HIV/AIDS prevention efforts in Malawi

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Introduction

Acquired immuno-deficiency syndrome (AIDS) was first described in 1981 among homosexual men in North America[1]. Since the first HIV-related diagnoses were registered in Malawi in 1985[2,3], the virus has achieved international notoriety. Globally, at least 38 million people are infected by HIV [4,5] and most of these are in the developing nations of Africa, south of the Sahara. It was estimated that by 2000, Malawi had up to 10% of its 10 million inhabitants infected by HIV[6]. HIV/AIDS has been responsible for decimation of households, increase in the numbers of orphans and destruction of social fabric all across the country[7]. The virus has also resulted in the escalating prevalence of tuberculosis (TB) especially sputum-smear negative[8]. The widening gap between the rich and the poor and neglect of proper clinical management are in alliance with HIV in fuelling TB[9].

HIV/AIDS has challenges for society at large and the health care delivery system. HIV is not just 'any other disease'. It is a political and a human rights issue. Politicians do not deal with HIV/AIDS as they do with hypertension, diabetes or *Haemophilus influenzae* meningitis. Few health conditions of public health significance have attracted wider publicity than HIV/AIDS. The disease is not the only chronic disease, neither is it the sole incurable viral condition and it is definitely not the only sexually transmissible infection (STI). HIV/AIDS raises emotions and those that wish to behave or think otherwise are likely to suffer the ridicule of not only their own families but society at large. Discussions about HIV/AIDS demand sympathy and empathy.

Modes of Prevention

The predominant mode of HIV transmission globally is heterosexual[10]. So simply, the HIV/AIDS pandemic would be curtailed dramatically if sexual activity were restricted to monogamous sexual relations among non-infected partners. This has been found to be a major ask for many[11-14]. Casual sexual intercourse with multiple partners seems to be an accepted lifestyle for many Malawians[15]. In a situation where permanent monogamous relationships, a challenge for both youths and married couples, are not the reality, the (male) condom has been advocated as an important tool in the prevention and control of not only HIV/AIDS, but also other STIs and unwanted and unplanned pregnancies. This is not to suggest that all persons that 'should' use condoms eventually use the sheath. While there are obviously personal reasons as to why individuals or couples fail to use condoms[16], society also has its own proscriptions. Condom use and promotion has not always been considered appropriate by various sections of society, including part of the Christian community. Of late, the condom controversy has attained particular notoriety after the re-launch of the Chishango condom in May 2002[17,18]. The promoters of the condom, Population Services International (PSI) indicated that they had wished to appeal to the youth and that the new packaging and design of promotion materials were in response to the target population's aspirations. On the other hand, some sections of society complained bitterly that the packing and billboard arising from it were so sexually explicit as to lack cultural sensitivity[18].

Dilemmas also surround mother-to-child transmission of HIV – usually during delivery or through breastfeeding – and they have not yet been resolved for Malawi. Should and can ARVs be made widely available and accessible to all women who are infected in order to prevent transmission? Should HIV positive women continue to breast feed their infants, and for how long? Should HIV testing be incorporated in antenatal care just as the VDRL has been?

Care and hope

Often associated with HIV/AIDS are a sense of hopelessness and helplessness, especially in the least developed countries. With no effective vaccine currently available[19] and treatment with highly active anti-retroviral therapy (HAART) out of reach for most of the population heavily affected, despair is often exhibited. In the past few years, however, it has been increasingly been recognized that a significant amount of good can be delivered and achieved with the limited resources available, or without necessarily waiting for HAART. There has therefore been a proliferation of community-based HIV/AIDS and orphan care groups, funded locally, nationally and in some cases internationally.

While TB as an HIV-related illness has been tackled to a certain level of satisfaction[20], the management of other conditions such as cryptococcal meningitis and Kaposi's sarcoma are inadequate and unstructured. The drugs used for these conditions are expensive and beyond the reach of the majority of the affected[21]. The Ministry of Health and Population (MoHP) has negotiated with international drug manufacturing companies to either provide Malawi with drug donations or at heavily reduced prices. By December 2001, some 84 Malawians were on combination antiretroviral therapy (ART) obtained from the public health care system. Abuse of drugs by patients and sexual partners has been observed (R Kalanda, personal communication). There have been instances where an HIV-positive individual has been prescribed ART that they have shared with their partner(s).

For an individual to be qualified for the subsidized ARV programme, they must be; HIV positive, provide indication that they will be able to afford drug fees for an extended period, be bona fide Malawian citizens (valid passport, documentation from District Commissioner or Traditional Authority or any other approved documentation). Several other laboratory tests are also carried out prior and during the course of therapy and the patients must be prepared to pay for costs.

In June 2002, MoHP's discussions with the American pharmaceutical company, Pfizer Inc resulted in the company donating and promising to continue supplying Malawi with Diflucan (Fluconazole) [22], an anti-fungal for the treatment of cryptococcal meningitis and oesophageal candidiasis. Unlike ARVs that are available at a cost of MK 2,500 per month, Diflucan is expected to be free.

The Challenges

The obstacles that the public health care system is facing and will continue to face in as far as providing adequate care is concerned are formidable. The health care human resource base for the country is sparse, increasing demands being pressed on them, with limited resources and staff morale [23]. The experience in the past years has been that publicly funded or sourced drug supplies in Malawi cannot be guaranteed. In the early part of 2002, anti-retroviral drugs in public central hospitals ran out despite the fact that patients were still willing to pay the subsidized cost. And we are still only talking about less than a hundred patients in all Malawi. It would take some effort in resource

allocation, forward planning and changes in policy to ensure that HIV/AIDS patients receive optimal care in Malawi. Poverty reduction efforts, which are obviously hampered by HIV/AIDS, must be enhanced in order to prevent the spread of the virus.

Conclusion

HIV/AIDS has probably surpassed all other health conditions that have affected Malawi and the sub Saharan Africa region. Prevention and control efforts must be multi-pronged. The availability of HAART to a major section of the affected communities will add to the armamentarium of prevention efforts[24].

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Revisiting human behaviour in relation to HIV/AIDS

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Abstract

It is widely recognised that human behaviour change is a key element in the fight against HIV/AIDS. The reality of the situation however is that the current approaches to instigating sexual behaviour change appear to have borne little fruit. This paper shall argue that in the fight against HIV/AIDS, a fundamental error is made in the numerous outreach programmes that exist within Malawi and elsewhere. This error is grounded in the assumptions that are made about how persons respond to the messages garnered to the control of the disease. Until this mistaken assumption is addressed, it is argued that no serious headway shall be made in the control of this disease, which threatens the very fabric of the Malawi nation.

Introduction

The most baffling thing about the impact of HIV/AIDS is that whilst there is so much awareness of it, there is so little accompanying behaviour change[1] . It can therefore be argued that somewhere along the line interventions are "missing" it. This brief discourse suggests an alternative approach that might shed brighter light in forging a more effective response to this dreaded disease.

Current approaches

The current messages aimed at controlling the disease work on the assumption that people change their behaviour after they receive information [2]. It is assumed that they then process the information cognitively and hence subsequently translate the message they have received into behaviour change. The messages therefore are targeted at the cognitive structures inherent within people. Such structures include information provision, leading to attitude changes, which it is assumed, would subsequently affect behaviour [3]. As a result of this assumption, numerous campaigns seek to provide information through posters, drama, music and lectures. These methods do clearly have their place and are pivotal in providing information leading to awareness. Information provision is always a first stepping stone.

However, awareness is not the main determining factor that results in behavioural change in Malawi. Green & Kreuter assert that an increase in knowledge by itself does not lead to behaviour change[4] . They do point out however that knowledge serves the function of a precursor to behaviour change. If there is present a sufficient amount of knowledge, when a powerful enough cue trigger is presented, a person shall then be motivated to act on the knowledge. Knowledge therefore is more a base for action. The premise of this argument is that behaviour change operates on the principle of combinations of factors. It is the bringing together of various combinations that will ultimately influence behaviour. Whilst behaviour may not change immediately due to knowledge, Green & Kreuter argue that the knowledge that is available impacts the prevailing beliefs, attitudes, intentions and perceived control leading to behaviour[5].

There are many causes of a health behaviour. There is therefore need for multi-dimensional approaches that will lead to behaviour change. No disease occurs in isolation, there are always mediating factors. Desjarlais et al. argue that behaviour "is so