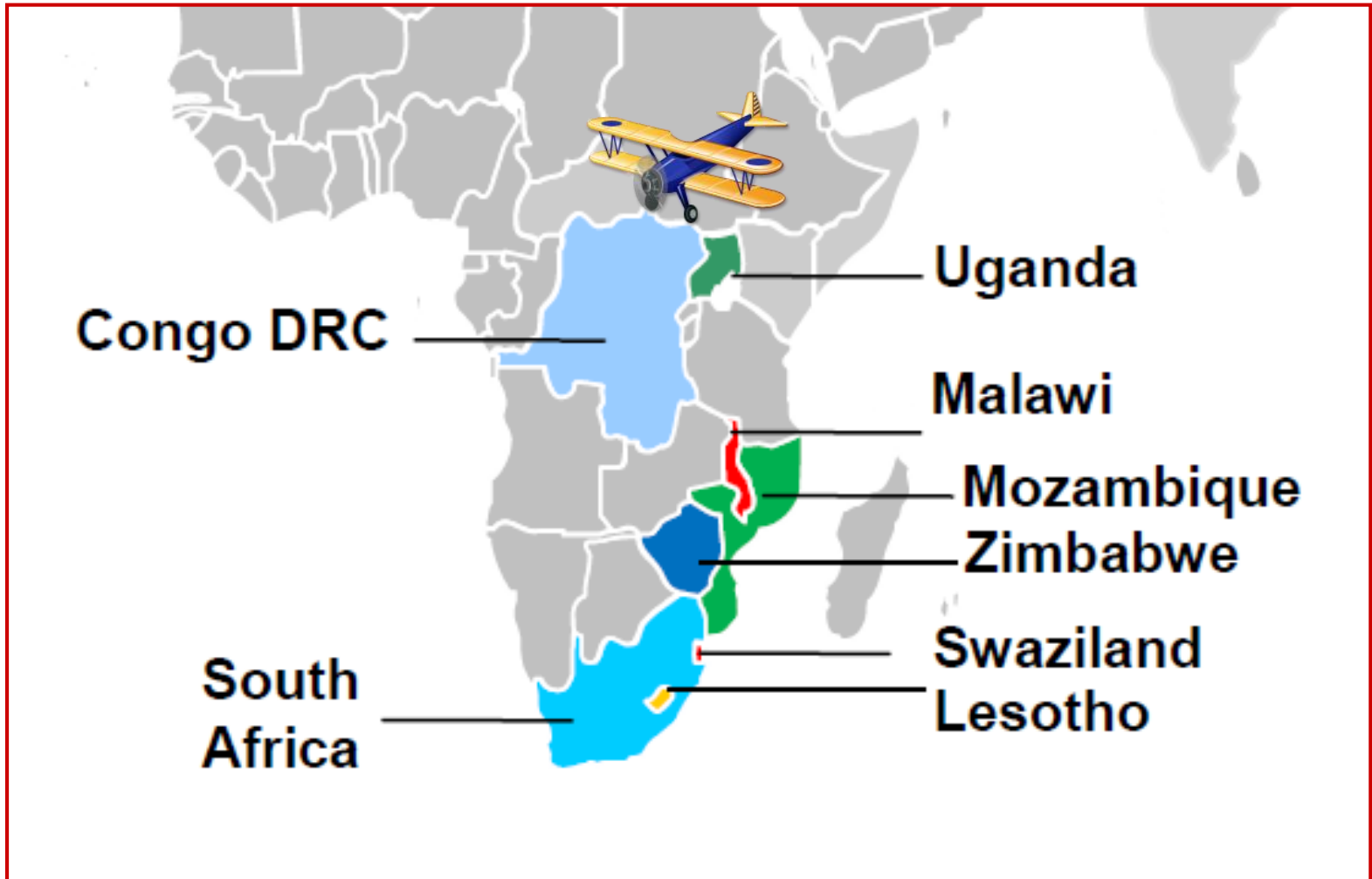
Summary of Priorities for Viral Load Implementation

- Laboratory
 - Which sample type and platform
- Preparing the Clinicians
 - The VL Algorithm and simplification
- Preparing the Counsellors
 - Enhanced Adherence Counselling
- Preparing the Patients and Community
 - ‘Undetectable’ misconceptions
 - From CD4 to Viral Load
- M&E

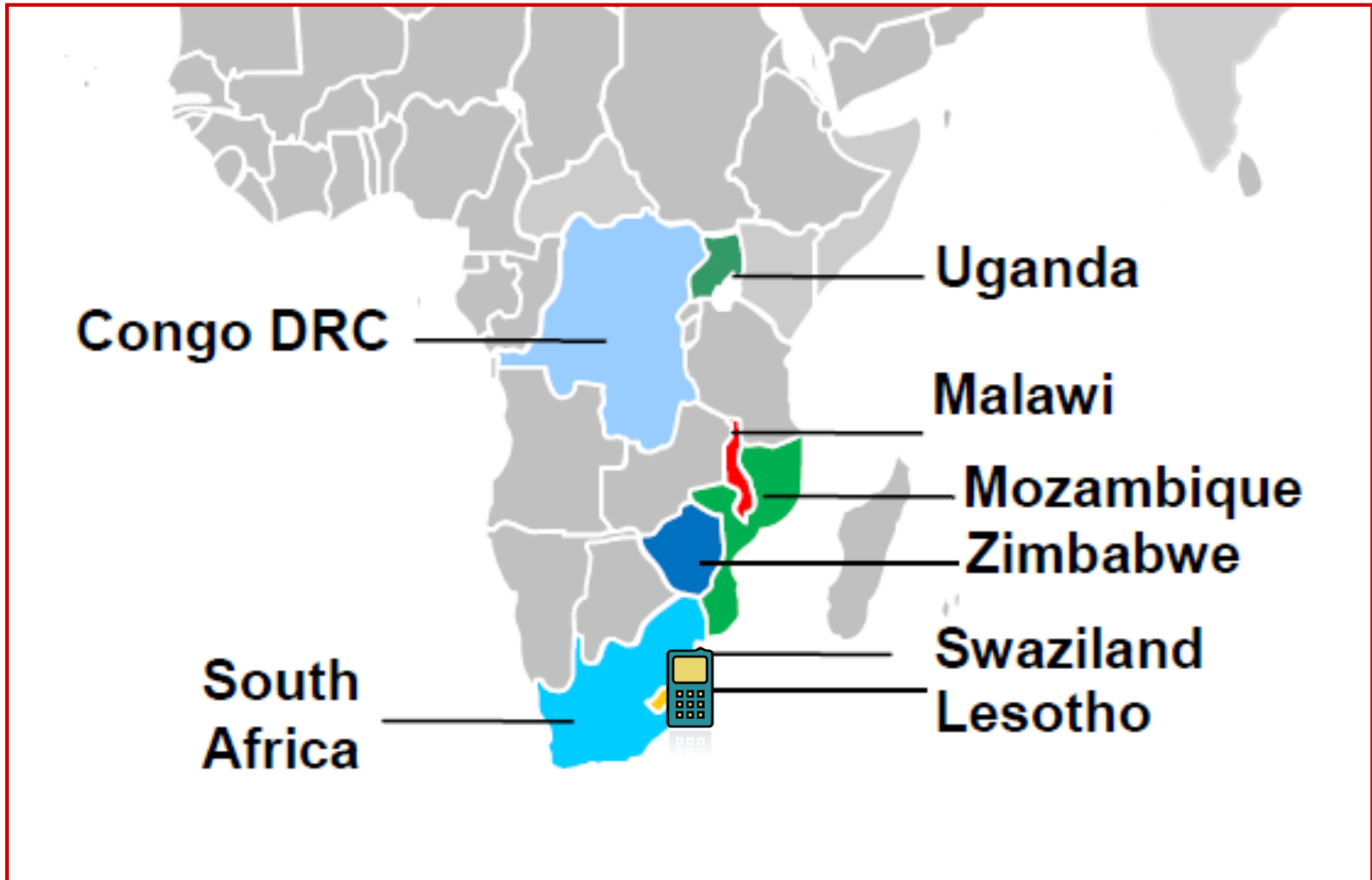
PoC or not?

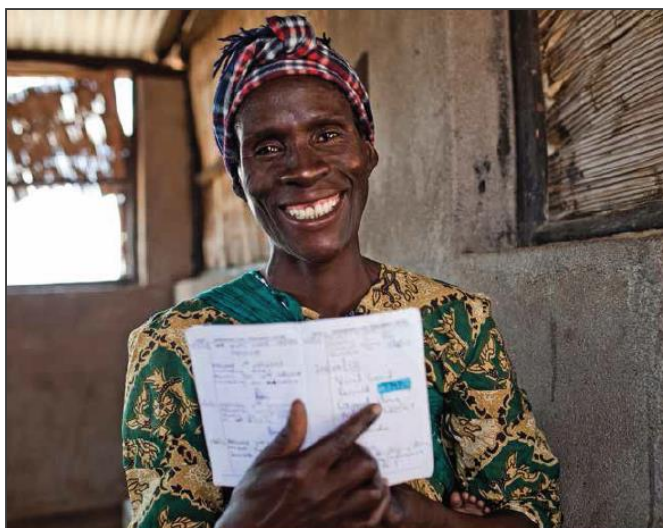


PoC or not?



PoC or not?





MÉDECINS SANS FRONTIÈRES

VIRAL LOAD TOOLKIT

AN IMPLEMENTER'S GUIDE TO INTRODUCING
HIV VIRAL LOAD MONITORING



samumsf.org

Thanks to :

Partnering Ministries of
Health

MSF Field teams

MSF Colleagues in
SAMU and Access
Campaign



