Adherence to two HIV programs in a conflict-affected setting: lessons learnt from South Sudan

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Introduction

In South Sudan, HIV/AIDS is one of the leading causes of mortality in adults. MSF OCBA in collaboration with the Ministry of Health supports HIV care in Malakal and Ulang hospitals since 2015 and 2018, respectively. Access to health care in an already weak health system is a significant challenge for populations in areas of the country where subnational violence often results in population displacement. Risk of violence, including revenge attacks, is a significant access barrier due to risk of being killed or raped when individuals seek health care. Severe seasonal flooding and lack of road infrastructure, frequent stockouts and stigma, are also important factors impacting adherence to HIV treatment. The aim of this study was to identify the main demographic and clinical factors associated with HIV adherence in the two supported cohorts.

Methods

Descriptive and survival analyses were conducted on routinely data collected from HIV cohorts from 2015(Malakal) and 2018(Ulang) till September 2022.

Results

The cohort in Malakal included 630 patients with 48.3%(304/630) of females and mean age of 34(SD:6). Retention in care at 6, 12 and 24 months was 66.3%(95%CI:61.7-70.5), 50%(95%CI:44.9-54.8) and 37.4%(95%CI:32.2-42.6), respectively. Lost-to-follow-up (LTFU) was associated to low BMI (RR 1.67(95%CI:1.1-2.5)). Baseline WHO stage 3-4 was found to be a protective factor (RR=0.69(95%CI:0.5-0.9)). There was no association between LTFU and sex. Ulang cohort included 178 patients with 50%(75/150) females and mean age(SD) of 35(5). Retention in care at 6, 12 and 24 months were 43.3%(95%CI:32.1-54), 38.5%(95%CI:27.2-50.1) and 35.9%(95%CI:24.2-47.8). No associations between clinical or sociodemographic factors have been observed. LTFU in Ulang was higher than in Malakal (RR 1.47(CI=1.1-1.9)).

Conclusions

Advanced WHO stages were a protective factor for LTFU in Malakal, suggesting that an increase in medical needs could have led to an improved adherence. Low BMI is a well-known LTFU predictor which is often related to socioeconomic and food vulnerability, both associated as well to poor retention in care. Compared to other studies, we didn't find association with sex. The existence of overwhelming contextual and structural factors (such as distance) might dilute the effect of other sociodemographic and clinical factors, especially in Ulang. Targeted interventions should be put in place to combat stigma in the community and to facilitate access to care adapted to unstable contexts, with a special focus to patients with low BMI and early WHO stages. Further qualitative studies on patients' health seeking behaviour could help understanding and addressing the high LTFU rate.

Ethics: This descriptive study is based on routinely collected programmatic data. MSF ERB has granted an exemption for this study and SSD National ERB exemption is currently in process.

Conflict of interest: No conflict of interest reported by the authors.