Anti-Retroviral Therapy in Context: Challenges to Scaling up HIV Programs in Zambia and Uganda

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Introduction: The Bridging Gaps Project (BG) was a 40 month intervention project. BG was designed to assess whether improved collaboration and communication between Biomedical Health Practitioners (BHP) and Traditional Health Practitioners (THP) could improve the quality of HIV and STI care in Zambia and Uganda. Here we report the first known use of the SCM to assess quality of HIV/AIDS care and support and the first known use of SCM among THP. Using data from the SCM we provide unique insight into some of the challenges and opportunities faced when attempting to scale-up ART in urban Zambia and rural Uganda.

Figure 1: SC in role plays during training.

Figure 2: Herbs, condoms, drugs, and pamphlets were collected by SCs during THP and BHP consultations.

Methods: The Simulated Client Method (SCM) has been widely used to assess quality of care in family planning and STI clinics. SCM uses trained research assistants to act the part of a patient with a standardized disease scenario. These patients then visit the health care provider as a normal patient would. After their consultation the simulated client's experiences are recorded and analyzed. Simulated client visits (SCV) were conducted among BHP and THP in urban Zambia and rural Uganda between February and November 2005. SCV followed one of four standardized scenarios. Scenarios sought counseling and advice for Voluntary Counseling and Testing (VCT), Sexually Transmitted Infections (STI), ART, or Prevention of Mother to Child Transmission of HIV (PMTCT).

SCs were school leavers recruited from outside the study areas. SC training included expectations of care, normalizing the THP experience, introduction & development of scenarios, colloquialisms, dress, researcher-patient balance, dealing with tricky questions/situations, extensive role playing, data capture tools, and field safety. SC were debriefed by field supervisors as soon after their consultations as possible. Data was recorded qualitatively in short descriptive narratives and quantitatively through a structured questionnaire.

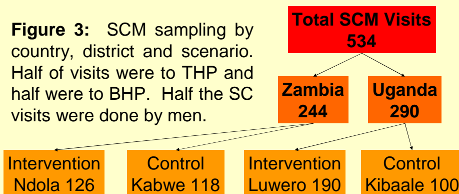


Figure 3: SCM sampling by country, district and scenario. Half of visits were to THP and half were to BHP. Half the SC visits were done by men.

Results:

Challenges: In Zambia 2 of 12 (17%) and in Uganda 2 of 31 (6%) of female SC who consulted male clinic staff were sexually harassed as illustrated by this narrative from a female SC consulting a VCT counselor in Zambia:

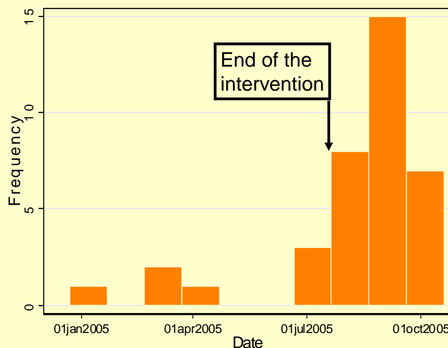
> ***Narrative 1:*** *Then he really went off topic and started asking me how old I am and started proposing to me and saying, "you come and see me… I hope you won't tell your sister that you are coming to see me. You have a nice face, nice hair". He wanted to start touching me and came near me. I felt very uncomfortable. I said to him that I was uncomfortable and I quickly left. I would definitely not go back to that counselor... Imagine if it was a younger girl than me. I was even inside the office with the door closed.*

None of the SC who consulted a THP reported sexual harassment.

The following quote from the narrative of a female SC in Kibaale, Uganda (control district) is an extreme example of the dangerous myths and misconceptions that THP can tell their patients:

> ***Narrative 2:*** *He tells me that these condoms were manufactured by whites to kill the African people. He said during the manufacturing process they put a fluid that contains HIV virus and so that when you use it you get infected immediately. He said that this thing that says that it prevents AIDS is a lie. Then he said, for example, I have slept with so many women, and I have 198 children and for me, I've never been infected. Then I told him, but how is this? He told me he has all kinds of herbs that can treat any kind of disease. I asked him, including AIDS? He said he has medicine that prevents someone from getting AIDS.*

Figure 4: Referrals from THP to BHP in Luwero, Uganda (intervention district) measured by real patient's referral forms collected at clinics. Plotted by referral date.



Opportunities: THP can play an important counseling and educational role in their communities as illustrated by this THP's comments to a male SC in Luwero, Uganda:

> ***Narrative 3:*** *"The youth are especially not talking about AIDS and they are given advice and still get Into problems." He said that sometimes they get into discussions and he joins in and the kids really listen to him. He said he had condoms but they were finished since he was sensitizing the youth… He told me where he goes for training, that they also say that parents who are positive can give birth to a child who is HIV negative.*

Table 1: Proportions and percentages of THP who counseled a SC that they could cure HIV/AIDS or that they could provide tattoos to prevent HIV/AIDS or STI. The p-value tests the difference between the % observed among THP who participated in the intervention vs control district THP.

Country	District	Can Cure HIV/AIDS	Tattoos Prevent HIV or STI
Uganda	Intervention	0/15 (0%)	No mention of Tattoos in Uganda
	Control	11/38 (29%)	
	p-value	p=0.019	
Zambia	Intervention	11/16 (69%)	3/21 (14%)
	Control	15/23 (65%)	11/32 (34%)
	p-value	p=0.82	p=0.105

Discussion: Barriers to ART roll-out exist among both BHP and THP. Sexual harassment ***(Narrative 1)*** is an extreme example of the generally poor interpersonal quality of care provided by BHP. This creates very tangible treatment seeking behaviour barriers. The most significant barriers that THP create for ART roll-out are the misconceptions and misleading advice that some THP provide to their patients on condoms and HIV treatments ***(Narrative 2)***. Still more worrying was the widespread claim by THP that they could cure HIV/AIDS (Table 1).

The views of THP and hence their impact on ART roll-out is very regional as illustrated by the differences between countries noted in Table 1. THP in Uganda do not use tattoos and therefore make no claims that they can prevent HIV infection in this manner (Table 1).

THP can play an important role in comprehensive HIV care and support programs ***(Narrative 3)***. No THP in Uganda who participated in the BG intervention claimed to be able to cure HIV/AIDS while 29% of THP in the control district claimed they could (Table 1). This illustrates that misconceptions held by THP can be overcome by engaging with them in collaborative interventions. THP can refer patients to BHP if THP are engaged in a in a way that builds trust with BHP as shown by the number of referral forms from THP which were recovered from clinics. (Figure 4). This is a substantial underestimate of the true number of referrals made by THP to BHP since not all THP are literate and can write formal referral forms, not all patients follow through on referrals, not all patients would tell a BHP that they had visited a THP first, and it is unlikely that all referral notes were retained by the clinics.

Conclusions:

- Interpersonal quality of BHP's care must be improved
- THP are influencing ART roll-out programs
- Local differences in THP views and practices must be accounted for when initiating ART roll-out programs.
- THP can be engaged in collaborative intervention projects to overcome misconceptions and improve counseling, education, condom promotion and referral practices.

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