

Research Article

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Prevalence and Associated Factors of Antiepileptic Drug Non - Department of Dilla University Referral Hospital, Dilla, Gedeo, SNNPR, Southern Ethiopia adherence among Epileptic Patients Attending at out Patient

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Abstract

Background: Antiepileptic drugs are effective in the treatment of epilepsy, but poor adherence to medication is major problem to sustained remission and to functional restoration. Poor adherence to treatment is one of many reasons for pharmacological treatment failure and seizure recurrence. Even though there were studies on the magnitude and associated factors of Antiepileptic drugs non-adherence, there is a shortage of published information regarding the prevalence and associated factors of Antiepileptic drugs none-adherence in Ethiopia.

Objective: To assess prevalence and associated factors of antiepileptic drug none-adherence among epileptic patients attending at Dilla University Referral Hospital.

Methods: Institutional based cross sectional study design was conducted at Dilla University Referral Hospital from March to May, 2016. A total of 265 individuals was selected by simple random sampling method and interviewed by using structured questionnaire 8-item Morisky Medication Adherence Scale was used to assess the prevalence of antiepileptic drug non adherence. Data was coded and exported to SPSS version 20 for analysis.

Results: The prevalence of Antiepileptic's drug none-adherence in this study was 38.1% and getting medication by payment [AOR=2.009,95%,CI:1.044,3.868], Patients who did not got health information about (their illness, duration of treatment and drug side effect), [AOR=0.319,95%,CI:0.184,0.534], poor social support [AOR=3.06, 95%, CI: 1.47-6.37], skip dose [AOR=2.462,95%,CI:1.375,4.407], patients who were on treatment for 2-5 years [AOR=1.48, 95%, CI: 0.722,3.035] were found to be significantly associated ($p<0.05$).

Conclusion: The prevalence of antiepileptic drug none-adherence among patients with epilepsy disorder was found 38.1%. Getting medication by payment, did not receive health information about [the illness, duration of treatment, medication side effect], skip dose, on treatment for 2-5 years, and poor social support were found to be the independent predictor of antiepileptic drug none-adherence.

Key words: Antiepileptic Drugs; prevalence; epileptic patients; Ethiopia

Introduction

Epilepsy is a chronic disorder of the brain and is one of the most common serious neurological disorders worldwide with no

boundary to age, race, social class, nationality or geographical location [1]. Worldwide around One billion people are affected by neurological disorders, including 50 million who had epilepsy, 24 million with Alzheimer disease & other dementias, and an estimated 6.8 million die each year due to neurological disorders [2]. Among patients who had epilepsy; 85% of them found in devel-

oping countries and estimated 40 million people do not receive appropriate treatment [1,3]. The overall mortality rate due to epilepsy increased by two to three fold as compared with the general population [4].

Medication none-adherence is defined as a voluntary or involuntary behavior of medication intake which includes: failing initially filling or refilling a prescription, discontinuing a medication before the course of therapy is complete, inability to cross pond with agreed recommendations from health care provider, taking more or less of a medication than prescribed and taking a dose at wrong time [5,6].

Antiepileptic drugs (AEDs) are effective in the treatment of epilepsy ,but poor adherence to medication is major problem to sustained remission and functional restoration [7]. Poor adherence to treatment is one of many reasons for pharmacological treatment failure and seizure recurrence [8]. The mortality rate in non - adherent patients was more than three times higher than that of adherent patients [9] .Even though around 70% of people who had epilepsy may expect to become seizure free with optimum antiepileptic drug (AED) treatment, patients didn't take their antiepileptic drugs appropriately [10].

A twenty review study indicated that one third of epileptic patients report negative experiences which may lead to poor adherence due to drug substitution [11]. The consequence of AEDs non-adherence behavior has been associated with: poor seizure control, increased morbidity and mortality along with increased time of hospitalization, worsened patient outcome, increased health care cost and death [12-14].

The mortality of untreated epilepsy become increase due to status epileptics and falling accident [15]. Recurrence seizure will result in poor quality of life, decreased productivity, seizure related joblessness and motor vehicle accident. AEDs non adherent patients had significant negative consequences like dropout from school and work as compared to those who were adherent to AEDs [16].

AEDs non - adherence will also lead to increase burden of inpatient and emergency department services [17, 18]. There was a negative relation between medication adherence and frequency of seizures. Patients who had poor seizure control are more likely to be anxious and feel as they are helpless due to their illness [19]. Moreover AEDs non-adherence also affects family members socially, economically and psychologically [3,20]. A review study revealed that a number of factors like patient centered, therapy related factors, social and economic factors, and health care system and disease factors were contributed to therapeutic non adherence [21]. Problem of non adherence to therapeutic regimen has been a matter of concern not only to the professionals and attendants but also to the country. Approximately 70% of people with epilepsy could lead normal lives if properly treated [22].

Even though there was a study done on the magnitude and associated factors of AEDs non-adherence, there is a shortage of published information regarding the prevalence and associated factors of AEDs none-adherence in Ethiopia. Therefore, assessing and showing the significance of antiepileptic non - adherence might be important to enforce policy makers and different stakeholders and to manage antiepileptic non - adherence.

Methods

Study Area and Period

The study was conducted at Dilla University Referral Hospital (DURH) from March to May, 2016 which is found in Dilla town, Gedeo zone, SNNPR, Ethiopia. DURH is established in 1977 E.C /1985 G.C as zonal hospital in Gedeo zone with the former name of Dilla Hospital until June 11/2001 E.C that changed in to DURH. It is located 360 km from Addis Ababa, the capital city of Ethiopia, and 90 km from Hawassa, the capital city of SN-NPRE. It provides curative and rehabilitative services for about 2 million catchment populations. At the time of its establishment, about 154 staffs were recruited, of them 104 are health professionals and the remaining are supportive staffs. Now the

hospital has five wards, namely Medical (39 bed), surgical (26 beds), oby/gyn (9 beds), Pediatrics (18 beds] and psychiatry (12 beds). Currently the hospital serves around 3 million peoples from which 95% belongs to Gedeo ethnic group. There are around 725 epileptic patients who are taking antiepileptic drugs annually.

Sample Size Determination and Technique

It was determined by Level of significance (0.05), Power (0.50) with $z=95\%$ confidence interval and The value of 'p' (p= proportion of prevalence) was taken as 36.8% of antiepileptic drug non - adherence from a study conducted in Jimma University specialized hospital, Southwest Ethiopia to estimate the sample size [17], total sample size for this study is 359. Then the total source of population are 725 that means less than 10,000; therefore it was used correction formula and by considering 10% non response rate, so final sample size 265.

A systematic sampling method was used to select study participants visiting Dilla University Referral Hospital during the study period from a total of 725 epileptic's patients.

Data Collection and Analyses Procedures

Data collection instruments

The instrument has five sections: it includes socio-demographic, clinical and treatment related factors, health care related factors, patient related factors and Morisky 8-item medication adherence questionnaire. A structured questionnaire was used to collect socio-demographic characteristics and antiepileptic drug non - adherence related factors. Data regarding the regimen of drugs and

presence of co morbid illness was collected by asking the patient and reviewing patients’ charts. Drug non -adherence was assessed by using 8 item version of self reporting questionnaire of Morisky Medication Adherence Scale (MMAS).

Social support was assessed by using the Oslo 3 item social support scales: the sum score scale ranging from 3-14, which is categorized into poor support 3-8, moderate support 9-11 and strong support 12-14 [36].

Felt stigma was measured by using kilifi stigma scale of epilepsy. It is a simple three point likert scoring system scored as not at all (0), sometimes (1) and always (2). A total of score was calculated by adding of all item scores. The score above 66th percentile of the data indicated presence of perceived stigma [37].

Data Collection Technique and Data Quality Control

Data was collected through interview by administering structured questionnaire and by reviewing patients chart. Training was given for data collectors and supervisors about the use of questionnaire, the ethical principle of confidentiality and data management prior to their involvement of data collection for two days was given.

Pre-test was done on 5% of the sample size, at wonago Health centre. Based on the finding of the pre test, the questioner was revised. Data collectors were supervised daily and the filled questionnaires were checked daily by the supervisors and principal investigator for completeness.

Data Processing and Analysis

The coded Data was checked, cleaned and entered into exported into Statistical Package for the Social Sciences (SPSS window version 20).

The Descriptive summary using frequencies, percentage and median were used to present study results.

A Bivariate analysis was performed to determine the effect each of factors on the outcome variable. Only factors with p.value <0.2 on Bivariate analyses were kept for multivariate analyses and a p value of < 0.05 on multivariate analyses was considered as statistically significant.

Ethical Consideration

Ethical clearance was obtained from ethical review board of Dilla University. Formal permission was taken for the hospital. All participants were well informed about the aims and purpose of the study, its contribution to the future development of health system in the country. The right was given to the study participants to refuse or withdraw from participation at any time during data collection without loss of any entitlement.

Result

A total of 265 patients were included in the study and mak-

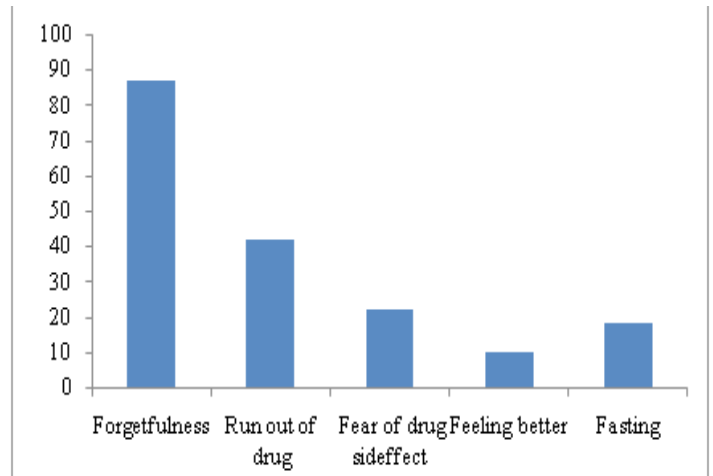
ing the response rate of 100% because all of them consented and completed the interview. The study subject was comprised of 140 (52.8%) male and 125 (47.2%) female. The majority [122 (46%)] of the patients were in the age group between years 26-44 of age. The majority of the study subjects 119 (44.9%) were orthodox, and 93 (35.1%) were farmers. Majority [116 (43.8%)] of the patients participated in the study were married and only 27 (10.2%) had Collage and above education

Socio-demographic characteristic	Number	Percentage [%]
Age		
18-25	100	37.7s
26-44	122	46.0
>/45	43	16.2
Sex		
Male	140	52.8
Female	125	47.2
Ethnicity		
Gedio	107	40.4
Oromo	75	28.3
Amhara	47	17.7
Gurage	12	4.5
Others	24	9.1
Religion		
Orthodox	119	44.9
Protestant	76	28.7
Muslims	38	14.3
Catholic	20	7.5
Others	12	4.5
Occupation		
Government employee	25	9.4
Farmer	93	35.1
Unemployed	29	10.9
Merchant	25	9.4
Student	52	19.6
Daily labor	37	14
Others	4	1.5
Educational status		
Unable to read and write	88	33.2
Able to read and write	112	42.3
Grade 1-8	21	7.9
Grade 9-12	17	6.4
Collage and above	27	10.2
Marital status		
Unmarried	104	39.2
Married	116	43.8
Divorced	24	9.1
Widowed	21	7.9

(Table 1): Socio demographic characteristics of the study subjects in Dilla University Referral Hospital, 2016 n=265

Clinical/Treatment/ Related Factors

More than half of the respondents 210 (79.2%) were on monotherapy and Phenobarbital was the most common prescribed drug. Among the respondents 217 (81.9%) had no any co morbid illness and 48 (18.1%) had co morbid illness. Depression disorder, HIV, dyspepsia, schizophrenia, and asthma are the type of co morbid illness. Medications which were prescribed concomitantly with AEDs were fluoxetine, haloperidol, cotrimoxazole and amitriptyline. Of 114 (43%) were on treatment for 2-5 years and among the participants 104 (39.2) reported that they experience side effect and the most reported experienced side effect was sedation. Regarding skip dose 128 (48.3) participants were reported missing their dose due to different reasons and the most reason was forgetting 87 [32.8%], run out off drug 42 (15.8%) (See table 2).



(Figure 1): Shows the frequency distribution of reasons for Antiepileptic drug dose skip epileptic patients attending at DURH, 2016 n=265

Variables		Category	Fre- quency	Percent [%]
Current AEDs	Phenobarbital	Total pre- scribed	162	61.1
	Phenytoin	Total pre- scribed	71	26.8
	Sodium- valproate	Total pre- scribed	10	3.8
	Carbam- azepine	Total pre- scribed	22	8.3
Medication other than AEDs		No	256	96.6
		Yes	9	3.4
Number of AEDs prescribed		One	210	79.2
		Two	48	18.1
		Three and more	7	2.6
Co morbid illness		No	217	81.9
		Yes	48	18.1
Reported experienced side effects		No	161	60.8
		Yes	104	39.2
Ever skip dose		No	137	51.7
		Yes	128	48.3
Duration on treatment		0.03-1 year	71	26.8
		2-5years	114	43
		6years and above	80	30.2

(Table2): Distribution of patients with epilepsy disorder by clinical and treatment related factors attending at Dilla University Referral Hospital, 2016, n=265.

Health Care And Patient Related Factors

Among the participants 78(29.4%) had free access to AEDs drugs. Regarding health information about 160 (60.4%) participants stated that they did not get health information from their health care provider concerning their illness, drug side effect and duration of treatment. About 90 (34%) respondents had perceived stigma and 76 (28.7%) had poor social support (see table 3)

Variables	Category	Frequency	Percent
How do you get your medica- tion	Freely	78	29.4
	Fee	187	70.6
Health informa- tion	No	160	60.4
	Yes	105	39.6
Use substance since starting Medication	No	256	96.6
	Yes	9	3.4
Substance use in 3 month	No	256	96.6
	Yes	9	3.4
Perceived stigma	No	175	66
	Yes	90	34
Social support	strong support	60	22.6
	poor support	76	28.7
	Intermediate support	129	48.7

(Table 3): Distribution of patients with epilepsy disorder by health care and patient related factors attending at Dilla University Referral Hospital,2016, n=265

Prevalence of Antiepileptic Drug None-Adherence

As measured by the 8-item MMAS, 101(38.1%) of the respondents scored two and more .The overall prevalence of antiepileptic drug non - adherence among the study participants were found to be 38.1%.

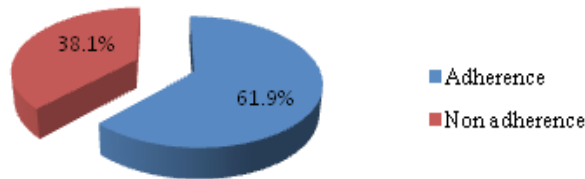


Figure2: Prevalence of Antiepileptic Drug Non-adherence among Patients with Epilepsy Disorder attending at Dilla University Referral Hospital, 2016

Factors Associated with Drug None-adherence

Bivariate Analysis

From the bivariate analysis of antiepileptic drug non adherence in relation to each variable, way of getting medication,

received health information from their health care provider, ever skip dose, social support, duration on treatment were variables that fulfilled the minimum requirement ($p < 0.2$) and for further analysis entered to multivariate logistic regression. On the other hand sex, age, occupation, marital status, number of AEDs medication, residence, and current substance use, experienced side effect, substance use since starting medication, perceived stigma did not fulfill the minimum requirements and were exclude from further analysis.

Multivariate Analysis

During the multivariate analysis of antiepileptic drug non adherence in relation to all independent variables, getting medication by payment [AOR=2.099, 95%,CI:1.044, 3.868], Patients who did not get health information about[their illness, duration of treatment and drug side effect] [AOR=0.319,95%,CI:0.184,0.554], poor social support [AOR=3.06, 95%, CI: 1.47-6.37], skip dose [AOR=2.462,95%,CI:1.375,4.407] and patients who were on treatment for 2-5 years [AOR=1.48, 95%, CI: 0.722,3.035] were found to be significantly associated ($p < 0.05$).

Independent variables	Drug non Adherence		COR [95% CI]	AOR [95% CI]
	No	Yes		
Educational Status				
Collage and above	12[44.4%]	15[55.6%]	1	1
Grade 9-12	8 [47.1%]	9[52.9%]	0.900[0.266,3.042]	1.111[0.329,3.756]
Grade 1-8	9 [42.9%]	12[57.1]	1.067[0.338,3.370]	0.937[0.297,2.962]
Able to read and write	45[40.2%]	67	1.191[0.510,2.781]	0.840[0.360,1.960]
Unable to read and write	27[30.7%]	61[69.3%]	1.807[0.747,4.375]	0.553[0.229,1.339]
Co morbid illness				
No	65[38.9%]	102[61.1%]	1	1
Yes	36[36.7%]	62[63.3%]	1.097[0.656,1.837]	0.911[0.544,1.525]
Reported experienced AED side effect				
No	52[42.6%]	70[57.4%]	1	1
Yes	49[34.3%]	94[65.7%]	1.425[0.866,2.345]	0.702[0.426,1.155]
Getting medication				
Free	18[23.1%]	60[76.9%]	1	1
Payment	83[44.4%]	104[55.6%]	0.376[0.206,0.685]	2.009[1.044,3.868]*
Received health information				
No	77[48.1%]	83[51.9]	3.133[1.805,5.433]	0.319[0.184,0.554]*
Yes	24[22.9]	81[77.1%]	1	1

Substance use since starting medication				
No	99[38.7%]	157[61.3]	1	1
Yes	2[22.2%]	7[77.8%]	2.207[0.449,10.83]	1.78[0.76,4.16]
Ever skip dose				
No	20[24.4%]	62[75.6%]	1	1
Yes	81[44.3%]	102[55.7]	0.406[0.227,0.727]	2.462[1.375, 4.407]*
Duration on treatment				
0.03-1 year	23[25%]	69[75%]	1	1
2-5 year	46[45.1%]	56[54.9%]	0.406[0.220,0.748]	1.48[0.722,3.035]*
6 years and above	32[45.1%]	39[54.9%]	0.406[0.209,0.789]	0.77[0.409,1.478]
Social support				
Strong social support	32[37.1%]	47[62.9%]	1	1
Poor social support	44[56%]	58[44%]	3.23[1.85,5.64]	3.06[1.47,6.37]*
Intermediate support	25[49.5%]	59[50.5%]	1.31[0.78,2.20]	1.39[0.72,2.67]
Perceived stigma				
No	63[57.5%]	54[42.5%]	1	1
Yes	38[66%]	110[34%]	3.01[2.01,4.51]	1.72[0.997,2.97]

Key: * statistically significance

Table 4: Factors associated with Antiepileptic Drug Non-adherence among patients with Epilepsy Disorder attending at Dilla University Referral Hospital: 2016 (n=265).

Discussion

Non adherence to treatment is one of many reasons for pharmacological treatment failure and seizure recurrence. In this study the prevalence of antiepileptic drug non adherence among patients with epilepsy disorder was 38.1% with [95%, CI: 32.3, 44.9].

It was greater than in studies done in USA 26% [18]. The probable explanation for this difference may be due to: the study design used, the medication prescribed, methods used to measure the non adherence and as well as difference in socio-demographic characteristics of the study participant or due to study area. But the non - adherence was smaller than those studies in Brazil, Nigeria and Palestine which were 66.2%, 67.4% and 64% respectively [28,31, 40] The difference from Brazil study might be due to duration of treatment and prescribed AEDs which were 71.1% of the respondents were on two to five AEDs and the mean duration of treatment was 21.5year. In this study the participants who were on two medications was 18.1% and the mean of treatment duration was 1.9 years and the difference in Nigeria might be due to socio-demographic characteristics and poly-therapy which was 85% of the participant took three and above AEDs. The difference in Palestine might be due to sample size, chronic illness and prescribed medication: the sample size in Palestine was small, 13.7% had other chronic diseases and more than half of the patients 63.2%

were on poly-therapy but in this study 37% the respondent had co morbid illness and 18.1% were on two medications.

From the study participants who were buying AEDs medications, the odds of being non adherence was about 2 times more likely to be non adherence as compared with patients who were getting their AEDs medication free of charge [AOR=2.009, 95%,CI:1.044, 3.868]. From all patients who were buying their medication 104(55.6%) were known to be non adherent. This study was in line with a study done in Kenya [34].

From all patients who did not get health information 160 (60.3%) were known to be non adherent. This finding was not in line with Egypt's study in which all patients include in the study (100%) did not get any health education about epilepsy from nurses but 6% received health education from physician [33]. The possible reasons might be health care providers may not have adequate time, poor doctor-patient relationship, negligence and might feel fatigue to explain related conditions with the disease and the treatment for their patients.

Concerning social support ,participants who had poor social support were three times more likely to be non - adherence as compared with patients who had strong social support [AOR=3.06, 95%, CI:1.47-6.37]. The study was in line with a study done in Egypt [33]. Among participants 210 (46.7%) were skipped their

medication dose at least once during their treatment. They have different reasons for skipping. Forgetting 87(32.8%) was the most reported reason for skipping dose.

Regarding the duration of treatment for those patients who were on treatment 2-5 years, the odds of being non adherence were about 1.488 times more likely to be non adherence compared with patients who were on treatment 3 month to 1 year [AOR=1.488, 95%, CI: 0.722,3.035]. As the study illustrated while treatment duration increases, the respondents more likely to be non adherent. The study was not similar with studies done in Kenya and Egypt [33,34]. This could be due to decreased the willingness to follow their treatment as well as forget fulness to follow the treatment for long period of time by patients and also the treatment duration increases the patient might feel better and more likely to be non-adherent to their treatment given.

Conclusion

The prevalence of antiepileptic drug non-adherence among patients with epilepsy disorder was found to be 38.1%

Getting medication by payment, did not receive health information about (the illness, duration of treatment, medication side effect), skip dose, on treatment for 6 years and above, and poor social support were found to be the independent predictor of AEDs non adherence.

Recommendations

Based on the findings and the conclusions, the following recommendations were forwarded for respective bodies.

To Ministry of Health

In order to improve adherence, it is better to design and implement programs that address getting medication free of charge

To Dilla University Referral Hospital

The hospital should develop standard protocol for the management of epileptic patients and manuals which describe strategies of drug selection, dosing, frequency of drug and duration of treatment.

To Health Care Providers

The health care providers should give time to provide the appropriate health information about disease condition, drug side effect, duration of treatment and the consequence of dose missing.

To Researchers

The researchers better to further study with other study design to provide strong evidence regarding the prevalence and associated factors of epileptic drug non adherence among patients

with epilepsy disorder.

Competing interest

All authors declare that they have no conflict of interest associated with the publication of this manuscript.

Authors' Contribution

Maregu Shegaw conceived and designed the study and collected data in the field, performed analysis, interpretation of data, and draft the manuscript. Reta kassa, Yigrem Ali and Negatu Adisu also involved in the design, analysis, and interpretation of data and the critical review of the manuscript. All authors approved and read the final manuscript.

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