Review

African strategies on HIV/AIDS awareness, prevention and fighting the stigma surrounding the disease: a leadership perspective

Bethabile Lovely Dolamo

Department of Health Studies, University of South Africa, South Africa. E-mail: dolamlb@unisa.ac.za

Accepted 23 October, 2015

Awareness, prevention of transmission, as well as fighting the stigma surrounding the disease, is an essential part of addressing the HIV/AIDS pandemic in Africa. Limited access to care, reluctance in the acceptability of care, appropriateness of care, and inaffordability of care are among the barriers to HIV prevention. Different studies have been conducted by scholars on strategies to use in Africa. This paper identifies selected African countries' strategies on HIV/AIDS awareness and fighting the stigma surrounding the disease. Bold decisions must be taken to exercise greater leadership in the governance of HIV/AIDS responses. Nurses have much to contribute to community-based efforts to promote societal and structural changes to reduce the HIV risk. This paper will further recommend strategies for Africa to avert from the HIV/AIDS stigma associated with this pandemic on the continent.

Key words: Africa, awareness, HIV/AIDS pandemic, leadership, prevention, strategies.

INTRODUCTION

According to a report by the United Nations Assembly on AIDS (UNAIDS), an estimated 34 million people are living with the human immunodeficiency virus (HIV) globally (2012a). The same report reveals that Africa remains the most affected, with Sub-Saharan Africa (SSA) accounting for 69% of the total number of people living with HIV/AIDS worldwide. According to the World Health Organisation (WHO), the main cause of mortality in Africa today is AIDS (UNESCO [sa]). HIV/AIDS accounted for about 20% of all deaths and disability-adjusted life-years (DALYs) lost in Africa, which made it the biggest single component of the continent’s disease burden. The pandemic reduced life expectancy by more than 10 years (Creese et al., 2002).

African leaders met in the Nigerian capital for a Special Summit of the Africa Union on the challenges posed by HIV/AIDS, tuberculosis (TB), Malaria and other life threatening diseases in Africa. Meeting the needs of Africans was said to be the collective goal by former Nigerian President Goodluck Jonathan. The summit concluded with a renewed and strong commitment to build on the achievements of the past twelve years to forge ahead towards the elimination of HIV/AIDS, TB and Malaria in Africa. To tackle these pandemics, African leaders agreed to intensify the mobilisation of domestic resources and reduce dependency on foreign aid to strengthen African health systems (Dispatch, 2013).

HIV/AIDS preventive education is an accessible and effective strategy for containing the pandemic in developing countries. Africa should stand by Sidibe’s vision (2009) of ‘zero new HIV infections, zero discrimination and zero AIDS-related deaths’; focusing on socio-cultural aspects of HIV/AIDS prevention in Africa for the purpose of identifying the cultural factors that must be taken into account in developing preventive programmes and strategies in order to ensure their relevance to specific situations and improve their effectiveness (UNESCO [sa]).

The purpose of this paper is to highlight African strategies on HIV/AIDS awareness, prevention and fighting the stigma surrounding the disease; to bring African leadership perspective on board.

HIV PREVENTION STRATEGIES

Preventing HIV transmission is an essential part of addressing the global HIV/AIDS pandemic. Combination
prevention advocates a holistic prevention approach, where HIV prevention is not a single intervention, but takes into consideration the location, available resources, and most affected populations. When HIV first emerged, it quickly became associated with marginalised groups, consequently becoming shrouded with stigma and denial. Some governments in sub-Saharan Africa denied the existence of HIV or the high-risk behaviours that spread the infection, leading many people to take HIV prevention into their own hands (AVERT [sa]). The development of highly-active antiretroviral therapy (HAART) in 1996, meant that efforts to curb the pandemic were largely focused on scaling-up treatment access, with less attention on HIV prevention strategies. The emergence of HIV in countries beyond sub-Sahara Africa resulted in widespread concerns that HIV would destabilise global development and security.

The United States President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria, marked the start of HIV prevention strategies delivered on a global scale (AVERT [sa]).

African governments face difficult choices in striking the right balance between prevention, treatment and care, all of which are necessary to deal comprehensively with the pandemic. Reduction in drug prices have raised the priority of treatment, though treatment access is restricted (Creese et al., 2002). The Post-2015 World Health Agenda, as agreed upon within the health fraternity, was that millennium development goals (MDGs) 4, 5 and 6 need to continue far beyond 2015 (Motsoaledi, 2010).

GLOBAL FUNDING AND THE DEVELOPED WORLDS’ IMPACT ON HIV IN AFRICA

The distribution of Global funds has been an attempt to address the HIV pandemic in Africa. However, this attempt has suffered from poor funding, slow distribution, and other political obstacles from some of the richest countries, such as the United States (US), who prefer to have their own initiatives (such as the PEPFAR) so that they maintain more control over where their money goes (Shah, 2009).

The Global Fund supports programmes that provide 7.3 million people with antiretroviral medication and have provided 2.7 million pregnant women with treatment to prevent the transmission of HIV to their babies (Global Fund, 2014). And yet the global fund is supposed to be a fund where countries donate without any strings attached. The US’s PEPFAR avoids supporting countries perceived to be hostile; those who may support programmes that it currently disapproves of, such as abortion and condom use; as well as those who use generic drugs that are cheaper than the ones from their pharmaceutical companies (Shah, 2009). These conditions set by rich countries destroy the fibre created by culture in Africa.

Major western media outlets seem to cover items driven by the agenda of rich nations, not of the actual events around the world. Gellman (2000) advises, “tie the needs of the poor with fears of the rich. When the rich lose their fears, they are not willing to invest in the problems of the poor”. Through long-standing and consistently bipartisan support for the US PEPFAR and Global Fund, the US has been a leader in turning this pandemic into a treatable disease (Global Fund, 2014). Concurrent with the biased concern of western media attention, are the actions of the multinational pharmaceutical companies and their lobbying efforts in the first world countries and international forums, which reveal that they are more focused on their profits than the plight of the African nations’ attempts to use generic versions of their expensive drugs, or pursuing other related policies (Warren, 2000).

The developed world is also robbing African countries of health staff (Coombes, 2005). There are large areas of Africa where there are no health workers of any kind. Africa produces doctors and nurses, because of lack of resources to pay and provide for them, the developed world entices them with money and good facilities. This calls for African leaders to review the strategies based on the numbers of patients the continent has to manage HIV/AIDS. According to WHO, Tanzania has one of the worst physician-to-patient ratios in the world, with just 0.02 doctors and 0.37 nurses and midwives per 1,000 population. Qualified doctors and nurses emigrating due to better pay, working conditions and training opportunities, means shortages remain a critical problem in managing HIV/AIDS and other health problems (AVERT [sa]).

VIEW ON AFRICAN STRATEGIES AGAINST A DEVASTATING GLOBAL PANDEMIC

By the year 2011 (after 30 years of AIDS in Africa), AIDS had claimed more than 25 million lives and 60 million people had become infected with HIV. Still each day, more than 7,000 people are newly infected with the virus, including 1,000 children. No country has escaped the devastation of this truly global pandemic (United Nations, 2011). In 2011, there were an estimated 23.5 million people living with HIV in sub-Saharan Africa. The increase in people living with HIV could have been partly due to a decrease in AIDS-related deaths in the region. There were 1.2 million deaths due to AIDS in 2011 compared to 1.8 million in 2005 (UNAIDS, 2012b).

Heywood in Kelly (2002) argues that national AIDS plans of several African countries explicitly recognise the public health imperative underlying the promotion of human rights and yet, few governments actively promote or assist a rights agenda in relation to AIDS. Szafierski et al. (2014) note that behavioural interventions have not
been successful in halting the HIV epidemic among African American, and sociocultural approaches are now strongly recommended.

Stigma, discrimination and gender inequality continue to undermine efforts to achieve universal access to HIV prevention, treatment, care and support. For three decades, evidence of what works has been debated in the General Assembly, parliaments, communities, places of worship and scientific forums (United Nations, 2011). According to Kelly (2002), stigma and discrimination remain a major fact of life for the estimated 29.4 million people with HIV in sub-Saharan Africa and for the more than 11 million children who have lost one or both parents to AIDS. Bold decisions must be taken to dramatically reshape the global response towards zero new HIV infections, zero discrimination and zero AIDS related deaths. This requires rejuvenated political commitment for more focused, efficient and sustainable responses. There is also the need to exercise greater leadership in the governance of HIV responses.

A health fraternity where WHO, UNAIDS, the African Union (AU) Health Minister’s Summit, Brazilian, Russian, Indian, Chinese and South African (BRICS) Ministers of Health Summit, the Commonwealth Health Ministers and the Southern African Developing Countries (SADC) should work very closely with African leaders in facilitating commitment and better understanding of the importance of eradicating the disease.

**Uganda**

Uganda was hit very hard by this pandemic in the 1980s. Truck drivers, migrants, soldiers, traders and miners caused the rapid spread of HIV as they engaged with sex workers (Avert [sa]). Uganda worked hard on promoting a strategy of abstinence, faithfulness, and condom use (ABC). Widespread promotion of abstinence and delaying sex for the youth, zero grazing or partner fidelity and distribution of condoms was embarked on in the 1980s. In addition to these efforts, mobilisation of community leaders, churches and the public in general helped to bring down the infection rate (Unisworth, 2008).

Currently, 7.2% of Uganda’s population is living with HIV. This amounts to an estimated 1.4 million people, which includes 190,000 children. An estimated 62,000 people died from AIDS in 2011 and 1.1 million children have been orphaned by Uganda’s devastating epidemic. HIV prevalence has been rising since its lowest rate of 6.4% in 2006. New infections are diagnosed in 150,000 people a year, of whom 20,600 are children. Despite this, the 2012 life expectancy of 55 years is nine years higher than the expectancy in 2000. The government’s shift towards abstinence-only prevention programmes, alongside a general complacency or ‘AIDS-fatigue’ has reduced the practice of safe sex (UNAIDS, 2012c). These approaches became dominant in previous years due to PEPFAR money for abstinence-only programmes.

It has been suggested that greater access to Antiretroviral treatment (ART) reduces people’s fear and urgency to get tested for HIV, increasing the likelihood of engaging in risky behaviour. The number of new infections per year exceeds the number of annual AIDS deaths. Only 39% of young people aged 15 to 24 know all the necessary facts about how HIV can be prevented, suggesting a lack of clear sex education (UNAIDS, 2012c). Women in particular are in need of sex education and access to HIV services; HIV prevalence is 5.4 to 2.4% amongst men. The fact that Ugandan women tend to marry and become sexually active at a younger age than their male counterparts, and often have older and more sexually experienced partners, places them at an increased risk of HIV (PlusNews, 2012).

Men have more than one sexual partner today than in 1990. Forty-three percent of new HIV infections are among heterosexual married couples, resulting in a campaign in early 2013 to encourage those men to use condoms in order to to prevent infecting their partners. The ‘abstain, be faithful, use a condom’ approach was the 2013 campaign as a contribution to rising HIV infections and showing how important all three areas of prevention are in fighting the scourge of HIV. Expectant mothers are encouraged to know their HIV status. Uganda follows the most recent guideline by WHO for prevention of mother-to-child transmission (PMCTC). Uganda has set the target of offering voluntary medical male circumcision to 80% of uncircumcised men by 2015 (AVERT [sa]).

AIDS-related stigma and discrimination refers to prejudice, negative attitudes, abuse and maltreatment directed at people living with HIV and AIDS. The consequences of stigma and discrimination are wide ranging: being shunned by family, peers and the wider community; poor treatment in healthcare and education settings; erosion of rights; psychological damage; and a negative effect on the success of HIV testing and treatment. Stigma and discriminations by families, local communities and the government continues to marginalise people living with HIV. This undermines national prevention and treatment efforts by creating a fear of being tested.

**South Africa**

Responding to HIV/AIDS is one of the most important tasks facing South Africa (SA) today. The South African government has made the fight against this disease one of its top priorities (Motsoaledi, 2010). The National Development Plan (NDP) implores on us, among others, three major issues: increase life expectancy to 70 years by 2015; have a generation of under 20’s free of HIV and AIDS; reduce maternal and child mortality (NDP).

The First case of HIV in South Africa was a white, homosexual air-steward from the United States of
America who died in 1982 of PCP Pneumonia. This brought a belief that HIV was a homosexual disease (AVERT [sa]). Although SA has seen some success in its efforts to encourage youths to use condoms and be wary of riskier sex practices, it must improve the way it teaches strategies for wellness and prevention to people already living with HIV. Easy to implement strategies like HIV-testing and male circumcision without developing counselling and treatment frameworks around those approaches are not helpful (Kelly, 2013). HIV/AIDS and Tuberculosis is said to be the first and biggest burden for South Africa (Motsoaledi, 2010). In order to guide the national response, the National Department of Health (NDoH) recently updated previous commitments and developed the National Strategic Plan (NSP) for HIV and STIs 2007 – 2011. The NSP outlines four key priority areas for the country: prevention; treatment, care and support; research, monitoring and surveillance; human rights and access to justice (Motsoaledi, 2010). Kelly (2013) believes that there is a good chance for creating a foundation for a new type of response, where people actually get more intense and more confident about the possibility of preventing HIV.

South Africa remains plagued by AIDS despite massive governmental and non-governmental organisation efforts in prevention and life-sustaining Antiretroviral programs. But the country has opened up another front to reduce new HIV infections by promoting circumcision. The country has the highest number of new HIV infections worldwide (News/Africa, 2014). The South African government adopted UNAIDS’s vision of zero new HIV infections; zero discrimination and zero AIDS-related deaths. SA however, added a fourth zero to the plan: zero new infections due to mother-to-child transmission; and SA has already seen a 50% reduction in HIV – MTCT between 2008 and 2010 (AVERT [sa]). It is also said that greater access to ART reduces people’s fear and urgency to get tested for HIV, increasing the likelihood of engaging in risky behaviour (AVERT [sa]). There has also been less and less sexual education, awareness and beyond awareness on HIV/AIDS programmes, as it was done in the 1990s by community leaders, churches, non-governmental organisations and social media.

CRITICAL ANALYSIS ON AFRICA HIV PREVENTION

Whereas Global Funding and PEPFAR assist in the treatment and prevention of HIV/AIDS in Africa, these international funders should give Africa its autonomy on how to utilise the funds according to the environmental needs. These funders should also take cognisance that African culture is different from other continents therefore, what is done in Europe will not be the same as what is done in Africa. Africa appreciates the funding but no restrictions should be attached. African leaders are to facilitate the mobilisation of domestic resources through these strategies. Figure 1 shows conceptual framework on African strategies. ABC prevention, circumcision and community conversation are part of preventive education.

ABC PREVENTION STRATEGY

‘Abstain from sex, be faithful if you do not abstain and use a condom if you are not faithful’. This strategy worked for Africa in the late 1980s, together with all community stakeholders who devoted all the chances they had to make communities aware of this dreaded disease. The failure of ABC was because African governments were faced with difficulties of choice in striking the right balance between prevention, treatment and care. Funds were not sufficient to distribute condoms to all communities; ARVs were not affordable to ordinary citizens; the stigma and discrimination was high and gender inequality was rife.

That ABC strategy should be emphasised in Africa irrespective of some communities, like Swaziland, announcing the scrapping of its ABC approach (2010). The Namibian women’s group and the Catholic Church are not agreeing to, ‘Africa stick to condom use’ (AllAfrica, 2008).

CIRCUMCISION

Traditional circumcision is still carried out in certain African communities as part of cultural rituals. This procedure is performed by specific traditional experts as identified in communities. It has been accepted that circumcised men are at a lower risk of being infected with HIV than the uncircumcised men. Male Medical Circumcision has been seen as another strategy to utilise in the prevention of HIV in Africa.

COMMUNITY CONVERSATION

Community conversation is a strategy used in Ethiopia for communities to communicate about specific issues in groups, using the coffee ceremony as vehicle. As a form of communicating issues in health under health workers’ guidance, community conversation assists in addressing awareness and beyond awareness issues. Community conversation has also proven to reduce stigma and discrimination.

ZERO NEW INFECTIONS

The United Nations and African leaders made a commitment in 2011 to zero new infections (United Nations, 2011). This strategy calls for bold decisions to
be taken by leaders on the continent. Zero new infections mean that only those who are presently infected will live with the virus. It is not only a commitment needed by African leaders, but also by individuals and communities to embark on this campaign to eradicate the existence of HIV on the continent. Children should be taught about HIV and AIDS in schools as is done in Zimbabwe (Avert [sa]). South Africa has used television programs like Siyayingqoba (a Nguni word meaning 'we are defeating it'), Khomanani (a SeTshonga word meaning 'work together'), Soul City and Soul Buddyz.

**Accept**

Zero new infections is important to all. Everybody must take precautions in achieving this goal. African leaders should see to it that focus funding is geared towards this strategy.

**ZERO NEW INFECTIONS DUE TO MOTHER-TO-CHILD TRANSMISSION**

When South Africa launched its National Strategic Plan on HIV, STIs and Tuberculosis in 2012 – 2016 (NDoH 2011), SA adopted the UNAIDS vision and added zero new infections due to mother-to-child transmission. Education to young women and pregnant mothers should be intensified, and funding made available to provide ARVs to prevent mother-to-child transmission. Africa should go back to its drawing board and utilise all the possible avenues in educating communities, especially young girls and pregnant mothers.

Why are we no more fearful of this disease? Churches devoted time slots in discussing HIV/AIDS; NGO’s went out to communities distributing pamphlets and talking to community members referring them for voluntary counselling and testing; institutions of higher learning had condom weeks where students were given information on the use of condoms; training of home-based carers and counsellors took place; and community workers were distributed to communities. “Africa wake-up, utilise the African ways of doing things together”.

**ZERO DISCRIMINATION**

Stigma, discrimination and gender inequality continue to undermine efforts to achieve universal access to HIV prevention, treatment, care and support. AIDS-related stigma and discrimination refers to prejudice, negative
attitudes, abuse and maltreatment directed at people living with HIV/AIDS. Mahajan et al. (2010) maintain that the complexity of HIV/AIDS related stigma is often said to be the primary reason for the limited response to this pervasive phenomenon. The consequences of stigma and discrimination are wide ranging - being shunned by family, peers and the wider community; poor treatment in healthcare and education settings; an erosion of rights; psychological damage; and a negative effect on the success of HIV testing and treatment (Foxnews, 2014).

The international community in the fourth decade of HIV/AIDS has a lot of knowledge and tools to fight the scourge of HIV/AIDS and 2011 was taken as a moment of truth (UNAIDS, 2011). It has been found that young adults have a vast knowledge of HIV/AIDS, but Africa still has increased numbers of teenage pregnancies and new HIV infections. This conundrum has been echoed by the Deputy President of South Africa: ‘the new infections in our country are quite alarming at this stage, and we would like to reverse that trend’ (Ramaphosa, 2014).

The stigma associated with HIV can deter governments from taking fast and effective action against the pandemic. It can make individuals reluctant to access HIV testing, treatment and care. The HIV stigma occurs alongside other forms of stigma and discrimination such as racism, stigmas based on physical appearance, homophobia or misogyny and can be directed towards those involved in what are considered socially unacceptable activities such as prostitution or drug use (Foxnews, 2014).

The Africa strategy on discrimination can be copied from Ethiopia’s use of community conversation during coffee ceremonies. These are gatherings under a tree, communicating on a particular theme and the coffee is provided (Esmael, 2014). This strategy has been said to reduce the stigma, as community members discuss HIV guided by the community health workers.

COMBINATION PREVENTION

Combination prevention programmes combine many different HIV prevention programmes into a single, all-inclusive programme (Avert [sa]). African leaders have committed themselves to tackling the pandemic; this calls for all other leaders in health institutions, leaders in communities, leaders in churches, NGO’s and individuals to commit themselves in intensifying the zero elimination of HIV in Africa.

Each country on the continent is to know its pandemic and know its response. Behavioural interventions seek to reduce the risk of HIV infections by addressing risky behaviour or activities. These are: sex education, harm reduction education, peer education, mass communication messages through social media, voluntary counselling and testing, as well as stigma and discrimination reduction programmes. This is still the most important intervention required in Africa. It worked before and it can still work tremendously now with the advance in ARV treatment. Biomedical interventions that include condom use and male circumcision need also be looked at with a focus on geographic and cultural aspects. Structural interventions that address poverty, protect people living with HIV, decriminalise sex work, homosexuality and drug use need Africa commitment to HIV prevention (Avert [sa]).

LEGAL ASPECTS IN HIV PREVENTION IN AFRICA

Legal guidelines for Africa are necessary to intensify the mobilisation of domestic resources, reduce dependency on foreign aid, strengthen health systems and prevent misuse of domestic resources. However, this need not interfere with individual’s right to privacy and of the human rights issues. In 2007, the Zimbabwean government shifted its focus from voluntary testing to provider-initiated testing, meaning that, whenever a person visited a healthcare facility, testing was part of the hospital service (Avert [sa]). This legal issue of provider-initiated testing is re-surfacing in Africa (Stangl, 2014).

CONCLUSION

African leaders agreed in 2013 to intensify the mobilisation of domestic resources and reduce dependency on foreign aid in order to strengthen health systems. Bold decisions must be taken to exercise greater leadership in the governance of HIV/AIDS responses in Africa. Nurses have much to contribute to community-based efforts to promote societal and structural changes to reduce the risk of HIV infection. The international funders should also take cognisance that African culture is different from other continents and therefore, what is done in Europe will not be the same as what is done in Africa. Africa appreciates the funding, but no restrictions should be attached.

REFERENCES

HIV/AIDS Interventions


