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Introduction

In sub-Saharan Africa and Asia treatment with highly active antiretroviral therapy (HAART) of many people living with AIDS (PLWA) is planned to be the reality in the coming years, as part of the WHO/UNAIDS' '3by5' Initiative (WHO/UNAIDS, 2003). Tailoring 3by5 strategy to local social and cultural conditions is important, in order to enhance its effectiveness and sustainability. Insights from health social science — medical anthropology and medical sociology — will be particularly useful in this respect. Moreover, at an early stage the 3by5 strategy can show unrealistic assumptions that may thwart the implementation process.

Over the past 20 years health social scientists have focused their research on understanding the socio-cultural context of HIV transmission, including lay aetiologies of the disease and the socio-cultural context of sexuality, and on providing support for efforts to prevent transmission of HIV infection. In the course of time, research on the effects of the disease on daily life and social infrastructure, and on home-based care were added. Insights from health social science studies of the interface of communities and basic health services, on appropriate use of medicines by consumers, and on organisational culture within the health services, among others, are another important resource on which the 3by5 Initiative can draw.

Where insights from health social science count

To underline where health social science input for strengthening 3by5 is particularly relevant I list its salient features, as well as important characteristics of the environments in which it will be introduced:

- The drug treatment has to be used for a long time. It will lead to mitigation and in many cases disappearance of symptoms. Users may believe themselves to be cured, but medically speaking will not be cured. The experience of feeling and appearing healthy, yet being infected and dependent on the regular supply and use of drugs, will be new to most people. It requires that they take on responsibilities and acquire a long-term view of their illness, which is

not always in concordance with their previous illness experiences, lay aetiologies of the disease that prevail in the community, as well as habits of using pharmaceuticals.

- The drug treatment may have adverse effects. The clinical efficacy of the new treatment is high, but there is the drawback of adverse effects. These may be short-term or long-term, mild or severe, visible for others or only experienced by the user. The importance of an adverse effect is firstly that it may affect the acceptance of the treatment and perseverance in following the treatment regimen, and secondly that it may affect people's self image and the way in which others treat someone showing signs of adverse effects.

Subsequently, certain adverse effects may lead to social exclusion and feelings of isolation.

- The drug treatment requires strict adherence, in order to prevent treatment ineffectiveness for the user and to prevent the virus becoming resistant to the drugs. In many countries public health services will play a major role in providing the drugs and supporting adherence to the drug regimen. Currently, public health care delivery in resource-poor environments is often characterised by organisational weakness and scarcity of drugs. Establishing and sustaining a regimen of strict adherence requires a combination of: (a) appropriate service delivery by public health services staff and community health workers; (b) a good relationship between health workers and their clients; and (c) motivated PLWA taking pharmaceuticals.

- To achieve appropriate services in resource-poor conditions it is necessary that public health staff are adequately paid and supervised in a supportive manner. It must be clear to them that the new tasks do not merely mean an additional workload. The training and involvement of community health workers (CHWs) should build on lessons learned with CHW programmes in the primary health care era, particularly regarding payment, recruitment, supervision and linkage to the public health services. The basis of a good relationship between health workers and their clients is trust, which in many sub-Saharan African contexts has been eroded during the past decades. Uninterrupted availability of drugs, regular provision of other treatment and positive

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Health social science support will enhance the effectiveness of WHO/UNAIDS' 3by5 Initiative

behaviour by health workers are crucial for building trust. For PLWA to start with a new drug regimen and strictly adhere to it is not self-evident. They may be on prescribed medication to curtail opportunistic infections, may also use drugs in self-treatment, or follow a dietary or traditional drug regimen prescribed by a traditional healer. The treatment that a patient is following or has followed is probably in line with local aetiologies and cultural interpretations linked to the complaints. Taking up the new drugs that are on offer requires trust that treatment will continue to be forthcoming, and that the information provided is correct. It also requires the adaptation of ways of dealing with illness and suffering which provide some security to life in miserable times. Finally, it requires that people shed any fear they have of stigma.

- Some groups have less power to access scarce resources than others. Specific medicines, including HAART drugs, belong, sometimes temporarily, to the realm of scarce resources. In the initial period while national and sub-national 3by5 programmes are unfolding the uptake may seem a slow process, but in due course a situation may emerge that is characterised by scarcity. Under such circumstances it is very important that there are in-built safeguards, so that those in need have equity of access. In other words, there need to be certainties that local differences in power and access to resources, that may be based on gender, age, location, class or birth, are not reflected in differences in access to life-saving drugs. This requires insight into the social organisation of society at local level.

- HAART treatment may affect prevention of HIV transmission in several ways. PLWA who will use the treatment regularly will: (a) have a longer life and therefore possibly more sexual contacts; (b) be in a much better physical condition; and (c) may have the conviction that because AIDS is treatable preventive action is less necessary. This last argument may also play a role in the considerations of people who are not HIV-positive. In addition it may affect the motivation of staff of public services and NGOs who are involved in preventive activities. One of the assumptions of the 3by5 Initiative is that successful therapy combined with continuation of activities aimed at improved prevention of HIV transmission will continue to enhance prevention. It is important to evaluate how realistic this assumption is when HAART is supplied on a large scale over a prolonged period.

- In many social environments the subject of AIDS is shrouded in a culture of silence, while those who are

or are supposed to have the disease face different degrees of stigma. Another core assumption of the 3by5 Initiative is that once the programme unfolds it will positively affect the culture of silence and concomitant stigmatisation. It is assumed that once the disease has become discussable this will strengthen the uptake and effectiveness of the programme. This assumption has to be evaluated as well.

- Improvement of the quality of life of poor PLWA also requires development interventions. When the new strategy becomes effective many poor PLWA will be able to live productive lives again. Suffering will decrease significantly. However, many PLWA live in poverty environments, in communities characterised by a burden of raising orphans, low educational levels and scant employment possibilities. It is important to assess timeously how, when and where additional development efforts are required to enable PLWA to use their new capacities to achieve better living conditions.

In addition to questions emanating from these general features of the 3by5 Initiative, there are questions pertaining to adaptation of its general programmatic principles to different socio-cultural contexts. There is also the need to monitor changes in the socio-cultural and socio-economic contexts of this programme in the long-term, as well as of its impacts on these contexts. It will emerge that many questions can be addressed by using results from past research. But there will also be a need for new studies. Among these, small longitudinal studies that follow the 3by5 process and measure its impact in different contexts figure prominently.

In conclusion

Medical professionals do not always recognise the important contributions that health social science studies can make to the effectiveness and sustainability of disease control programmes. Perceptions that such studies often take too much time and do not necessarily result in appropriate insights easily lead to delaying involvement of health social scientists until the moment when problems become really serious. This has often been the case, for instance, when implementation of the PHC strategy in diverse local conditions ran into problems. The present 3by5 endeavour, that also has to be realised at community level under diverse social and cultural conditions, can learn from this experience.

WHO/UNAIDS (2003) Treating 3 million by 2005. Making it happen. The WHO strategy. Geneva.