Highly active antiretroviral therapy for HIV-1 infection: patients' quality of life and treatment adherence
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Chapter 7

Adherence to HAART:
Why is it so difficult? In reply.

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Interestingly, Peach and colleagues found comparable results in their study on adherence to HAART using a similar design as we did. Their findings add to the evidence that only about half of all patients take HAART as directed when both skipping of antiretroviral pills as well as deviation from the recommended intake schedule are being considered.

Peach and colleagues found no effect on adherence of dosing frequency and number of pills prescribed. Because they investigated adherence in an observational study, this finding could have been owing to prescription bias. Most likely, physicians prescribe simpler regimens to patients known or suspected to have problems with adherence. Consequently, comparable levels of adherence are to be expected when comparing simple and more complex HAART regimens. Determining the effect of regimen complexity on adherence would require random allocation of therapy. Indeed, higher adherence rates have been reported for a HAART regimen with twice-daily dosing without mealtime instructions compared with a HAART regimen with 3 times-daily dosing in addition to mealtime instructions in a randomized clinical trial [1]. Highly active antiretroviral therapy regimens are of the most complex therapies ever prescribed for an indefinite time. We feel that every effort should be made to simplify HAART regimens in order to facilitate patient adherence.

At present, factors that influence adherence as well as the mechanism by which they influence adherence are not clearly defined. There is evidence that non-adherence is not a stable patient characteristic but rather a dynamic phenomenon influenced by multiple factors varying over time [2, 3]. Despite the relevance of adherence for successful HAART, the question how to ensure sufficient adherence to HAART remains largely undetermined. Only a few studies investigating the effectiveness of interventions to enhance adherence have been reported so far, which hardly provide evidence of sustained effectiveness of interventions [4].

Insight into mechanisms that influence adherence to HAART could provide a starting point for designing adherence interventions. In a variety of chronic diseases, medication adherence was found to be influenced by an implicit cost-benefit analysis in which patients’ beliefs about the necessity of prescribed medication for maintaining health or preventing illness are weighed against concerns about the negative effects of taking it [5]. Possibly, future interventions that take into account the perceived trade-off between burden and benefit of HAART could improve patient adherence and thereby therapy outcome.
References


