EDITORIAL

Attrition from HIV care among adolescents and adults in a low-income setting

Rashida A. Ferrand^{1,2}<http://dx.doi.org/10.5588/pha.16.0035>

The global scale-up of antiretroviral therapy (ART) has dramatically reduced mortality among people living with the human immunodeficiency virus (HIV).¹ The success of ART programmes, however, relies on patients remaining in care and adhering to treatment. Under programmatic conditions, in addition to mortality, a proportion of patients drop out of treatment programmes without seeking care elsewhere.² These patients are at high risk of morbidity and death within a short time of attrition.³ A number of studies have examined retention in care, but few have evaluated outcomes by age, particularly among adolescents and youth. This is a very heterogeneous age group with respect to physical, psychological and cognitive development, but studies tend to group adolescents variably as adults aged >16 years or >18 years.

The study in this issue of *Public Health Action* by Matyanga et al., from a public sector clinic in peri-urban Zimbabwe, is the first to compare attrition in a non-research cohort between younger (age 10–14 years) and older (age 15–19 years) adolescents and between younger (age 20–29 years) and older (age ≥30 years) adults, over a 2-year period.⁴

The rates of retention in care by 24 months were greater than 80% in all age groups except young adults, where 26% were not in care by the end of 24 months. These rates are higher than those reported in earlier studies, demonstrating that progress has been made in retaining patients in care.⁵ The significantly lower rates of retention in care in young adults is, however, of concern. This age group has the highest HIV incidence of any age group, and it is highly mobile. The study was conducted in a clinic that serves a population where the majority live in informal housing, and it is likely that there are high levels of migration for work, which may result in interruption of HIV care.

More than three-quarters of attrition across all age groups was due to patients being lost to follow-up, a finding also reported by other studies.² Attrition was associated with late presentation, and it is probable that many of those lost to follow-up died.³ This highlights the need not only to improve tracing of those who default from care but also to implement innovative HIV testing strategies so that timely HIV treatment can be started. Notably, more than a third of patients initiating ART had advanced disease, which is associated with poorer clinical outcomes. Among adolescents, 91% had

a body mass index of <17 kg/m², demonstrating very high rates of stunting and wasting. While this may be partly explained by food insecurity, it is much more likely to be due to late diagnosis of vertically infected children who have slow-progressing disease.⁶

The 2015 World Health Organization HIV treatment guidelines recommend ART for all HIV-infected individuals, regardless of clinical or immunological stage.⁷ Much larger numbers of individuals will therefore be eligible for treatment now, many of whom will be asymptomatic. To achieve the ambitious Joint United Nations Programme on HIV/AIDS (UNAIDS) 90–90–90 targets of identifying 90% of HIV-positive persons through testing, initiating 90% of these on ART, and achieving viral suppression in 90% of those on ART, there is now an even more pressing need to develop innovative strategies not only to identify HIV-infected individuals, particularly hard-to-reach groups such as men and adolescents,⁸ but to focus efforts on retaining those at high risk of attrition. To achieve this, tracing procedures of those who drop-out will need to be strengthened.

References

- 1 Antiretroviral Therapy Cohort Collaboration. Life expectancy of individuals on combination antiretroviral therapy in high-income countries: a collaborative analysis of 14 cohort studies. *Lancet* 2008; 372: 293–299.
- 2 Fox M P, Rosen S. Patient retention in antiretroviral therapy programs up to three years on treatment in sub-Saharan Africa, 2007–2009: systematic review. *Trop Med Int Health* 2010; 15 Suppl 1: 1–15.
- 3 Brinkhof M W, Pujades-Rodriguez M, Egger M. Mortality of patients lost to follow-up in antiretroviral treatment programmes in resource-limited settings: systematic review and meta-analysis. *PLOS ONE* 2009; 4: e5790.
- 4 Matyanga M J, Takarinda K C, Owiti P, et al. Antiretroviral therapy outcomes: younger versus older adolescents and adults in an urban clinic, Zimbabwe. *Public Health Action* 2016; 6: 000–000.
- 5 Rosen S, Fox M P, Gill C J. Patient retention in antiretroviral therapy programs in sub-Saharan Africa: a systematic review. *PLOS Med* 2007; 4: e298.
- 6 Lowenthal E D, Bakeera-Kitaka S, Marukutira T, Chapman J, Goldrath K, Ferrand R A. Perinatally acquired HIV infection in adolescents from sub-Saharan Africa: a review of emerging challenges. *Lancet Infect Dis* 2014; 14: 627–639.
- 7 World Health Organization. Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva, Switzerland: WHO, 2015.
- 8 Joint United Nations Programme on HIV/AIDS. Global HIV/AIDS response: Epidemic update and health sector progress towards Universal Access. Geneva, Switzerland: UNAIDS and WHO, 2011.

AFFILIATIONS

- 1 London School of Hygiene & Tropical Medicine, London, UK
- 2 Biomedical Research and Training Institute, Harare, Zimbabwe

CORRESPONDENCE

London School of Hygiene & Tropical Medicine
London, UK
e-mail: Rashida.Ferrand@lshtm.ac.uk

Conflicts of interest: none declared.

PHA 2016; 6(2): 53
© 2016 The Union