Open Access Library Journal
2023, Volume 10, e9729
ISSN Online: 2333-9721
ISSN Print: 2333-9705

Loss of People Living with HIV/AIDS in the Care Centers of Kinshasa, Democratic Republic of the Congo

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How to cite this paper: Bongenya, B.I., Dikati, N.M., Losenga, L.O., Selenge, S.M., Booto, G.I., Ntumba, T.K., Kabengele, B.O., Sombo, M.-T.A.S., Bumoko, G.M.M. and Kamangu, E.N. (2023) Loss of People Living with HIV/AIDS in the Care Centers of Kinshasa, Democratic Republic of the Congo. *Open Access Library Journal*, **10**: e9729.
https://doi.org/10.4236/oalib.1109729

Received: January 5, 2023
Accepted: March 28, 2023
Published: March 31, 2023

Abstract

Context: The retention of People Living with HIV (PLHIV) and on Antiretroviral (ARV) in Outpatient Treatment Centers (OTC) remains a major challenge in Africa, particularly in cross-border areas due to the high mobility of the population. **Objective:** The objective of this study was to determine the reasons behind the loss of patients on Antiretroviral Treatment (ART) after 6 months of follow-up. **Methods:** This study is a descriptive survey to present the reasons for the loss of PLHIV at the 6th month of ART in the OTC for HIV in Kinshasa. The population of the present study was HIV-infected adults over the age of 18 on first-line ART in the OTCs included in the study. The parameters of interest followed for the present study were: age, sex, clinical condition and reasons for loss of PLHIV. **Results:** At the sixth-month medical follow-up appointment, 62 patients had responded and were thus included; 61.3% were women and 38.7% were men. The loss of patient's rate from D0 to M6 was 47.9%. 61.8% of patients were at clinical stage 3 according to WHO, followed by 29.1% of patients who were in clinical stage 1. 67.9% had normal clinical status and 28.3% had good clinical status. The most common reasons were respectively travel and lack of contact for 10.5% each; followed respectively by non-respect of appointment dates and fear of blood samplings for 8.8%, each, and forgetfulness for 7.0%. **Conclusion:** Nearly half of the patients no longer return to the treatment centers where they started.

The most common reasons for not keeping appointments are travel, lack of contact, not keeping appointment dates, fear of blood samples and forgetfulness.

Subject Areas

HIV

Keywords

Loss of Sight, PLHIV, Kinshasa, DRC

1. Introduction

Human Immunodeficiency Virus (HIV) infection is one of the most complex infections today. This complexity is even more accentuated in Africa and particularly in cross-border areas where population mobility is very high [1]. Socio-economic status and poverty are the main factors that facilitate the spread of HIV in countries; almost permeable borders, wars, and the atrocities they cause facilitate the movement of populations and the emergence of different variants of HIV in countries [2].

The advent since 1996 of Antiretrovirals (ARVs) and Highly Active Antiretroviral Therapy (HAAT) have transformed the natural history of HIV infection [3]. Several definitions have been given to the loss of sight in the context of HIV infection as being any patient who has not given any news three months after the date of his last appointment [4].

Despite the policy of free care and ARV Treatment (ART) for all People Living with HIV (PLHIV) and the decentralization of ARV care from large cities to health districts in order to facilitate physical and economic accessibility to care, the psychological suffering persists, and needs to be considered as an integral part of the treatment in order to guarantee its effectiveness [5]. Psychological disorders and social stigma significantly affect their quality of life and adherence to treatment [6].

The retention of PLHIV on ART at the various Outpatient Treatment Centers (OTCs) remains a major challenge. On the other hand, the rupture or discontinuation of ART can lead to a deterioration of the clinical state, a drop in immunity and an increase in viral load in the patient [5].

In the Democratic Republic of the Congo (DRC), the average prevalence of HIV infection is estimated at 1.2% [7]. In 2020, the country registered 510,000 PLHIV; and in 2021, 376,617 PLHIV (75.9%) were receiving ART [8] [9]. The fight against HIV and the care of PLHIV in the DRC are faced with various problems such as the increase in new infections, the lack of information, poor diagnoses of HIV, shortages of stocks of ART and Rapid Diagnostic Tests (RDTs), different cultures, insufficient financial means for comprehensive care of patients and health personnel, the emergence of new variants and co-infections, poor me-

dication intake [10] [11]. The strong belief in traditional healers and the stigmatization also make the problem even more complex with a very large number of people lost to follow-up [1].

Hence the objective of this study was to determine the reasons behind the loss of patients on Antiretroviral Treatment (ART) after 6 months of follow-up.

2. Methods

2.1. Study Design, Patient and Sample Setting

This study is a descriptive survey aimed at studying the reasons for the loss of PLHIV at 6 months of ART in the Outpatient Treatment Centers (OTC) for HIV in Kinshasa, Democratic Republic of the Congo (DRC). All the patients were questioned about various reasons that may lead them to no longer attend OTCs.

2.2. Study Population

The population of the present work was HIV-infected adults over the age of 18 on first-line ART in the OTCs included in the study.

2.3. Parameters of Interest

The parameters of interest followed for the present study were: gender, clinical status and reasons for loss of PLHIV.

2.4. Ethical Consideration

The confidentiality of PLHIV was respected as well as the anonymity of patients in the study. It was approved by the research ethics committee of the School of Public Health, Faculty of Medicine, University of Kinshasa. Authorization to access the OTCs has been obtained from the authorities.

2.5. Statistical Analyzes

Only available data were analyzed, missing data were considered completely random.

3. Results

At the start of the cohort, on Day zero (D0), 119 patients were included. At the sixth month medical follow-up appointment, sixty-two (62) patients had responded and thus were included in this study. Sixty-one percent (61.3%) of the patients were female while 38.7% were male; giving a sex ratio of 1.58 in favor of women (**Figure 1**). The loss rate of patients from D0 to M6 was 47.9% in the centers of Kinshasa.

Sixty-two (62) percent (61.8%) of patients were at WHO clinical stage 3; followed by 29.1% of patients who were at clinical stage 1, and 9.1% at clinical stage 2 (**Table 1**). Almost sixty-eight percent (67.9%) had normal clinical status, 28.3% had good clinical status, and 3.8% had poor clinical status (**Table 1**).

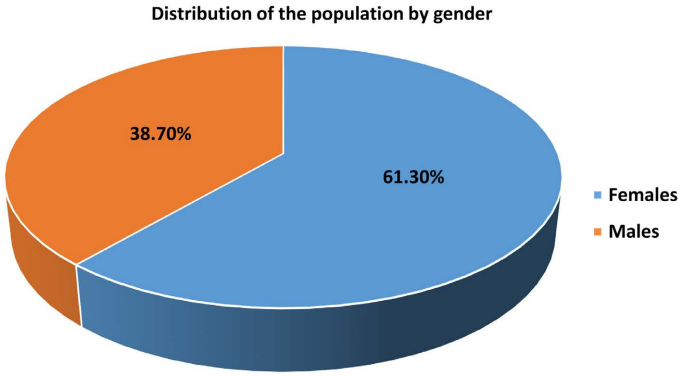

Figure 1. Distribution of the population by gender.

Table 1. Clinical parameters.

Parameters	M6 (n = 62) %
Clinical Stage	
Stage 1	29.1
Stage 2	9.1
Stage 3	61.8
Stage 4	0
Clinical Status	
Normal	67.9
Good	28.3
Bad	3.8
Moribund	0
Pre-Moribund	0

The reasons most presented by the patients were respectively travel and lack of contact for 10.5% each; followed respectively by non-respect of appointment dates and fear of blood samples for 8.8%, each, and forgetfulness for 7.0%. Table 2 presents the above data exhaustively.

4. Discussion

The objective of this study was to describe the reasons for the loss of People Living with HIV at 6th month of ART in the follow-up cohort. At the start of treatment (D0), 119 patients were included in the study. At the sixth month medical follow-up appointment, sixty-two (62) patients had responded and were included in this study.

The loss of patients' rate from D0 to M6 was 47.9% in the centers of Kinshasa. This high loss rate for Kinshasa is similar to that published in 2019 [11]. The high rate of lost to follow-up is also found in various studies published in the Democratic Republic of the Congo and elsewhere where it varies between 28.8%

Table 2. Reasons for loss of PLHIV after 6 months of ART.

Reasons for loss of PLHIV	M6 (n = 62) %
Lack of transportation	5.3
Trip/vacation	10.5
Oversight	7.0
Refusal to accept his serological status	1.8
Voluntary refusal of appointments	1.8
Failure to meet appointment dates	8.8
Personal inconvenience	1.8
Voluntary change of treatment centers	1.8
Lack of contact	10.5
Total refusal of support	3.5
Spiritual belief	0.0
New motherhood	3.5
Missing person	3.5
Fear of blood samples	8.8
Moving or change of physical address	3.5
Death	1.8
No specific reason	26.3

in Bunia [12], 33.4% in Uganda [13], 36.0% in Senegal [14], and 50.0% in other Central African countries [15]. These data show that it is difficult to retain PLHIV in a cohort for a long time, especially in countries with limited resources.

Sixty-one percent (61.3%) of the patients were female while 38.7% were male; thus giving a sex ratio of 1.58 in favor of women. These data showing a predominance of the female sex in a cohort monitoring PLHIV are similar to the various studies published in recent years for Kinshasa and even for Central Africa [5] [6] [7] [12] [13] [14] [15] [16].

Sixty-two (62) percent (61.8%) of patients were at WHO clinical stage 3; followed by 29.1% of patients who were at clinical stage 1, and 9.1% at clinical stage 2. More than half (61.8%) of the patients were at stage 3 of the infection after 6 months of TRAV so that almost a third were in stage 1; no patient was in the AIDS stage. start ART late at high stages when the clinic begins to deteriorate. This observation has also been made by various authors [10] [11] [12] [13] [14] [17]. This delay in diagnosing patients has an impact on their care and the prognosis for monitoring PLHIV.

Almost sixty-eight percent (67.9%) had normal clinical status, 28.3% had good clinical status, and 3.8% had poor clinical status. Six months after starting ART, the clinical condition of the patients tends to improve compared to inclusion.

The majority of patients have normal clinical status and less than 4 percent have poor clinical status. These data demonstrate that the effectiveness of ART. These results are similar to those presented by different studies [17] [18] [19].

The reasons most presented by the patients were respectively travel and lack of contact for 10.5% each; followed respectively by non-respect of appointment dates and fears of blood samples for 8.8% each, forgetfulness for 7.0%, and lack of transport for 5.3%. These reasons are also presented by the patients of different studies but have different percentages; financial difficulties (15.9%) and travel (12.7%) in Douala [20], and forgetfulness (46.3%) and travel (22.6%) in Bamako [19].

5. Conclusion

After 6 months of follow-up under ART, nearly half of the patients no longer return regularly to their treatment centers where they started. The most common reasons for not keeping appointments are travel, lack of contact, not keeping appointment dates, fear of blood samples and forgetfulness.

Acknowledgements

The authors would like to thank the patients of the various centers who agreed to participate in this study, all the teams of the outpatient treatment centers of Kinshasa who participated, as well as all the authorities who enabled the progress of the study.

Conflicts of Interest

The authors declare no conflict of interest for this study.

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