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Therapy Duration, Treatment Fatigue from Antiretrovirals, and Adherence to Antiretroviral Therapy in People Living with HIV: A Cross-Sectional Study

The prevalence of Human Immunodeficiency Virus (HIV) in Indonesia is increasing. The primary management of people living with HIV is the provision of antiretroviral (ARV) drugs for a lifetime. The success of ARV therapy is mainly influenced by the adherence to the therapy.

Objective — to identify factors influencing adherence to ARV therapy.

Materials and methods. This study used a cross-sectional analytical design. The sample was determined using a purposive sampling technique and a total of 289 respondents were obtained. The data collection instrument was a questionnaire. Univariate analysis used frequency distribution to describe the percentage. Bivariate logistic regression analysis (adjusted OR and 95 % confidence interval (CI)) and multivariate analysis used Multiple logistic regression with adjusted OR, 95 % CI, and a significance p-value < 0.05.

Results and discussion. The results of the study showed that the factors influencing adherence to ARV therapy were knowledge with a p-value < 0.001 (95 % CI 7.15—8.87), attitude with a p-value < 0.001 (95 % CI 2.05—4.11), treatment fatigue in taking ARVs with a p-value = 0.004 (95 % CI 1.59—4.41), and therapy duration with a p-value = 0.001 (1.88—4.21).

Conclusions. Knowledge, attitude, treatment fatigue in taking ARVs, and therapy duration are factors influencing adherence to ARV therapy. Thus, it is important to have sustainable programmes or socialisations to increase public awareness about the support needed by people living with HIV/AIDS to comply with ARV therapy.

Keywords

Adherence, antiretroviral, HIV, therapy duration, treatment fatigue from antiretrovirals.

Human Immunodeficiency Virus (HIV) is a virus that infects the body's immune system, making a person more vulnerable to other infections and diseases [30]. HIV is a virus that causes an infectious disease resulting from HIV infection which attacks the immune system [24]. This virus is found in body fluids, especially in blood, semen, vaginal discharge, and breast milk [25]. This infection causes a decrease in the body's immune system, making individuals very susceptible to other infections and diseases [32]. The incubation period for this disease is six months to 10 years [12]. People living with HIV need antiretroviral (ARV) therapy to reduce the amount of the virus in the body in order to delay the onset of AIDS and to prevent opportunistic infections and complications. Patients need to comply with ARV therapy for life [2].

WHO reported that a total of 36.9 million people were diagnosed with the HIV in 2017 [28]. The highest number of HIV cases is found in Africa (69.93 %), Southeast Asia (9.52 %), the United States (9.25 %), Europe (6.26 %), the Western Pacific Region (4.08 %), and the Eastern Mediterranean Region (0.95 %) [28]. In the Southeast Asia region,

Table 1. **Characteristics of respondents**

Characteristics		Number	Percentage
Sex	Female	135	46.71
	Male	154	53.29
Age	20—35 years old	149	51.56
	> 35 years old	140	48.44
Education	University	54	18.68
	Senior High School	126	43.60
	Junior High School	109	37.72
Occupation	Farmer	156	53.98
	Private employee	71	24.57
	Entrepreneur	41	14.19
	Unemployed	21	7.27
Knowledge	Good	168	58.13
	Poor	121	41.87
Attitude	Positive	179	61.94
	Negative	110	38.06
Treatment Fatigue in Taking ARVs	Present	143	49.48
	Absent	146	50.52
Therapy Duration	< 1 year	122	42.21
	> 1 year	167	57.79

Indonesia ranked first with 630,000 cases (540,000—740,000), followed by Thailand with 440,000 cases (390,000—510,000) and Vietnam with 250,000 cases (220,000—280,000) (WHO, 2019) [30]. In Indonesia, the highest number of HIV cases was in East Java followed by DKI Jakarta and Central Java [15].

Adherence to ARV therapy is key to suppressing the development of the disease, reducing the risk of drug resistance, improving overall health, quality of life and survival and reducing the risk of HIV transmission. People living with HIV need to comply with ARV therapy to prevent the development of the virus. Non-adherence to ARV therapy can increase the risk of the virus growing in the body [7]. The utilisation of health facilities is a form of behaviour aimed at improving health [13]. Lack of utilisation of health facilities is caused by some factors such as predisposing factors manifested in stigma, attitudes, knowledge, and beliefs; strengthening factors include the availability of facilities, infrastructure, accessibility, and ease of accessing health facilities in terms of distance, cost, readiness of transportation, and the existence of rules and community commitments to support this behaviour; and supporting attitudes and behaviour of families, health workers, and community leaders; medication saturation; and therapy duration. Adherence to ARV therapy can reduce the progress of HIV disease; reduce the risk of drug ineffectiveness; improve health, quality of life and longevity; and reduce the risk of spreading the disease [29]. People living with HIV need to comply with ARV therapy to prevent the growth of the virus [10]. Non-adherence to ARV therapy can increase the number of viruses in the body [22].

The Ministry of Health Regulation No. 21 of 2013 on HIV management contains efforts to control HIV in Indonesia [27]. The handling of HIV includes promotive, preventive, diagnostic, curative, and rehabilitative services to reduce morbidity, and mortality, and limit transmission and spread of the disease to other areas in order to minimise the negative impacts. Many people living with HIV do not comply with ARV therapy.

Objective — to identify factors influencing adherence to ARV therapy.

Meterials and methods

Study design and sampling. This quantitative analytical study used a cross-sectional design. The population of this study consisted of individuals diagnosed with HIV in Kebumen District, Central Java. The inclusion criteria were people living with HIV (PLWH) aged > 5 years, present at the research location at that time, and willing to participate in this study. The sample was determined using a purposive sampling technique. The sample size was calculated using the HSIEH (1989) formula, resulting in 289 respondents.

Questionnaire. The questionnaire used in this study includes a demographic section covering age, gender, education, and occupation. To measure adherence to antiretroviral therapy (ART), the author employed the Morisky Medication Adherence Scale (MMAS), which was validated with a Cronbach's alpha coefficient. For the variable assessing medication fatigue, a questionnaire adapted from the Maslach Burnout Inventory was utilised, yielding a Cronbach's alpha coefficient of 0.665.

Data Analysis. Univariate analysis for each variable (dependent and independent variables) used a frequency distribution to describe the percentage. Meanwhile, bivariate analysis was used to estimate the effect of each variable using Logistic regression (Adjusted OR and 95 % confident interval) and adherence to the ARV therapy as the dependent variable. Variables with a p-value < 0.25 were considered significant and could be entered into the next model. Multiple logistic regression was used to determine the variables that affect the variable (adherence to ARV therapy). The multivariate analysis used the Adjusted OR, 95 % confidence interval (CI), and a significance p-value < 0.05.

Results

Table 1 shows that the majority of respondents are male (53.29 %), aged 20—35 years (51.56 %), have high school education levels (43.60 %), and

Table 2. **Bivariate analysis using simple logistic regression test**

Independent variable		Number	% Non-adherence	Crude OR	95 % CI	p-value
Sex	Female	43	27.34	1		0.201
	Male	47	34.15	1.82	2.15—3.53	
Age	20—35 years old	68	41.90	1		0.007
	> 35 years old	55	38.46	2.22	1.3—3.8	
Education	University	3	30.00	1		0.715
	Senior High School	40	27.78	0.89	0.80—3.75	
	Junior High School	55	34.86	2.34	0.56—5.97	
Occupation	Farmer	18	11.54	1		< 0.001
	Private employee	47	66.20	15.01	7.5—30.1	
	Entrepreneur	14	34.15	3.98	1.8—8.95	
	Unemployed	11	52.38	8.43	3.14—22.6	
Knowledge	Good	25	14.88	1		< 0.001
	Poor	65	53.72	66.64	5.82—9.57	
Attitude	Positive	45	25.14	1		0.005
	Negative	45	40.91	2.06	1.24—3.43	
Treatment Fatigue in Taking ARVs	Present	89	37.93	1		< 0.001
	Absent	21	4.89	4.8	2.64—5.71	
Therapy Duration	< 1 year	36	23.08	1		0.001
	> 1 year	54	40.60	2.28	1.37—3.79	

Table 3. **Multivariate analysis using multiple logistic regression test**

Independent variable		Number	% Non-adherence	Crude OR	Adjusted OR	95 % CI	p-value
Age	20—35 years old	68	41.90	1	1		0.056
	> 35 years old	55	38.46	2.22	25.7	6.1—8.95	
Occupation	Farmer	18	10.54	1	1		0.170
	Private employee	47	67.20	14.01	23.04	7.1—75.3	
	Entrepreneur	14	44.10	7.98	7.8	2.1—89.9	
	Unemployed	11	42.43	5.43	9.3	2.7—32.7	
Knowledge	Good	15	4.80	1	1		< 0.001
	Poor	75	63.74	66.34	16.42	7.15—8.87	
Attitude	Positive	25	20.13	1	1		< 0.001
	Negative	55	45.90	2.18	8.84	2.05—4.11	
Treatment Fatigue in taking ARVs	Present	89	37.93	1			0.004
	Absent	21	4.89	4.8	2.64—5.71	1.59—4.41	
Therapy Duration	< 1 year	36	23.08	1			0.001
	> 1 year	54	40.60	2.28	1.37—3.79		

work as farmers (53.98 %). Additionally, most of the respondents have good knowledge (58.13 %) and good attitudes (61.94 %), do not experience treatment fatigue (50.52 %), and have a therapy duration < 1 year (57.79 %).

Table 2 shows that age, occupation, knowledge, attitude, treatment fatigue in taking ARVs and therapy duration have a significant effect on adherence to ARV therapy with a p-value < 0.25. Thus, they can be included in the next model to assess the strength of the relationship.

Table 3 shows that factors influencing adherence to ARV therapy are knowledge with a p-value < 0.001 (95 % CI 7.15—8.87), attitude with a p-value < 0.001 (95 % CI 2.05—4.11), treatment fatigue in taking ARV with a p-value = 0.004 (95 %CI 1.59—4.41), and therapy duration with a p-value = 0.001 (95% CI 1.88–4.21).

Discussion

Table 3 shows that knowledge has a significant effect on adherence to ARV therapy with a p-value < 0.001 (95 %CI 7.15—8.87). High adherence levels are found in 168 patients who have good knowledge. Respondents understand the benefits and functions of ARV. Knowledge regarding ARV indirectly

affects patient adherence to taking ARVs, while their behaviour is not based on knowledge [11]. This is in line with D.S. Putra et al. found that the level of knowledge has a significant relationship with adherence to ARV therapy [23]. It is assumed that PLWHA with good knowledge can have a high level of adherence to ARV therapy [6]. However, it does not mean that people with low education always have low knowledge because knowledge is not obtained from formal education only, but also from non-formal education [16].

The low knowledge scores can be overcome by interventions in the form of providing simple guidelines for respondents [26]. The low knowledge scores are due to the lack of learning and reminder about ARV therapy [21]. The guidelines contain additional information in addition to the lecture or counselling methods that have been given by nurses during check-ups [31]. This is based on Taylor's theory in Smet's work that written instructions may help improve patients' understanding of the benefits of the treatment. This important factor is often forgotten [2]. Many health workers assume that patients will follow their advice without realising whether the patients will perform it or not [5].

The results of the study showed that the majority of respondents are not bored with taking ARVs. This is in line with Urba, who stated that ARV is a complex therapy with more than one type of medication and is taken for the long term [33]. Kusuma revealed that the longer the respondents suffered from the disease, the worse their quality of life [20]. These results are in line with M. Mukosha, et al. where the duration of suffering from the disease is a significant factor affecting quality of life [17]. Moreover, it supports a previous study by Nojomi, Anbary, and Ranjbar found that the longer the patient suffers the disease, the worse the quality of life of the patient [3].

Taking ARVs daily can make patients feel bored and even some cannot stand the side effects [19]. The respondents in this study experience treatment fatigue from taking ARVs. This happens because they have to take ARV daily for a lifetime [8]. Therefore, the family and the surrounding community need to support the patient in order not to give up [18]. As the disease progresses, the longer the patient suffers from it, the more their health deteriorates. This is related to the decrease in the number of CD4 in the body as the disease advances [1]. Thus, the longer the patient as the disease advances from this disease, the more susceptible the patient is to various complications of the disease. The available treatment for this disease so far has only been to suppress viral replication but does not cure it [4]. Patients have to take ARVs for a lifetime in order to maintain the stability of the disease [14]. In addition to treatment fatigue, this can provide side effects such as digestive disorders, dizziness, and other complaints which eventually affect the overall aspects of the patient's quality of life [9].

The results of the study showed that there is a relationship between the therapy duration and adherence to ARV therapy. Based on the researcher's assumptions and findings in the field, the therapy duration is one of the factors causing a low level of adherence to ARV therapy because the patients have to take the same medicine every day for a lifetime. The results of this study are in line with a study in Cameroon showed that there is a relationship between the ARV therapy duration and adherence to ARV therapy with a p-value of 0.001 (95 % CI 1.88—4.21).

Conclusions

Based on the results of the study, it can be said that factors influencing adherence to ARV therapy are knowledge, attitudes, treatment fatigue in taking ARVs, and therapy duration. A special sustainable program or socialisation is needed to increase public awareness about the support needed by people living with HIV/AIDS to comply with ARV therapy. The provision of counselling by healthcare workers must be in accordance with existing guidelines and further explore patient barriers to starting ARV therapy as well as patient conditions, so that they are motivated to start therapy in order to improve their quality of life.

Recommendation. For future research, it is recommended that studies be conducted using qualitative methods to enable a deeper exploration of adherence to antiretroviral (ARV) therapy among individuals living with HIV. It is also expected that nurses will enhance their approaches to addressing treatment fatigue. Nursing interventions are necessary to mitigate treatment fatigue in order to improve patient adherence to ARV therapy.

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Author contributions. Wulan Rahmadhani conceived the original idea, analyzed sequence data, interpreted data, created figures, and drafted the manuscript. Hardianti Aprina performed data analysis and formulated hypotheses. Wulan Rahmadhani and Hardianti Aprina developed the study objectives. Pall Chamroen conducted the theoretical and literature search and applied statistical and analytical approaches.
Ethics approval. The study protocol was approved by the Health Research Ethics Committee of Universitas Muhammadiyah Gombong under protocol number 11125000002. The approval was granted under authorization number No: 035.6/II.3.AU/F/KEPK/I/2024, dated January 25, 2024.

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Тривалість терапії, втома від лікування антиретровірусними препаратами та прихильність до антиретровірусної терапії в людей, які живуть з ВІЛ: перехресне дослідження

Поширеність вірусу імунодефіциту людини (ВІЛ) в Індонезії зростає. Основним методом лікування людей, які живуть з ВІЛ, є довічне забезпечення антиретровірусними (АРВ) препаратами. Успіх АРВ-терапії значною мірою залежить від прихильності до лікування.

Мета роботи — визначити чинники, які впливають на прихильність до терапії АРВ.

Матеріали та методи. У дослідженні використано аналітичний дизайн поперечного зрізу. Визначення вибірки проведено методом цільового відбору. Отримано 289 респондентів. Для збору даних використовували анкету. Уніваріативний аналіз проведено за допомогою розподілу частоти для опису відсотків. Біваріативний логістичний регресійний і мультиваріативний аналіз проводили за допомогою множинної логістичної регресії зі скоригованим відношенням ризиків, 95 % довірчим інтервалом (ДІ) та значущістю < 0,05.

Результати та обговорення. Дослідження показало, що чинниками, які впливають на прихильність до терапії АРВ-препаратами, були знання (p < 0,001; 95 % ДІ 7,15—8,87), ставлення до терапії (p < 0,001; 95 % ДІ 2,05—4,11), втома від лікування АРВ препаратами (p = 0,004; 95 % ДІ 1,59—4,41) і тривалість терапії (p = 0,001; 95 % ДІ 1,88—4,21).

Висновки. Знання, ставлення до терапії, втома від лікування АРВ препаратами та тривалість терапії є чинниками, які впливають на прихильність до АРВ-терапії. Тому важливо мати постійні програми чи соціалізацію, щоб підвищити обізнаність суспільства щодо підтримки, необхідної людям, які живуть із ВІЛ/СНІДом, для дотримання АРВ-терапії.

Ключові слова: прихильність, антиретровірусні препарати, ВІЛ, тривалість терапії, втома від лікування антиретровірусними препаратами.

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