Sharing country experiences on RVLT demand creation

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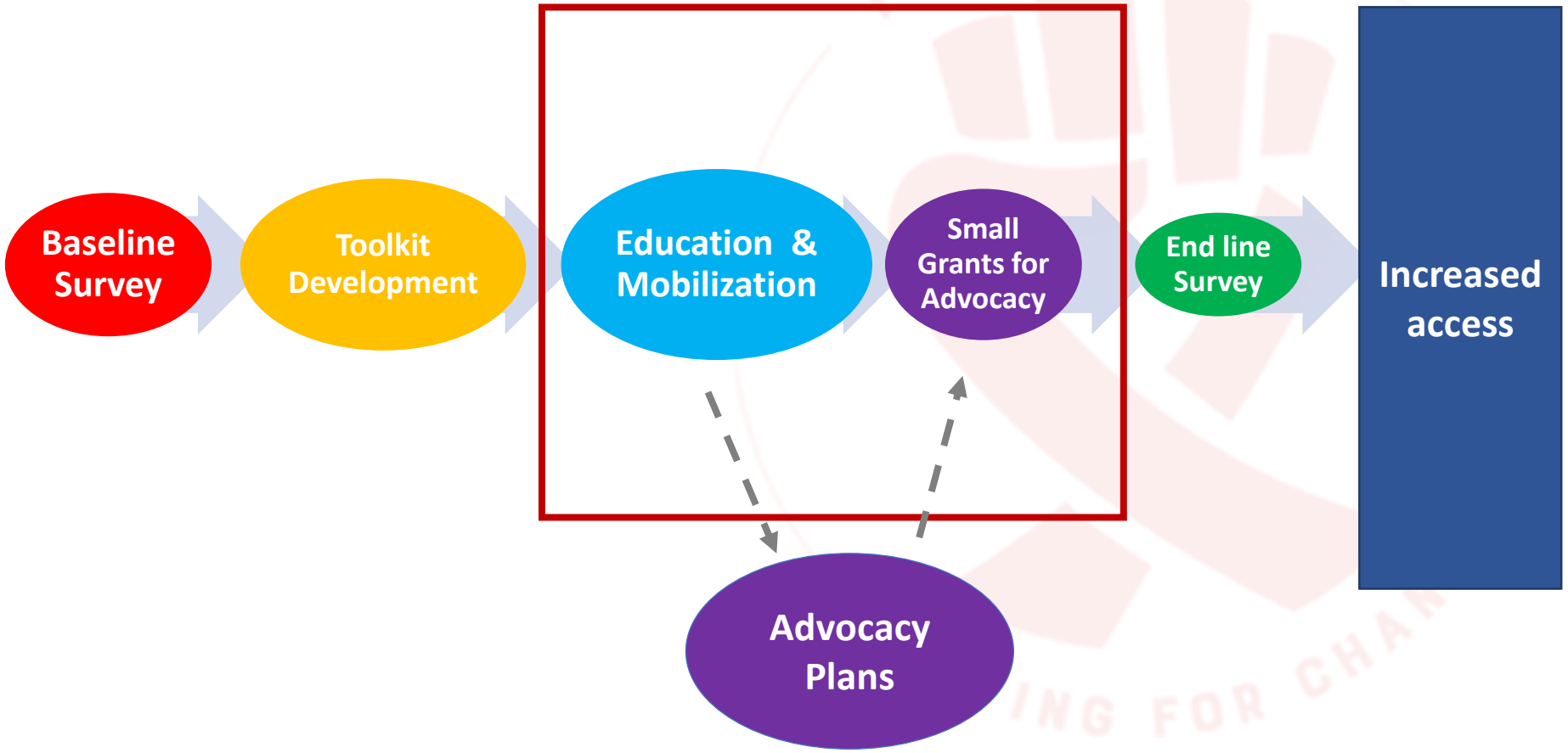
ITPC Demand Creation Model



Case study (Small Grant): Zambia

Community interventions on RVLT

- Targeted demand creation workshops on RVLT, particularly on new WHO guidelines on VL, for PLHIV, HCW and community workers
- Community mapping to assess availability of VL testing in 3 districts
- Policy engagement meeting (PLHIV, HCWs, and policy-makers)

Case study (Zambia): Some successes

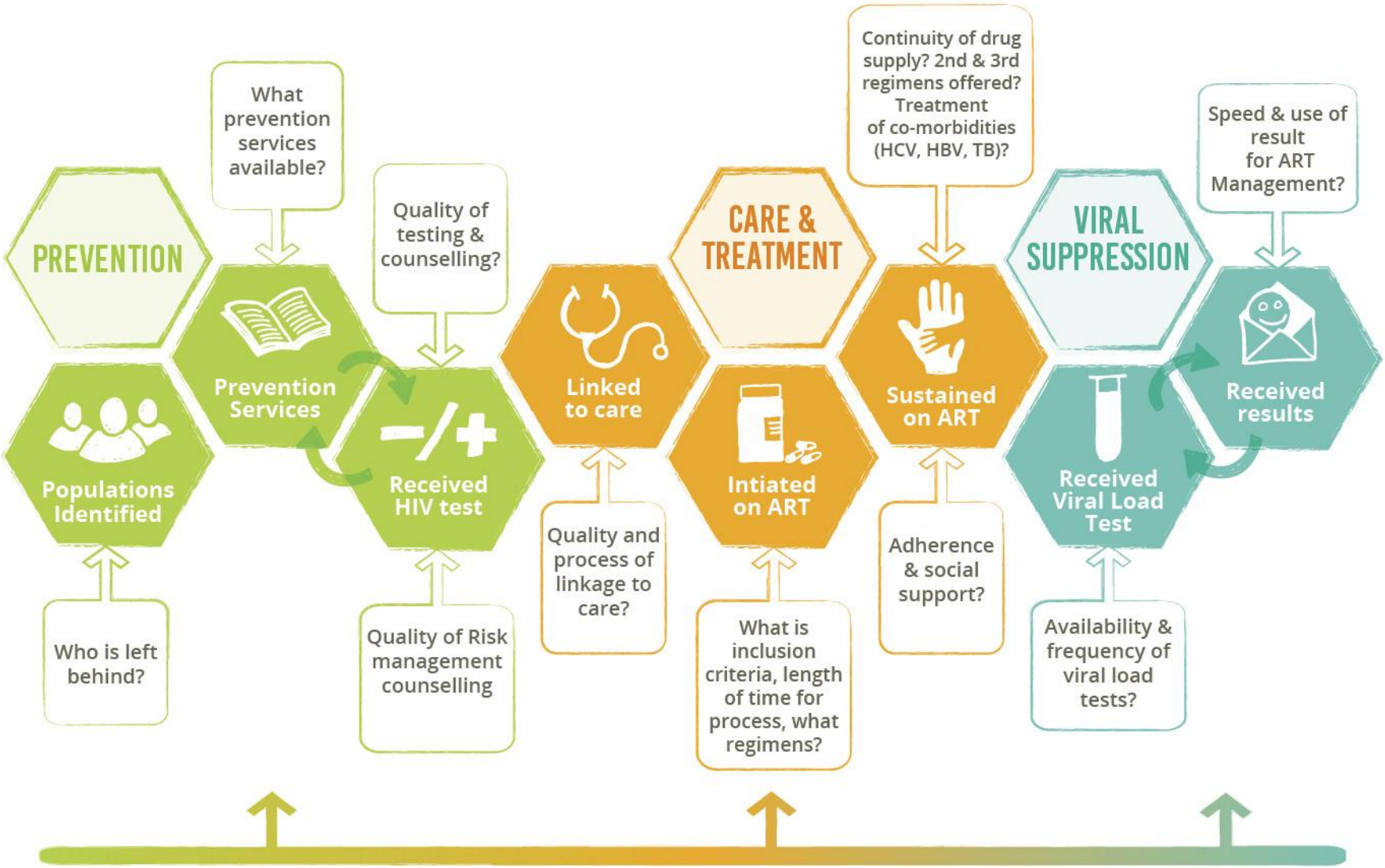
- PLHIV, CHW and HCW were sensitized about the importance of VL and the recommendations in the latest WHO treatment guidelines
- Combined pressure from increased community demand and policy engagement meetings led to provincial health offices demanding VL machines, eventually purchased by MOH. All provincial hospitals equipped with committment for expansion to district level facilities
- 87% (615 out of 720 test results) carried out April/May 2018 in district hospitals in Kafue were undetectable, according to in-country PEPFAR data (May 2018)

Case Study (Zambia): Persistent challenges and observations

- Tests carried out but no results (*Kapiri district),* ART samples transported to Lusaka and results delayed or samples lost (*Kabue district)*; VL machine not operational, unskilled lab technicians and transport challenges (*Kaoma districts*)
- HCW unaware of the WHO treatment guidelines since 2013, particularly in rural areas (reliance on CD4)
- VL is particularly low in rural areas, stockouts of specimen containers for CD4 and VL testing and no transport to provincial centers for testing
- **Demand creation and interest in VL is met with unavailability of VLT and stockouts of VL tests and test reagents at the target district**

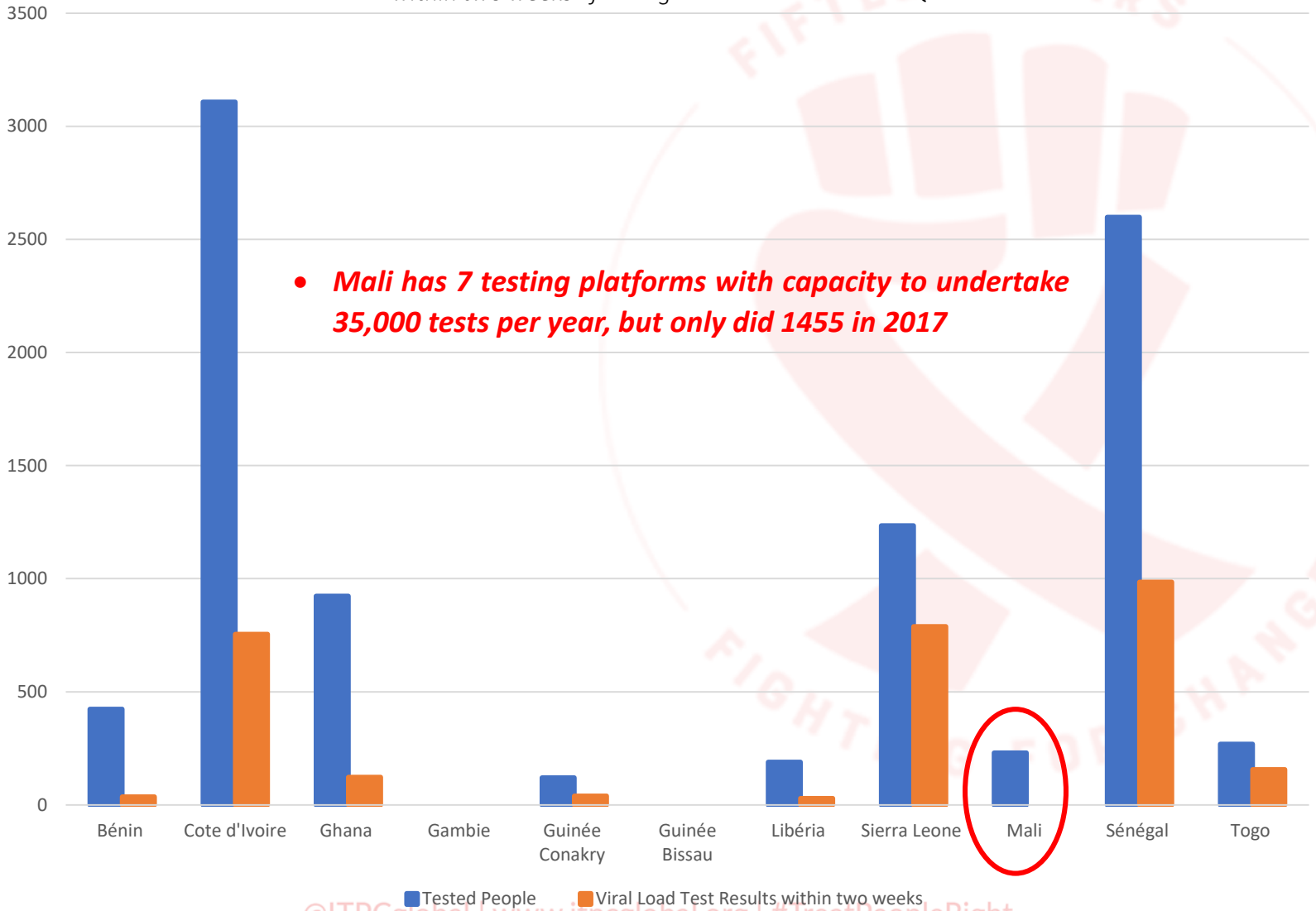
COMMUNITY MONITORING

Along the HIV Continuum of Prevention, Care and Treatment



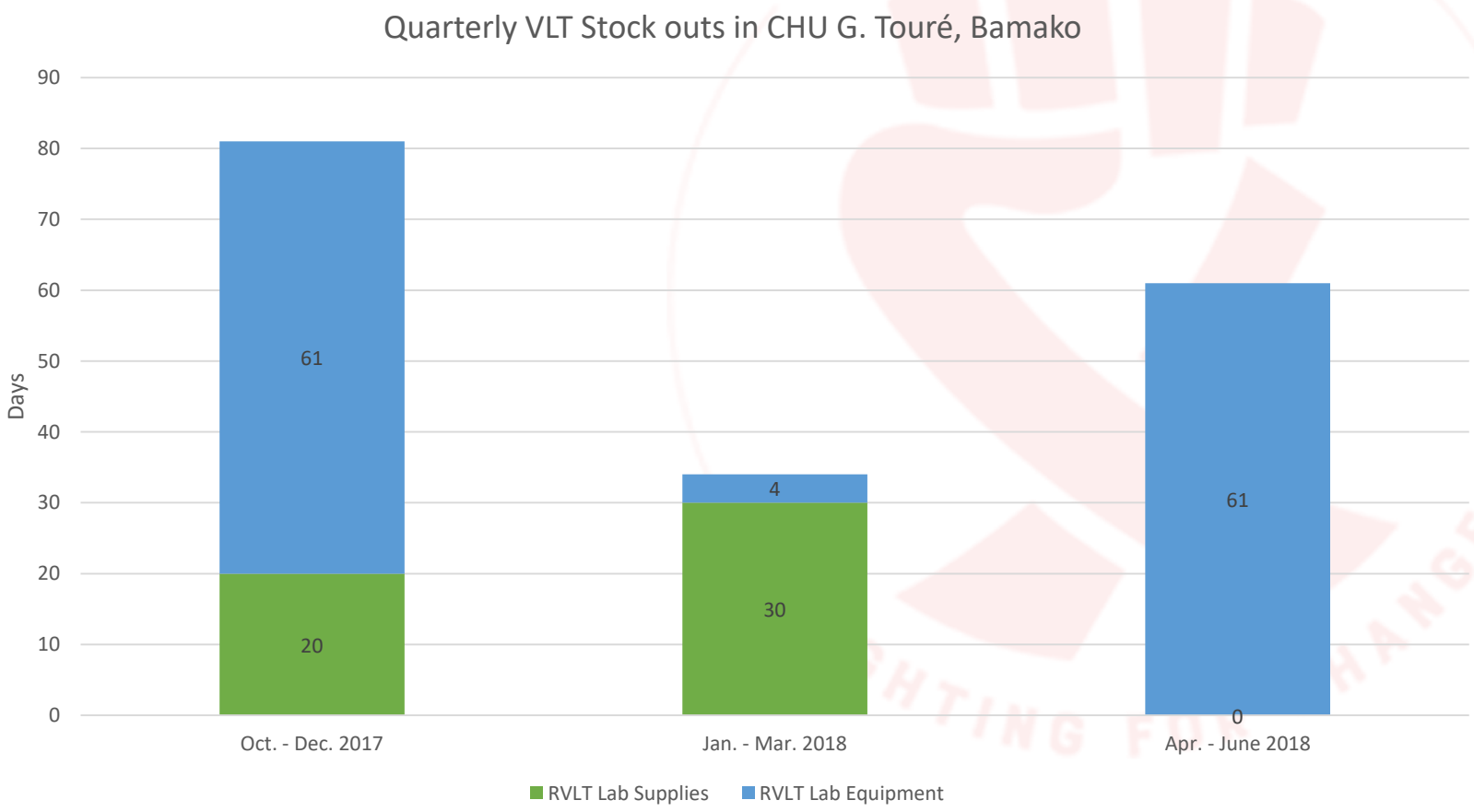
Regional Community Treatment Observatory data on viral suppression rates in West Africa

*Number of PLHIV that have **done a viral load test** compared with the Number of PLHIV that **received their viral load test result within two weeks** of taking the test – Cumulative Q1 2018*



- ***Mali has 7 testing platforms with capacity to undertake 35,000 tests per year, but only did 1455 in 2017***

Case Study (Mali): Persistant challenges and observations



Case study (Small Grant): Pakistan

Community interventions on RVLT

- Training of over 200 community leaders, service providers and policy makers on the importance and significance of RVLT (local language)
- Advocacy meetings targeting AIDS Control Program stakeholders on the importance of VL and low coverage

Case study (Pakistan): Demand creation

- Educating selected community members on need and importance of RVLT and establishment of community support groups and building capacity on advocacy skills
- CSGs advocacy meetings with Provincial AIDS Control program implementers for expansion of VL testing
- Sensitization (trainings and advocacy meetings) with national and provincial partners ie national and provincial AIDS control program implementers, UNAIDS, UNICEF, UNODC on low coverage of VL testing

Case study (Pakistan): Successes

- Increased demand from PLHIV for VL at ART centers and through APLHIV complaints management cell, as a result of trainings
- Formalised agreement for Aga Khan laboratories to increase coverage of VL testing (involvement of NACP/UNAIDS/WHO, APLHIV, CSGs)

  1500 tests with 82% suppressed VL

Case study (Pakistan): Lessons learnt

- Importance of demand creation and community-led advocacy in bringing about change
- Collaboration and involvement of all relative stakeholders led to successful increased coverage
- Community monitoring identified opportunities for greater use of the national ART MIS to support treatment management client management

Countries that have Achieved the 90–90–90 Targets/Near

	First 90	Second 90	Third 90		Viral load suppression among all people living with HIV
Achieved (90% or greater)	Czechia Eswatini Greece Lithuania Malawi Namibia Portugal Romania Serbia Singapore South Africa Thailand	Algeria Austria Botswana Burundi Cambodia Comoros Congo Democratic Republic of the Congo Denmark Eswatini Ethiopia Italy Lesotho Luxembourg Maldives Mauritania Mexico Mozambique Namibia Netherlands Niger Rwanda Saudi Arabia Zimbabwe	Botswana Brazil Cambodia Chile Czechia Denmark Germany Hungary Ireland Kuwait Lao People's Democratic Republic Lesotho Luxembourg Malaysia Montenegro Myanmar Nepal Netherlands Pakistan Portugal Saudi Arabia Serbia Singapore Slovenia Sri Lanka	**Achieved (73% or greater)**	Botswana Cambodia Denmark Eswatini Namibia Netherlands
Nearly achieved (85–89%)	Austria Botswana Bulgaria Burkina Faso Cambodia Denmark Germany Ireland Italy Luxembourg Netherlands Slovakia Zimbabwe	Argentina Croatia Germany Kuwait Mongolia Nigeria Portugal Singapore Slovakia Togo Uganda	Armenia Croatia Eswatini Georgia Honduras Malawi Namibia Suriname Thailand The former Yugoslav Republic of Macedonia Viet Nam	**Nearly achieved (65–72%)**	Germany Ireland Italy Lesotho Luxembourg Portugal Singapore

* Data are for 2017, except as as follows. 2016: Austria, Czechia, Denmark, Germany, Italy, Luxembourg, Netherlands, Portugal, Serbia, Slovenia. 2015: Croatia and Hungary. Estimates are for citizens of the country only for Kuwait and Saudi Arabia.

Source: UNAIDS special analysis, 2018; see annex on methods for more details.

Botswana: A success story

- Political political will and involvement research partners (eg BHP) led to focus on RVLT from start of treatment program
- Lower threshold measure for viral suppression (50 copies/mL)
- Centralised lab for RVLT, followed by a decentralisation process, satellite labs at district level (overall 25 VL machines nation wide)
- Trained lab technicians

Conclusion

How can communities be engaged to help the problem?

- Build the knowledge of communities to increase demand for RVLT (extended to HCP)
- Build community monitoring systems to identify barriers to access, monitor stock-outs, and measure quality of service
- Encourage community engagement and advocacy, to create desired change and facilitate opportunities to deliver services differently (duplicating ART CAGs model)

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