

ART in Zambia: Barriers to Access

The barriers to access to ART in Zambia are many: financial, social and organizational. Financial barrier is the largest obstacle in both public and community-based healthcare sectors. The average annual cost per patient for a first-line HAART regimen in Zambia is \$488, including drugs, monitoring tests, capital and training costs. Second-line regimen cost rises well above \$1000 per year. In a country where 80% of people are under the poverty line, living on less than \$1 a day, and largely unemployed, the ART is unreachable for majority. President Mwanawasa's government is currently able to cover only 15,000 (11%) of patients in need of ART. Providing HAART to everyone clinically eligible seems to be impossible. The estimated cost to cover is \$50 million in the first year, rising to \$160 million by the fifth year, which is well over twice the annual public health budget of Zambia.¹

Social barriers such as stigma, discrimination against HIV-positive individuals, gender inequality, and lack of education also represent great challenges to providing ART in Zambia. The example where perceptions and education toward HIV-positive patients may pose as significant obstacles to access ART as financial barrier is in the area of prevention of mother-to-child transmission (PMTCT). PMTCT is one of the most cost-effective of all HIV/AIDS interventions. Per-patient drug costs for prevention of mother-to-child transmission are low-about \$0.23 for each mother-and-child pair if Nevirapine (NVP) is used. The HIVNET-012 trial has shown that NVP could reduce vertical HIV transmission by almost a half. PMTCT is very important since mother-to-child transmission is a major contributor to childhood mortality in Zambia. For example, in Lusaka 25% of pregnant women are HIV infected, and considering that the risk of transmission is 30-40%, it is estimated that 1 in 10 newborns in Lusaka will become infected.²

One study that surveyed 225 public and private sector maternity healthcare providers, including physicians, midwives and nurses throughout Zambia, reported non-adequate education about NVP and widespread stigma.² Only a minority of respondents could correctly identify the baseline rate of MCTC in breastfeeding mothers if ARV is not used, and the efficacy of NVP. Also, only 30% of them were routinely prescribing ARV. Most commonly reported obstacle was lack of medication, but from the following statistics it may seem that financial barrier is not the only obstacle to providing NVP to women in need. Majority of respondents (84%) believed that the diagnosis of HIV was associated with negative images such as prostitution and marital infidelity and that HIV-positive patients were treated worse in the community because of their diagnosis. Almost half of the respondents (47%) said that they personally felt that HIV was something to be ashamed of. Astounding number of the practitioners (60%) had chosen not to be tested for HIV infection themselves, mainly because they would rather not know if they were infected. These statistics warn that even healthcare providers in Zambia may be influenced by the discrimination within the community towards the disease and that their perception and education may represent a significant barrier to access to ART. However, even when pregnant women are given NVP for self-administration, one in four did not take the pills. The physical access to ART is not a complete answer in itself.

Another example of unnecessary deaths due to lack of education is given by Bwafwano Community Organization in Lusaka area.³ This organization reports that many infected with HIV and opportunistic infections are dying in their homes because they cannot afford the travel cost to the hospital, but also because of their lack of knowledge about HIV/AIDS and TB. In Bwafwano coverage area it is common to assume that anyone who loses weight has AIDS. Therefore patients fail to obtain more affordable treatment for TB and other opportunistic infections.

It is obvious that treatment with medicine doesn't work in isolation and the attitudes and behaviors of those both providing and receiving the treatment are crucial for the success. The providers need to have positive attitude with an approach based on tolerance, non-discrimination, and compassion and both have to be knowledgeable about the disease and treatment. Education, counseling and support are the key words.

Due to lack of resources in the public health sector vast majority of people cannot obtain care and treatment. Community-based organizations are emerging as a complement to public health efforts in providing ART. A survey by Sidaction shows that many African communities are already dispensing antiretroviral therapy on a significant scale, and facilitating access to treatment through advocacy, education, voluntary counseling and testing, providing home based care, bulk purchasing of medicines and mental support. People affected by HIV are also receiving a greater role in providing healthcare and designing and implementing national programmes.⁴ They can be strong advocates and participate in the process of education, planning, management and even providing treatment themselves. They can combine the acquired technical knowledge with the first-hand experience with the disease to ensure that the treatment services are credible, relevant, and people with HIV-friendly. An involving person with HIV/AIDS does not only increase numbers and quality of providers of healthcare, but also strongly benefits the individuals themselves. For example, at the Salvation Army's Chikankata Health Services (reference-improving access to HIV treatment), involvement in the care and prevention teams had helped people with HIV to identify opportunistic infections at an early stage and seek medical attention as soon as they became sick.⁵

UNAIDS acknowledges that expanding access to HIV treatment through community-based organization is an important step and call for support for through lining up the resources, convincing governmental partners and donors to recognize their work, and developing ways to monitor and evaluate their efforts. There are many community-based healthcare centers in Lusaka area, such as Lusaka Family Health Trust, Bwafwano Community Organization, Churches Health Association of Zambia. Besides relieving the hospital overload and reducing nosocomial transmission of TB through home based care, these community-based organizations provide psychosocial assistance not commonly offered in public health services. They also focused on helping groups of people who tend to be left out from the public sector healthcare, such as poor, orphans and women gain access to treatment. They are critical for bringing people living with HIV out of isolation and into treatment. The biggest problems that community-based organizations are facing are lack of funding to buy ARV and to sustain the treatment leading to breakdowns and disruptions in ARV supply, and to sustain the human and operational needs in ARV supply.

According to Joaquin Blaya, a MIT/Harvard student who worked on improving healthcare in Zambia last year, most of the community-based centers are specifically in

need for development of a central patient information database, a formal curriculum for educating primary and secondary healthcare providers and ways to provide income generation. These are the areas that we as a class might want to concentrate on in our future efforts.

References

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