

Use of Clinical Mentors in Scaling up HIV Viral Load Testing and 2nd Line ART Uptake among PLHIV at 30 High Volume Care and Treatment Clinics in Tanzania (June-August 2017)

Author's: R. Kisanga¹, H. Msuya¹, J. Mziray¹, P. Mtango^{1,2}, S. Mlangwa¹, E. Mtumbuka¹.

Affiliations: ¹Clinton Health Access Initiative-Tanzania, ²National Aids Control Program-MOHCDGEC

Background

WHO recommends viral load monitoring as the preferred approach in monitoring patients on ART compared with immunological and clinical monitoring to provide an early and more accurate indication of treatment failure and the need to switch to second-line drugs, reducing the accumulation of drug-resistance mutations and improving clinical outcome.(1)

The MOHCDGEC through NACP released HVL guideline and operational plan for scaling up HVL testing in September 2015 which gave direction on HVL monitoring and plan to scale up HVL testing in Tanzania.(2) The operational plan had an ambitious target of making sure 50% of PLHIV on ART are monitored using HVL by 2017. However, since this was a new initiative a number of challenges were anticipated; demand creation to increase access to viral load testing, documentation into monitoring tools, tracing and prompt utilization of generated results. This is a write up to show the impact of data utilization by clinical mentors to increase access to HVL testing as well as addressing gaps across the cascade.

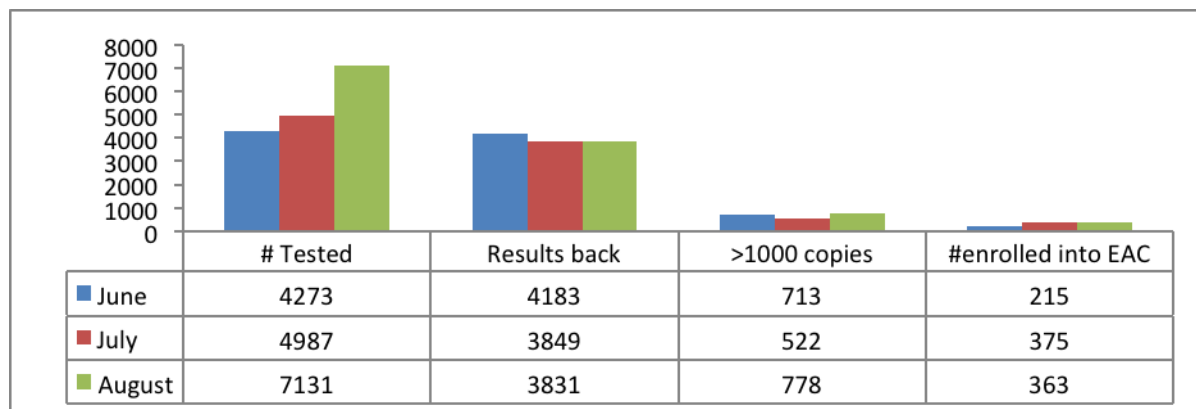
Methodology

A team of HVL mentors composed of Clinicians, Laboratory technicians and adherence counselors were deployed at 30 selected high volume facilities within the country. Mentors used HVL registers and CTC2 database to identify number of clients on ART > 6months and pulled patient charts to review if they have received VL tests as per National guideline. The teams went through HVL register and identified patients with detectable (>1000copies/mL) viral load results and made sure that the patients had been enrolled into EAC program. In addition, Mentors worked with health care workers at the facility in addressing gaps identified through onsite mentorship.

Results

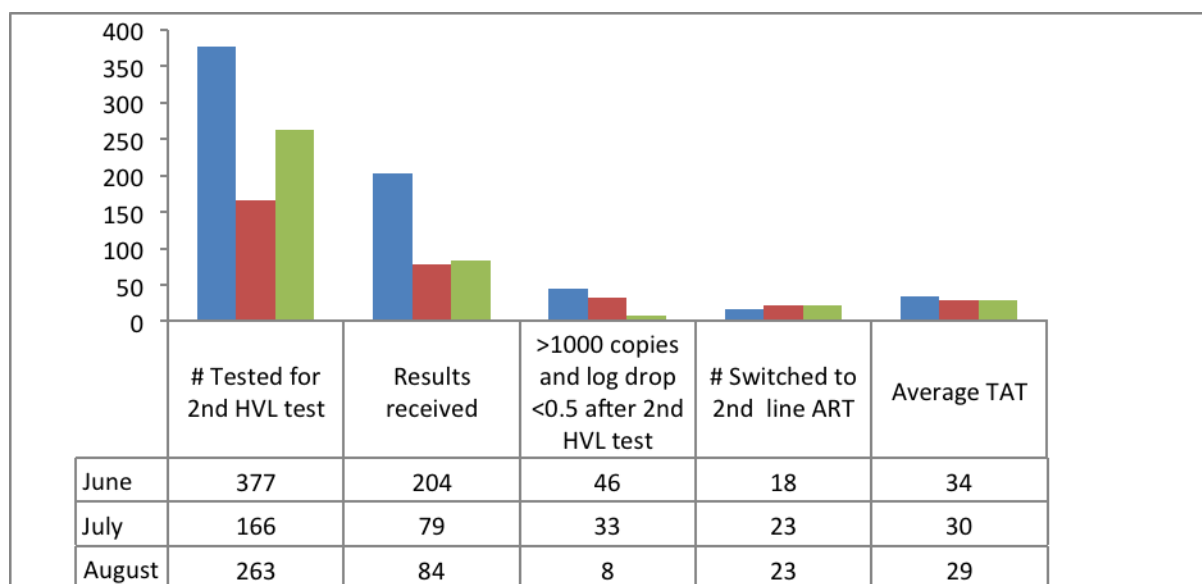
HVL mentorship increased HVL testing from 4,273 tests in June 2017 to 7,131 tests in August 2017 which is 67% increase in HVL testing. In the same period the number of patients with high viral load enrolled into EAC increased from 30% in June 2017 to 46% in August 2017.

Figure 1; Testing trends by months and utilization of the results through enrolment into EAC



A total of 367 results of patients tested for 2nd HVL test following completion of Enhanced Adherence Counseling were received in June to August 2017 of which only 24% had >1000copies and log drop of <0.5. There was also improvement in average Turnaround Time (TAT) which decreased from 34 days to 29 days.

Figure2; Showing 2nd HVL testing after EAC and outcomes



Conclusion

HVL clinical mentorship improved utilization of data to increase viral load testing, turnaround time and results utilization to improve monitoring of patients. However, intensified follow-up through supportive supervision and mentorship need be instituted to address challenges across the cascade.

References

1. World Health Organization. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach. World Heal Organ. 2016;155 p.
2. The United Republic of Tanzania. National Aids Control Programme National Operational Plan for Scaling Up Hiv Viral Load Testing. 2015;