Sustaining adherence to antiretroviral therapy among HIV/AIDS patients in Uganda
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Summary

This thesis is the product of a PhD project, entitled ‘AIDS Medicines in Resource-Poor Settings: Learning from District Level Transformations in Health Cultures and Arrangements in Uganda and South Africa’ (2004), funded by the Dutch Foreign Ministry. The generic proposal consisted of national, district, and community clusters. In particular, this PhD is located in and contributes to the cluster of ‘community level transformations and effects’. The objective of this cluster was to formulate best practices for introducing antiretrovirals (ARVs) in resource-poor settings, and to develop a generic model for implementing pragmatic ARV regimes for People Living with HIV/AIDS (PLWHA) in resource-poor settings.

At the operational level, the theoretical argument that guided this particular PhD was that adherence to life-long ARV treatment in Uganda’s resource-poor settings was an outcome of a reciprocal relationship between biomedical and environmental factors. That argument was intended to establish the relationships between biomedical factors in the form of the host (patient), the agent (health damaging organism), and the healthcare settings, on the one hand, and the environmental factors in the form of social, cultural, and economic factors, on the other hand. The actual fieldwork was implemented at two comparative ART accredited sites in Uganda, namely: Mbuya Reach Out, known as the urban-based Mission Facility (UMF), and Kayunga Hospital, known as the rural-based Public Facility (RPF). The Mission Facility was implementing comprehensive HIV/AIDS services in the form of medical, psychosocial, and socio-economic support; while the Public Facility was providing basic HIV/AIDS services in the form of medical and psychosocial support. The rationale for selecting two different sites was that these sites were likely to manifest different patterns in adherence to antiretroviral therapy (ART). The actual methodology entailed iterative qualitative and quantitative methods implemented over a time period of more than two years (January 2006 and May 2008). The actual fieldwork lasted longer than expected because of the desire to collect data against emergent research questions and hypotheses as writing progressed through advanced stages. The measurement of adherence was based on pill-count data for a period of three years preceding the study. The adherence results were validated by health indicators, namely: CD4 count, weight, and functional status at 6 month intervals.

Results indicated high adherence rates. Out of the 262 patients, 90% (236) achieved a pooled 95% adherence for the 3 years preceding the study. Surprisingly, there was
no significant difference between the two different health facilities: 89% of patients in UMF (providing comprehensive healthcare services) and 92% in RPF (providing basic healthcare services) achieved the 95% adherence. In fact, analysis of optimal adherence (100%) shows that 74% (89) of patients in the RPF compared to only 23% (32) of patients in the UMF achieved the 100% adherence. Retrospective longitudinal analysis of adherence reflected consistently high adherence levels, as well as positive evolution in health indicators throughout the entire treatment period.

In a complex relationship, biomedical and environmental factors facilitated and constrained adherence to ART. At the patient level, the factors associated with high adherence rates were mainly biomedical in nature, namely: 1) previous health condition; 2) desire to achieve personal goals in life; 3) therapeutic skills; 4) effective HIV/AIDS treatment; and 5) individual characteristics. Beyond the patient level, the quality of healthcare services and the availability of social support from kinship and associational have facilitated access and adherence to HIV/AIDS treatment.

Even in terms of adherence barriers, sub-optimal adherence was attributed to: 1) biomedical factors (sickness, side effects, feeling better or worse, and forgetfulness); 2) livelihood activities (domestic work, production work and social engagements), and; 3) access related barriers (mainly the inability to raise money for transport, difficult journey, access to food).

Both the facilitating factors and adherence barriers are mediated by external barriers. In this study, the physical-ecological conditions (weather conditions) was found to be the major external environment influencing factor.

The findings in this study confirmed the initial theoretical argument that adherence to life-long antiretroviral treatment in Uganda's resource-poor settings was an outcome of a reciprocal relationship between biomedical and environmental factors. However, the composition of adherence barriers reveals that, contrary to background studies in the developed world, biomedical barriers did not feature prominently.

As part of fulfilling one of the research questions, this thesis proposes recommendations for sustaining adherence to ART in Uganda's resource-poor settings.