Qualitative Study; Knowledge, Arv Access, and Adherence among People Living With HIV in Bulukumba District, South Sulawesi

by Risnah Risnah

Submission date: 23-Dec-2018 06:47AM (UTC+0700)
Submission ID: 1060252203
File name: tuirnitin_2.docx (20.97K)
Word count: 2942
Character count: 16518

Qualitative Study; Knowledge, Arv Access, and Adherence among People Living With HIV in Bulukumba District, South Sulawesi

Risnah, Andi Suswani

ABSTRACT

Background: HIV/AIDS is a complex problem that requiring active involvement of people living with HIV/ AIDS (PLHIV) to control it. Knowledge about ARV access and adherence is essential for PLHIV to improve self-care behavior in seeking health services. This study aim was to obtain a description of knowledge, ARV access, and adherence among PLHIV in Bulukumba District.

Method: Qualitative study was conducted among 10 participant, consisting PLHIV, doctor, counsellor, The National AIDS *Commission* staff, peer support. Participant was identified by using Snowbal sampling with Content analysis.

Result: The result of study provide a description which is most PLHIVs already know the basic information about Human immune deficiency virus (HIV) Acquired immunodeficiency syndrome (AIDS), prefer to access ARV outside of Bulukumba district, and their reason of not adherence in treatment.

Conclusion: This result suggest to establish a place as a gathering of PLHA for sharing knowledge, mutual support, and reminding each other. Starting antiretroviral (ARV) and adherence are importance to maintain and improve their quality of life.

***Keyword** : HIV/AIDS, Knowledge, ARV Access, Adherence*

INTRODUCTION

HIV/AIDS is one of seriously health problems and challenges in the world. Until now, there wer 36.9 million PLHIV and 17.1 million were. 22 million of PLHIV did not get access to ARV therap including 1.8 million of children.[1,2] Mathers and Loncar (2006) predicted the deaths due to HIV/AIDS will continue to increase in 2030.[3]

Ministry of Health (MoH) reported that HIV prevalence in Indonesia was 191,073 people and AIDS cases were 77,112 people. The number of PLHIV who received ARV therapy is 63,066 people. This means that only about 33% of HIV patients who received ARV therapy.[4] South Sulawesi is the second larges of HIV prevalence in eastern Indonesia and Bulukumba district is the third rank of HIV /AID prevalence in South Sulawesi.[5] The risk factor of HIV transmission are heterosexual, IDU's, and pregnancy/breast feeding. Bulukumba hospital reported that number of PLHIV who started ARV is onl 6.7% of HIV diagnosed.

Knowledge about ARV therapy is importance and dispensable for PLHIV. Lack of knowledge related to ARV therapy can make PLHIVs making wrong decisions about their treatment.[3,6] Previou study reveals the quality of life among PLHIV can increase after ARV initiation. Additionally, adherence I also an important component in the success of ARV therapy and improve their quality of life. However, ARV access is still a polemic in developing countries.[7,8] This study seeks to provide a description of knowledge, ARV access, and adherence of PLWHA in Bulukumba District.

METHOD

Qualitative study as conducted among 10 participants including PLHIV, doctor, counselor The National AIDS *Commission* staff, and chairman of peer support NGO in Bulukumba district. Data were collected by using structured interview instruments in in-depth interview with PLHIV and Focus Group Discussion (FGD) with health officer. Snowball sampling was used to determine the sample. Data was analyzed by content analysis method. The steps on content analysis include; 1) Making a transcript, 2) determine the meaning unit, 3) summarizing and organize data, 4) performing data abstraction, 5) creating categories and theme compilations, 6) drawing a conclusion.

ETHICS

15 This research has obtained Ethical Approval Recommendation Hasanuddin University Number: 547/ H4.8.4.5.31/PP36-KOMETIK/2017-KOMETIK/2017

FINDINGS

Characteristic of participants

Total of 10 participants, consisting of 6 PLHIV with five male and one female, one of doctor, one of counsellor, one of The National AIDS *Commission* staff, and chairman of peer support NGO Interviews with informants were formulated 3 themes, namely knowledge about basic HIV/AIDS information and its treatment, ARV access and adherence to ARV treatment.

Knowledge of HIV/AIDS

PLHIVs knowledge based on interview result as follows:

"HIV/AIDS is deadly disease, most feared by people because it can be transmitted through sex, needles, vertically from HIV-positive pregnant women to their babies and from breast milk. Prevention by not doing risky behavior, always trying to increase knowledge and treated with ARV treatment.
(PLHIV: SR, 33 years, AB, 27 years)

"HIV is a virus that destroys white blood cells, incurable diseases and having negative stigma in society. It is transmitted through unsafe sex, sharing needles, and from mother to child. HIV can be prevented by not performing risky behavior and can be treated with ARV treatment"
(PLHIV: IK, 33 years)

Our study identified that most of PLHIV understood HIV is a virus which attacks white blood cells, a deadly disease and not healing if it were not treated, transmitted through needles, sex, drugs injection, and mother-to-child transmission. PLHIV considered that HIV is a deadly and feared disease bu it can be prevented by increasing information and avoiding risk behavior of HIV transmission. They has known that ARV therapy is a treatment to maintain their quality of life.

ARV access

Interview results with PLHIV related to ARV access, as follows:

"...Some PLHIV started ARV therapy in Makassar with consideration that safety, comfort, and confidentiality can be more secure compared start treatment in their district. They still do that although they have to spend money for their transportation "

(PLHIV: SR, 33 years)

"……Actually,we have tried asmuch as possible to overcome the problem of ARV accessat Bulukumba hospital, but PLHIV already started ARV therapy in Makassar did not want to move treatment at Bulukumba hospital.They feel more comfortable undergoing treatment in Makassar"

(Doctor: WW, 44 years)

] often motivate friends to keep taking ARV Therapy even though the place of taking medicine is so far. It's been one time Bulukumba hospital did not provide ARV regiment. So, there are some of PLHIV who were forced to move treatment in Makassar……"

(Peer support: DL, 43 years)

Ourinterview identified that about there were 3 of participants accessing ARV treatment in Makassar (outside of Bulukumba district) and others accessing ARV at Bulukumba hospital. They als said thatARV therapy were not difficult to obtain but transportation cost, consumption, and accommodation every month for who treated in Makassar incriminate participants.

Adherence

Interview results with PLHIV related to treatment adherence as follows:

"… personally, I try to drink ARV therapy on a dose and on time, but sometimes I have to stop taking the medicine when my ARV therapy runs.

(PLHIV: SR, 37 years)

Average of PLHIV adhere on treatment and sometimes they must borrow his friend's regiment which is same regiment type. They do that because they didn't have a time to take it at the hospital. But, PLHIV did not drink their ARV regiment when they fell is better and they only multiply exercise to increase their healthy condition

(Counselor: IB, 45 years)

The behavior of mutual need is always present among PLHIV, for example remind and support each other in medication drinking, especially new PLHA who start ARV therapy. They desperately need information about the benefits, ARV side effects, and how to improve their quality of life.

(Peer support: DL, 43 years)

The interviews results shown that all participants have experience not adherence. Not adherence ARV therapy increases the risk of treatment failure related viral resistance.

CONCLUSION

a. Knowledge of PLHIV

Based on in-depth interviews were conducted among 6 participants shown that most of participants have known basic information about HIV/AIDS. While HIV knowledge will support healthy behaviors because knowledge is a mediator of behavioral change for the individual."

Participants know the transmission mode of HIV/ AIDS through needles, sex unsafety, non-sterile blood transfusion, mother to ch[13] by blood, semen, and breast milk product. But if mother initiated ARV therapy during pregnancy then risk of mother-to-child HIV transmission by 1%.[13] In our study, HIV

prevention are knowledge enhancement and avoid risk behavior. Previous study reported that healt education and condom are recommended in the HIV prevention.[14,15,16,17] Additional, study in Africa shown that circumcision accepted as an important strategy for the HIV prevention.[18,19]

Health education is a long-term behavioral investment. Increasing knowledge of PLHIV can be provided through continuous health education. Its mean, impact of health education can onlybe seen a few years later. In the short term, health education only produces changes or increases for people's knowledge.[20] Previous study shown that Adequate knowledge/ about HIV and ARV therapy will increase adherence and the quality of life.[2]

a. ARV Access

Health care system should be obtainable in every time needed by society that is distributed based on socio economic, community and geographical needs. This study shown that most of participants try not to be known by the crowd when they access ARV therapy. Participants who prefer to access treatment outside of district, they hope thehospital can give a sense of safety, comfort and confideatial.

Health worker said that number of PLHIV at Bulukumba district is increased but only 6.9% of PLHIV who started ARV at hospital. PLHIV participant confirmed that they started ARV therapy outside of district because sometimes drugs stock at Bulukumba hospital runs out. Predisposing factor for increasing health care access is health care system.[22] PLHIV who is easily toaccess ARV therapy have twice opportunities to adhere ARV therapy than those who is difficulty to access it.[23]

Additional, PLHIV said that health status are closely related seeking health care service. This study support previous studies which access to health care system is strongly influenced by their condition as unhealthy feelings. It is one of indicator to decide accessing health care services.[24-27] It is there fore a clear understanding of ARV therapy is needed to increase ARV access.[27]

District health offices(DHO) reported that only 4.3% of PLHIV access ARV therapy at Ujung Bulu sub-district which is Bulukumba hospital established. It shown that goals of fast Track the SDG 2030 program to achieve 90% of people know his HIV status, 90% of people who know his status soon start ARV therapy and 90% who had started ARV therapy showed viral load suppression is still distant.[28] This target can achieve with a strategy.

One strategy developed at Uganda is establish Community ARV Group (CAG). It focus on community based ARV services which facilitate access to ARV therapy, improve ARV therapy adherence by reduce travel time of patients to the clinic or hospital for drugs taking.[29]

c. Adherence

The successful of ARV therapy is determined by at least 95% of adherence and viral suppression.[27] In our study, all PLHIV participants were identified have experience not adherence. Not adhere were caused by negligence of putting drugs on the medicine box, did not on time take drugs, be embarrassment to the health services, distance factors, hoping drugs from peer support, drug side effects, inappropriate drug dosage, stigma, and cost factors. This result is apprehensive because not adherence was identified increasing the risk of treatment failure and viral resistance.[30]

Others obstacles of adherence were identified among participants such as cost of transportation, accommodation, administration, and blood checks. Previous study identified that the cost burden caused

by HIV disease is greater when having ARV therapy. This suggests that although ARV drugs have been provided free of charge by the government but the financial burden of care remains great. Financial problems indirectly can lead to low adherence of PLWHA in taking ARVs.[31]

The side effects and size of ARV regiment are also a detention for adherence. Side effects suchas nausea, dizziness, and anemia aremost frequently appear in the early treatment. But not all PLHIV who initiated ARV therapy experienced side effect of treatment.[26] Stigma is also a factor inhibiting treatment, they feel uncomfortable to pick up their drugs at hospital because stigma. Previous study reported that 50% of PLHIV have to skip the time of drinking medicine because they are fear his friends or family knows their HIV status.[32]

The knowledge about ARV therapy, self-motivation, and support from family friends, peer support, health workers, society, and government also are an important for PLHIV adherence.[33-38] All parties obliged to keep the rights of PLWHA in obtaining good and optimal health services, particularly ARV services and maintaining therapy.[27]

Conclusions

Most of PLWHA already know the definition, transmission, prevention and ARV therapy although all participants ever experienced not adherence. PLHIV who started ARV therapy outside Bulukumba district hope they can more secure, comfortable and confidentiality. Gathering place is recommended for PLWHA which is a place of HIVknowledge sharing, mutual support, and ARV therapy reminder to improve their quality of life.

Conflict of Interest : There is no conflict of interest

Source of Funding : Directorate General of Higher Education, Ministry of National Education, Indonesia

1. Huang M-B, et al. Characterizing the HIV/AIDS epidemic in the United Statesand China. International journal of environmental research and public health. 2015;13(1):30.
2. UNICEF, (USA): Summary UNICEF. of 2012. HIV / AIDS Response Review. New York
3. Mathers of CD, disease Loncar from D. 2002 Projections to 2030. of Plos global medicine. mortality 2006;3(11):e442. and burden
4. MoH in RI. Indonesia Report in on the 2015. situation Jakarta: Ministry of of HIV-AIDS Health. development 2016.
5. Cohen antiretroviral MS, therapy. et New al. England Prevention journal of of HIV-1 medicine. infection 2011;365(6):493-505. with early
6. Poka-Mayap and its therapy in retrospective V, determinants referral cohort among centre study. in BMJ open. patients infected with Yaounde, HIV-1 Cameroon: on 2013;3(7):e003210. Pefura-Yone EW, Kengne AP, Kuaban C. Mortality antiretroviral a
7. Ayu life dr. r. aong M. Relation HIV Djamil between Patients hospital,padang antiretroviral at voluntary 2014, therapy adherence conseling andalas university; with and 2014. kuality testing of clinic,

Mills EJ, et al. Adherence to HAART: a systematic review of developed and developing nation patient-reported barriers and facilitators. Plos medicine. 2006;3(11):e438

8. Nursalam. Concept and application of research methodology of nursing science: thesis and nursing research instrument. Salemba Medika; 2008.

9. CDC. Control cfd, Prevention. Today's HIV/AIDS epidemic. URL: http://www.CDC.Gov/nchhstp/newsroom/docs/hivfactsheets/todaysepidemic-508.Pdf [accessed 2014-05-18]. 2013.

10. Lewis D, Latif A, Ndowa F. WHO global strategy for the prevention and control of sexually transmitted infections: time for action. The Medical Society for the Study of Venereal Disease; 2007.

11. Ojo O, et al. Interventions to reduce risky sexual behaviour for preventing HIV infection in occupational settings. The Cochrane Library. 2011.

12. Indonesia KKR. Basic Health Research 2013. Jakarta: Indonesian Health Research and Development Agency. 2013.

13. Kabbash I, Sayed ELN, Nawawy AIA, Shady I, Zeid A. Condom use among males [15-49 years] in Lower Egypt: knowledge, attitudes and patterns of use. 2007.

14. Wahdan I, Wahdan A, Gueneidy EIM, Rahman EllA. Prevalence and determinants of condom utilization among people living with HIV/AIDS in Egypt. EMHJ. 2013;19(12):967.

15. Himmich H, Ouarsas L, Hajouji FZ, Lions C, Roux P, Carrieri P. Scaling up targeting truck drivers in Morocco: community-based HIV prevention and counseling interventions effectiveness on HIV testing. BMC infectious diseases. 2015;15(1):208.

16. Zhang T, et al. Community based promotion on VCT acceptance among rural migrants in Shanghai, China. Plos one. 2013;8(4):e60106.

17. Moses S, Bailey RC, Ronald AR. Male circumcision: assessment of health benefits and risks. Sexually transmitted infections. 1998;74(5):368-373.

18. Westercamp N, Bailey RC. Acceptability of male circumcision for prevention in subSaharan Africa: a review. AIDS and Behavior. 2007;11(3):341-355.

19. Suliha U, Herawani S, Resnayati Y. Health knowledge in Nursing. Jakarta. EGC. 2002.

20. Mbonye M, Seeley J, Ssembajja F, Birungi J, Jaffar S. Adherence to antiretroviral therapy in

Jinja, Uganda: a six-year follow-up study. Plos One. 2013;8(10):e78243.

21. Retnaningsih E. Access to Health Service. PT rajagrafindo Persada;2013.

22. Mahardining Family PHJ. Support With 2010;5(2). AB. Relationship adherence Between antiretroviral Knowledge, therapy among Motivation, PLHIV. And KEMAS.

23. Atella V, Brindisi F, Deb P, Rosati FC. Determinants of access to physician services in Italy: a latent class seemingly unrelated probit approach. Health economics. 2004;13(7):657-668.

24. Van Ourti T. Measuring horizontal inequity in Belgian health care using a Gaussian random effects two part count data model. Health Economics. 2004;13(7):705-724.

25. Kesehatan D. Pedoman Nasional Perawatan, dukungan dan pengobatan bagi ODHA. Jakarta, 2006.

26. Yasin NM, Maranty H, Ningsih WR. Analysis of antiretroviral therapy response to HIV / AIDS patients. Pharmaceutical Magazine Indonesia. 2011;22(3):212-222.

27. HIV/AIDS junpo. The gap report. Geneva: UNAIDS. 2014;3.

28. Rasschaert F, et al. Adapting a community-based ART delivery model to the patients' needs: a mixed methodsresearch in Tete, Mozambique. BMC Public Health. 2014;14(1):364.

29. Duggan JM, Locher A, Fink B, Okonta C, Chakraborty J. Adherence to antiretroviral therapy: a survey of factors associated with medication usage. AIDS care. 2009;21(9):1141-1147.

30. Riyarto S, et al. The financial burden of HIV care, including antiretroviral therapy, on patients in three sites in Indonesia. Health policy and planning. 2010;25(4):272-282.

31. Rao D, Kekwaletswe Hosek S, Martinez J, Rodriguez F. Stigma and social barriers to medication adherence with urban youth living with HIV. AIDS care. 2007;19(1):28-33.

32. Curioso WH, Kepka D, Cabello R, Segura P, Kurth AE. Understanding the facilitators and barriers of antiretroviral adherence in Peru: a qualitative study. BMC public health. 2010;10(1):13.

33. Han N, Phoolcharoen W, Perngparn U. Antiretroviral drug taking in HIV positive among Myanmar migrants in central area of Thailand. JHR. 2009;23:33-36.

34. Watt MH, et al. "It's all the time in my mind": Facilitators of adherence to antiretroviral therapy in a Tanzanian setting. Social Science & Medicine. 2009;68(10):1793-1800.

35. Yuniar Y, Handayani RS, Aryastami NK. Factors Supporting Compliance People with HIV AIDS (ODHA) in Drinking Antiretroviral Drugs in Bandung and Cimahi. Buletin of health research. 2013;41(6):72-83.

36. Ayer R, et al. Clinic Attendance For Antiretroviral Pick-Up Among Hiv-Positive People In Nepal: roles of perceived family support and associated factors. Plos one. 2016;11(7):e0159382.

37. Kamila N, AIDS on Siwiendrayanti A. the Role of Perceptions of People with HIV and Peer Support Groups. PHJ. 2010;6(1).

Qualitative Study; Knowledge, Arv Access, and Adherence among People Living With HIV in Bulukumba District, South Sulawesi

ORIGINALITY REPORT

8%	4%	6%	%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	implementationscience.biomedcentral.com Internet Source	1%
2	www.thrive.or.ug Internet Source	1%
3	Vreeman, Rachel, and Scanlon. "Current strategies for improving access and adherence to antiretroviral therapies in resource-limited settings", HIV/AIDS - Research and Palliative Care, 2013. Publication	1%
4	www.jmir.org Internet Source	1%
5	Young, Sera, Amanda C. Wheeler, Sandra I. McCoy, and Sheri D. Weiser. "A Review of the Role of Food Insecurity in Adherence to Care and Treatment Among Adult and Pediatric Populations Living with HIV and AIDS", AIDS and Behavior, 2014.	1%

Publication

6	Ayer, Rakesh, Kimiyo Kikuchi, Mamata Ghimire, Akira Shibanuma, Madhab Raj Pant, Krishna C. Poudel, and Masamine Jimba. "Clinic Attendance for Antiretroviral Pills Pick-Up among HIV-Positive People in Nepal: Roles of Perceived Family Support and Associated Factors", PLoS ONE, 2016. Publication	1%
7	Moges, Beyene, Gizachew Yismaw, Afework Kassu, Berihun Megabiaw, Shitaye Alemu, Bemnet Amare, and Dagnachew Muluye. "Sexually transmitted infections based on the syndromic approach in Gondar town, northwest Ethiopia: a retrospective study", BMC Public Health, 2013. Publication	<1%
8	Dowshen, Nadia, Lisa M. Kuhns, Camdin Gray, Susan Lee, and Robert Garofalo. "Feasibility of Interactive Text message Response (ITR) as a Novel, Real-Time Measure of Adherence to Antiretroviral Therapy for HIV+ Youth", AIDS and Behavior, 2013. Publication	<1%
9	aidsuganda.org Internet Source	<1%
10	dl.sciencesocieties.org	

	Internet Source	<1%
11	www.perbanas.ac.id Internet Source	<1%
12	www.omicsonline.org Internet Source	<1%
13	137.215.9.22 Internet Source	<1%
14	jiasociety.org Internet Source	<1%
15	Jamaluddin M. Sakung, Saifuddin Sirajuddin, Andi Zulkifli, Stang Abdul Rahm, A. Arsunan Ar, Masni ., Nurhaedar Jafar, Bohari .. "Influence of Nutrition Education and Provision of Instant Chayote to Change in Blood Pressure", Pakistan Journal of Nutrition, 2018 Publication	<1%

Exclude quotes	Off	Exclude matches	Off
Exclude bibliography	Off		