

1-1-2012

HIV/AIDS Prevention Programs in Uganda and Zimbabwe

Brittney Wesche
Grand Valley State University

Follow this and additional works at: <http://scholarworks.gvsu.edu/honorsprojects>

Recommended Citation

Wesche, Brittney, "HIV/AIDS Prevention Programs in Uganda and Zimbabwe" (2012). *Honors Projects*. Paper 157.
<http://scholarworks.gvsu.edu/honorsprojects/157>

This Open Access is brought to you for free and open access by the Undergraduate Research and Creative Practice at ScholarWorks@GVSU. It has been accepted for inclusion in Honors Projects by an authorized administrator of ScholarWorks@GVSU. For more information, please contact scholarworks@gvsu.edu.

HIV/AIDS Prevention Programs in Uganda and Zimbabwe

Brittney Wesche

Honors Senior Thesis Project

HNR 499

In Collaboration with Dr. Nancy Schoofs

HIV/AIDS Prevention Programs in Uganda and Zimbabwe

Ever since it was discovered, HIV and AIDS has been considered an epidemic of gigantic global proportions. Even though the epidemic is said to have peaked in 1999, it is estimated that 34 million people were still living with HIV/AIDS at the end of 2010 (AVERT, 2011b). However, despite the downward decline of HIV prevalence, almost two million people died in 2010 alone from AIDS related opportunistic infections (AVERT, 2011b). Sub-Saharan African countries specifically have been hit with the AIDS epidemic in ways that have collapsed their health care system, government infrastructure, and social patterns. The magnitude of this epidemic encompasses nearly every aspect of normal life for people living in Sub-Saharan Africa.

The options to slow HIV spread are limited in areas with high poverty levels, such as in Africa. Despite the continued decreased cost of the life-prolonging anti-retroviral therapies (ARVs), they are still out of reach for many Africans living in poverty. ARVs do lower the chances for HIV transmission, but the disease can still be passed on. It has long been determined that the best way to slow the spread of HIV/AIDS in Africa is through educational programs that teach prevention methods that will protect against the acquisition of HIV/AIDS. Many organizations and countries have partnered together to create various HIV educational programs intended to slow the spread of HIV. Some have been deemed successful, some unsuccessful.

One of the best examples of a country that has been successful in reversing their HIV epidemic is Uganda. In the late 1990s, Uganda estimated as many as 29% of adults had HIV/AIDS. By 2002, it was estimated only 8% of adults had HIV/AIDS (Fournier, Kipp, Mill, & Walusimbi, 2007). Though these infection numbers vary slightly depending on which article is

referenced, many have cited Uganda's ABC program as the reason infection rates have substantially declined. Though many additional factors, such as governmental response and stigma reduction, contributed to HIV decline, this education program helped the process in many ways.

On the opposite side of the spectrum, there are other Sub-Saharan countries that have not had the same success with their HIV prevention campaigns. Zimbabwe for example, has been highly criticized for its meager prevention efforts. After two decades of prevention efforts, little has changed in HIV infection rates or AIDS stigma in Zimbabwe compared to what prevention efforts have accomplished in Uganda (Duffy, 2005). So what are the differences between the prevention campaigns of Zimbabwe and Uganda? Why has Uganda been successful in decreasing HIV prevalence, while Zimbabwe has not accomplished the same amount of success?

This paper will address the implications of the ABC program used in Uganda, and discuss the amount of success this program has brought to Uganda in decreasing HIV prevalence, as well as the significant amount of criticism this program has accumulated. Also, it will examine the role of stigma and how decreasing stigma leads to a decreasing transmission rate. It will then compare the HIV prevention efforts in Uganda to the efforts made in Zimbabwe, and discuss possible ways Zimbabwe could be more successful by using Uganda's programs as a model. Also, the vital role of the nurse in an HIV stricken country will be examined, along with the challenges, responsibilities, and ways that nurses can help prevention efforts. Overall, this paper will prove how African countries like Zimbabwe can learn from Uganda's progress as a prevention model in addition to its current programs to increase knowledge and help prevent the spread of HIV.

Epidemiology of HIV/AIDS in Uganda and Zimbabwe

Before the prevention efforts can be examined, the epidemiology of HIV/AIDS must be understood. Sub-Saharan African countries have been the hardest hit by the epidemic in recent years and carry approximately 68% of the world's HIV burden (UNAIDS, 2011). There are special characteristics of these countries that allowed HIV to sweep so thoroughly throughout them. These factors include poverty, a poor health care system, misinformation or lack of education, and the effects of gender roles. All of these components work together in a vicious cycle that continues to destroy the health of the country's citizens. These elements specific to Sub-Saharan African countries like Uganda and Zimbabwe must be studied and understood in order to create an effective prevention program.

Economic Hardships

It is well known that Uganda and Zimbabwe are third world countries that do not have ample monetary resources. Both Uganda and Zimbabwe have experienced recent inflation, droughts, and food shortages that deter health care efforts. In 2005, the Zimbabwean President initiated 'Operation Murambatsvina', a program which was intended to move people from urban to rural areas, but instead left thousands homeless and without food or work (AVERT, 2011a). Recently, Zimbabwe has experienced a nearly 100,000% inflation rate, effectively collapsing its economic system (AVERT, 2011a). When a country experiences economic collapse of these proportions, the country cannot afford to care for the health needs of its citizens. Because of these economic hardships, young women often have to turn to prostitution in order to eat. Many surveys have showed that “inability to earn income in other ways was the major reason cited for engaging in commercial sex” (Wilson, Sibanda, Mboyi, Msimanga, & Dube, 1990, p. 609).

Obviously the more sexual contacts a commercial sex worker has, the higher chance of her catching and spreading HIV. Though Uganda has faced similar economic problems as Zimbabwe, they are also facing a rapid population growth, which is severely straining the food resources (Kibuka, 2011). All of these factors contribute to poor outcomes when it comes to keeping people healthy and preventing HIV/AIDS.

Failing Health Care Systems

The current economic condition of Uganda and Zimbabwe leaves little room for a successful health care system. Rampant malnutrition in these countries have left many citizens more susceptible to acquiring and transmitting HIV as well as developing AIDS faster. Also, health care provider shortages have left a major hole in the health care system. In Uganda, there is approximately one doctor for every 13,000 people (Mullan, 2008). Many health care providers are burnt out because of severe shortages of basic health resources such as clean water, bedding, pharmaceuticals, and safety equipment (Fournier, Kipp, Mill & Walusimbi, 2007). Some nurses have reported ratios of up to 100 patients to one nurse in a single night shift (Fournier et al., 2007). Displacement in Zimbabwe has led to even less access to health care for the thousands left homeless (AVERT, 2011a). Because of these factors, AVERT reports a “near total collapse of the health system” in Zimbabwe (2011a). Without proper access to medical resources, HIV positive Africans have little hope of staying healthy and decreasing their risk of transmitting the disease.

Minimal HIV Education

Many citizens in Uganda and Zimbabwe are not educated on HIV/AIDS; and of what little information they have, much is incorrect. In Zimbabwe, only 76% of women knew that

condoms help reduce risk of HIV transmission (AVERT, 2011a). Rural Zimbabweans have a popular belief “that sex with a young person provides protection from HIV or that sex with a virgin can cure one of AIDS” (Duffy, 2005, p. 24). This practice has caused the rates of HIV incidence in young women to grow exponentially. Traditional spiritual beliefs are a large part of life in both Uganda and Zimbabwe. Even many proclaimed “Christians” in these areas also believe in traditional spirits and do not fully understand that HIV is a pathological process involving microorganisms, not a punishment or misfortune caused by an angry spiritual ancestor (Duffy, 2005). These misinformed ideas contribute to educational campaigns that are not taken seriously by their intended audience.

Gender Inequalities

The cultural dominance of men over women, especially in Zimbabwe, is a major reason why prevention programs are still only moderately effective after nearly two decades of campaigning. Female incidence of HIV has been on the rise in the past decade, as it is estimated that 90% of HIV transmission in this country happens heterosexually (Duffy, 2005). There are gender inequalities in the citizens’ personal lives and the economy as well. Women have very few options for employment, and besides being a street employed vendor or a domestic servant, prostitution is the only other option (Wilson et al., 1990). Much gender inequality comes from man's dominance in their world and refusal to change sexual habits in order to protect themselves and their partners, and the woman's inability to convince the man otherwise. With most sexual contacts, and especially with commercial sex workers, there is a “nearly unanimous agreement that it is the man's choice whether condoms are used” (Duffy, 2005, p. 27). In the past, men considered it a trait of masculinity to acquire a sexually transmitted infection while it was

considered shameful for a woman to have an STI (Halperin et al., 2011). Many women fear for their safety if they do not submit to men, as “women refusing sexual advances... or suggesting condom use can lead to violent confrontation. The threat of HIV is diminished when the concern is immediate safety or economic security” (Duffy, 2005, p. 24). The cultural norms of male dominance must be challenged in order to better protect men and women from HIV.

HIV/AIDS Prevention in Uganda

HIV/AIDS in Uganda

At the beginning of the HIV/AIDS epidemic, Uganda had one of the highest infection rates in the world. Along with Thailand, Uganda is cited as the first country in the world to reverse their HIV/AIDS epidemic. In 1991, Uganda hit a peak of 21.1% of citizens testing sero positive for HIV. By 2000, that number was down to 6.1% (Green, 2003). However, it must be said that these infection numbers vary depending on the source used. The President of Uganda has been highly praised for his national response to HIV, and has played a large part in reducing the prevalence in his country. The ABC Program, which was adopted by Ugandan health officials, was made globally known through the success it produced in Uganda even though there is much criticism of the program and of the data that proves this campaign's success. Clearly, there is still much to be learned from Uganda and its HIV fame.

The logistics of HIV prevention programs in Uganda are very different from other countries. Uganda had a central coordinating team, the Ugandan National AIDS Control Program (NACP), that oversaw all other organizations involved in the prevention process (Slutkin et al., 2006). All the money donated by various organizations was combined and used by the Ugandan NACP. Many countries do not have a central management that coordinates all efforts and

resources, usually reducing the agency's overall efficiency. Instead of having many organizations trying to work alone, the Ugandan government hoped that having one body that oversaw the entire coordination effort would eliminate overlaps and gaps in funding and resources.

The ABC Prevention Program

Cited by many as one of the most successful HIV/AIDS prevention campaign in the world, the ABC program began in Uganda and has played a major role in the public's education on HIV/AIDS. It has aimed to reduce incidence of HIV infection by promoting 'Abstinence', 'Be Faithful' or 'Use Condoms'. This idea of promoting ABC as the basis for all prevention efforts in Uganda is highly politicized and encouraged by the President of Uganda, Yoweri Museveni, and has even been nicknamed "The Museveni Approach" (Green, 2003). President Museveni aimed to change the entire sexual culture of his country, thus preventing HIV transmission.

There has been ample discussion concerning the best ways to implement ABC into the culture. Some believe that each aspect of ABC should be encouraged equally, and some think each piece should be pushed in accordance to its ability to prevent transmission. Health officials in Uganda seemed to take the latter approach, and downplayed the C portion of the equation unless absolutely necessary. Health officials told adults to "First, abstain from sex. If you cannot abstain, stick to one partner. If you can't stick to one partner then you have to use a condom. But be sure that condoms are not 100 percent effective" (Green, 2003, p. 153-154). In general, Uganda encouraged people to reduce their sexual partners to zero or one partner, and if that was not possible, then use condoms as a last resort to protection. This is arguably what made the programs so potent compared to other countries who mostly encouraged condom use. Since

condoms are not entirely effective and are generally not used for every sexual encounter or even available regularly in third world countries, Ugandans argued that condom use is not the best way to prevent HIV transmission (Green, 2003). However, the experts unanimously agreed that at least one of the three ABC strategies must be used by every single person in their country.

Criticism for the ABC Program

Many say that ABC was not as successful as it is portrayed and that there are many inconsistencies in the data concerning its viability. First of all, many Ugandan documents about HIV/AIDS in the 1980s have been lost or destroyed because of the political turmoil of that time. Thus, it is hard to get an entirely truthful picture of what really happened at the beginning of the epidemic where there are significant data gaps (Kuhanen, 2008). Also, it is popularly cited that the ABC campaign came from the Ugandan NACP at the very beginning of its AIDS Strategy Plan. However, it appears the acronym was not used in Uganda until the 1990s, almost ten years after prevention efforts started (Parkhurst, 2010). Experts have argued that behavior changes started occurring in the late 1980s, with reduction in number of partners being the biggest reason HIV infection rates began dropping in the early years of HIV (Parkhurst, 2010). However, in the time before ABC was introduced as a cohesive program in Uganda, the ideas it represented (abstinence, being faithful, and using condoms) were heavily pushed by the government. Uganda had many campaigns that encouraged abstinence, faithfulness, and condoms as methods to prevent HIV infection; however, all three ideas were not encouraged as one overall prevention program. Later, ABC was introduced as a nicely packaged way of combining all previous efforts. Therefore, ABC can still be seen as a valid and successful approach to reducing HIV transmission.

Other Campaigns in Uganda

Uganda also had other successful prevention campaigns, such as 'Zero Grazing' and 'Love Carefully' in the late 1980s, when the AIDS epidemic was beginning to sweep the nations. Both slogans encouraged sexually active adults to stay faithful and limit the number of sexual partners, as promiscuity in Uganda was and still is the most prominent risk factor for contracting HIV (Rule, 1987). The frankness of these slogans helped people to understand that they had responsibilities to themselves and their partners when it comes to HIV prevention. Those campaigns pushed important aspects of what was later introduced cohesively as the ABC program.

Other Influences on HIV Decline

Beyond prevention campaigns designed specifically to alter behavior, there are other things that contributed to the drastic decline of HIV in Uganda. Many have discussed the fear of AIDS, reduced stigma, and the quick government response as additional reasons the HIV prevalence fell in Uganda. As prevention programs are created and modified in Uganda and other countries, it is important to understand all possible reasons Uganda has been successful.

Especially in the 1990s, fear of HIV/AIDS was rampant. The health care system shifted to home based care, meaning that family members were often taking care of other dying family members. This caused increased fear of HIV/AIDS, as people saw first hand the suffering it inflicted. Ugandan marketers also tried to induce fear of HIV/AIDS by posters and pamphlets describing the horrors of the disease. One poster with a skull and crossbones read, "I wish I had said no to AIDS, my quick pleasure led to a slow, painful death" (Green, 2003, p. 142). This aspect of a fundamental fear of HIV/AIDS is unlikely to be repeated. In the beginning of the

epidemic, HIV was a new and unknown disease with obvious disastrous effects that scared people into behavior change (Parkhurst, 2010). This is no longer the case as HIV is increasingly understood by the population. However, through various models and statistical analysis, it has been shown that fear alone has contributed to, but has not significantly decreased, the prevalence of HIV in African countries (Green, 2003).

The decreased fear of HIV has led to the decrease of stigma against HIV positive people. In Uganda, there is less stigmatization which creates a climate where HIV can openly be discussed (Green, 2003). Citizens of other African countries will go to great lengths to hide their HIV status, which makes prevention and education difficult (Holzemer & Uys, 2004). One author stated that the “real battle against AIDS in Africa is being played out in the families and villages of Africa, where the authority of government rarely extends. This sort of discrimination is intensely personal and it takes many forms” (Holzemer & Uys, 2004, p. 169). Though decreased fear alone may not contribute to a decline of HIV transmission, decreasing fear can help reduce stigmatization of HIV/AIDS patients and help to create open communication regarding protection.

Another aspect that could have assisted in declining HIV prevalence rates is the rapid and consistent intervention by the government. Ugandan government has been highly praised for the way it quickly stepped up to face HIV/AIDS. President Museveni took the threat of HIV seriously, which was not the case for many leaders of other countries. One article said that “the President guided all ministers and other senior level government officials to mention and speak about AIDS at all public functions... As far as we know, no single speech [of Museveni's], local or international, ended without talking about HIV/AIDS” (Slutkin et al., 2006, p. 358). The

government also challenged the media to participate in mass education through radio, television, newspaper and theater (Slutkin et al., 2006). Government involvement “[seemed] to have resulted in the awareness and subsequent involvement in AIDS education of... influential people normally not involved in health issues, such as political and religious leaders, teachers, traders, leaders of women’s and youth associations and the like” (Green, 2003, p. 174). Led by the President and coordinated with the NACP and the media, behavior change programming was extensive and successful (Slutkin et al., 2006). Dedication to eradicating HIV/AIDS by the leaders of Uganda helped reinforce the importance of protecting oneself from HIV, and is essential for successful decline of HIV transmission.

Conclusion of Ugandan Prevention

Though there is heated debate on whether or not the acronym ABC originated in Uganda, and whether or not it made any difference in the initial decline of HIV incidence, it is still a valid program to study when planning prevention programs in other countries. Even though it was not introduced until HIV rates had already started dropping, the prevention efforts used at the beginning of the epidemic can be easily summed up as ABC. HIV transmission has been on the decline, but rates are still too high to relax and not keep fighting. Therefore, it is crucially important to continue to implement and improve what has worked in the past. There are other factors that could have contributed to HIV decline in Uganda, such as decreased fear of the disease, destigmatization, and governmental support, but these factors could be hard to implement in other countries. The simplified ways that ABC presented HIV prevention are accurate, understandable, and easily implemented to the public as an HIV prevention campaign that is still desperately needed.

HIV/AIDS Prevention in Zimbabwe

HIV/AIDS in Zimbabwe

The epidemic of HIV/AIDS has ravished Sub Saharan Africa, but perhaps none as much as in Zimbabwe. Before AIDS, Zimbabwe was a stable country thriving off tourism and tobacco production. Dr. Edward Tick stated that until HIV swept the country, “[Zimbabwe] was considered the breadbasket of Africa... it was a country of great promise and resources” (2007, p. 613). A little more than two decades later, the average life expectancy plummeted, largely due to AIDS, to only 34 years for women, and 37 years for men. At that time, it was the lowest life expectancy of any country in the world (BBC News, 2006). Even though the situation has improved, the average life expectancy in 2009 was still only 42 years (UNAIDS, 2011). According to AVERT, “as many as 1 in 4 children in Zimbabwe are orphaned as a result of parents dying from AIDS” (2011a, p.1). Zimbabwe has long been known as part of the epicenter of the epidemic, and relatively little has changed despite increased efforts.

In many ways, Zimbabwe is a model of 'what not to do' for the beginning of an epidemic such as HIV/AIDS. The President of Zimbabwe, Robert Mugabe, has been highly criticized for his government's late and inefficient HIV/AIDS response. In addition to that, Zimbabwe has experienced an economic meltdown and a severe cholera epidemic in recent years that has hindered HIV prevention efforts (AVERT, 2011a). The government has been reportedly hostile towards foreign non-governmental organizations, and has proven irresponsible with funding from these organizations (AVERT, 2011a). Zimbabwe could be considered the antithesis of Uganda's response to HIV, in both programs and outcomes. So can Zimbabwe's prevention efforts become more effective, and can Uganda be a model for this desperate country?

Current HIV/AIDS Programs in Zimbabwe

By looking at Zimbabwe's current HIV prevention programs, it is obvious that Zimbabwe has much to learn and do to improve their programs. It appears that a potentially effective theoretical framework is in place, but has yet to be enacted. Even after publishing the Zimbabwe's National HIV and AIDS Strategic Plan [ZNASP] in 2006, it does not appear much has changed. The government seems to have an idea of what to do and has laid out an effective plan, but the progress seems to have significantly slowed from there. Though the ZNASP is in place, it needs to begin, for thousands of lives are on the line.

The National AIDS Council published the ZNASP, and according to the long and detailed document, Zimbabwe is highly committed to the 'Three Ones Initiative' (2006). This initiative was developed by donors and developing countries at a UNAIDS meeting in 2004 to help “improve the ability of donors and developing countries to work more effectively together, on a country by country basis” (WHO, 2004, para. 5). The Three Ones Initiative focuses on unity and cohesiveness in HIV/AIDS related programs within each country. This initiative encourages countries to have “one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad based multi-sector mandate; and one agreed country-level monitoring and evaluation system” (WHO, 2004, para. 2). Generally speaking, The Three Ones means one plan, one authority, and one evaluation for all HIV/AIDS related programs. Zimbabwe has expressed extensive commitment to this initiative in the ZNASP; however, there is little confirmation that Zimbabwe is doing anything about the Three Ones Initiative other than talking about it.

In the ZNASP, the ABC program is mentioned occasionally as one of a few

educational prevention campaigns. However, according to some studies, behavior has not been changed despite high levels of HIV knowledge in many parts of Zimbabwe (Nhamo, Campbell, & Gregson, 2010; Gregson, et al., 2007). This should raise serious concerns about the effectiveness of ABC-like prevention programs in Zimbabwe. Even if knowledge is gained by the programs, if positive health choices are not subsequently made, the education is useless. This raises questions about why ABC worked in Uganda, but not in Zimbabwe.

Creating Successful ABC Campaigns in Zimbabwe

There are many factors that could be contributing to the decreased effectiveness of ABC prevention programs in Zimbabwe. These factors need to be understood and dealt with prior to implementation of ABC campaigns. Things that could be hurting current ABC programs include a high HIV stigma, a generally low self-efficacy of HIV positive patients, and an extensive gender inequality gap. Looking back at the history of Uganda's program, it is obvious that these factors were dealt with prior to ABC campaign implementation.

One of the very first things the Ugandan government did with the AIDS epidemic was talk about it, and talk about it a *lot* (Green, 2003). Talking openly and honestly slowly reduced stigma, which had a snowball effect on patients' self-efficacy, shame and fear, as well as produced a sense of togetherness in the fight. The Ugandan government compared AIDS to a "hungry lion that has entered a village; people must act together to protect the village and the nation" (Green, 2003, p. 168). As perceptions of HIV/AIDS were shifting, the ABC programs came in, giving people ammunition for the battle they were already prepared to fight together against HIV. According to Dr. Holzemer, "unless stigma is conquered, the illness will not be defeated" (2004, p. 165). Essentially the opposite happened in Zimbabwe, as little to no efforts

were made to reduce stigmatization of HIV positive people, resulting in isolation and dishonesty. One Zimbabwean church elder was quoted saying, “people with HIV are immoral and they are heathens, these people have been promiscuous, therefore it is only right and proper” (Nhamo, et al., 2010, p. 1665). Because stigma is so high in Zimbabwe, it could be a main factor in the decreased effectiveness of ABC programs.

Another component that could be hurting HIV prevention programs is people's decreased self-efficacy. Researchers who have worked in rural Zimbabwe have found that when people do not believe they have the strength and resources to resist HIV, they are very unlikely to try (Nhamo, et al., 2010). Another study showed that when people felt a greater sense of self-efficacy, they were less likely to become infected with HIV (Gregson, et al., 2011). In Zimbabwe, one of the groups with the highest self-efficacy is married, highly educated men. Not surprisingly, this group of people has been shown to have the greatest amount of behavioral change to prevent HIV transmission (Halperin, et al., 2011). Zimbabweans have stated that “people have no confidence anymore” in many aspects of life, contributing to a sense of hopelessness and helplessness (Nhamo, et al., p. 1664). Increasing self-efficacy is a long and often difficult process that requires dedication and most of all, education. However, it is necessary to help empower the people to prevent the transmission of HIV.

The last big issue Zimbabwe needs to address before ABC campaigns can be truly effective is the gender inequality of its people. This topic has already been discussed at length in this paper, but it is important to point out again how much gender inequality is hurting the prevention programs in Zimbabwe. Uganda had been relatively successful in decreasing gender inequalities prior to the epidemic of HIV/AIDS, where Zimbabwe had not. Regardless of the

education and prevention strategies women are given, if they are powerless to use the tools because of men's dominance, HIV will continue spreading at a rapid rate (Duffy, 2005).

There are many reasons why ABC-like campaigns have not been as effective in Zimbabwe as they previously have been in Uganda. However, if things like stigma, self-efficacy and gender inequality are examined and changed at the population level, it is obvious that HIV transmission rates would drop due to prevention campaigns like ABC. Uganda dealt with these social issues before the AIDS epidemic and at the beginning of the ABC programs. Zimbabwe is trying to deal with these issues two decades after the start of the AIDS epidemic and prevention programs, rendering these programs much less effective.

Nurses' Role in Prevention Program Implementation

When it comes to prevention programs, nurses can play a vital role in many areas of education and program implementation. In African countries, some nurses originate from local communities, while others come from abroad through various aid organizations. Regardless of the nurse's specialty, one would be hard pressed to find a nurse practicing in Africa who has not extensively dealt with a patient living with and dying from AIDS. These nurses have a very dynamic role in the health care system crippled by HIV/AIDS and rightfully so, as nurses are in the prime position to help. Beyond the normal responsibilities of a nurse, HIV/AIDS nurses also must fill extra duties. Additional nursing roles specific to HIV prevention in Africa include prevention education, bridging the gap between traditional and Western medicines, and offering emotional support, as well as being politically active on behalf of their patients. Nurses in Africa face incredible challenges dealing with resource shortages, but that discussion is not within the scope of this section, since nurses are oftentimes not in the position to help the shortages. Nurses

who want to help prevent further HIV infection have additional responsibilities to their patients which include extensive education, communication and support of patients, families and the communities.

HIV prevention education should be one of the main priorities for all nurses practicing in Africa because without an intense prevention focus, HIV transmission rates can not decrease. All over the world, nurses provide knowledge to their patients as one of their main job duties, and in Africa it is no different. One study in Swaziland showed that adolescents preferred nurses giving health education over anyone else (Buseh et al., 2002 as cited in Ehlers, 2006). According to Ehlers, "Nurses are also familiar with the cultural traditions and taboos of specific communities and can convey health education messages in cultural congruent terms" (2006, p. 661). Because of this congruency, nurses are more effective in their teaching and often results in positive health behaviors, which is the ultimate goal of any prevention program.

Another responsibility of these nurses is to bridge the gap between Western and traditional medicine, which is really just an extension of providing education. Many Africans employ local traditional healers because of the common belief of animism, or the belief in ancestral spiritual influences on the body (Duffy, 2005). These patients are oftentimes receiving medicines from both Western doctors and traditional healers, which can be dangerous and counter-productive. In addition, since AIDS cannot be cured, these deep rooted spiritual beliefs can make it hard for the infected to understand the concept of disease control rather than curative treatment. According to Ehlers, "this is a foreign concept to many African people who consider illnesses to be attributable to specific causes which get cured by addressing the identified causes" (2006, p. 659). Traditional spiritual beliefs also make it hard to understand the immunological

system and how it can become so severely compromised by HIV/AIDS. It makes sense that some may have difficulty comprehending “why sexual abstinence or the use of condoms could prevent deaths from [opportunistic diseases such as] tuberculosis or pneumonia; without any apparent connection between sexual intercourse and the chest” (Ehlers, 2006, p. 659). Many traditional healers share this point of view and therefore do not treat the real pathophysiology behind the disease. Healers often aim to correct or reverse the witchcraft, taboo or social norm they believe was violated, therefore resulting in HIV infection (Ehlers, 2006). Nurses can play a vital role in educating both the healers and the patients of what HIV/AIDS is and is not. By understanding the pathophysiology of HIV/AIDS, the disconnect of accurate HIV information can be corrected.

All nurses have a responsibility to their patients to provide some degree of emotional support, but when dealing with HIV/AIDS patients, that responsibility is nearly as important as providing physical and medical support. Emotional support in this context includes helping the patient develop strategies to deal with the stigma and fear of this terminal illness. Nurses can accomplish this because “[they] have the most frequent interaction with HIV-infected clients and can provide crucial assistance to clients in developing positive coping strategies to deal with the psychological challenges of illness and the stigma associated with this particular disease” (Sowell & Phillips, 2010, p. 394). One HIV positive patient reported that the emotional suffering he felt was comparable to the physical pain of the end stages of his disease (personal communication as cited in Sowell & Phillips, 2010). Nurses have more time to address these issues than physicians and are trained to provide emotional support. Even with minimal mental health training, nurses “have a unique opportunity to influence the trajectory of HIV/AIDS through counseling and interventions that address HIV/AIDS stigma with clients, communities,

and society” (Sowell & Phillips, 2010, p. 394). HIV positive people often deal with intense feelings of shame and unworthiness, which nurses can help overcome by supportive counseling in collaboration with other mental health professionals. Nurses are responsible for caring for their patients holistically, which includes supporting their emotional needs as well.

An additional responsibility of these nurses is to be advocates for their patients and be involved in the policy formation on both the local and governmental level. Studies have shown that “the participation and contribution of nurses to the political process at a national level, where decisions and policies affecting their welfare and practice are made, is critical for effective implementation of policy” (Phaladze, 2003, p.23). African nurses tend to be a more submissive type, and on the rare occasion that they are included in the policy formation process, do not contribute much (Phaladze, 2003). Both nurses and policy makers share the blame in this situation. However, strides are being made to include more front-line health care providers in the policy formulating process. One example of this is the Southern Africa Development Community AIDS Network of Nurses and Nurse-Midwives (SANNAM). This group is continually involved in active partnership with many facets of policy forming and aims to collaborate, understand and act upon the challenges facing nurses and the health care system alike (Anonymous, 2006). With increased participation in groups such as this, nurses can act as better advocates for their patients and for themselves.

Any health program is not complete without a nurse, this is especially true with HIV prevention programs in Sub-Saharan Africa. These nurses have normal nursing roles to fill, but they also have additional duties to perform. The extra duties include prevention education, correcting information gaps in traditional healing practices, providing emotional support, and

being a patient advocate in politics and policy formation. Nurses in this situation are in the prime position to make an enormous impact on the health behaviors of their clients.

Conclusions

In the past twenty years, HIV/AIDS has ravished the world, brutally ending millions of lives. The only way to stop this from continuing is to prevent HIV transmission. In Uganda, many factors have played into the success of its prevention campaigns. After witnessing Uganda's successfulness, it seems as if Zimbabwean government tried to take the ABC program and implement it without tailoring it to the specific needs of their people. Factors such as stigma, low self-efficacy, and gender inequality could be playing a much larger role in Zimbabwe's inability to create successful prevention programs than originally thought. Although HIV infection rates have dropped dramatically after a decade of intense global prevention efforts, now is not the time to stop. Treating HIV/AIDS with ARVs is not going to stop the epidemic. Only focused prevention will save millions of lives from the painful and excruciating death that is AIDS. There is a lot of work to be done on the HIV forefront in Sub-Saharan Africa, but especially in Zimbabwe. Nurses can play a vital role in this fight against the transmission of HIV as they have the training to help heal both body and mind, and the drive to transform their culture to make positive health behavior changes. A united, cohesive, holistic approach to restraining this epidemic is the only thing standing between millions and their premature death.

“Overcoming poverty is not a gesture of charity. It is an act of justice. It is the protection of a fundamental human right, the right to dignity and a decent life. While poverty persists there is no true freedom. Do not look the other way. Do not hesitate. Recognize that the world is hungry for action, not words. Act with courage and vision. Of course the task will not be easy.”

-Nelson Mandela

References

- Anonymous. (2006). Success story: The SADC AIDS network of nurses and midwives. *The Canadian Nurse*, 102(2), 13.
- AVERT. (2011a). HIV and AIDS in Zimbabwe. In *AVERTing HIV/AIDS*. Retrieved February 11, 2012, from <http://www.avert.org/aids-zimbabwe.htm>
- AVERT. (2011b). World Statistics. In *AVERTing HIV/AIDS*. Retrieved February 13, 2012, from <http://www.avert.org/worldstats.htm>
- BBC News. (2006, April). Zimbabweans have 'shortest lives'. In *Africa*. Retrieved February 28, 2012, from <http://news.bbc.co.uk/2/hi/africa/4890508.stm>
- Duffy, L. (2005). Culture and context of HIV prevention in rural Zimbabwe: The influence of gender inequality. *Journal of Transcultural Nursing*, 16(1), 23-31.
doi:10.1177/1043659604270962
- Ehlers, V. J. (2006). Challenges nurses face in coping with the HIV/AIDS pandemic in Africa. *International Journal of Nursing Studies*, 43(6), 657-662.
doi:10.1016/j.ijnurstu.2005.11.009
- Fournier, B., Kipp, W., Mill, J., & Walusimbi, M. (2007). Nursing care of AIDS patients in Uganda. *Journal of Transcultural Nursing*, 18(3), 257-264.
doi:10.1177/1043659607301301
- Green, E. C. (2003). *Rethinking AIDS prevention: Learning from successes in developing countries* (pp. 141-253). Westport, CT: Praeger Publishers.
- Gregson, S., Adamson, S., Papaya, S., Mundondo, J., Nyamukapa, C., Mason, P., & Garnett, G. (2007). Impact and process evaluation of integrated community and clinic-based

- HIV-1 control: a cluster-randomised trial in eastern Zimbabwe. *PLoS Medicine*, 4(3), 545-555. doi:10.1371/journal.pmed.0040102
- Gregson, S., Nyamukapa, C., Schumacher, C., Mugurungi, O., Benedikt, C., Mushati, P., & Campbell, C. (2011). Did national HIV prevention programs contribute to HIV decline in Eastern Zimbabwe? Evidence from a prospective community survey. *Sexually Transmitted Diseases*, 38(6), 475-482.
- Halperin, D. T., Mugurungi, O., Hallet, T. B., Muchini, B., Campbell, B., Magure, T., & Benedikt, C. (2011). A surprising prevention success: Why did the HIV epidemic decline in Zimbabwe? *PLoS Medicine*, 8(2), 1-7.
- Holzemer, W. L., & Uys, L. R. (2004, November). Managing AIDS stigma. *Journal of Social Aspects of HIV/AIDS*, 1(3).
- Kibuka, R. D. (2011, December 13). An alternative policy response to Uganda's economic challenges. *The Independent*, pp. 1, 6.
- Kuhanen, J. (2008). The Historiography of HIV and AIDS in Uganda. *History in Africa*, 35, 301-325.
- Mullan, Z. (2008). Uganda: Losing its grip on HIV/AIDS? *The Lancet Infectious Diseases*, 8(8), 471. doi:10.1016/S1473-3099(08)70170-1
- Nhamo, M., Campbell, C., & Gregson, S. (2010). Obstacles to local-level AIDS competence in rural Zimbabwe: Putting HIV prevention in context. *AIDS Care*, 22(2), 1662-1669. doi:10.1080/09540121.2010.521544
- National AIDS Council. (2006). HIV and AIDS in Zimbabwe situation and response analysis. In *Zimbabwe National HIV and AIDS Strategic Plan*. Retrieved March 13, 2012

- Parkhurst, J. O. (2010). Evidence, politics and Uganda's HIV success: Moving forward with ABC and HIV prevention. *Journal of International Development*, 23(2), 240-252. doi:10.1002/jid.1667
- Phaladze, N. A. (2003). The role of nurses in the human immunodeficiency virus/acquired immune deficiency syndrome policy process in Botswana. *International nursing review*, 50(1), 22-33.
- Rule, S. (1987, November 1). Frank talk on AIDS brings praise for Uganda. *The New York Times*.
- Slutkin, G., Okware, S., Naamara, W., Sutherland, D., Flanagan, D., Carael, M., & Blask, E. (2006). How Uganda reversed its HIV epidemic. *AIDS and Behavior*, 10(4), 251-360. doi:10.1007/s10461-006-9118-2
- Tick, E. (2007). Zimbabwe: light from darkness. *The Journal of Science and Healing*, 3(6), 613-615. doi:10.1016/j.explore.2007.09.008
- UNAIDS. (2011). Data and analysis. In *Joint United Nations Program on HIV/AIDS*. Retrieved February 13, 2012, from <http://www.unaids.org/en/>
- Wilson, D., Sibanda, B., Mboyi, L., Msimanga, S., & Dube, G. (1990). A pilot study for an HIV prevention programme among commercial sex workers in Bulawayo, Zimbabwe. *Social Science Medicine*, 31(5), 608-618.
- World Health Organization. (2004). "Three Ones" agreed by donors and developing countries. In *The 3 by 5 Initiative*. Retrieved March 16, 2012, from <http://www.who.int/3by5/newsitem9/en/>