Retention in care in the South African setting...

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Numbers in sub-Saharan Africa in 2015:

• 19 of 37 million people living with HIV (>50%) are in sSA.
• Health care resources are limited; but still achieved >10 million people on ART.

Still 470,000 AIDS-related deaths in 2015.
Losses on ART programmes are high:

Takuva et al, AIDS 2017

Fig. 1. Estimated HIV continuum of care in 2012 in South Africa. HIV-infected, n = 6511 000; linked to HIV care, n = 3300 000; on ART, n = 2140 000 and viral suppression (viral load <400 copies/ml), n = 1550 000. All numbers are rounded off to the nearest 1000.

Fox and Rosen, JAIDS 2015

FIGURE 1. Average retention at specified time points, by region. Note: y axis starts at 40%.
Losses on ART programmes are high:

17.7% had discontinuation of treatment before 16 weeks.

Njunguna et al, Plos One 2013.
Katz et al, CROI 2015
Specific populations:
Pregnant women –
Losses were high before B+
Specific populations:
Pregnant women – losses are still high with B+

Phillips et al, JIAS 2014

Haas et al, Lancet HIV 2016
Specific populations:
Pregnant women – losses are still high with B+

6 Month Retention Cascade, 186 health facilities, Uganda, OHTA, 2014

25% Never came back after 1st visit
Specific populations:

Youth:
Increased rates of viral failure.
(Nglazi et al, BMC Infect Dis 2012)

Increased risk of poor adherence, treatment interruptions and lost to follow up.
(Orrell, JAIDS 2015)

(Evans et al, AIDS Hum Retroviruses 2013)
Specific populations:

Previous raised viral load – implementation and discontinuation go hand in hand

**Figure 3:** A Kaplan-Meier survival curve depicting risk of loss to care overtime. Losses include deaths and those lost to followup. Those who never experience virological breakthrough are more likely to remain in care overtime. Losses to care are greater in those who experience breakthrough and do not differ by future virological outcomes (failed or resuppressed).
Cycling in and out of care:

1154 patients received ART

- 188 patients transferred to other ART clinics
- 64 patients died on ART
- 291 patients defaulted ART

- 611 in care and never defaulted
- 96 patients resumed ART
- 195 patients did not resume ART and were lost to follow-up

707 in care: 611 never defaulted 96 treatment interrupter

Kranzer et al, JAIDS 2010
Why?

**Competing demands** – caring for others, travelling for funerals or work take precedence.

**Unexpected events** – travel delays, accidents, violence.

**Lack of funds** to attend – further clinics

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Figure 1. How missed visits may become disengagement from HIV/AIDS treatment and care in Africa. doi:10.1371/journal.pmed.1001369.g001

Ware et al. Plos Med 2013
Why?

Dissatisfaction with care - long waiting times; rude behaviour of staff.

Reluctance to come back – staff behaviour, fear of negative interaction

Ware et al. Plos Med 2013
Summary?

Losses are great, especially in the first few months of care;

Some populations need more support;

We can’t prevent every loss, but we can do better with what we have.
Improving retention in care:

Changes to clinic structure:

• Improve initial engagement: dedicated team, streamlining of care / defining trajectories.

• Improved monitoring: notice EARLY when someone is missing...use available data e.g. pharmacy refills.
Improving retention in care:

Changes to clinic structure:

• New models of care: ease of use and access e.g. adherence clubs in the community, nearer peoples homes; dispensing machines or drug delivery.
Improving retention in care:

Changes to clinic staffing:

• Appropriate staff for the patient load (over-burdened, under-skilled)

• Encourage good staff interaction, for patients to feel are cared for and belong.

• Embrace when return to care.
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