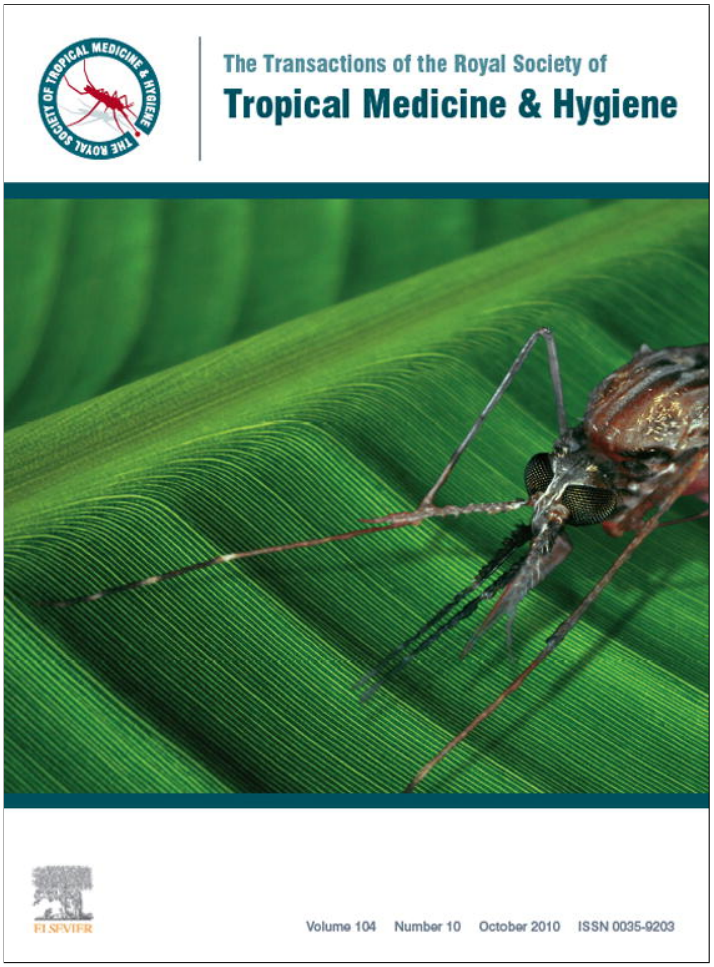

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Attrition of HIV-infected individuals not yet eligible for antiretroviral treatment: why should we care?

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By reporting on additional country experiences, Van Griensven and colleagues add nicely to current discussions on patient attrition from HIV/AIDS programs.[1–3] The shared concern is that among enrolled patients, attrition is unacceptably high for both patients not yet eligible for antiretroviral treatment (ART) (thus waiting to become eligible) and for those already eligible but still waiting for ART. Pre-ART attrition reached levels as high as 49% in Cambodia[1] and 76% in Malawi.[2] The question raised by Van Griensven et al. is, *'Should we care about such pre-ART attrition?'* The answer – undeniably 'yes'. Improving pre-ART attrition in those not yet eligible for ART will give us an opportunity to enhance the uptake of preventive interventions such as cotrimoxazole prophylaxis, Isoniazid Preventive Therapy, family planning and promoting safer sex practices which could impact on HIV transmission. Similarly, for those eligible for ART, enhancing retention should improve the timely initiation of ART which in turn should reduce adverse ART program outcomes, prevent TB and other HIV related morbidity, and reduce HIV transmission.[4] Logically, this should foster a 'healthy cohort effect' favouring task-shifting to reduce waiting lists in settings with high case-loads and a shortage of human resources.[5]

The global community now requires countries to show strong momentum towards reducing HIV/AIDS related mortality by achieving the Millennium Development Goal targets of Universal ART access and reversal of the HIV/AIDS epidemic trend by 2015.[6] An integral part of this effort should be aimed at achieving high retention rates not only among those already on ART but also among those waiting for ART. In this vein, a notable weakness of current evaluations of most HIV/AIDS programs in resource-limited settings is that they are confined to 'on-treatment analysis' which may significantly underestimate overall program attrition and present a skewed picture of program success. As Van Greinsven et al. point out, pre-ART attrition might be related to factors such as unfavourable attitudes of health workers and patients, poor or ill-adapted counseling techniques, repeated appointments, cost-of-transport, relatively long waiting times at the clinic, and unascertained deaths due to severe diseases such as undiagnosed TB and bacteremias/septicemias. High pre-ART attrition is thus a 'red flag' sign reflecting the status of those who have entered the system but then slip through without benefiting from available interventions.

The World Health Organization (WHO) recently revised ART eligibility guidelines aimed at encouraging an earlier start on ART.[7] The direct implication at program level is that there will be larger proportion of patients in the pre-ART waiting line. If the current status-quo is maintained this might lead to a further increase in pre-ART attrition.

So what needs to be done to change this paradigm? First, programs will need to be more inclusive in their program monitoring and should report on: (a) the proportion of enrolled patients who are not yet eligible for ART that are retained (b) the proportion of those who meet the criteria to start ART that eventually do so and (c) attrition that is inclusive of both pre-ART and ART groups. We would strongly encourage the WHO to include such recommendations in their current monitoring and reporting guidelines.[8]

Second, active tracing of those who do not turn up for scheduled appointments is currently only applicable for those who start ART. Thus, when a patient in the preparation phase of ART does not turn up for a scheduled appointment, no action is taken, i.e., this is not reported and existing patient tracing systems make no effort to find them. We suggest (a) to agree on a standardized definition of loss to follow up for those in the pre-ART phase, e.g., 'a patient not seen for one month or more after the date of scheduled appointment', (b) routinely record those who do not turn up for scheduled appointments and (c) ensure that existing and other innovative patient tracing systems (e.g., cell phone calls and SMS reminders)[9] are activated for all enrolled patients (ART-eligible or not) who miss scheduled appointments.

We will only be compelled to act on the problem of high pre-ART attrition if we see it. It is high-time that programs are judged by the rates of retention and attrition among all enrolled patients and not just amongst those who start ART.

Conflicts of interest: None declared.

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