

Perceptions and Therapeutic Challenges in the Management of Chronic STIs in Africa: Comparing HIV and Hepatitis B in the University Teaching Hospital Yaounde, Cameroon

Loveline Ndi

Department of Anthropology, Faculty of Arts, Letters and Social Sciences, University of Yaounde 1, Cameroon

Copyright©2019 by authors, all rights reserved. Authors agree that this article remains permanently open access under the terms of the Creative Commons Attribution License 4.0 International License

Abstract Sub-Saharan Africa and Cameroon in particular are experiencing a persistence and consistency in the incidence rates in chronic sexual infections such as HIV and HBV. The prevalence rates stands between 8-10% for HBV and 4.3% for HIV in the general population. Surveys on therapeutic results show more challenges in the management of HIV than HBV. This disparity is due to the differences in perceptions and representations, although similar in pathogenic forms, modes of transmission and chronicity. A call to compare these differences that creates fear, shame and guilt towards HIV compared to HBV, thus, preventing many patients from disclosing their HIV statuses and exposing uninfected partners. A health education system that embraces health beliefs highly needed to demystify the mystery around HIV. This study explains the reasons for negative perceptions with stigma resulting to therapeutic challenges in the management process. A qualitative study that uses in-depth interviews and participant observations on a sample population of about 250 patients undergoing therapeutic education sessions, collected data, analyzed and interpreted using the content analyzes model. Findings show that, negative perceptions towards HIV are the cause of therapeutic challenges. Need to integrate socio-cultural realities in strategies to demystify this prejudice around HIV.

Keywords Perceptions, Therapeutic Challenges, Management, Chronic STIs

HIV and HBV in Africa has not been fully accepted for the inability to identify, recognize and diagnosed symptoms in the indigenous laboratories. A cause for the development of negative health beliefs is that reject these infections. In a context where the concern for one another is centered on human existence, the arrival of HIV and HBV has deconstructed many families and causing fear of death and shame. Stigma developed towards infected persons has caused many patients to refuse or fell reluctant to seek medical help. Rather, they opted to seek for alternative therapies. Unfriendly attitudes and behaviors often constitute the responses towards infected and affected persons. Attitudes such as name-calling by the social entourage, labeling by the medical corps, rejection by close relations, and discrimination in the daily life activities resulting from stereotypes and prejudgments and also the classification of certain social classes as high-risk. Efforts to fight the epidemic of HIV and HBV have been influenced by the persistence of these perceptions.

Care providers are faced with the challenges of managing therapeutic failures arising from the non-respect of medical advice. These challenges are felt at the level of changing mentalities, attitudes, behaviors, beliefs, practices, perceptions and representations with the objective to stabilize or reduce new infections and reinfections. The management of these infections in Cameroon is facing challenges manifested in non-adherence and non-observance to the medical recommendations. Most patients are not motivated to adopt new ways or lifestyles that are less risky to new infections and re-infections. Although the perceptions surrounding HIV have changed over the years, there is still a persistence of negative perceptions that prevents the management and the flow of the social discourse concerning HIV. This has contributed to therapeutic challenges as the number of patients presenting therapeutic, immunological and

1. Introduction

Health beliefs are an important part of the African culture that cannot be easily wiped out or totally transformed by forces of modernization. The arrival of

clinical failures increased. There is a great resistance from this community caused by a lack of confidence in the medical practice in place.

The motivational factor to study this issue seeks to give explanations that link health beliefs to therapeutic challenges on this health issue. The present study explains the influence of health beliefs contained in perceptions, interpretations and representations on HIV and HBV in Cameroon. The cultural diversity in Cameroon has caused different cultural groups to have different ideologies, beliefs and representations even within the same group. It's a result from the differences in the level of understanding, assimilation and accommodation. Therapeutic challenges consist of all the difficulties that are involved in management process of these infections. The level of therapeutic challenges towards HIV is alarming compared to that of HBV for a number of reasons; the first class of persons diagnosed with HIV in the USA (homosexual, intravenous drug users), the content of sensitization packages not culturally adopted, and the non-Africanization of preventive strategies.

Therapeutic challenges faced by most patients emanate from their social entourage. The number of patients who abandon their treatment in this community explains the level of psychological, emotional and social trauma caused by social responses towards these infections. Knowledge on health beliefs and perceptions towards these infections will contribute to the understanding of therapeutic behaviors around HIV and HBV in this community. Knowledge produced in this work would enrich the practical knowledge on therapeutic challenges on chronic STIs and give a theoretical model to handle this phenomenon. There exist an important gap in the previous therapeutic studies on HIV and HBV at the level of Cameroon and Sub-Saharan Africa in general. New types of health behaviors are being developed as persons living with these infections try to cope with this health challenge as a means to respond to the social response weighing on them. This study enriches the theoretical knowledge on the influence of health beliefs and perceptions on therapeutic management on chronic STIs in general and HIV and HBV in particular. It answers the question on therapeutic challenges and proposes better policy development on the management of HIV and HBV in Africa and the context of Cameroon. In the rest of this paper, the research problem, an overview of the study, the state of debate around this issue, the main findings, discussions and conclusion will be presented.

1.1. Study Background

This study was carryout in the University Teaching Hospital Yaounde in Cameroon. This is a referent health institution that receives patients from the four corners of this country, with different cultural backgrounds come for medical services. It has a technical platform that is

adapted to manage complicated cases of opportunistic infections and also has one of the pioneer centers for the management of HBV and other types of hepatitis with severe health problems in Cameroon. It is amongst the best health institutions with specialists in various domains that wish to express their expertise. Most of the doctors are lecturers in the faculties of Medicine and Biomedical Sciences and therefore train the young doctors. Many patients scramble for their services. Despite the above technical plate form, there are still a lot of challenges arising from the management of patients suffering from chronic STIs.

1.2. Research Problem

In the course of performing my duties as a therapeutic educator, a counselor and social welfare assistant, I observed that, there is a consistency in the number of patients presenting resistance to ART due a number of factors such as; psychological, financial, social and cultural. All these boil down to the noncompliance to the clinician' recommendations. These category of patients present therapeutic challenges such as, frequent opportunistic symptoms, immunological failure, clinical failure and drug resistance. Refractory attitudes towards medical advice are a cause for the non-conformity to therapeutic norms. Despite the efforts of the medical practitioners and the government to arrest this situation for the past three decades, the therapeutic survey results in this context are not encouraging compared to those of other contexts such as the Western countries.

This is a problem because, it is certain that, if nothing is done urgently, HBV can take the same curve as HIV and in this case, more persons will be infected and more lives lost than the number that have died from HIV. Normal life in the intimate or emotional aspects have been deconstructed with the emergence of HIV as many families have been wiped out, many marriages broken, many orphans left behind, and a rise in single persons due to broken relationships. This issue about HIV has made it more of a social than a biomedical issue. The issue is of a very high magnitude because it touches all categories of people without any distinction or discrimination in the social class, race, religion or ethnic group. Moreover, the infection rates are very high.

Recent surveys in Africa show that Cameroon is one of the countries in sub-Saharan Africa that is still struggling with an HIV prevalence of above 5%. Over 540 000 out of the estimated 18,900 000 people of Cameroon live with HIV and almost two third of this number is made up by young people (Mbanya et al. [1]). By late 2003, UNAIDS reported that 4.8% of the population was infected by the virus. This number rose to 5.5% in 2004, creating an alarm that called for the emergency intervention of the Cameroonian government, civil society organizations and International bodies stepped up policies and actions against

HIV/AIDS. Over 390,000 people are estimated to have died from AIDS in Cameroon with a large percentage of this figure from the young population. This is a problem to the global population because everyone is either directly or indirectly infected or affected with HIV or HBV. It has been noted that HIV weighs more on young people especially girls than boys. Most young infected girls have lost their sexual partners and have remained single at the moment they are noticed HIV positive.

In a context where community spirit still exist, the problem of one being the problem of all. It is in the same way that those infected with HIV do not only feel the impact as their personal problem but the concern of the whole family and at times an extended family which is the community. If this situation is not handled with care, the possible consequence will negatively affect the economic, political and socio-cultural outputs of this community. People living with other chronic illnesses stand a better position to be assisted and benefit from social assistance than the former that is deathly with huge financial resources already invested due to stigmatization. From the above situation, the main research question that probed is;

1. What are the perceptions surrounding HIV and HBV in Cameroon?
2. How have these perceptions contributed to therapeutic challenges towards HIV and HBV in Cameroon?

The hypotheses that emerged from these questions are that;

1. HIV and HBV are considered as foreign illnesses due to their non-recognition in these local indigenous laboratories.
2. Negative perceptions around these infections have contributed to the lack of confidence in the therapeutic practice.

2. Methodology

This is a qualitative study carried out using a comparative approach with the techniques of passive observations, participant observations and in-depth interviews applied to collect data. The study population drawn from the assembly of all patients living with HIV, HBV, and co-infections HIV/HBV who are visited this health care unit for their medical follow-up. Our sample consisted of a patient infected with HIV, HIV/HBV, or HBV recruited without a distinction of social class, age or sex. The most inclusive recruitment criteria was the non-observance and non-compliance to therapeutic norms. Data was collected with patients who had to undergo therapeutic education sessions. These sessions were intended to access the patients' needs so as to assure a better medical care. This data was analyzed and interpreted using the content analyses model and interpreted using the Cultural Interpretative Theory. This method helped us to gather information used to identify the various perceptions and

explain their contributions to the therapeutic challenges in the management of HIV and HBV infections in Cameroon.

2.1. Study Population

Our study population was regrouped in to three categories: the first category drew samples from the patients who came for their clinical follow-ups for HIV or HBV with clinical, therapeutic, social or psychological problems. The second categories were those infected with HIV or HBV who are members of some social networks or associations. And the last categories were health care providers engaged in the care-providing for these patients. Sample consisted of a patient suffering from a chronic infection with therapeutic challenges, a care-taker or a health care provider. The sampling method was convenient that took in to account the availability of the study units at the time of data collection. The sample size depended on the saturation point of information. A representation of all or most ethnic groups in Cameroon was used to draw conclusions on our hypotheses.

Two major methods were used to collect our data. These were the direct and indirect methods. The direct method consisted of coming in contact with informants for a face-to-face and in-depth interview, and the indirect method consisted of gathering information from participant-observations and documentary sources. The former method enabled us to proceed to a social construction of knowledge through the use of the content analyses of our data. Meanwhile, the later method enabled us to gather information through the observations of attitudes, gestures, body expressions, facial language from the research subjects and existing literature.

2.2. State of Debate around this Issue

The review of some literature on HIV/HBV infections in the context of Africa presented the state of knowledge around health beliefs, perceptions and therapeutic challenges. The nature of literature on this issue was mostly on empirical that is directly or indirectly related to this issue. The thematic approached adopted and two main themes coined.

2.3. Perceptions towards the Management of HIV and HBV in Africa

For perceptions around HIV and HBV in Africa, an extensive literature exists in social sciences on this issue. The general strength of knowledge showed that, health beliefs, perceptions, interpretations and social responses vary from one individual to another, from one context to another and from one era to another. Authors such as, Paul Farmer [2]; Nigel Crawhall [3], Miles [4], have affirmed this in their various studies. Some examples taken from South Africans AIDS educators working in African language constituencies show how health educators are

faced with the challenge of handling sexual issues. They argued that, it is delicate to be explicit and precise without offending the audience. They have also illustrated that, there is a conflict between Western and African views of HIV and AIDS. According to Barnett and Blaike [5], Atta El-Battahani [6], AIDS puts its victims in to a condition of socially stigmatized, defining them as morally 'impure'. Victims are perceived as morally impure, dangerous and untouchable, and liable to illicit moral panic. In Sudan, even among the most educated elites, people look with disgust and appreciation on AIDS victims. He argued that, for many Islamists, AIDS is not a disease of the Muslims, it is the disease of the non-Muslims. For Humphrey Moshi [7], women migrate into distant areas, both rural and urban, tend to hide their identity and background of where they come from and what happened to their husbands so that they do not 'scare' their male customer friend. In the same light, Oyekami [8], illustrated the belief that married women felt that even if their husbands contracted any sexually transmitted disease, "God would not allow them to catch it". This extreme positivism has been developed in many cultures as a means of wishing away whatever bad phenomenon that could not be controlled. Women in particular seem to have developed this defense mechanism to a larger extent than men.

2.4. Challenges towards the Management of HIV and HBV in Africa

Laborious studies in medical sciences have treated issues on the challenges surrounding the management of HIV in Africa with a general strength of the current debate laying more emphasis on therapeutic challenges. Some studies have based these challenges on the complicated nature of HIV as it changes over the years causing drug resistance and preventing the development of AIDS vaccine due to viral mutations (Paul Farmer [9]; Christian Obbo[10]). It has also been argued that, the time and discipline required for medication is difficult to observe for many, thus securing the support of convenient and efficient medical services is impossibility in most cases. Besides avoiding the emergency of drug resistance and clinical monitoring of adverse reactions, resistance to therapy may occur deterioration when treatment is interrupted. According to Acquah[11]; Kilson, [12]), Western medicine has never gained total acceptance and traditional medicine continuous to play a social, psychological and also a medical role. Generally, this literature is limited to show the relationship between health beliefs and perceptions on the therapeutic practice in place. The epistemological gap of this study is to show how the patients' perception of HIV contributes to therapeutic challenges.

3. Findings

Africans believe that HIV is not a disease that originated from their cultural milieu. The fact that these

infections were first discovered in the Western countries makes Africans to believe that their social life as far as sexuality is concern is deviant. The arrival of HIV in Cameroon in the early 80s clouded over the opposition between the past epidemics and modern illnesses. Contrarily to what people thought of in many years, the age of infectious diseases had probably given way then to viral infections. When the first cases of HIV were discovered in USA, the conceptions were that, it was a disease of the socially devalued class. Many people believed this and avoided victims of this viral infection. These socially devalued classes were intravenous drugs users, homosexuals and people with multiple partners before reaching heterosexuals. This instilled a psychological trauma in a context where sexuality is still a taboo. As such, HIV has been denied because it is a disease that came from 'outside' (Western world), and therefore must be defended or rejected as an outside enemy. Rejection in this sense is a cultural causing HIV and HBV to be perceived as 'strange and a foreign diseases'. These infections not recognized in the African indigenous health system. In order to be defended from this external enemy, self and collective defense mechanisms are developed at all levels to reject this common stranger. This is manifested in the non-acceptance of the disease by the population through a permanent doubt and thoughts that, it is a disease created by the 'White-man' to eradicate the African race or disturb from enjoying sex. This ideology has been translated in terms such as; "How can one eat banana in the peeling?" This language is used as a means to deny the use of condoms as one of the preventives measures. This idea has eaten several minds and has served as one of the obstacles that negatively influence the smooth functioning of the therapeutic practice in place.

These are collective and individual reactions that give the present day impression about HIV in this context with a diverse culture. These impressions according to some respondents rang from; "*a killer diseases*", "*a shameful disease*", "*a disease of the century*", "*the disease of the White-man*", "*a foreign disease*", "*a strange disease*", "*a disease like any other diseases*", "*a slim disease*" and "*a virus*".

These two infections emerged at different eras in Cameroon contributing to the differences in their perceptions. Due to the similarities in their pathogenic form, modes of transmissions and chronicity, we expected of a convergence in their perceptions. Many people doubted the reality of HIV from the beginning, and so too is the same with HBV now our days. The doubt about HBV has developed a luck warm attitude with no negative social responses developed in relation to the health beliefs or perceptions towards them. 'Doubt', 'witchcraft', 'sorcery' and 'slow poison' about HIV prevailed people's minds before the late 90s. The introduction of ART in this health system gave another phase to the social history of these infections. Although some attitudes have persisted, new

attitudes have developed in relation to the new perceptions towards these infections. Africans have started believing in HIV after experiencing a lot of deaths. Negative impressions about these infections have created an atmosphere of constant rejection towards infected and affected persons. The belief that ART are just control measures and not a cure for HIV has developed attitudes of non-concordance of the patient's behavior with the medical practice. This belief has negatively influenced most patients to think that their destiny with HIV remains the same whether drugs are well taken or not. HBV on the other hand is still an emerging disease in Cameroon due to its shallow level of sensitization campaign compared to HIV. It is believed to be a chronic 'Yellow fever' or 'Jaundice', due to the first physical symptoms that consist of yellowish eyes.

3.1. The Influence of Perceptions on the Therapeutic Practices on HIV and HBV in Cameroon

The discovery of ART motivated discordant couples to continue their conjugal relationships without forcefully using condoms. This period marked the end of the epidemic that enabled many people to take decisions towards changing attitudes towards infected and affected persons. In early 2015s, a systematic treatment of pregnant women prevented their unborn babies from being infected. This motivated many infected couples who had denied making children to start a new life in childbearing. But the management of HIV had various challenges as health care providers in their therapeutic counseling, prohibited the use of alternative therapies alongside ART. Most patients failed to respect therapeutic rules such as the time to take their drugs, regular control of biological and clinical controls. A lot of negligence has been observed towards medical practices such as; reluctance to visit care units, denial to do medical controls, lack of confidence in management practices, a continuous search for alternative therapies, a partial or total abandonment of ART for fear of stigmatization or rejection, refusal of patient positive status, and non-respect of therapeutic norms. This resulted in clinical and immunological failures and drug resistance. The non-respect of these therapeutic norms due to the health beliefs have been manifested in attitudes such as;

3.2. Lateness to Visit Care Units

Many patients arrive in the care units when the virus is already in an advanced stage. This is due to refusal to be diagnosed at the early stage, the non-recognizance of particular physical symptoms that signals the presence of an HIV virus with acknowledgments that the first phase of this viral infection is asymptomatic. The same case goes with HBV where most patients are diagnosed at the active phase of the virus that is cancerous, demanding mostly palliative care.

3.3. Non-compliance with the Doctors' Recommendations

Compliance is the respect of the patient to the doctors' recommendations. The lack of trust in the health care system in place as far as the management of HIV and HBV are concern is due to the incoherency of different sources of information acquired from sensitization campaigns. This has led to the non-compliance of the patient with the medical practitioner's view. Most patients do not respect the hours to take their drugs, are reluctant to do biological and clinical controls examinations that are very important in their follow-up package. This has led to the poor evolution of their clinical results as the drugs seem not to be efficient and result to frequent opportunistic infections. Some patients end up with other complications such as kidney or liver failures. Non-compliance is also manifested in the refusal to respect to the check-up appointments of the doctor causing at times other health problems such as resistance to ART.

3.4. Non Observance in the Taking of ART

Observance is the measure of the degree of concordance between the doctors' recommendations and the behavior of the patient at the level of drugs taking. False beliefs have developed negative social responses that induced many patients in to error as far as taking their drugs are concern. The doctors recommend a strict respect of time in the taking of ART to assure the total control of the drug over the awakening and evolution of the virus. Some patients who are already clinically well, that is, whose symptoms have disappeared after taking the ART for some time, see no need to take these drugs again and consequently abandon them. This is because the disappearance of the clinical symptoms that served as signs to make them be suspected of HIV/HBV has put them in clinical free status. The asymptomatic phase puts both healthy carriers and non-carrier in the same clinical position. There is this belief that; 'no symptoms, no illness'. This then makes it difficult for those at the asymptomatic phase to conform to regular follow-up.

3.5. Non Adherence to the Health Care System in Practice

Adherence is the general attitude of the patient with regard to the health care system in place. The general attitudes of patients infected with HIV and HBV are not positive with respect to the health care system in place. There is an opposition of some patients in their attitudes manifested in the continuous search for alternative treatments. Some patients immediately after being diagnosed as HIV or HBV positive turn to alternative therapies without or alongside the medical treatment. The medical practitioners prohibit the use of other alternative therapies alongside the medical therapy, but this is not the

case in this community. There is a persistent and consistent use of other alternative medicines alongside the ART in the cases of HIV and HBV in Cameroon. This has prevented the achievement of good results in the management of these infections.

3.6. Search for Alternative Treatments

The search for an alternative treatment is a common attitude for most patients infected with HBV in Cameroon. Most HBV patients believe that this infection is better treated by the use of indigenous therapies than medical therapies. In the same way, those who believe that HIV is a 'slow poison' or 'disease of sorcery' turn for alternative therapies. Another reason that accounts for the preference for alternative therapies is the cost of treatment which is seemingly high with respect to an average Cameroonian. The high cost of treatment for HBV limits access to the treatment. The belief that HIV or HBV is an illness inflicted through witchcraft, sorcery or a 'slow poison', is the motivation for this choice of indigenous therapies. Meanwhile the efficiency of traditional therapists is geared towards opportunistic infections and not to prevent the evolution of the virus.

3.7. The Choice of Care Units

Shame and guilt has caused many patients to abandon nearby treatment centers to far distances for the fear of being recognized by close friends, social networks and relations. It has also contributed to the attitude of non-compliance and non-observance for the fear and curiosity of others who can seek to know why they are frequenting this or that care unit. Because some patients have to travel for long distances for their medical appointments, some patients most often have not been able to fulfill this assignment for time or financial reasons. They have 'lost contact', with their doctors. This is a contributing factor for other health complications. Consequently, frequent cases of therapeutic failures from the poor evolution of the body immune system or drug resistance are registered.

4. Discussions

This debate is focused on the disparities in perceptions and therapeutic challenges between HIV and HBV in the context of Cameroon. Campaigns against HIV have produced so many interpretations and representations that are more or less opposed to those prescribed by the World Health Organization (WHO). Those who are informed about Hepatitis could hardly make a difference between HBV and HCV. This is also one factor that causes the differences in the health beliefs. Belief is defined as 'a strong feeling that something/somebody exists or is true; confidence that something/somebody is good or right'.

From the historical presentations of HIV with respect to HBV in Africa, most people had the strong feelings that HIV is bad sick and a disease of shame that affects mostly the low social class. These misconceptions about HIV arise from the misinformation in the quality of information contained in the first sensitization packages. The quality of information has been one of the main factors that have contributed to the various views and interpretations to these infections. The approach used in the first sensitization campaigns on HIV did not take in to consideration cultural difference. This made some people to consider it as a brutal way of turning people's mind from their way of life especially in sexual matters. HIV and its devastating effects came like a wave of shock with trauma that instilled fear on the public. The number of deaths registered daily caused many to fear and prevented them from doing HIV screening. On the other hand, insufficient awareness on HBV has no negative consequence on the population and thus patients are motivated to disclose their status for the search of more awareness, moral and financial support.

There is non-uniformity in the level of understanding in the population and health care providers concerning knowledge on HIV and HBV. There is also a difference in the medical discourse amongst health care providers. While some people stick to whose recommendations for their information packages, others take in to account their field experiences. Many patients do not believe in this HIV virus as far as they remain physically strong and able to perform their normal activities.

Doubts in the efficiency of the biomedical practice have retarded the success in the management of these infections. There is a conflict between the scientific medicine and traditional African indigenous medicine. The superiority that the western medical practice claims over other health issues has proved it limits in the case of HIV and HBV. The failure to discover a proper therapy for HIV and HBV is one of the main reasons for the conclusion that Africans have given to this virus as a 'killer disease'. Most patients have decided to keep the secret of their HIV or HBV sero-positive status in order to avoid stigmatization, discrimination and rejection. Those who are keeping the secret are most often likely to fall among the categories of patients who are not willing to adopt positive behaviors and consequently will continue to spread the viruses to other through new infections and re-infections. Negative perceptions constitute some cultural barriers that contribute to the challenges in the management of these infections. Care Providers are faced with the dilemma of violating the professional ethics by disclosing the patient's statuses to their partners and social entourage or respecting confidentiality and allowing new infections of ignorant partners. The fear of losing a partner, receiving humiliation from the social entourage, rejection from love ones, discrimination in socio-economic, cultural and political milieus, stigmatization and name calling from car-providers, are some of the reasons why infected

persons are unwilling to disclose their status to others and prefer to die in emotional silence.

It is not the stigmatizing attribute that is problematic, but the social relations that are induced in the contact between the carrier of the stigma and the others. In order to manage stigmas towards HIV infected persons, patients have developed some strategies to overcome these attitudes such: changing the package of their drugs, keeping the secret, and abstention from discussions related to this issue. Perceptions about HIV places infected persons in a particular situation vis-a-vis their family members, social entourage and colleagues. In this case, HIV or HBV is not only a biological problem, but a social disability that weighs more than HBV. The social pressure exerted on someone infected with HIV or HBV causes therapeutic challenges more than biological problems.

The patient's circuit from the pre-diagnoses to his/her placement on ART is very long and involves a lot of persons on the way. Due to stigma, people have developed strategies to maintain their confidentiality in the different spheres of life. In order to overcome the psychological trauma suffered by persons infected with this virus, some patients have created extra professional relationships with some health care providers who act as middlemen between the patient and the doctor. This has greatly contributed to the loss of contacts between the doctor and many patients.

In the same way, many patients because of the fear to be identified as infected with this shameful infection have developed the attitude of hiding their identity or masking by changing the drug packages. They change their real names so that, they could not be easily identified by those who know them. Most patients are ashamed to seek for financial aid from close relations if financially limited. Others use another personality in their own place. For example, someone who comes to the hospital to collect his ART or to renew his medical prescriptions and by a mistake sees a relation or friend, he/she runs away in order not to be seen or uses the pretext that, he/she has come to collect the drugs of a relative. HBV patients on the other hand, are open and wish to explain their situation to relations in order to seek for financial, psychological and material support. Consequently, there is this eagerness to respect medical advice for a health solution. Although most patients abandon this treatment for its cost for alternative treatments. The individual and collective beliefs of infected and affected persons cause therapeutic challenges resulting in more deaths and bad memories of HIV. HIV causes social and emotional pains in persons that differ from that of other chronic illnesses that have existed over the years.

Uncertainty amongst persons living with these viruses is a consequence to the non-motivation or support from the concern and his/her entourage. Acceptance of the infection will lead to the adoption of behaviors that are less risky and to become part and particle of the treatment, thus reducing therapeutic challenges. A multitude of psychological,

social and existential uncertainties about the future in a 'normal way' makes HI a nightmare and poses great challenges to the medical corps who have not only struggled to stabilize its spread but to limit the number of deaths. This is a concern to social scientists as they look for reasons to explain the persistence in therapeutic challenges in Africa despite the efforts put in place.

5. Conclusions

Beliefs play a vital role in the perception and representation of health and illness. It accounts for most of the decisions that are taken in health related matters. Africanizing therapeutic strategies will enable a rapid understanding and change of mentalities by public health workers and the population at large. The answer to the question of conflict between Western practices and indigenous beliefs will induce many persons to a better choice in health practices. The integration of socio-cultural realities in therapeutic measures through the use of adapted language within the different social strata, consideration of African health beliefs in therapeutic practice, re-adaptation of sensitization strategies with respect to cultural diversities and realities, and the involvement of traditional authorities as elements to modify of some traditional practices and beliefs that promote the spread of these infections is a way out.

Abbreviations

ART: Anti-Retro-Viral Treatment

HBV: Hepatitis B Virus

HBC: Hepatitis C Virus

HIV: Human Immune Virus

STIs: Sexually Transmitted Infections

WHO: World Health Organization

UNAIDS: United Nation AIDS programme

REFERENCES

- [1] Mbanya et al. "Current status of HIV in Cameroon: How effective are Control strategies? International Journal of Environmental research and public health, 2008.
- [2] Farmer P. "AIDS and Social Scientist: Critical reflections". Codesria, CNLS, Orstom, 1996.
- [3] Nigel C. "Using a sociolinguistic approach to safe promotion in Cape Town: The challenge of multiculturalism". Codesria, CNLS, Orstom, 1996.
- [4] Miles A. "Women, health and medicine, Buckingham: Open University Press, 1991.
- [5] Bernett T. and Blaike P. "AIDS in Africa: it present and

future impact, London: Bellhaven Press, 1992.

- [6] Atta El-Battahani. "AIDS and politics in Sudan: Some reflections. Codesria, CNLS, Orstom, 1996.
- [7] Humphrey P. "The impact of AIDS on the national economy: the case of women labour force in Tanzania, Codesria, CNLS, Orstom, 1996.
- [8] Oyekanmi F. "Women's attitudes towards sexually transmitted disease in Nigeria: a case study in Ilesha in Osun state". *Africa development*, 1994b. XIX (2): 147-165.
- [9] Farmer P. "Social inequalities and emerging infectious diseases". *Emerging Infectious Diseases*. 1996a, 2:259-269.
- [10] Christine O. "HIV transmission through social and geographical networks in *Uganda*". *Social Science and Medicine*. 1993a, 36(7): 949-955.
- [11] Aqquah J. "Accra survey, London (Reprinted), 1992.
- [12] Kilson M. "Africa urba kinsmen: the Ga of Centrla Accra, Accra/New York, 1974.