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ORIGINAL ARTICLE

Gaps in the implementation of Anti-Retroviral Treatment: A case for addressing gender and mental health consequences of HIV positive individuals

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ABSTRACT

This paper looks at the current status of HIV infection in Zambia. The results show that Zambia is among the worst affected with a prevalence of 14.3% in the age group of 15-49 (ZDHS, 2011). Further it is noted that Prevention and control of HIV and AIDS has been a priority of the Zambian Government however only 63 percent of those eligible have access to ART. We also found that women are more susceptible to HIV infection than men. This could be due to a number of socioeconomic and cultural factors such as loopholes in enforcement of laws regarding property ownership, economic opportunities and autonomy, inheritance, marriage and sexual negotiations with their husband or partners that have yet to be fully addressed. These inequalities have the potential to cause negative psychosocial problems.In rural communities due to long distances to health posts it is still difficult for people to access treatment for psychosocial concerns. This further compromisesthe immune functioning of HIV positive individuals. In the some regard we report that there is a paucity of professionals to provide neuropsychological support. There is need for evidence-based and action-oriented approaches in addressing gender and mental health concerns of PLWHA to score successes in ensuring adherence to ART as well as reducing new HIV infections.

Zambia is among the worst affected countries in Sub-Saharan Africa in terms of HIV infection, with a prevalence of 14.3% in the age group of 15-49.[1]Each year about 1.6 percent of the adult populationget infected of HIV.[2] The country first reported AIDS diagnosis in 1984, and this was followed by a rapid rise in HIV prevalence.[3] While Zambia's national prevalence rate has remained high, the country has made significance strides in increasing antiretroviral treatment access[3] which has been made possible with donor funds such as PEPFAR and supported by the national HIV and AIDS strategic plan.

Prevention and control of HIV and AIDS has been a priority of the Zambian Government. Emphasis was placed on promoting care for those infected and affected, and need to devise measures for reducing the personal, social and economic impact of the pandemic.[2] The National HIV/AIDS/STI/TB policy, formulated in 2005, provided monumental turnaround for patients infected by HIV and AIDS, as during the same year, a decision was taken to provide Anti-Retroviral Treatment (ART) free of charge to all those in need of treatment. The target was to provide ART to 1, 000 HIV positive individuals by the end of 2005 in the first instance.

Other challenges to providing ART include lack of established clinical infrastructure, negative social stigma and the cost effectiveness of HIV prevention programmes. While there has been a scaling up of ART with about 75, 000 on ART, this only represents about 63% of people in Zambia who need them.[4] Although provision of ART has been a major stride in the mitigation of HIV and AIDS in Zambia, how proactive has the structure been in meeting the challenges of providing ART as well as addressing other consequences of being HIV positive?

Gender, culture and tradition

Research evidence[5]demonstrates that women are more susceptible to HIV infection than men. For instance in Sub-Saharan Africa, HIV/AIDS has had a

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disproportionate impact on women. In the region, for every HIV positive young man (15-24 years), there are three HIV- positive young women.[6] Equally, HIV prevalence among Zambian women is three times as high as in men. For example, in terms of gender HIV prevalence in women aged 15-49 is significantly higher than that of men in the same age cohort, 16.1% and 12.3% respectively.[2] This scenario has been attributed to a number of socioeconomic and cultural factors. For instance, women still experience disadvantages in enforcement of laws regarding property ownership, access to various economic opportunities and autonomy, inheritance, marriage and sexual negotiations with their husband.[7,8] Women may be more vulnerable to HIV because of traditions such as sexual cleansing (kusalazya) and wife inheritance (Kunjililamung'anga).

Over the years the awareness to HIV is much less in women than men. Gender issues have been prioritized in the national policy on the fight against HIV and AIDS.[9] The Ministry of Health has made it compulsory for all pregnant women to undergo voluntary counseling and testing and to be put on ART if found positive. Often times though, when women are found to have the HIV virus, men and society places blame on them for bringing the virus into the home. Hence, many women keep the status of being HIV positive to themselves to avoid stigmatization, divorce or abandonment.[10,11]This is at a huge psychological cost to themselves (guilt of not sharing their status, depression and the trauma of knowing they are positive).

Many times, women are predisposed to HIV infection due to biological and social factors, implicated and stigmatized for the spread of the virus and often perceived as responsible for infecting their spouses and children and their rights to access ART are denied or violated as a consequence perceived complicity.[11] Moreover, when a woman on ART request that their husbands use condoms during sexual encounters; the consequence these women face is that they end up being beaten or verbally abused and or suspected of having extra marital affairs.[12,6] Further even when ART is available women take antiretroviral drugs in secrecy because of this stigma.[6]

Gender inequalities are a major driving force behind the AIDS epidemic. To a larger extent, it is as a result of gender inequalities that new infections continue to happen despite several years of experience in implementing prevention programs. According to UNAIDS in the National Report,[2] success in accelerating access to treatment has not been scaled up with similar successes in prevention such that for every two people who start Antiretroviral Treatment (ART), five others get newly infected. Is it therefore enough to prioritize gender issues but not have any deliberate attempt made to ensure that women who are on ART, continue to be on ART? Is there not a gap between research findings and practice in this area? How are the mental health issues being addressed?

Rural communities

Rural communities bear a higher burden of the cost of HIV and AIDS as it threatens food nutrition, food security and their wellbeing.[13] Sadly, because of long distances from health centers, many HIV related psychosocial concerns such as depression, related anxieties, and end of life concerns, bereavement and trauma of seeing relatives being sick and dying are not treated. These psychological consequences may further lead to compromised immune functioning in HIV positive individuals.[14,15] In addition, though it is government policy and donor policy to ensure that anti-retroviral treatment is available to all Zambians, long distances from health centers act as a barrier in preventing rural dwellers in accessing medical help and psychosocial support that they need. Although there has been a deliberate effort to step up the ART in rural areas, there has been very little that has been done to deal with the psychological effects of being HIV positive. Is this situation contraindicative to providing ART?

Mental Health

The relationship between HIV infection and the mental health of HIV positive individuals has been researched vastly.[16,17,18] A World Health Organization (WHO) Neuropsychiatric AIDS study[19], carried out in five geographical areas predominantly affected by HIV suggests that the symptomatic stages of HIV are associated with increased prevalence of depressive symptoms. Similarly another study[20] found that though ART is indispensable in improving the health of PLWHA, lack of psychological support to these, can render the treatment useless. HIV positive individuals experience a lot challenges such as anxiety, suicidal behavior, depression and Post Traumatic Stress Disorders (PTSD) which can affect adherence to treatment thereby worsening one's health condition. A recent neuropsychological study carried out in Zambia[21]

suggests cognitive impairment in HIV positive individuals. As there are hardly any professionals available to do neuropsychological functioning in Zambia, one way of addressing this problem was to train graduates in neuropsychology, made possible through funds from NoradMasters Program (NOMA). There lies an ambiguity as to the effects of ART on neuropsychological consequences. But there is much more to be done in this field in Zambia which would need resources as well as commitment at a national level.

Zambian NGOs and CBOs

Zambian NGOs and CBOs play a critical role in responding to HIV and AIDS, shouldering much of the country's response to HIV and AIDS.[22] Among their constraints are high dependence on donor funding and limited financial assistance from government, limited coverage and scale, and poor distribution across the country.[23] Another challenge is the inadequate knowledge in clinicians attending to HIV patients. Many patients show a grave concern about the natural history of HIV, when to start ARV's, what are the different interactions if they are on other drugs, when to switch to the next regimen of ARV's, what is the impact of ARV's on their social and occupational well being, whom to see for common opportunistic infections and also if they need psychological counseling or psychotherapeutic drugs? These concerns among PLWHA are very real. This is because getting infected, including the time around HIV testing, disease progression, illness and death are closely associated with mental, physical and spiritual adjustment and losses that individuals confront.[24]

Indeed more research is needed in Zambia to address gender and mental health problems faced by HIV positive individuals if the implementation of the ART is to be effective. We are of the view that there is need for evidence-based and action-orientedapproaches in addressing gender and mental health concerns of PLWHA to score successes in ensuring adherence to ART as well asreducing new HIV infections.It is evident that there is a big gap in research done in HIV and relative implementation of the results at the grass root level. The question we ask here is how effective is the implementation of ART in a microscopic way ignoring the mental health consequences of being HIV Positive? We argue that in doing so, we are creating new mental disturbances, which we need to be aware of and address.

CONCLUSION

This paper has brought out issues pertaining to adult issues in HIV/AIDS care such as gender,culture,tradition, rural communities and mental health. However, it is important to recognise that children have often been the tail end of care such as, accessing anti-retroviral care. Therefore this in itself is a gap in care that must always be consciously addressed if childrens' rights are to be preserved in HIV AIDS and care.

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