

## Prevention Strategies

*Sammy Gumbe*

### Overview

Sub-Saharan Africa has just over 10 per cent of the world's population, but is home to more than 60 per cent of all people living with HIV—approximately 25.4 million (23.4 million to 28.4 million) people. In 2004, an estimated 3.1 million (2.7 million to 3.8 million) people in the region became newly infected, while 2.3 million (2.1 million to 2.6 million) died of AIDS. Among young people aged 15-24 years, an estimated 6.9 per cent (6.3-8.3 per cent) of women and 2.2 per cent (2.0-2.7 per cent) of men were living with HIV by the end of 2004 (UNAIDS Report 2004).

Prevention has been identified as a priority in sub-Saharan Africa due to the unprecedented impact of the HIV/AIDS pandemic upon its population.

Adult HIV prevalence has been roughly stable in recent years. But stabilization does not necessarily mean the epidemic is slowing. On the contrary, it can disguise the worst phases of an epidemic—when roughly equal numbers of people are being newly infected with HIV and are dying of AIDS (*UNAIDS Report 2004*).

Take for example Mozambique, located on the east coast of southern Africa:

### Daily infection rate in Mozambique

- In adult population (15-49): 500
- Mother to child transmission: 90
- New cases of AIDS: 109,000
- Deaths because of AIDS: 97,000
- People requiring ARVs: 218,000
- People receiving ARVs: 6,000
- Projected number to be treated: 8,000
- Orphans 1.6 million
- Orphans due to AIDS 273,000

### Intervention by target groups

The delivery of information to a particular target group can be made more appropriately by:

- Discussions within the community (peer-driven)
- Use of peer educators
- Use of appropriate media
- Activities such as drama, plays and storytelling.
- Sensitivity to local cultural background and gender issues.

*Already Infected:* People who are already HIV-positive need to be taught how to prevent transmission of HIV to others and gain access to medical and other support.

*At risk:* These are people who are at high risk of HIV infection and need to be taught how to protect themselves from acquiring infection. Programs should aim at teaching how to change high-risk practices within the population and promote empowerment

*Potential risk:* This includes the youth and student population. Much criticism has been levelled at the sex education messages that are targeted at this group, because of the risk of promoting sexual activities, but there is no evidence to support the idea that this does occur.

*General population:* These are people with no or minimal risk of HIV infection. Intervention messages should explain how HIV is *not* transmitted to prevent unnecessary fears about everyday situations. This may be delivered by the mass media, such as television, radio or cinema.

### **Cooperation with churches**

Churches in Africa offer an established, available network for delivering services to AIDS patients and the community for the following reasons:

- *Presence factor:* The church has a wide distribution of points of presence (POP) within the community, which is a key to mobilization.
- *Longevity factor:* Churches generally have a life-long commitment to the community, therefore people develop trust in them. They are perceived as setting the example and taking a leading role in behaviour changes.
- *Human capacity / infrastructure factor:* Members are available as volunteers for modelling and mentoring. The existing church infrastructure provides ready channels of service delivery.

### **Prevention strategies**

#### ***Voluntary counselling and testing***

This is a program where an individual undergoes counselling to enable him/her to make an informed choice on being tested for HIV. This decision must be entirely the choice of the individual and he/she must be assured that the process will be confidential. There is therefore a need for more of these centres.

Some of this counselling is being done at the grassroots level by the volunteers who go to the villages to talk with the people, while in other areas a van is provided to go across the communities to talk with community groups and churches.

### ***Condom use***

The issue of condom use and how to communicate its message has been a great challenge to the Church. However, we emphasize the use of condoms only in the marital context where one or both parties are infected. With this approach, it is easier for partners to discuss and respond positively.

*Behaviour change* is a term much used in AIDS prevention circles. It is often used narrowly to mean adopting condoms. But one could argue that the condom option is really a harm reduction solution for people who *don't* change their risky behaviour.

Ugandan President Hon. Museveni stated his views in a speech to the First AIDS Congress in East and Central Africa (Kampala 20<sup>th</sup> November 1991). In regards to condoms he said, "Just as we were offered the 'magic bullet' in the early 1940s, we are now being offered the condoms for 'safe sex'... I feel that condoms have a role to play as a means of protection, especially in couples who are HIV-positive, but they cannot become the main means of stemming the tide of AIDS."

### ***Combating stigma***

Stigma and cultural taboos are heart issues, and no amount of legislation alone can overcome these hurdles. When stigma is addressed, many people come out openly and declare their status without the fear of being judged or rejected. This helps to encourage others who live with the same status to face life in a positive way.

"The first battle to be won in the war against AIDS is the battle to smash the wall of silence and stigma surrounding it" (Secretary General Kofi Annon, January 10, 2000).

### ***Promotion of human rights***

When we violate a person's rights, we cross a boundary that we as humans have said we would not cross. This is serious enough, but when we violate inherent human dignity, the matter takes on another dimension. It is not only the person per se who we violate, but also God. This happens all too often, in too many churches.

Governments must be made accountable to their constitutions and the conventions to which they are signatory. The need to integrate HIV/AIDS mitigation into broader development and humanitarian initiatives is now essential.

### ***Prevention of sexual transmission***

An intervention strategy aimed at a large proportion of the population might include:

- Comprehensive sex education (beginning at the elementary school level, because some become active at this stage).
- A campaign program. *Turn the Tide* ministry held a meeting where over 10,000 youth participated and more than 3,000 teenagers bought rings and made a commitment to abstain from sexual activity until marriage.
- Behaviour changes among individuals are more likely to succeed if the moral standard of the society they interact in also changes.

### ***Prevention of vertical transmission***

Scaling up of MTCT prevention programs. One of the greatest achievements of the past decade is the demonstration that antiretroviral drugs can dramatically reduce mother-to-child-transmission (MTCT) of HIV. Attaining success in this area will be difficult, however, because of the absence of uniform access to antenatal care and the need for breastfeeding.

In spite of these difficulties, a reduction of MTCT by 50 per cent has already been demonstrated in the developing world through the use of Nevirapine or short-course Zidovudine (AZT). These programs must be put in place in every healthcare setting.

### ***Prevention of parenteral transmission***

Prevention strategies rely on an integrated approach between drug dependency units and health workers responsible for HIV care. Such strategies include working with the Drugs Network organization, the people who are drug dependent and those who are rehabilitated.

“Active participation of the (affected) communities is the central element in successful AIDS interventions” (World Council of Church publication).

## **Challenges regarding prevention of HIV infection**

### ***Cultural taboos***

In the African culture it's a taboo to talk about sex with children. Many believe that this infection is a curse from evil spirits and cannot be discussed. Some traditions practise wife inheritance and other cleansing ceremonies that are of high risk to infection.

### ***Acceptance by some clergy and layman within the Church***

The Church and many of its leaders are having difficulty accepting that this pandemic is with us. There is therefore a slow response from the Church in regards to any issues that point to HIV/AIDS.

***Dissemination of key information to the grassroots level***

There is a lack of availability of proper materials in local languages. Due to the high illiteracy level, most of the information that is shared does not get to the root of the problem because of communication barriers. The illiteracy level in Mozambique, for example, is 55 per cent.

***Lack of support and care for the caregivers***

Due to lack of care and support for the caregivers, many give up their efforts as a result of stress or their own health constraints. Many caretakers are themselves HIV-positive. If they are not taken care of, stress and strain can take a toll on them.

***Lack of proper infrastructures***

Rural areas are highly populated and the health centres are few and inadequate. The health system caters to only 35-40 per cent of the total population in Mozambique.

***Shortage of drugs and lack of monitoring systems***

We cannot rule out poverty. Most of the infected people, due to their geographical location and other factors, cannot get access to the drugs available in the centres. If they do not, there is no monitoring and follow-up system and as a result the program becomes a failure. Over 70 per cent of the population is living under the poverty line in Mozambique.

***Access to funding***

Due to the red tape and the bureaucracy involved, it is difficult to tap into available funding. When monies are available, there is competition and lack of coordination and cooperation, which leads to disunity and mismanagement.

***Lack of skilled personnel***

Because of lack of skilled personnel to handle these cases, we find ourselves limited in what we can do to combat the HIV/AIDS pandemic. As a result, implementation of HIV/AIDS prevention strategies becomes a challenge.

***Gender inequality***

In this war against HIV/AIDS, one of the major issues that we cannot afford to ignore is gender. If we are going to be part of the solution in seeking to reduce and finally eradicate the spread and impact of HIV/AIDS on the African continent, we must fully understand the impact of gender-related issues. “HIV/AIDS research holds that gender-based inequalities overlap with other social, cultural economic and political inequalities – and affect women and men of all ages” (*Gender inequalities are major driving force behind the AIDS epidemic,*”(UNAIDS, 2000).

**Prevention opportunities*****Hope (drugs, de-stigmatization, acceptance)***

Because of new developments made by scientists and the availability of drugs from organizations like Health Partners International, there is hope for a medical breakthrough in addition to the increase of acceptance within communities.

***Capacity-building development***

Development at the local grassroots level builds compassion, love and centralization. This involves training and equipping patients and their families with life skill techniques that bring sustainability.

***A political context that actively supports prevention***

The involvement of the government is vital in the joint effort of fighting the HIV/AIDS pandemic. Protecting and promoting human rights, including the rights of women and children, and the creation of an enabling environment, which puts people in a position to protect themselves and others from infection, is also vital. This is a prerequisite to upholding the rights of PLWHA, before we enact any further laws and policies to deal with the problem.

***The role of communities and grassroots initiatives***

Belief in the capacity of communities to care, change, name and document their change, share and transfer their experience with others and sustain hope in the midst of the HIV/AIDS pandemic is foundational to an expanded response. Communities have the capacity to reflect on their concerns related to HIV/AIDS, to make decisions and changes in the areas of care and prevention, to name indicators of these changes and document their response, and to transfer experience and skills to others.

***Involvement of people living with HIV/AIDS***

PLWHA have a critical role to play in designing and implementing HIV/AIDS prevention and care programs. The prevention messages delivered by people living with the infection have a powerful impact for behaviour change and help reduce fear, denial, stigma and discrimination, leading to care and mitigation of the impact of HIV/AIDS.

***Increased access to treatment***

It should be re-emphasized that antiretroviral therapy is already being used in the developing world, although on a small scale in low-income countries, demonstrating that it is feasible and effective. The benefits of antiretroviral therapy and treatment of sexually transmitted diseases extend beyond the immediate medical result of an improved physical health. These benefits include an improved psychological status, stabilization of the family unit, increased uptake of VCT, prevention of opportunistic infections and a lowering of the transmission rate in the population.

It is always worthwhile for states and communities to invest early in prevention, since it avoids the high follow-up cost of the growing HIV epidemic.

**We Need your Help**

An African Proverb says, “When you want to go fast, go alone. When you want to go far, go together.” An African child has put it this way:

*You can help; help us to save our communities, our parents, brothers, sisters, friends and my fellow children of Africa who are dying of this pandemic. We have hope to win, when we come together and act. This is my story (Son of Africa, the Future Leaders of Tomorrow).*

Thank you.  
Obrigado.  
Kanimbo.

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