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Short communication

Default from Anti-Retroviral Treatment Programme in Sagamu, Nigeria

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ABSTRACT

To determine the rate and reason for default from antiretroviral treatment (ART) program in Sagamu Nigeria, a cohort of 100 patients on ART was followed up for 12 months at the centre for special studies Olabisi Onabanjo University Teaching Hospital Sagamu between July 2000 and September 2003. The patient chart at the clinic were reviewed to collect the socio-demographic data of patients who defaulted ART treatment (defined as PLWA who refused to come back to collect ART medications for at least 6 months from the last visit). The patients were traced to their place of residence with the address given on the clinic chart. Where such patients were found at home, a reason for default from treatment was inquired from them. For those who were not met at home proxy interviewees such as a neighbour or a family member were asked if they were available. Of the 100 patients who had enrolled in the ART treatment programme during the study period, 36% of the study population defaulted treatment, 18% had died while 46% were alive and well. Major reasons for default includes: opting for spiritual/faith/alternative healing (8%), lost of interest in the programme/financial (7%), moved to home town of origin (6%), changed address (5%), untraceable home address or name (5%), side effects of ART (2%), widowhood rites (1%). Two individuals were not met at home after repeated visits by the Community health extension workers. About a third of PLWA defaulted from treatment. The major reasons for default were psychosocial factors unrelated to the treatment regimen. Ensuring adherence to therapy in communities must take into consideration the psychosocial and cultural practices and norms of the people to avert the emergence and transmission of drug-resistant strains.

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INTRODUCTION

Over 40 million people have been infected with the human immune deficiency virus (HIV) since it was first described over two decades ago. Africa alone accounts for 70% of the infection with two-third of these living in sub-Saharan Africa (UNAIDS/WHO, 2005). The first reported case in Nigerian was in 1986 and ever since there has been a steady increase in the incidence of HIV infection in Nigeria. With the 5% National HIV sero-prevalence rate, Nigeria is in a state of generalized epidemic involving all geographical areas of the country (FMOH, Nigeria, 1997).

Until recently the hope of survival for HIV infected persons has been very bleak especially in developing countries where there has been limited access to antiretroviral treatment. The best offered care in most developing countries before now has been treatment of opportunistic infections and in some instances palliative care. With the current global initiative which brought to focus the inequity in access to care between developing and developed countries, there has been increasing resources to enable developing countries to have access to anti-retroviral treatment (ART) especially with the 3 by 5 programme of the World Health Organization (WHO, 2003). Anti-retroviral treatment has been shown to improve the quality of life and has led to the reduction in morbidity and mortality comparable to observations made in developed countries (Daquin 2003).

A critical issue however to the success of ART is adherence to treatment regime. .Adherence is a complex dynamic behaviour influenced by several factors. Non-adherence to ART will lead to the development of drug resistance virus and ultimately drug failure (Romano *et al* 2002). Adherence therefore remains a public health concern, which needs to be addressed so that the maximum benefit from ART can be obtained. Thus this study was embarked upon to assess the pattern and reasons for default from ART treatment in Sagamu.

MATERIALS AND METHODS

A cohort of 100 HIV positive patients attending the Centre for Special Studies (CSS) specialist clinic located at Olabisi Onabanjo Teaching Hospital Sagamu, Ogun State Nigeria. All HIV positive receiving ART at the centre were enrolled into the study and followed up for one year.

Study Area and ART Control Programme

The study was carried out in Sagamu Local Government area, Ogun State, Nigeria. The town is a semi-urban area with an estimated population of 200,000 people. It is located midway about 50km northward from Lagos and southward from Ibadan.

One hundred and one patients were recruited into the drug program between June 2000 and September 2003.One patient was a rape case who had one month post-exposure prophylaxis (PEP) treatment. The remaining hundred patients were selected depending on the world health organisation (WHO) guidelines for initiating treatment. The antiretroviral medication was supplied by the Starfish project, Centre for Special Studies New York City (NYC). All combination antiretroviral drugs were selected by the CSS Sagamu clinician's after consultations with the clinicians at the CSS-NYC before commencement of therapy. Each patient was followed up as outpatients on a monthly appointment. If for any reason a patient is admitted in the hospital, a community health extension worker (CHEW) from the CSS-Nigeria team administers the ART drugs to the patients in the wards. The CHEW followed up patients who miss their monthly appointment to know the reasons why they missed appointment. Patients who default from treatment were defined as those who had failed to collect medication for more than 6 consecutive months after the date of the last attendance during the course of treatment. Information was collected with the aid of a proforma's designed for the study. Data was analyzed using standard statistical procedures including the use of Epi 6 statistical soft ware.

RESULTS

A total of 100 HIV positive patients attending the CSS clinic were enrolled into the study. There were 43 men and 57 women with male: female ratio of 1:1.3. The patients were aged between 16-

58 years. The mean age of patients in this study was 35.7±11.4.The mean age of men was significantly higher than for women (39.2±11.1 vs 33.1±11.1; p =0.007). Heterosexual route was identified as the major route of acquisition of HIV 96%, while 4% was plausibly through blood transfusion .There was no history of men who have sex with men or intravenous drug use. Majority of the respondents were currently married 60%, Christians 80%, from Yoruba ethic group 84% and secondary school education 45%. (Table I).

Table 1:
Socio-Demographic Characteristics of Patients on ART In Sagamu.

CHARACTERISTIC	*PERCENT (%)*
AGE	
15-24	12
25-34	36
35-44	29
45-54	17
>55	6
SEX	
Male	43
Female	57
MARITAL STATUS	
Single	18
Married	60
Separated	4
Divorced	9
Widowed	9
EDUCATIONAL STATUS	
No formal education	10
Primary education	33
Secondary education	45
Post-secondary education	11
Classification of HIV patients	92
HIV 1	2
HIV 2	6
HIV1&2	

Thirty-six respondents had defaulted treatment during the follow up period, 18 had died while 46 were still alive and well after one year of follow up (Table II).

Among the 36 individuals who had defaulted ART treatment, the main reasons for default were: opted for spiritual/faith/alternative healing (8%), lost of interest in the programme (7%), moved to home town of origin (6%), changed address (5%), untraceable home address or name (5%), side effects of ART (2%), widowhood rites (1%). Two individuals were not met at home after repeated visits by the Community health extension workers.

Table 2
Treatment Outcomes of patients receiving antiretroviral therapy

Outcomes	**Percentages**
Defaulted	36
Dead	18
Still on/Alive and well	46
Total	100

DISCUSSION

The study reveals that about a third of the study population had defaulted treatment during the 24 months of follow up. The rate of default is high considering the grave consequences of treatment failure and the development of drug resistant strain that will require second line treatment which are difficult and expensive to manage. The study highlights that both biomedical and social factors are important in issues of adherence to treatment in developing countries.

Stigma and rejection are daily issues facing people infected with HIV/AIDS especially in developing countries. The issue of stigma has been a barrier to people living with AIDS disclosing their status and getting access to available support and care services. This may be responsible for patients giving wrong address or changing their address and relocating to a new location where they are not known. Furthermore family members relocated some of the patients to avoid suspicion from neighbours and friends about the status of their kin. The effort aimed at challenging stigma and discrimination can lead to improvement in how PLWHA take care of their health and access available care.

Personality trait, depression and emotional

adjustment to the HIV infections have been observed as other possible reasons why patients are non-adherent to anti-retroviral drug use, thus it is not surprising to observe patients loosing interest in the treatment programme which could be due to several factors which may be intrinsic or extrinsic. Therefore, intensifying counselling of patients before initiating and during treatment is of utmost importance so that PLWA can adjust both psychologically and emotionally to the disease.

Other factors identified such as abandoning treatment to seek spiritual/faith healing especially when they feel better on the drugs is also worrisome. The unverifiable claim especially on the media by spiritualist and traditional medicine practitioners of an instant cure for HIV infection contributed a great deal to patients abandoning treatment. The government has a role in regulating the misinformation and misconception about HIV that is being propagated in the media. Also traditional and spiritual leaders need to be involved in the fight against HIV'AIDS by proper training as they can be used as change agents for positive action against HIV/AIDS in our community.

In the African setting particularly when a member of the family is ill, major decisions that affect the patients are taken by the immediate and extended family. It was observed that family members took some patients to their town of origin, to forestall the huge expenses that will be incurred if patients should die far away from their home town. It was observed that most of the family members were not aware of the HIV status of their wards nor were they aware of the type of medications being taken. PLWA must be encouraged to disclose their status to family members who can provide treatment and psychological support.

Another factor responsible for default was staying away to perform widowhood rites which were practised by indigents in this community. Some of the women had lost their husbands to HIV/AIDS and were required by the local custom to 'mourn the dead' for a period of 3 months or more. After this period some of the women are married out to close family members many of whom are not aware of the HIV status of these women. This has considerable implication for continued transmission of drug- resistant strain of HIV infection in the community.

It must however be noted that many of the patients enrolled into the program were not residing in the town. The cost of transportation and other service charge including paying for medications for the management of opportunistic infections may have contributed to default from treatment. The decentralisation or ART programme using existing primary health care structure may need to be considered in bringing ART services closer to the people. Other services such as treatment of opportunistic infections should be provided free to PLWA.

In conclusion, the introduction of anti-retroviral treatment into drug naïve communities needs to take the social and cultural factors into consideration to prevent the emergence and transmission of drug-resistant HIV strain in the community. Effectively addressing the issues of stigma and discrimination, intensifying counselling, decentralisation of ART services and providing free treatment for opportunistic infections will go a long way in ensuring adherence of patients to ART.

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