



IMPACT OF DIFFERENT LEVELS OF ADHERENCE ON THE COURSE OF HIV INFECTION

Laziz N. Tuychiyev

*Head of the Department of Infectious and Children's Infectious Diseases
Tashkent Medical Academy
Tashkent, Uzbekistan*

Gulnara K. Khudaykulova

*Head of the Department of Public Health and Management
Tashkent Medical Academy
Tashkent, Uzbekistan*

Khumoyun Mirzo A. Sadikov

*Assistant of the Department of Infectious and Children's Infectious Diseases
Tashkent Medical Academy
Tashkent, Uzbekistan*

ABOUT ARTICLE

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Abstract: This article discusses the impact of different levels of adherence on the course of HIV infection. Reasonable adaptation of a person living with HIV infection is aimed at distributing his/her forces both taking into account the objective limitations that have arisen due to the disease, and taking into account his potential capabilities.

OIV INFEKTSIYASINING KECHISHIGA TURLI DARAJADAGI RIOYA QILISHNING TA'SIRI

Laziz N. Tuychiyev

*Yuqumli va bolalar yuqumli kasalliklari kafedrasi mudiri
Toshkent tibbiyot akademiyasi
Toshkent, O'zbekiston*

Gulnara K. Xudaykulova

*Jamoat salomatligi va boshqaruvi kafedrasi mudiri
Toshkent tibbiyot akademiyasi
Toshkent, O'zbekiston*

Xumoyun Mirzo A. Sadiqov

Yuqumli va bolalar yuqumli kasalliklari kafedrasi assistenti

*Toshkent tibbiyot akademiyasi
Toshkent, O'zbekiston*

MAQOLA HAQIDA

Kalit so'zlar: rioya qilish darajalari, OIV infeksiyasining kechishi, oqilona moslashuv, ob'ektiv cheklovlar.

Annotatsiya: Ushbu maqolada turli darajadagi rioya qilishning OIV infeksiyasi jarayoniga ta'siri muhokama qilinadi. OIV infeksiyasi bilan yashovchi shaxsni oqilona moslashtirish uning kuchlarini kasallik tufayli yuzaga kelgan ob'ektiv cheklovlarni hisobga olgan holda va uning potentsial imkoniyatlarini hisobga olgan holda taqsimlashga qaratilgan.

ВЛИЯНИЕ РАЗЛИЧНЫХ УРОВНЕЙ ПРИВЕРЖЕННОСТИ НА ТЕЧЕНИЕ ВИЧ-ИНФЕКЦИИ

Лазиз Н. Туйчиев

*Заведующая отделением инфекционных и детских инфекционных болезней
Ташкентская медицинская академия
Ташкент, Узбекистан*

Гульнора К. Худайкулова

*Заведующий кафедрой общественного здравоохранения и управления
Ташкентская медицинская академия
Ташкент, Узбекистан*

Хумоюн Мирзо А. Садилов

*Ассистент кафедры инфекционных и детских инфекционных болезней
Ташкентская медицинская академия
Ташкент, Узбекистан*

О СТАТЬЕ

Ключевые слова: уровни приверженности, течение ВИЧ-инфекции, разумная адаптация, объективные ограничения.

Аннотация: В данной статье рассматривается влияние разного уровня приверженности на течение ВИЧ-инфекции. Разумная адаптация человека, живущего с ВИЧ-инфекцией, направлена на распределение его сил как с учетом объективных ограничений, возникших вследствие заболевания, так и с учетом его потенциальных возможностей.

INTRODUCTION

HIV infection is an urgent problem of modern health care, as it remains one of the 10 most significant diseases for humanity, posing a real threat to health, the prospects of the nation and national security in many countries of the world.

According to the World Health Organization (WHO) (2010), there were more than 33.4 million people living with HIV in the world. Currently, the annual rate of new HIV infections exceeds the number of deaths from this infection (2.7 million and about 2 million people,

respectively, including 300,000 children die of AIDS). Less than half of those who need antiretroviral therapy receive it—about 10 million HIV carriers. The real number of people living with HIV is approaching 66 million.

For the first time, since 2010, there has been a downward trend in the growth of HIV infection in the world. However, the death rate of people living with HIV/AIDS is on the rise.

THE MAIN FINDINGS AND RESULTS

The epidemic situation with HIV infection in Tajikistan remains tense and tends to sustainable development. Currently, in the Republic of Tajikistan, according to official data (as of December 31, 2012), the total number of HIV-infected people is 4674 people.

HIV infection has moved beyond traditional vulnerable populations (injecting drug users, sex workers). Infection most often occurs through a heterosexual route. People of young working age (20-39 years), pregnant women, wives of labor migrants and prisoners are increasingly in the coverage area of HIV infection, that is, there is a tendency for the HIV epidemic to move from a concentrated stage to a generalized one.

HIV infection is a long-term incurable infectious disease characterized by damage to the immune system and the development of opportunistic diseases leading to the death of the patient.

More than thirty years have passed since the first cases of HIV infection were registered. Although from the very beginning of the pandemic, the whole spectrum of the variety of social problems of HIV / AIDS manifested itself, the realization and recognition of this fact occurred much later.

The epidemiology of HIV infection at its most climax in all countries has been social rather than individual. The epidemiology of HIV infection at its most climax in all countries has been social rather than individual. The HIV/AIDS epidemic has had a serious impact on the development of society as a whole, on the development of social institutions and human development.

The spread of HIV/AIDS threatens the main value - human life and has far-reaching consequences for the demographic, economic, social situation, moral development of society and, without much exaggeration, one can say for the national security of the country.

The growth of HIV infection, as a result of risky behavioral patterns (injecting drug use, unprotected sex), is associated with structural factors, among which the main ones are gender inequality, the lack of active preventive strategies for socially significant diseases, including drug addiction and HIV infection, sexual illiteracy and low awareness of the population, the prevalence of risky behavioral practices among the youth.

Over the years that have passed since the first cases of HIV infection, significant progress has been made in the study of HIV infection, drugs have been developed that can significantly

extend the period of a full, active life for people with a positive HIV status. Recently, it has become common practice to replace the term “HIV-infected” with “people living with HIV” (PLWHA). Such a replacement indicates that this problem is increasingly acquiring social meaning.

AIDS, covering such important areas of humanity as health, emotional, social and economic well-being, has changed the view of scientists and forced to reconsider issues of quality of life. And what is extremely important, since AIDS has sharpened the need for preventive measures in all areas of human life. The emergence of AIDS has forced society to take a fresh look at many established concepts of social life, such as human rights, humanism, security.

Reasonable adaptation of a person living with HIV infection is aimed at distributing his forces both taking into account the objective limitations that have arisen due to the disease, and taking into account his potential capabilities.

The relevance of the study of quality of life, first of all, is dictated by the fact that AIDS is an incurable chronic disease, shrouded in social problems, and the presence of stigma and discrimination against people living with HIV/AIDS, of course, brings discomfort to the lives of these people, which affects the quality their lives. Social, psychological and spiritual factors have a significant impact on the quality of life with HIV infection.

In addition, in our opinion, the importance of research in this area lies in the lack of knowledge of multidimensional aspects of the problem of the impact of HIV infection on the quality of life of PLWHA: the presence of opportunistic infections, the issues of psychosocial adaptation of patients in society and the social integration of PLWHA, the effectiveness of antiretroviral therapy and life expectancy of patients. Unfortunately, in the available literature there are only a few studies on the assessment of the conditions and lifestyle of HIV-infected people, their ethno-cultural characteristics and traditions.

The study of this problem is of both scientific and great practical importance in the system of public health for optimizing medical care for patients and managing it, ultimately, in order to improve the quality of life of these patients. HIV infection mainly affects young and middle-aged people, who, as the disease progresses, may completely or partially lose their health and performance.

The disease, disrupting the natural way of life of people living with HIV/AIDS, leads to a sense of dissatisfaction in various areas of life, which eventually affects their quality of life. Despite significant achievements in the treatment of the most pressing diseases of mankind and significant technological progress in modern medicine, as well as in the context of globalization of medical information and the expansion of its access, the structure of morbidity is changing dramatically - there are more and more chronic patients who cannot be cured, despite the progress of modern medicine. medicine. An increase in the proportion of chronic patients is the most

important (significant) factor in the deterioration of their quality of life. This trend dictates an improvement in the quality of life of this category of patients. At the present stage of development of medicine, the quality of life is recognized as one of the key criteria that reflect the state of health in terms of potential risks. At present, it is necessary to be guided by an integrated approach to assessing the health of the population and be based not only on objective data, but also on the subjective perception of the person himself of the psychological, emotional and socio-hygienic aspects of his life. The study of QoL in medicine is an important approach that makes it possible to fundamentally change the view of the problems of the disease and the patient. Based on these positions, it should be noted that the questions of studying QoL in each disease, depending on the characteristics of development, have their own characteristic evaluation indicators. The quality of life is an important criterion for social adaptation, therefore, at present, in all branches of medicine, including public health, close attention is paid to assessing the quality of life of patients. At the same time, health is one of the important indicators of assessing the quality of life of a person. In certain diseases, the patient's assessment of his condition is the most important indicator of health. Question history. The concept of quality of life is rooted in ancient philosophy. Aristotle called the quality of life a kind of happiness that depends on the activity of the soul. Quality of life (English - quality of life, abbreviated - QOL; German - Lebensqualität, abbreviated LQ) - a category that characterizes the essential circumstances of the life of the population, which determine the degree of dignity and freedom of the personality of each person. For the first time the term "quality of life" in medicine appeared in 1920, but the American scientist D. Karnofsky in 1947 pointed out the importance of a broader study of the influence of the disease on a person. In his classic works, Columbia University professor D. Karnofsky example of oncological patients showed the need to study the whole variety of consequences of the disease, not limited to generally accepted medical indicators [18]. The introduction of the concept of "quality of life" into medicine was historically facilitated by the definition of health adopted by WHO in 1948 as a state of complete physical, mental and social well-being, and not just the absence of diseases and physical defects.

In a medical context, the term "quality of life" was first used in 1966, namely in the editorial article "Medicine and Quality of Life" by J. R. Elkinton in the *Annals of Internal Medicine*. Originally used in sociology and political science, the term "quality of life" was officially recognized in medicine in 1977, when it appeared as a rubric of the *Cumulated Index Medicus*. G. Sosso defined QOL as an individual correlation of one's position in the life of society in the context of its culture and value systems with the goals of this individual.

An important role in the development of the methodology for studying QOL was played by the studies of A. McSweeny, who proposed to assess QOL based on four aspects (emotional state, social functioning, daily activity and leisure activities).

Why has the interest of medical professionals in the problem of QoL increased so much, despite the achievements of modern medicine, which made doctors turn to the concept, which was originally the prerogative of philosophers, sociologists and political scientists? According to M. Edlund and L. Tancredi, the progress of medical science, the improvement of medical technologies in the last decades of the twentieth century led to the fact that often in clinical practice situations began to occur when the patient is biologically alive and socially dead.

The term “health-related quality of life” (quality of life due to health) was first proposed in 1982 by R.M. Kaplan and Bush, which made it possible to single out the parameters describing the state of health, care for it and the quality of medical care from the general concept of QoL.

At the beginning of the XXI century, the concept of “quality of life associated with health” (health related quality of life, HRQL) become the subject of scientific research. Today it is a reliable, informative and economical method for assessing the health of the patient, both at the individual and at the group level.

In 1995, WHO experts developed 6 main criteria necessary for assessing QoL: physical, psychological, level of independence, social life, spirituality, and the environment. Quality of life means the subjective satisfaction experienced and/or expressed by a person, and is determined by all personality parameters: physical, psychological, functional and social. For the patient, “quality of life” means how close the patient’s ideal ideas of what kind of life is acceptable and the real situation due to the disease. An analysis of the literature data shows that both in the interpretation of the concept of “quality of life” and in the assessment of its interpretation, there are significant discrepancies.

Quality of life is an assessment of not only the physical, but also the social and psychological components of the patient's health. Meanwhile, American scientists consider QOL as “the degree of satisfaction of human needs”, and in Russia “QOL is the degree of comfort of a person both within himself and within his society”.

In the available literature, we found many definitions of QoL. According to V.N. Abrosimov et al., there can be no universal definition of QoL, since society is constantly evolving, and each the next generation puts forward its own criteria for the quality of life.

Quality of life is a subjective criterion that shows a person’s satisfaction with the degree of physical, psychological and social well-being. Thus, QoL, which is directly related to health, is an integral indicator that makes it possible to evaluate its components and “objectify” the level of health.

There are no common approaches to its definition, each selected tool has its own criteria and evaluation scale. The obtained data do not allow assessing the clinical severity of the disease. They reflect how the patient tolerates his disease. So, with a long-term illness, some individuals seem to get used to their illness and stop paying attention to its symptoms.

In such individuals, even an increase in the level of QoL can be registered, moreover, this will not mean a regression of the disease. In addition to the supporters of the method, there are opponents of the study of QoL and the creation of questionnaires. So, D. Wade in his book "Measurement in Neurological Rehabilitation" writes that without a clear definition of QoL, it is impossible to measure it. He believes that QoL is such an individual concept, so dependent on the level of culture, education and other factors that it cannot be measured or evaluated.

In addition, in addition to the disease, the assessment of QoL is influenced by many other factors that are not taken into account when forming questionnaires. A similar point of view is shared by S. Hunt, who believes that the quality of life is a hypothetical, theoretical construction that is not subject to quantitative measurement. There are no single generally accepted criteria and norms of QoL. This is a purely subjective indicator of objectivity, and therefore the assessment of QoL is possible only in a comparative aspect (a patient is healthy, a patient with one disease is a patient with another disease, etc.) with the maximum leveling of all third-party factors. Participation of the patient in the assessment of his condition: the most important and unique component of QoL, which allows, along with the traditional medical opinion made by the doctor, to take into account the opinion of the patient himself and draw up the most complete and objective picture of the disease and its consequences. This situation indicates not only the need to study QoL, but also emphasizes the great interest of specialists around the world in this problem.

WHO, since 1991, has been developing a single international instrument for assessing the quality of life. The questionnaire "Quality of Life Scale" (QOLQ-100) developed by WHO experts is one of the tools to measure the well-being of patients and their satisfaction with their living conditions in connection with the disease, as well as to determine the effectiveness of the intervention, since the patient himself evaluates many aspects of his life.

The quality of life of patients with HIV infection is becoming an important component in the overall assessment of health care and the management of health care facilities. This is one of the performance indicators of PLHAS management.

S. Saunders (1966), founder of the modern St. Christopher's Hospice in London, introduced the concept of "general pain", which defines the approach to alleviate any symptoms of illness. She found that every complaint contains physical, psychological, and even spiritual components. Pain is more difficult to tolerate by patients on the background of depression, experiencing feelings

of guilt, loneliness, fear of death, and anxiety. Empathy for the patient, psychological help and support can significantly alleviate his condition.

Kohli R.M. et. al. (2005), having specially adapted some tools for assessing QoL in HIV-infected individuals, studied their relationship with socio-demographic characteristics and stages of disease development, as well as changes in QoL depending on the duration of the disease. The results of the study showed a significant positive cross-domain correlation between QoL and CD4 scores. QoL declined with falling CD4 counts, mainly in the area of physical health. As a rule, QoL indicators were high at the follow-up visit compared to baseline. A modified MOS scale with Cronbach's alpha greater than 0.7 and a linear relationship between CD4 levels and QoL indicates the reliability and validity of estimates of the QoL of HIV-infected people in India. About 80% of AIDS patients die from opportunistic infections.

Clinical symptoms associated with opportunistic, secondary, comorbidities in patients with HIV infection are extremely diverse, occur throughout the course of the disease, often combined with each other, long-term, intense, significantly affecting the quality of life of a person infected with HIV. M.A. Chesney and S. Folkman (1994) note the significant impact of opportunistic infections on QoL. Thus, in people with pneumocystis pneumonia, the quality of life indicators were lower than in HIV-positive people with other types of diseases.

This is due to the fact that with pneumocystis pneumonia, due to the soreness of the symptoms, a person cannot engage in professional activities. Therefore, to improve the quality of life of people living with HIV/AIDS, it is extremely important to conduct adequate prevention and timely specific treatment of opportunistic diseases. Scientists from Zimbabwe Sebit M.B. et al. (2000) evaluated using WHOQOL the impact of herbal medicine in 105 patients with various stages of HIV infection on socio-demographic characteristics and their quality of life.

Of these, 79% of patients received a course of herbal medicine, and 21% - conventional medical care. In 96 (91.4%) cases, the disease was asymptomatic and in 6 (8.6%) - with symptoms of the disease. Treatment modalities correlate significantly in the spiritual domain ($p=0.045$). The proportions of scores in the five study areas measuring aspects of patients' QoL were much lower with phytotherapy than with conventional therapy ($p<0.0001$). Deepika Anand et al. (2010) assessed QoL and its association with body mass index (BMI) and CD4 count in 153 HIV-infected individuals using the HIV WHOQOL BREF. PLWHA with lower BMI showed a significant decrease in QoL ($p<0.05$) [52]. QoL and antiretroviral therapy (ARVT). Health-related quality of life has become one of the priorities for long-term treatment of HIV-infected people.

Individual monitoring of QoL should be carried out before the start of treatment, during treatment, as well as at the stages of early and late rehabilitation. Here, the prognostic value of the

results of the QoL assessment takes place. Pre-treatment results provide valuable information about the possible outcome of a disease with a particular treatment and thus help in choosing the right tactics for managing the patient.

Modern medicine has made great strides in the treatment of HIV infection, thanks to the emergence and development of highly active antiretroviral therapy (HAART). The life expectancy of HIV-infected patients with timely antiviral treatment and a high degree of adherence should not differ significantly from that in the general population.

The availability and effectiveness of health care, especially when combined with antiretroviral therapy, has slowed the progression of the disease and prolonged the lives of people living with HIV. Consequently, the impact of HIV infection on indicators of quality of life, including physical and emotional well-being, social support, has become one of the key issues for people living with HIV.

The study of the importance of various aspects of the quality of life of patients with HIV infection allows us to assess the effect of ARVT on their condition in the course of the disease and, if necessary, to carry out appropriate (drug and/or psychotherapeutic) correction.

In a study conducted by I.M. Ulyukin and H.S. Chikova (2006), most patients, regardless of receiving ART, believed that their overall QOL and health were average, but at the same time, it was found that in the absence of ART at stage A, the overall QOL and health were considered good by 30.16% of patients, bad - 20.63%, at stage C - 6.25% and 50.0%, with a disease duration of up to 3 years - 28.85% and 25.0%, more than 7 years - 16.67% and 25.0 % of patients, respectively.

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Meanwhile, patients who received ART at stage A, and with a disease duration of up to 3 years, the overall quality of life and health was considered good by 20.0%, bad - none, at stage C - by 15.38%, more than 7 years - 16, 67% and 25.0% of patients, respectively.

Changing ARVT regimens can lead to a significant decrease in QoL, mainly due to side effects from drugs. However, treatment with the same antiretroviral drugs improves all aspects of quality of life.

In our opinion, for the introduction of various algorithms and schemes, as well as the development of new and improved methods for assessing the quality of life, first of all, it is necessary to adapt them, taking into account regional and ethno-cultural characteristics.

In essence, QOL is an objective indicator based on subjective perception, which characterizes the difference between the patient's expectations and his achievements. The less pronounced these differences, the higher the QOL. An analysis of the literature data shows that the multidimensional aspects of the problem of the impact of HIV infection on the quality of life of people living with HIV/AIDS are insufficiently studied: the presence of opportunistic infections, the issues of psychosocial adaptation of patients in society and the social integration of PLHIV, the effectiveness of ARVT and life expectancy of patients.

CONCLUSION

Thus, quality of life is an integral concept that allows for a deep analysis of the psychological, emotional and social problems associated with HIV infection, in order to achieve a more effective and comfortable life for people living with HIV/AIDS, along with maintaining their working capacity and well-being, and in the sense of predicting potential risks.

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