

A Soberting Community Review of Routine Viral Load Testing Access in 12 Countries in Africa



BACKGROUND

Over the last two decades, global HIV treatment coverage has steadily increased. As of March 2015, 15 million people living with HIV were accessing antiretroviral therapy. Despite these gains, close to half of those in need of treatment still have no access to life-saving medicines. It is also not clear how many people on treatment have access to an essential component of successful treatment – routine viral load (RVL) testing.

As recommended in Section 7.3 and Section 9 of the 2013 World Health Organization (WHO) ARV guidelines, viral load testing is the gold standard in antiretroviral therapy (ART) monitoring. It measures the amount of HIV in the blood and indicates if a treatment regimen is working or not. The WHO recommends viral load monitoring six months after starting ART, at 12 months, and routinely every year thereafter.

At a time when HIV-related deaths are decreasing in all age groups, HIV is now estimated to be the number one cause of death among adolescents (10-19) in Africa. Studies attribute this mainly to poor quality or no HIV treatment, which is directly linked to low levels of routine treatment monitoring. At present, it is not known how well people living with HIV are doing on various regimens, how many are failing treatment and how many are (or should be) switching to other regimens. All these unknowns beg the question – what is the quality of

treatment celebrated by improved treatment coverage?

It is because of these uncertainties and the alarming treatment monitoring issues raised in the July 2014 WHO Monitoring Report, “Global Policy, Local Disconnects: A Look Into the Implementation of the 2013 HIV Treatment Guidelines”, that the International Treatment Preparedness Coalition (ITPC), joined with the AIDS and Rights Alliance for Southern Africa (ARASA) to determine whether routine viral load testing is widely used in 12 African countries. The findings of this survey will inform a campaign for the implementation and/or scale up of strategic routine viral load testing in Africa and beyond, to ensure that people living with HIV can access quality HIV treatment everywhere.

SURVEY METHODOLOGY

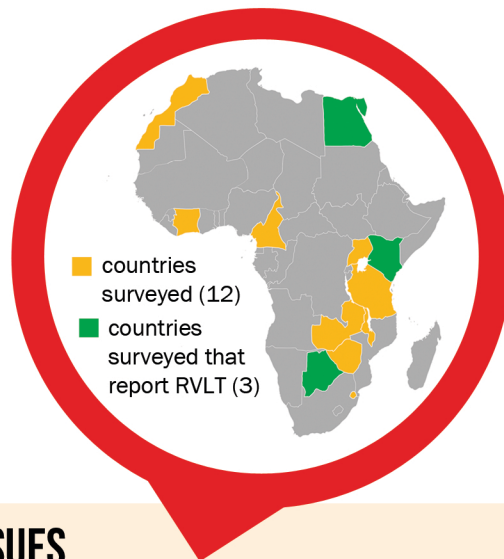
A community research team carried out a survey in 12 countries in Africa - Botswana, Cameroon, Cote d’Ivoire, Egypt, Kenya, Malawi, Morocco, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. A summary report of national level data on the current use of RVL and implementation barriers was gathered from policy makers (Ministry of Health, National AIDS Councils), service providers (doctors, nurses, community health workers), recipients of treatment and care (people living with HIV, including key populations, adolescents, and others) and representatives of non-governmental organizations. The survey aimed to be a ‘quick and dirty’ way to gather a broad

WHY WE EMPHASIZE THE STRATEGIC (VS. TARGETED) USE OF ROUTINE VIRAL LOAD TESTING (RVLT)

The *strategic* use of RVLT promotes a phased process, that ensures populations with high incidence of HIV and in areas with high treatment coverage, access RVLT first. This will help to achieve positive health outcomes for those most affected by HIV. A phased and strategic process can scale up the full roll out of RVLT to all people on treatment. Strategic also points to the rational use of RVLT versus CD4 testing in monitoring treatment – it is cheaper, more accurate and beneficial. Strategic also implies that treatment cascade resources are appropriately allocated to include RVLT.

Targeted is a narrow term with potentially discriminatory elements that could negate the spirit of the right to health and access for all. Under the wrong mandate, it can be used to forcefully have certain people tested, thereby denying individuals the right to choose. The use of this term is also very numbers driven and fails to draw attention to the quality of treatment and health outcomes of people living with HIV.

swath of national level information in 12 focus countries – as a result findings are not widely generalizable but instead point to emerging themes and issues that warrant further investigation. Findings reveal insights and opportunities for further research, they are not definitive and do not represent the situation in all countries, parts of a particular country, regions or contexts.



"In Zambia, I visited an ART center in a rural area where I met 38 patients and 2 clinical officers. All the patients there that day had no idea what viral load testing was. The doctors explained that viral load testing had never really taken place since the clinic was opened in 2010 – they never received a viral load test result even if when they ordered it and the blood samples were collected. It is sad."

- Owen Mulenga, Treatment Advocacy and Literacy Campaign (TALC), Zambia

SUMMARY OF KEY EMERGING ISSUES

- Two thirds of the 12 countries (8) surveyed, reported the existence of a government policy that mandates providers to conduct routine viral load testing as part of HIV treatment monitoring. However, viral load monitoring is NOT routinely (as defined by the WHO 2013 Guidelines) done in the majority of the countries surveyed – only Botswana, Egypt and Kenya reported routine viral load testing.
- Almost 60% of countries reported that viral load tests are patient initiated, meaning that the small percentage of people living with HIV who are aware of viral load testing (and its importance) are the ones that request VL monitoring from their health care providers. Even more alarming, greater than half of the countries surveyed reported that patients accessing VL are asked to pay for the service. Most countries reported that patients also have to pay for genotype testing if available.
- ^a The time it takes to receive VLT results varies by country ranging from 1 to 5 weeks, and, worryingly, one-third of the countries (4) report frequent stock-outs of viral load test kits and commodities, making the result wait-period even more unpredictable.

CONCLUSION

A viral load test, although routine in rich countries, is scarce and expensive in Africa. The mere existence of good government policies on treatment monitoring does not translate into people living with HIV accessing routine viral load testing. Even though it is encouraging to note that countries have taken steps to incorporate RVL in their policies, this does not drive demand for viral load tests. Even though it is encouraging to note that countries have taken steps to incorporate RVL in their policies, this does not drive demand for viral load tests. Treatment educated people living with HIV are key to better treatment outcomes – the more people who know the importance of RVL, the more it will be demanded and consequently used by providers.

The burden however, cannot be on people living with HIV to demand RVL testing; governments must take the responsibility to ensure the right to health for all.

CALL TO ACTION

Governments - We urgently call on all governments to:

- Adopt the 2013 guidelines on the strategic use of routine viral load;
- Invest in the direct and strategic operationalization of guidelines that recommends the use of routine viral load testing; and
- Invest in the expeditious implementation of the RVL guidelines at health care facility level.

Manufacturers - We call on all manufacturers of viral load tests to speed up the production of point of care VLTs and to make them

affordable to countries that need to scale up RVL.

Donor Governments - We call on donor governments to incorporate RVL into strategic investment funding to facilitate scale up of the use of RVL and to fund further research on implementation, based on the real experiences of people living with HIV.

To learn more about ITPC's and ARASA's ongoing work that advocates for the strategic use of routine viral load testing, please visit

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