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Psychosocial Issues Affecting Surgical Care of HIVAIDS Patients in University College Hospital Ibadan, Nigeria, West Africa.

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The paper discloses that patients with HIVAIDS receive sub-optimal surgical care in the University College Hospital Ibadan, Nigeria. Reasons adduced are, in the majority, of a psychosocial hue and these are explained under subheadings of the rigid mindset of the surgical care-givers themselves, the stigma attached to both infected patient and non-infected relation also, the fraudulent 'AIDS for gain' population and lastly the socio-cultural practices that do not augur well for good surgical health-care delivery. The paper concludes that without a mental paradigm shift, adequate and speedy surgical care will continue to elude HIVAIDS patients in Ibadan, Nigeria.

Introduction

In the past, the University College Hospital Ibadan, Nigeria had no clear-cut policy regarding treatment of patients with HIVAIDS. Indeed even doctors with needle-stick injuries had no directives on post-exposure prophylaxis (PEP). Before 2004, patients diagnosed with HIV had to procure items required for surgery at their own expense otherwise surgical treatment is delayed. In fact such patients would not be allowed to be wheeled into theatre by the theatre matrons unless all the items were complete. The mindset of the theatre custodians was that since they were not 'covered' by the hospital (if they get infected in the line of duty), the onus was on them to protect themselves. This proposal for a 'shopping list' for the unfortunate patients was agreed to by the hospital authorities so it became a standard operating protocol (SOP) for surgical management of HIVAIDS patients[1].

The downside of this SOP was that the new (at that time) antiretroviral drugs were very expensive, thus combining that with expenses to be incurred from procuring surgical items ended up delaying or even preventing surgical treatment for HIVAIDS patients of whom many belonged to the low socioeconomic strata of society. Note that these purchases are separate from operation and anaesthesia fees payable before surgery. When PEPFAR (President's Emergency Plan for AIDS Relief) was started in the UCH Ibadan in 2006, antiretroviral drugs were now administered free but the problem of procuring items for surgery by infected patients and their payment of hospital fees was still in place. Many patients complained to PEPFAR about their inability to obtain surgical treatment on time. PEPFAR then picked up the mantle of procuring these items for the surgically-needy patients. In August 2010, the UCH Ibadan authorities decided to exempt all HIVAIDS patients from paying fees making it easier and faster for such patients to access surgical treatment however a few issues, mostly psychosocial, have crept in, creating some obstacles to surgical treatment of HIVAIDS patients in The University College Hospital Ibadan. These issues are discussed under the following subheadings:

1. Rigid mindset of the surgical health-care givers
2. 2nd hand stigma i.e. stigma of non-infected relations
3. AIDS for gain.
4. Societal norms and cultures that do not favour women especially.

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Rigid Mindset of Surgical Health-care Givers

Many nurses still prefer not to 'touch' HIVAIDS patients especially theatre nurses who are exposed to patients' bodily fluids such as blood, urine, saliva and gastrointestinal contents, while assisting during operations [2]. The reason for this is not far-fetched; AIDS still carries a stigma in Nigeria. Over 90% of infection from HIV in Nigeria is from sexual intercourse[3]. A significant proportion of health workers still feel that infected patients behaved immorally and as such deserved their situation [4].Who will care to believe that your infection came from exposure to the virus in the operating theatre? How many people are you going to convince? , Your husband? , Your in-laws? The population at large in Nigeria generally believes nurses are promiscuous thus an infected nurse will have an uphill task in proving her infection was nosocomial [5]. Indeed, recently, 2 nurses in the hospital committed suicide when they found they were HIV positive! It will not be far-fetched to imagine how their friends and colleagues in the nursing fraternity will feel about HIVAIDS patients.

Doctors on the other hand are more knowledgeable to some extent about HIVAIDS and universal precautions and are less likely to refuse to offer service to HIVAIDS patients compared to other hospital workers[6]. Majority of surgeons are willing to operate on infected patients as long as protective wear is made available[7]. However the problem is that these protective items are not made available on time or not at all[8]. In centres where they are made available, the universal precautions get relaxed or shoddy and doctors have been shown to be consistently noncompliant with universal precautions [9,10]. We still have doctors operating without protective eye-wear, without double gloves, collecting scalpel blades directly from the scrub nurse's hand [11]. In fact very few obey the disposal of 'sharps' policy into designated containers which should be incinerated afterwards. When sharps containers are used at all, they are 'recycled' in the sense that the used needles, scalpel blades, cannulas, trocars and others are poured into a central dustbin and the emptied sharps container then returned to the theatre suite it was taken from. Thank God for PEP (Post-exposure prophylaxis) from PEPFAR because many more doctors are having needle stick injuries in UCH Ibadan.

Some religious mission hospitals in Ibadan rigidly perform HIV and Hepatitis B screening for any patient intending to have surgery. They are so strict about this that any patient who refuses screening has to seek surgical help in another hospital because they will disallow theatre entry for such a patient. Some people have claimed that this infringes on the ethics of voluntary counseling and testing (VCT) however the bigger picture is safety-first for theatre personnel[12]. Thus some patients move from hospital to hospital, especially if they know they are HIV positive, in order to find a hospital that will treat them without asking them to do a screening test. This may end up prolonging their time to treatment and expose them to quacks that may complicate their initial problem.

Second-hand Stigma or Stigma of Non-infected Relations

This involves the reluctance of relatives, usually first degree, who are HIV positive to bring them to a hospital for surgical care. Many of these relations are usually those who work in the hospital or are high-ranking government employees who feel that knowledge of their close association with their infected family members may harm their standing in the society. Thus they only bring their infected relatives to the teaching hospital if their surgical operations cannot be handled in private hospitals. Others only get to know the status of their relations shortly before or after surgery. The University College Hospital Ibadan does not strictly require retroviral screening of patients before surgery because the theatre practitioners are advised to uphold universal precautions in every patient. However, this test may be called up if a patient is not making the expected post-operative progress or if an unusual infection is developed by such a patient. The mother of a priest had an elective cholecystectomy for gall stones at the UCH Ibadan. Her post-operative period was uneventful and she was discharged on the 10th day. We heard later that she developed a persistent

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cough and was admitted to a mission hospital where she had a chest x-ray done. The chest x-ray appearance of patchy broncho-pneumonic opacities prompted a retroviral screening which turned out to be positive. The priest, her son, strongly tried to convince himself and the UCH surgeons that she must have received a blood transfusion. She did not receive any blood. Another case occurred with the mother of a medical student. The mother was HIV positive and needed a mastectomy for breast cancer. He wanted the report hidden. We kept the informed theatre personnel on that day to the barest minimum yet our duty required we disclose to the anaesthetist and the porter who would clean up the suite after the operation. This kind of situation affects the writing of medical reports, workmen's compensation reports or death certificates as such relations would prefer that the HIV part is left out [13].

Fraudulent Aids, 'AIDS for Gain' of 'Ghost AIDS'.

Ever since PEPFAR began procuring the required materials for surgery for HIV patients, some dependency plus complacency of such patients came into play: inappropriate or unreasonable requests soon followed: transport money, feeding money and occasionally house-rent money were demanded by these group of patients who were getting free drugs, free consultation, free admission and free surgery. When the HIV-free members of the public got to know of this largesse, the era of 'fake AIDS' came into being and such healthy people would pay laboratory scientists to give them fake HIV positive blood tests in order to get hospital services free of charge! To the best of our knowledge, this is the only hospital in Nigeria where this kind of scam was developed! The whistle got blown because those AIDS patients who got free treatment from UCH Ibadan actually had their bills sent to PEPFAR for repayment. On comparing the names attached to the huge bills, PEPFAR could not find majority of such patients on their registers! The downside of this is that now, PEPFAR will have to verify UCH requests against their own registers before an operation is okayed. This then leads to some delay before surgical care is offered. This is a big departure from patients paying laboratory scientists to release results which show they are negative when they test positive. Indeed a twist in this tale occurred in Ghana, another West African country where a pre-employment retroviral screening test for a woman was negative. The laboratory scientist decided to give her a positive result and then solicited a bribe to help change it to negative [14].

Society Norms and Culture Unfavourable to Women

Women usually concede their autonomy to their husbands and husbands' family members once their bride price ('owo ori' in Yoruba which literally means money paid for her head) is paid. This makes it difficult to obtain consent for surgery in Nigerian women as, culturally; they are not empowered to give consent for themselves[15]. Only the husband can give consent. Thus the surgeon has to wait for a go-ahead from the husband before surgery can take place. This makes it difficult especially in emergency situations to commence early surgical treatment on HIV-positive females who are married [15]. In a polygamy-permissive culture, the stigma of HIVAIDS may lead to a woman being forced out of her matrimonial home, even if the husband (most likely) was the source of her infection. Without family support, access to funds for surgical care for such an unfortunate patient will be hindered [16]. Many times, the health-seeking behaviour of Nigerians preclude coming early to hospital when sick. Even non-HIVAIDS patients would have made the rounds from church to church to native doctor, from primary health centres to secondary health centres before finally coming to a tertiary health centre ostensibly 'to die'. The notion of seeking help in a tertiary centre like UCH Ibadan is phobia-inducing in the general population[17]. It has been reported that less than 10% of infected individuals are aware of their HIV status, thus most HIV-positive individuals will present for care only when life-threatening AIDS-defining illnesses are developed[18].

Conclusion

From the above, it would appear that most of the impediments to speedy and appropriate surgical care of HIVAIDS patient rest within human nature/behaviour. Materials e.g. personal protective equipment (PPE) can be provided but if they are disregarded, what can one do? The most difficult

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thing to change is human nature whether it is just blatant aversion to AIDS patients or blind adherence to societal/cultural practices inimical to proper health-care delivery.
Thus surgical care or indeed any form of health care at all, will probably not be adequate for HIVAIDS patients in Nigeria at the present time and the near future.

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