Background
HIV/AIDS is recognized to affect both the life expectancy and the quality of life of individuals (Wright, 1999). Evidence from clinical trials has proved that antiretroviral therapy (ART) is an effective intervention for extending the life of HIV patients while reducing morbidity outcomes (Vohr, 2001).

Health Related Quality of Life (HRQoL) assesses people’s perceptions of their health status i.e., a combination of statements about multiple aspects of the individual’s well being including disease as symptoms, physical functioning, work, social activities, and mental status. However, very few examples of this type of assessment are found in resource poor settings and none is related to the provision of antiretroviral therapy (ART) for people living with HIV/AIDS in Uganda.

We assessed the performance of the Luganda version of the Medical Outcomes Study HIV Health Survey (MOS-HIV) in HIV infected individuals in Entebbe, Uganda.

Methods
We recruited a sub-group of study participants (18 years) of the DART trial (an open-label randomised trial evaluating different ART management strategies), at Entebbe site before they started taking ART (DART group (DG); n=276), and HIV infected individuals who were ART naïve (Entebbe Cohort Group (ECG); n= 159). Participants were administered a socio-economic questionnaire and the Luganda version of the MOS-HIV, a 35-item questionnaire that assesses the functional status and well-being of HIV infected individuals. The questionnaire was administered face-to-face in the local language (Luganda). The degree to which responses were internally consistent was evaluated.

Results
The majority of the participants from both groups were females, with 64% in the DART group and 76% in Entebbe Cohort Group. This difference was statistically significant at conventional levels (Pearson chi2(1) = 6.9040; Pr = 0.009). The mean age of the participants was 36.5 and 35.7 for the DART and Entebbe groups; the age distribution was comparable among groups. Only one participant from DART did not know her age. The level of education for Entebbe Cohort participants was slightly lower than among those in DART group. Although the difference was not significant at the 5% level (Fisher’s exact test; 0.262). The groups differed with respect to marital status; DART participants were more likely to be married than the Entebbe Cohort participants, and the Entebbe participants were more likely to be widowed than those in the DART. This difference was statistically significant at 1% level (Pearson chi2(4) = 60.9160; Pr = 0.000).

Both groups reported selling perishable goods in the market as their main economic activity. DART participants reported a higher family expenditure, 155,310 Ugandan Shillings (US$85) per month, than Entebbe Cohort participants, which reported an average of 117,927 Ugandan Shillings i.e., US$64, per month. However, there was no statistical difference between the two groups.

We observed a 100% response and good acceptability of the MOS-HIV. Internal consistency reliability coefficients for multi-item scales were > 0.70 in the two groups except for role functioning (0.69) and mental health (0.68) in the DG and for vitality (0.65) in the Entebbe Cohort Group (See Table 2). Item-interval consistency and discriminatory power was satisfactory, ranging from 0.40-0.67 for those dimensions that were found reliable. Factor analysis revealed that physical health (PH) and mental health (MH) components together accounted for 57% of the variance (See Graph 1). Overall MH had the highest factor loadings for vitality, pain and physical subscales and for Overall MH the highest factor loading was quality of life (See Table 3).

Conclusions:
Our results demonstrate the feasibility of assessing HRQOL in HIV infected individuals using the Luganda version of the MOS-HIV. Further work using repeated measure designs is underway to identify the sources of variability in responses in those dimensions that were found unreliable in this study.

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