Progress towards achievement of the UNAIDS 3rd 90 in Zimbabwe:

Capacity and functionality of viral load monitoring in 22 Districts

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BACKGROUND

- Zimbabwe is one of the 22 high burden countries that adopted the UNAIDS 90-90-90 targets, and launched a viral load (VL) scale up plan in 2015. The plan provides a road map to scale up VL monitoring from 3% in 2015 to 70% by the end of 2017 and 90% by 2018.
- HIV prevalence in Zimbabwe is 14.6%. [1]
- VL suppression among PLHIV currently on ART is estimated to be 86.5%. [2]
- VL monitoring coverage for clients on ART remains low with some clients having no access to the test.
- To support the Ministry of Health and Child Care (MOHCC) in its efforts, the Organization of Public Health Interventions and Development (OPHID) conducted a rapid assessment establishing existing capacity and functionality of VL monitoring in Zimbabwe.

OBJECTIVE

Establish existing capacity and functionality of VL monitoring in the 5 Provinces where OPHID and partners implement the PEPFAR-USAID funded Families and Communities for Elimination of HIV (FACE HIV) program.

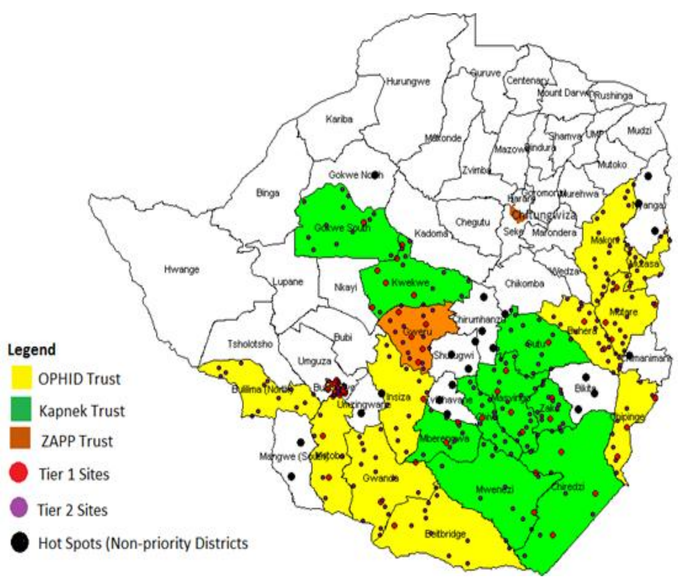
Specific objectives were to:

1. Describe the availability of VL monitoring in each District and the functionality of equipment.

2. Document the human resources trained and in-post for conducting VL monitoring.

3. Identify existing bottlenecks and barriers to effective and efficient use of VL monitoring, in line with existing Ministry of Health and Child Care (MOHCC) policies and targets

Figure 1. FACE HIV Program 22 priority districts



METHODS

- In May 2016, a cross-sectional snap programmatic survey was conducted among District health authorities using a standardized questionnaire.
- The survey captured current availability of VL monitoring, functionality of equipment, human resource capacity and existing bottlenecks in 22 purposively sampled districts serving over 530 health facilities (Figure 1).
- Stata V12 was used to conduct the descriptive analysis.

RESULTS

1. **VL sample collection:** At time of survey, 50% (11/22) of districts were <u>not collecting samples for VL monitoring</u>.

Less than 5% of health care workers in post were identified as being trained in VL sample collection or results interpretation.

RESULTS continued

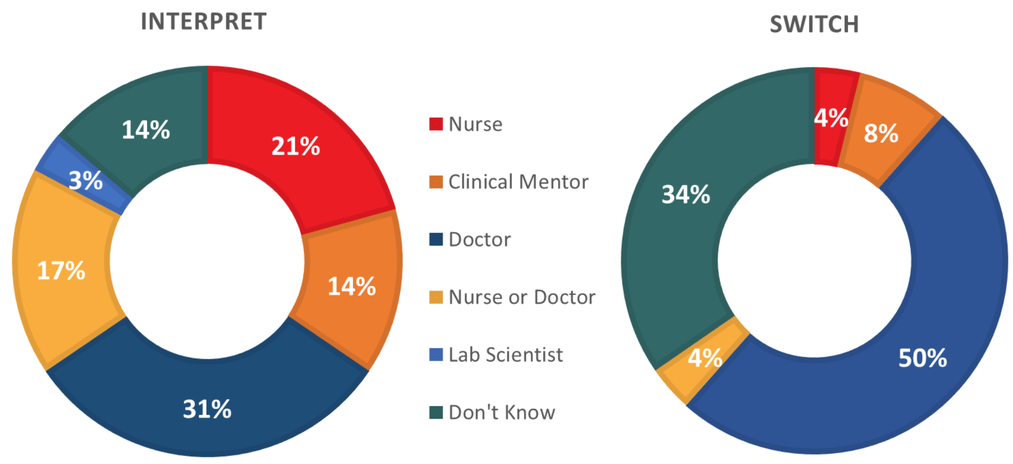
2. VL sample transportation & result notification:

Highly variable systems for VL sample transportation collection and result notification within and between Districts – dependent on implementing partners at site level.

All labs reported sending physical paper-based results back to sites

> *'The courier only comes to the district hospital twice a week and we are not yet aware how long the specimens can be kept at room temperature before transportation to the lab.'*
>
> *-Health care worker, Manicaland Province*

Figure 2. Perceptions on health care worker cadre able to interpret and initiate clinical action based on VL results



3. Viral load result interpretation:

- Lack of clarity regarding health care cadre with authority to interpret VL results or initiate a switch in ART regimen based on VL monitoring results (Figure 2).
- None of the districts implementing VL had standard operating procedures which states who can interpret VL results and initiate switch to second line regimens.
- No district (0%) indicated health care workers are "confident at interpretation of VL results".

4. VL targets: only 18% (4/22) districts and 33% (1/3) of the labs surveyed were aware of their annual viral load target.

5. VL cost: All districts conducting VL reported the test being offered at no cost to the client

CONCLUSIONS

- The snapshot assessment revealed limited availability and capacity to conduct VL monitoring in 22 districts serving over 365,000 people on ART.
- There is an urgent need to support MOHCC to make VL accessible and affordable for PLHIV on ART to reach the 3rd 90 in Zimbabwe.
- In response to assessment findings, OPHID developed a VL monitoring sensitization training curriculum and job aide.
- Standardization of VL sample transportation and result notification must be prioritized.
- Improved communication of national policies and targets to provincial, district and site level is needed to achieve VL scale up.
- Expansion of VL monitoring and capacity building health workers should be simultaneous to ensure quality of care and ensure VL monitoring results in appropriate clinical actions.

REFERENCES

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