Retention and virological outcomes from a PMTCT programme in rural Zimbabwe: 2013 to 2015

M Dhodho¹, C Metcalf², C Gumunyu¹, R Harrison¹, T Bonyo¹, S Simons¹, H Bygrave²

¹Medécins Sans Frontières, Zimbabwe
²Medécins Sans Frontières, Southern Africa Medical Unit
Background

• PMTCT Option B+ introduced in Gutu District, Zimbabwe in July 2013

• Adapted counselling for women entering the PMTCT Option B+ programme, including a rapid ART initiation session

• Viral load testing 3 & 12 months after starting ART, & then annually
Setting: Gutu District, Zimbabwe

- Rural district in Eastern Zimbabwe
- Population: 203,533
- HIV Prevalence: 14.5%
- Analysis included information from 1 district hospital and 9 primary care facilities
- Women aged 15 to 45 years at ART initiation
- Started ART between August 2013 & June 2015, while pregnant or breastfeeding
Objectives

To determine:
• Retention in care (RIC) among women initiated on ART in the PMTCT B+
• Reasons for loss-to-follow-up (LTFU) and factors associated with LTFU
• Viral load coverage & virological suppression 3 and 12 months after starting ART

Methods

• Analyzed electronic medical records in an M&E database & viral load results in a lab database
• Tracing of a sample of 200 women LTFU carried out by phone & home visits by community health workers (CHWs)
Characteristics of women included in the analysis

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age in years, median (IQR)</td>
<td>28 (22 to 33)</td>
</tr>
<tr>
<td>Pregnant at initiation, n (%)</td>
<td>435 (73.5%)</td>
</tr>
<tr>
<td>WHO Stage 1 or 2, n (%)</td>
<td>574 (98.0%)</td>
</tr>
<tr>
<td>CD4 &gt; 500 cells/µl, n (%)</td>
<td>142 (43.7%)</td>
</tr>
</tbody>
</table>
Characteristics of women included in the analysis

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age in years, median (IQR)</td>
<td>28 (22 to 33)</td>
</tr>
<tr>
<td>Pregnant at initiation, n (%)</td>
<td>435 (73.5%)</td>
</tr>
<tr>
<td>WHO Stage 1 or 2, n (%)</td>
<td>574 (98.0%)</td>
</tr>
<tr>
<td>CD4 &gt; 500 cells/µl, n (%)</td>
<td>142 (43.7%)</td>
</tr>
</tbody>
</table>
10.4% did not return following ART initiation
Retention-in-care (RIC)

10.4% did not return following ART initiation

79%

78%

Proportion RIC

Months on ART
Retention in care (RIC) by pregnancy status at ART initiation

- BF 84%
- Preg 76%

p = 0.3546
Retention-in-care (RIC) by facility

- 9 PHCs: 86%
- GRH: 71%
- p = 0.0002

Months since starting ART

- 9 smaller facilities
- Gutu Rural Hospital
Tracing of women lost-to-follow-up

- Tried to trace: 200
- Traced: 115 (57.5%)
- On ART: 38 (19%)
- On ART out of district: 25 (12.5%)
Reasons for defaulting

Not given: 44%
Disclosure: 25%
Moved: 9%
Stopped by partner: 6%
Religious beliefs: 3%
Side effects: 1%
Other: 12%
Coverage of viral load testing & viral suppression

3 months
- Eligible: 374
- Tested: 234 (63%)
- Suppressed: 215 (92%)

12 months
- Eligible: 226
- Tested: 109 (48%)
- Suppressed: 92 (84%)
Conclusion

• Retention of women started on ART in PMTCT is a challenge
  • Higher risk for those initiated whilst pregnant (aHR 1.4; p = 0.150)
  • Higher risk for those attending Gutu Rural Hospital, the largest facility (aHR 2.1; p <0.001)
• Limitations of facility-based M&E systems to record “silent” transfers
• Disclosure is a common reason for women to be lost to follow-up
• 90% of women suppressed their viral load 3 months after starting ART (meeting 90-90-90 target) BUT this still left 10% of exposed infants were exposed to ongoing risk
Recommendations

• Increased support is needed for counseling at ART initiation & during the first months on ART

• Improve access to counseling in the largest facility – focus on the mobility of patients attending these sites

• Appointment system needs strengthening & systematic defaulter tracing in all facilities