CASE STUDY

Improving Access to Viral Load Monitoring through Viral Load Camps

To ensure viral load suppression is being monitored for people living with HIV, the USAID Applying Science to Strengthen and Improve Systems project (ASSIST) is working with the district health offices in northern Uganda to increase access to viral load monitoring with a focus on the backlog of patients. Conducting viral load camps was one of the innovations taken up by ASSIST to improve access to viral load monitoring in northern Uganda to reduce on the backlog of clients with missing viral load test results. To prepare for the camps, viral load eligible patients were clustered by villages and resources were mobilized. At the camps, the health workers at the camp venue took the lead in conducting the camp and they were supported by the District Lab Focal Persons and district HIV focal person from the district health office. District-based ASSIST staff also provided additional support to the team. In a few instances where the anticipated load was high, health workers were mobilized from neighbouring facilities to provide extra help. There was an increase in clients accessing viral load testing during the intervention period. A total of 5,664 patients received viral load testing in 11 weeks during the intervention.

Introduction

UNAIDS’ 90-90-90 strategy is targeting 90% of all people living with HIV knowing their HIV status; 90% of all people with diagnosed HIV infection receiving sustained antiretroviral therapy (ART); and 90% of all people receiving antiretroviral therapy attaining viral suppression. In order to contribute to the viral suppression target (“third 90”), Uganda adopted Viral load (VL) for monitoring clients on ART in 2014. Despite this, there has been insufficient access to VL monitoring in several parts of the country, including northern Uganda.

Objective

The USAID Applying Science to Strengthen and Improve Systems project (ASSIST) is working with the district health offices in northern Uganda to increase access to VL monitoring with a focus on clearing the VL backlog between October and December 2016.

Intervention

Conducting VL camps was one of the innovations taken up by ASSIST to improve access to VL monitoring in northern Uganda to reduce on the backlog of clients with missing VL test results.

Key Steps in VL Camp preparations

1. Review of records at ART & Mother-baby care points to ascertain eligible clients
2. Generate a list of eligible clients and attach a sticker on their files for easy identification
3. Assign linkages facilitators to trace the patients in the community
4. Mobilize necessary camp logistics based on the expected patients coming for the camp

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Preparation: Assessment was done at all ART sites to ascertain the number of eligible clients for VL at ART and mother-baby care point (MBCP) clinics that have not had the testing. Patient details including name, age, sex, and ART number were captured and their files traced. The files had stickers attached to them for easy identification. Patients on the lists of eligible clients at each site were clustered according to residential address (villages/parishes). Based on numbers of VL eligible clients, districts prioritized facilities for the camps. In some districts, however, all sites were considered so as to clear the VL backlog at all the ART sites in the district.

Dates for running the camps were set through support and guidance of the District Health Officer’s (DHO) office. The clients were mobilized to come to the camp venues on the set days.

Having clustered VL eligible patients according to the villages they come from, linkage facilitators and village health teams (VHTs) were assigned to trace them from the community and mobilize them for the camp. Mobilization was mainly done through physical visits to their homes and persuading them to come to the facility on the designated camp days.

ASSIST worked with the District Lab Focal Persons (DLFP) and Central Public Health Laboratories (CPHL) to mobilize the required logistics (VL testing kits and request forms) for the camp. Quantification of the camp logistical requirements was guided by the anticipated need as per the generated lists of eligible clients expected at each camp site. The DLFP mobilized what they could within the district and where it was not sufficient Central Public Laboratory was contacted to boost the supply.

The Viral Load Camp: The camps were facility-based and were conducted between October and December 2016 with each selected facility holding one camp. Health facilities were selected based on the numbers of clients due for VL testing but in some districts all the ART facilities conducted VL camps. The decision on the venue for the camp was by the district under the leadership of the DLFP and/or HIV focal person with participation of ASSIST staff.

The health workers at the camp venue took the lead in conducting the camp and they were supported by the DLFP and district HIV focal person from the district health office. District-based ASSIST staff also provided additional support to the team. In a few instances where the anticipated load was high, health workers were mobilized from neighbouring facilities to provide extra help.

The linkage facilitators at the camp venue and some VHT members took part in registration, retrieving of files, and helping clients find directions to service points.

Client flow: On arrival to the camp venue, the client was received at the waiting area, registered and their names were confirmed on the VL eligibility list earlier compiled. Clients’ files were retrieved, sample collected, and after sample collection the patients’ particulars were updated in the VL register.

Results

There was an increase in clients accessing viral load testing during the intervention period. A total of 5,664 patients received viral load testing in 11 weeks during the intervention. As shown in Figure 1 below in one of the districts the number of samples received at CPHL significantly increased between October and December 2016.
Figure 1: Increase in the number of samples received by CPHL from Kitgum District (March 2016-February 2017)

Other than the camps no other change is known to have occurred during the intervention period that could have contributed to the change in access to viral load testing.

Challenges

It was difficult to get to some eligible clients as they had changed their registered addresses and they did not have telephones. In some cases, clients failed to turn up on the camp days despite having been reached with the message leading to low turn up for some camps. In some districts the rejection rates increased during the camps possibly due to the high client numbers handled during the camps.

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