Thursday, 22 February 2024 LabCoP ECHO session: Low level viremia during anti-retroviral therapy; Lessons from a Uganda study

SN	Questions	Answer/ Response / Comments
1.	Some countries in SSA use various testing platforms with lower limit of detection as low as 40 copies/ml for plasma VL. Why did you use the cut-off of 50-999copies/ml for LLV?	We chose this range of 50-999 copies/ml, following the WHO definition of Low-level viraemia (LLV).
2.	Intensive Adherence counselling in most SSA countries is offered only to clients with unsuppressed VL results. Is this same in Uganda?	In Uganda, intensive adherence counselling (IAC) is now also offered to PLHIV with LLV, as per the 2022 WHO recommendations.
3.	Completing all three sessions of IAC is a big challenge in most health facilities in Cameroon. Your study indicates 100 percent completion (68/68). What were your strategies in the study to achieve this high completion rate and if it applies to the standard of care in Uganda?	In our study, we gave a transport refund to the participants when they came for the IAC sessions. We also used continuous reminders to follow up those who were scheduled for IAC in the study.
4.	What is IAC??	IAC is Intensive adherence counselling, and this originally refers to targeted counseling offered to PLHIV on ART with a non-suppressed viral load (VL of 1,000 copies/ml or more). It involves three monthly sessions of targeted counselling, after which a VL test is repeated in the fourth month.
5.	How could LLV (50-1000copies/ml) contribute to treatment failure unless the clients not adhering to the regimens?	PLHIV on ART are expected to completely suppress the virus and have a non-detectable viral load status. Hence if a PLHIV has LLV, they could already be having drug-resistant HIV, which if not managed well, can lead to treatment failure.
6.	I might have missed it: on follow-up, what percentage of patients in the study were found to have persistent LLV?	56.3% of PLHIV had persistent LLV on follow-up.
7.	How do you exactly define LLV?	Low-level viraemia was defined as a viral load of at least 50 copies/mL but less than 1000 copies/mL (≥ 50 copies/mL to < 1000 copies/mL)
8.	What is your comment on re-introduction of immunological markers such as CD4 + T cells in monitoring HIV degree progression and prognosis.	Immunological markers like CD4 are very helpful in complimenting viral load monitoring to predict patient outcomes, in the era where we aim to achieve epidemic control.
9.	Do we know what proportion of the LLV is associated with LLV versus suboptimal drug intake?	We need to do further research to understand this.
10.	Is there a maximum number of repeat IAC and repeat viral loads for a client with low viremia considering the cost of reagents and public health approach?	We also need to investigate this further.
11.	When is a client said to have HIV drug resistance?	This can easily be determined by doing HIV drug resistance testing for all eligible PLHIV.


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