Latest HIV Status South Africa

VIRAL LOAD TRAINING

Garden Court O.R. Tambo
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VIRAL LOAD TRAINING
GARDEN COURT O.R.TAMBO
OUTLINE

• Introduction (current challenges)
• VL testing in PLHIVs
• VL monitoring (per ART guidelines)
• Principles of VL Monitoring
• Switching clients on ART (Importance of VL)
• 90 90 90 Cascade
Introduction: Current gaps

• Challenge of taking VL when due
• No systems in place to manage VL results at facility level after NHLS delivery of results
• No clear responsibility for VL recording & filing
• Delayed or no action taken to act on abnormal VL
PLHIVs & Viral load (revised ART guidelines)

• All people living with HIV (PLHIV) are eligible to start ART regardless of age, CD4 cell count and clinical stage.

• First VL at 6 months on ART. If virally suppressed (< 50 c/mL), repeat VL at 12 months on ART and 12-monthly thereafter if viral load remains suppressed.

• If a client has not had a VL test in the last 6 months, additional VL testing outside of the routine VL monitoring schedule should NOT be done.

• The client should await the result of their routine annual VL test to determine their eligibility to switch to DTG.
Viral load

- Viral load should be measured to timeously detect problems with adherence or treatment failure
- Remember, an elevated VL is a medical emergency!
Principles of Viral Load Monitoring

• Achieving and maintaining VL suppression is the first goal of ART and fundamental to good patient outcomes
• The ART guideline uses two VL thresholds:
  – VL < 50 c/mL: This is the threshold for defining VL suppression (previously < 400 c/mL)
  – VL > 1000 c/mL: This is the threshold for defining failure (unchanged from the previous guideline)

• **Principle 1: Any VL more than 50 c/mL requires action**
• A VL > 50 c/mL implies that viral replication is taking place in the presence of ART and puts the client at risk of developing treatment resistance.
• A VL between 50 and 999 may be a viral “blip” that returns to levels below 50 c/mL.
• Alternatively, the client may be progressing to failure with VLs over 1000 c/ml.
Principles cont....

- **Principle 2: Never change one drug in a failing regimen (VL > 1000)**
  - If a single drug substitution is made within a failing regimen, the new drug may be the only active drug in the regimen. The client will effectively be on monotherapy, as only one drug may be working.

- **Principle 3: Eligibility for second-line ART will be determined by the client’s VL, the current regimen they are failing, and the time they have been on ART**

- The definition of “confirmed virological failure” i.e., two VLs > 1000 c/mL on at least two consecutive occasions
90 90 90 cascade

90-90-90 Cascade - Total Population
(Aug 2019 - South Africa)

- PLHIV: 7,594,976
- PLHIV who know their status: 6,835,479 (91% of PLHIV)
- PLHIV on ART: 6,151,931 (69% of PLHIV who know their status)
- Viral loads done: 3,494,973 (73% of PLHIV on ART)
- Virologically Suppressed: 2,894,746 (83% of Viral loads done)

Actuals vs. 90-90-90 Target

Progress against previous pillar:

- 91% for PLHIV who know their status
- 69% for PLHIV on ART
- 73% for Viral loads done
- 83% for Virologically Suppressed