Barriers to HIV care in rural Uganda

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Abstract: More than 70% of HIV infections occur in sub-Saharan Africa, where the epidemic continues to have a profound impact on public health and economic growth (1-3). Significant progress has been made over the last decade with the introduction of antiretroviral treatment, which has resulted in an increased number of people living with HIV, and a decreased number of AIDS-related deaths. Many studies have looked at retention in HIV clinics in Africa (4-16) as well as HIV treatment outcomes (17-26), and have concluded that low retention in care threatens the sustainability of the early success of treatment programs in resource limited settings (RLS).

The purpose of this study was to identify barriers to HIV care in rural Uganda and determine the impact of these barriers on HIV treatment outcomes. The study comprised a two part, mixed method approach, including data from the two separate sources analyzed concurrently. A cross-sectional qualitative study was conducted with key informant interviews of healthcare providers and patients at the Mbarara ISS Clinic in Uganda. A sub-study comprised quantitative analysis of secondary data from the Uganda Antiretroviral Rural Treatment Outcomes (UARTO) cohort collected over the first 12 months of enrollment in UARTO.

Findings from the qualitative analysis show that stigma, financial constraints, and inflexible clinic schedules present barriers to patients accessing and sustaining care. The availability of antiretroviral therapy, treatment success, trust in the healthcare providers, social support, and a strong reliance on spirituality emerged as strong facilitators to care. For the Quantitative study, results from the survival analysis showed that travel time to clinic longer than 45 minutes was associated with mortality as was being male. Being male was also associated with increased odds of treatment failure (odds ratio (OR) = 0.5, 95% CI 0.28-0.89). Age was associated with being lost to follow up (OR = 1.00 95% CI 0.98-1.03). Higher levels of internalized stigma were associated with lower MEMS adherence (OR = 0.90 95% CI 0.81-0.99). Having a lower asset index predicted treatment interruptions lasting 7 days or shorter (OR = 0.74 95% CI 0.61-0.91) and increased travel time to clinic predicted a decreased odds of treatment interruptions lasting 30 days or longer (OR = 0.98 95% CI 0.96-1.00). There were no significant associations between the predictor variables of stigma or social support and the outcome variables of loss to follow up, treatment failure and mortality. While the quantitative data did not support the hypothesis that social support mitigates structural and economic barriers to care, the findings suggest points of intervention that are targeted towards reduction of stigma at the individual level.

The study concluded that barriers to sustained HIV care in a rural resource limited setting include a combination of factors that are structural, economic, and social, which act independently or through complex interactions. Strategies to improve HIV care in resource limited settings should aim at targeting all three components of these barriers, while strengthening health care systems and building local leadership remain the foundation for sustained success.

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