

# ELEVEN

## HIV/AIDS in Africa

*Contradictions, Controversies, and Containment*

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### INTRODUCTION

HIV/AIDS in Africa presents a very complicated picture because of its unique characteristics and the difficulty of fully understanding its etiology, courses, and impact on people and their communities. Persistent contradictions are evident in the conflicting views on circumcision, homosexuality, and sex education. Similarly, pervasive controversies are exemplified in different views of HIV/AIDS funding, the value of social media, and the new environment of complacency.

However, there is abundant hope on account of the significant positive results from effective uses of anti-retroviral (ARV) treatments that underline the unfolding expectations that the disease can now be checked. In the final analysis, the challenges of African HIV/AIDS healthcare are part of the global healthcare management system. Sustainable development of Africa is inextricably linked to the success of African healthcare management.

The pandemic poses challenges for effective healthcare management, with the attendant intercultural dissonance and its tripartite characteristics of contradictions, controversies, and containment. Globally, healthcare management is facing serious challenges of funding, public education, behavioral change, and resistant cultural practices, all of which are implicated in the global AIDS phenomenon and its containment. These apply with force and potency in Africa, where HIV/AIDS continues to be

an ever-present danger to individuals, communities, and nation states. It is one of the greatest threats to the development of sustainable economies and one of the biggest drains on healthcare resources across the continent.

The full extent of its deleterious consequences extends beyond its toll as an incurable viral pandemic. It wreaks havoc through loss of trained personnel, strains the public health and education systems, reduces local productivity, and contributes to the continent's pervasive negative image. The pandemic continues to be a serious threat to the sustainable development of the continent and presents many difficulties in diverse areas for personal and national well-being. Prewitt (1988, p. ix) rightly noted that "even these many development-related difficulties do not exhaust the harm being visited on Africa by AIDS."

HIV/AIDS made its historic appearance in Africa in the early 1980s, when it was regarded as the "mysterious disease," with strange symptoms. Its mystique has never diminished, even after more than three decades of grappling with its etiology. Even when HIV/AIDS manifests differently in different regions of the continent, it is interculturally dissonant in the sense that awareness or knowledge of it does not accord with expected behavior. Higher levels of knowledge do not guarantee lower rates of infection. Although considerable progress has been made in HIV/AIDS healthcare management in Africa, much of what is known can best be characterized as contradictory because of conflicting views, and widespread disagreements about funding for its treatment. Healthcare planners cannot seem to agree on the best ways to manage the phenomenon. There are, however, some silver linings in the sky, arising from stabilization and containment measures that are yielding positive results in AIDS healthcare management. Largely, the good news has to do with treatment therapies and changing social values.

In this chapter, we describe the variegated nature of the pandemic and illustrate its contradictions and controversies, even when the situation holds good promise for containment. The disastrous effects of the pandemic in Africa are not in doubt, nor are its implications as a drain on healthcare resources.

#### HIV/AIDS IN AFRICA: TRIPLE DISASTER

The global HIV/AIDS phenomenon takes on a uniquely more sinister and pernicious garb in Africa than on any other continent, not only in its unparalleled ravaging nature but also in the way it catalyzes other health problems. The pandemic provides fodder for Africa's detractors who are ever so eager to find cause to castigate the continent for the disastrous consequences. Indeed, it is more than a simple disaster. Prewitt (1988, xi)

referred to AIDS in Africa as a triple disaster which provides unwarranted justification for some of the continent's detractors:

There is the tragedy of the disease itself, the human suffering, and death. There is [sic] the multiple ways in which AIDS complicates the already daunting development problems facing the continent and threatens to reverse hard-won advances. Finally, the special characteristics of AIDS—its mysterious origin, its resistance to biomedical treatment, its association with social deviance and its hint of exotic behavior—provide a ready justification for those who would just as soon not be bothered by Africa, its need for international aid, and its development difficulties.

HIV/AIDS in Africa is not only a triple disaster but also a very complicated healthcare and socio-cultural problem. The complexities are underscored by the dauntingly high prevalence of the infection; the full demographic impact on women, children, and young adults; the varying rates of infection in different countries and regions; and the different responses by national political leadership, among other groups involved. The healthcare impact of AIDS in Africa is tremendous and further complicated because the compromised immunity leads to greater incidence of other diseases such as malaria, tuberculosis, respiratory infections, diarrhea, pneumonia, and sexually transmitted diseases.

#### AFRICA AT RISK: PREVALENCE

The average adult HIV prevalence in Africa is 4.6 percent, which is significantly higher than the global prevalence of 0.8 percent (WHO 2013b). By 2011, an estimated 23.5 million people who were living with HIV resided in Sub-Saharan Africa, constituting over 69 percent of the global HIV burden. The continent also accounted for 92 percent of the pregnant women living with HIV and 90 percent of children who acquired HIV in 2011, according to UNAIDS (2012a).

Swaziland had the highest HIV prevalence, at 26 percent of the population, in the world as of 2011. That year, South Africa, which is in the same region with Swaziland, had the world's largest national population of people living with HIV (5.6 million) and a prevalence rate of 17.3 percent (UNAIDS 2012a, 2012b). Africa, especially the countries of the Sub-Saharan areas, have been at greatest risk on account of the high prevalence rate and the devastating demographic, social, and economic consequences of the pandemic. This large continent stands alone at the front of the global HIV battle (DeCock, Mbori-Ngacha, and Marum 2002; Rugalema 2000; Whiteside 2002). This unparalleled severity has led many to conclude that, but for Africa, the global HIV/AIDS pandemic "would still be tragic but substantially less important" (DeCock, Mbori-Ngacha, and Marum 2002, 68).

The situation of high prevalence is made worse by the tragic incidence of new cases, especially among children and other members of vulnerable groups. In such countries as Angola, DR Congo, Equatorial Guinea, and Guinea-Bissau, cases of new HIV infections increased between 2009 and 2011, according to UNAIDS (2012a). North Africa, which has fared better than other parts of the continent, reported a 17 percent increase in AIDS mortality and a 35 percent increase in the rate of new HIV infections.

Although new infections are no longer equated with a death sentence, on account of the effects of anti-retroviral (ARV) medications, the unavailability of these treatments among needy Africans heightens the risk for AIDS mortality. About 43 percent of people eligible for ARV medications in Sub-Saharan Africa had not received the proper treatment as of 2011 (UNAIDS 2012a, 2012b). Whereas ARVs are widely accepted in many parts of the world where they are readily available, in Africa, the challenges come from unavailability and also the social stigma associated with being identified as an ARV user and thus a HIV/AIDS case.

Negative social stigma in African communities impedes the effectiveness of ARV interventions and worsens the situation for better management of the HIV pandemic (Rankin, et al. 2005). The fear of social stigma is known to prevent some expectant women from getting HIV testing because a positive test result is tantamount to outright ostracism for themselves and their babies. Fear of social stigma is also responsible for nonuse of condoms among some married couples in Africa (Rankin et al. 2005). In many African communities, it is common for people identified as living with HIV to be isolated by their social networks and even their own families. In some African communities, the entire family may be shunned if one member is infected. There can be serious financial implications because others will not do business with a "HIV-tainted" person. Some families do not list HIV/AIDS as the cause of death in newspaper obituaries (Rankin et al. 2005). It is commonly believed that more than half of people living with HIV in Zambia, Rwanda, and Kenya have experienced verbal attacks by others because of their health status. In Cameroon, 13 percent of people living with HIV have encountered rejections at health services outlets as a result of their HIV status (UNAIDS 2012a). The high prevalence notwithstanding, it is not an entirely hopeless case.

#### HOPE RISING

Even though Africa still hosts more people living with HIV than any other continent, the intervention and education programs launched in the past decades have produced significant and positive results. UNAIDS (2012b) reported that AIDS-related deaths in Africa were successfully

reduced by one-third between 2005 and 2011. The percentage of decline in AIDS-related deaths was observed in most African countries in this six-year period. Some countries dropped the death rate by more than half, as was the case in Botswana (71 percent), Rwanda (68 percent), Namibia (60 percent), Zambia (56 percent), Ethiopia (53 percent), and Cote d'Ivoire (51 percent).

According to UNAIDS (2012b), an estimated 9 million lives have been saved by the more available and affordable ARV medications. The cost of standard ARV was dramatically reduced from U.S. \$10,000 per person annually to about U.S. \$100 in some countries (UNAIDS 2012b). From 2009 to 2011, about 2.3 million people have been added to the HIV treatment programs in Sub-Saharan Africa. Some African countries, particularly Botswana, Namibia, Rwanda, Swaziland, and Zambia, achieved over 80 percent treatment coverage in the targeted population. A significant increase of HIV treatment coverage has been observed in Zimbabwe (118 percent), South Africa (75 percent), and Kenya (59 percent) in recent years (UNAIDS 2012b). This change dramatically ended the HIV-epidemic peak of the late 1990s and significantly improved the quality of life for people living with HIV. Many of them can return to their regular life routines, continue to work, and take care of their families.

New HIV infections in Sub-Saharan Africa reportedly decreased from 2.4 million in 2001 to 1.8 million in 2011, a 25 percent decline. Over this ten-year period, many African countries experienced a sharp decrease in the rate of new infections. For example, the newly infected cases dropped by 90 percent in Ethiopia, 72 percent in Malawi, 71 percent in Botswana, 68 percent in Namibia, 66 percent in Ghana, and 60 percent in Burkina Faso. The rate of new HIV infections dropped by 50 percent to 58 percent in Zimbabwe, Gabon, Rwanda, Togo, Zambia, Djibouti, and the Central Africa Republic. Between 2001 and 2011, a relatively slower pace in reducing new infections has been observed in some other countries, particularly Kenya (32 percent), Mozambique (31 percent), Niger (29 percent), Swaziland (37 percent), and Sierra Leone (37 percent) (UNAIDS 2012a, 2012b).

Other encouraging news on the African HIV/AIDS situation includes the widespread success in reducing the number of children who are newly infected with HIV. In more than twenty African countries, there is a decline in the number of children newly acquiring HIV. In such countries as Burundi, Kenya, Namibia, South African, Togo, and Zambia, the rate of new infections among children has been successfully reduced by as much as 40 percent to 59 percent. This success is largely attributed to the increasing strategic initiatives and healthcare services designed to prevent mother-to-child transmissions (PMTCT). In twenty-one African countries, PMTCT has been extensively integrated into maternal and child healthcare. For example, in Botswana, Ghana, Namibia, South Africa, Swaziland, and Zambia, the PMTCT covered up to 75 percent of the

targeted population by 2011 (UNAIDS 2012a, 2012b). The signs of hope in HIV/AIDS treatment in Africa come, not only from the expanded public education, increasing ARV treatment, and better services to prevent mother-to-child transmissions, but also from increasing investments by individual African countries.

In the past, almost every African country relied nearly exclusively on international donors, but recently, many countries are becoming more self-reliant. South Africa, which has made the largest domestic funding for AIDS in Africa, invested U.S. \$1.9 billion in 2011, a five-fold surge from 2006. Other countries, such as Kenya, Togo, and Zambia, have significantly increased their domestic investment for HIV/AIDS prevention. Most of the expenses covered are for programs in basic HIV prevention and treatment; promoting male circumcision and condom use; enhancing treatment, care, and support for people living with HIV; preventing mother-to-child transmission; and enhancing behavioral changes.

There is no doubt that HIV/AIDS is an ever serious and present danger in Africa. However, there are silver linings in the clouds, which are now leading many to see the situation as reflecting a mixed picture.

#### THE MIXED PICTURE: HALF-FULL OR HALF-EMPTY

Globally, HIV/AIDS remains an evolving mystery in spite of the significant advances in understanding its etiology and seemingly overcoming it, albeit temporarily, with effective ARV treatments. In Africa, it is still wrapped in abundant contradictions and endless controversies, which are punctuated with modest containment. There is no doubt that as ARV programs become more common and affordable, the disease once regarded as always fatal, is increasingly being commonly perceived as a chronic illness, leading many to argue that HIV/AIDS is no longer as readily stigmatized by the society as it used to be.

People living with HIV can live relatively long and stable lives by receiving proper medications, thereby lessening the social stigma associated with the condition. This is true in countries like Brazil (Abadia-Barrero and Castro 2006), but not necessarily in Africa. In Rwanda, for instance, the visible change of body appearance, a side effect of taking ARV medications, can generate social stigma and inhibit medical adherence (Mutimura, Stewart, and Crowther 2007). A longitudinal study that investigated over 1,400 people living with HIV in Lesotho, Malawi, South Africa, Swaziland, and Tanzania revealed that although social stigma declined over time for affected individuals surprisingly, those following the treatment experienced more social stigma over time than people who did not. Thus, as valuable as ARVs may be as containment instruments, they can lead to contradictory and controversial results with regard to

stigma. Thus they demand careful attention from healthcare professionals, especially in treating new patients.

The African HIV/AIDS glass is both half-empty and half-full, as the picture is both disheartening and hopeful and promising. Contradictions are evident in the changing prevalence, the increasing and declining number of cases of new infections, and perceptions of stigma, but especially in the roles of circumcision, homosexuality, and sex education in the African situation. Not to be underrated are the controversies associated with funding, especially the President's Emergency Plan for AIDS Relief (PEPFAR), social media, and complacency. The irony in the contradictions and controversies is made more poignant by the prospects for containment, which find expression in the putative value of ARVs, decreasing incidence of new cases, and Africa's changing social values. The reductions of HIV mortality and new infections definitely provide rising hope. Yet the lags in HIV prevention services and the rise in new HIV cases in some countries lead many to agree that the crisis of HIV/AIDS is not over. It is at best only contained in the face of contradictions and controversies.

#### AFRICAN HIV/AIDS AND CONTRADICTIONS

HIV/AIDS in Africa presents a perplexing picture that is wrapped in perennial contradictions, some of which have proved impervious to resolution and correction. Some of the earliest untruths and misinformation about its true origin, nature, causes, manifestations, and consequences have persisted after over three decades of purposeful public enlightenment by local and international organizations. Some of the issues surrounding HIV infection stand at the confluence of culture, tradition, personal beliefs, religion, morality, and biological or sexual drives. The contradictions associated with HIV/AIDS in Africa are bound to change from time to time and from one region to another.

At this writing, three of the most noteworthy contradictions relate to circumcision, homosexuality, and sex education.

##### *Circumcision*

It is not surprising that circumcision is a contradictory subject in HIV/AIDS discourse in Africa because, whereas it is wholly accepted among some ethnic groups, it is abhorred and derided among others. The situation has become more confusing with recent campaigns against female circumcision while other campaigns are, at the same time, calling for stepping up the practice among all male members in the belief that it can contribute to fewer new HIV infections. Some studies show that, when provided by well trained professionals in safe settings, medical male

circumcision (MMC) potentially reduces sexually transmitted diseases and specifically reduces the risk of contracting HIV in heterosexual men by 60 percent (AVERT 2013). Based on successful randomized studies in Kenya, South Africa, and Uganda, which attested that MMC reduced the rate of HIV contraction by 60 percent, 53 percent, and 51 percent respectively (WHO 2013), the World Health Organization (WHO) and the Joint United Nations Program on HIV/AIDS (UNAIDS) encouraged the scale up of MMC as a preventative strategy against the spread of HIV. Indeed voluntary MMC was encouraged in thirteen African countries, including Uganda, South Africa, Tanzania, Namibia, and Malawi (Hankins, Forsythe, and Njeuhmeli 2011).

However, the seemingly beneficial prevention tool is surrounded by contradictions, and thus has been challenged by scientists, health practitioners, and government officials, among others. Cultural beliefs among some African groups make MMC less attractive, especially in those societies where the practice was traditionally nonexistent. For example, in the Kenyan Luo community in Nyanza province, the region in which the epidemic is most serious (15.3 percent), people who opt for circumcision are ridiculed by their peers. The fear of appearing to be too eager for foreign values has made some elders less supportive, even when they do not oppose it (IRIN News 2012). Respect for traditional values intersects with local politics, ethnic practices, and religion to compound the contradictions associated with circumcision, as is the case in Malawi (Parkhurst, Chilongozi, and Hutchinson 2013). Due to such contradictions, many African countries are reluctant to adopt the practice wholesale.

Nevertheless, such countries as Uganda, Kenya, and Botswana have adopted the practice. The Ugandan National HIV/AIDS Strategic Plan 2011/2012 revealed that 380,000 men had been circumcised by March 2012. The government was determined to circumcise 1 million men every year for the next three years to achieve the target of 4.2 million men (IRIN News 2012).

One contradiction about circumcision is based on the observation that it provides some ill-informed men with a false sense of protection, as they wrongly believe circumcision makes them immune to infection after their operation. The true value of circumcision in the fight against HIV/AIDS is likely to remain contradictory and controversial. For example, Sub-Saharan Africa, where circumcision is common, still has the highest HIV/AIDS prevalence rate in the world, with some countries having prevalence rates as high as 24 percent (AVERT 2013), while Europe, with its lower incidence of circumcision, has lower rates of HIV/AIDS. If circumcision presents a contradictory picture in Africa, so does homosexuality, which is often clothed in a religious and moral fashion.

### *Homosexuality*

There are few issues on which different African countries have more agreement among themselves than the issue of homosexuality. It is massively disapproved of by governments, religious groups, and traditional leaders. Not even civil society and human rights organizations in Africa have risen enthusiastically and potently to the defense of gays and lesbians on the continent. According to Naurath (2007), Africa has the lowest acceptance level of gays and lesbians. When asked if the place they live is good or bad for homosexuals only 8 percent of African respondents answered in the affirmative, while 77 percent said it was not good. In thirty-eight out of fifty-two African countries, homosexuality is illegal (Afro-News 2009), and it is closely associated with immorality and sexually transmitted infections. In such countries as Nigeria and Uganda, the legislative bodies have promulgated stringent laws against homosexuality.

Even though there is no significant association between homosexuality, or men having sex with men, and HIV/AIDS, a combination of opposition from legislators and politicians, disapproval by Christian and Muslim religious leaders, and condemnation by traditional leaders has resulted in an unsafe social environment for gay people in Africa. The pervasive and prevalent negative attitude towards homosexuality in Africa does not necessarily result from fears of HIV transmission. Rather it reflects the people's unwillingness to get in line with the global trend of increasing acceptance of gays, lesbians, bi-sexual, and transgender lifestyles. The situation in Africa requires strategic education and advocacy campaigns, which will not be easy to accomplish because sex education in Africa presents its own contradictions.

### *Sex Education*

In many Western countries, sex education is freely discussed between parents and their young primary school-age children. Many such children are also formally educated on human sexuality as part of the school curriculum.

The situation in Africa is quite different. Parents and teachers seem to believe that what their wards don't know cannot hurt them, and thus parents are averse to providing children with the enlightenment they need about human sexuality. Even into their teen years, many African youths are denied ready access to sex education. According to Biddlecom et al. (2007), about half of fifteen to nineteen year olds in Malawi, Kenya, Burkina Faso, Ghana, and Uganda did not receive sex education. The instruction was not available at home or offered at school, especially for students who dropped out of school before reaching the higher grades. The result is a high level of ignorance about sexually transmitted dis-



eases. UNICEF (2009) reported that in many African countries, although more than 90 percent of fifteen to nineteen year olds have heard of HIV/AIDS, less than 40 percent know how to prevent it or how it is transmitted. Many African youths also are reportedly ignorant of other sexually transmitted infections, with Botswana and Ghana having the lowest level of knowledge. In the absence of a cure for HIV/AIDS, the best defense is effective sex education, which is best initiated before harm is done by ignorance.

Unfortunately, in many African countries and communities, talking to young people about sex and sexually transmitted infections is still taboo. Considerable progress is being made in the education of girls. However, work must continue to break the cycle of ignorant children growing up and continuing the tradition of not talking about sex with their children.

Sex education, when properly planned and successfully implemented, can be an effective tool in checking unhealthy sexual conduct among various community members of all demographic groups. Comprehensive sex education is effective in improving knowledge and reducing risky sexual behaviors. It does not necessarily increase sexual activity of which the community disapproves. Adolescents and young people are less likely to be vulnerable to HIV when they are offered relevant, gender-sensitive prevention information, skills and services in an enabling, protective environment.

Education, especially sex education, is the primary tool that can directly address the increasing incidence of new HIV/AIDS infections among the youth. The value of sex education is not limited to young people and can be one of the best approaches to addressing the increasing incidence of discordant couples. The traditional silent approach contradicts scientific knowledge and popular belief in the power of knowledge to redress problems. These contradictions are all part of the mystique surrounding HIV/AIDS in Africa. They are made even more mysterious by insidious controversies.

#### AFRICAN AIDS AND CONTROVERSIES

If there are contradictions in our approach to the HIV/AIDS pandemic in Africa, there are also controversies in the way HIV/AIDS is discussed. This contributes in no small way to some current challenges. The very nature of the affliction is controversial, and there is less than unanimous agreement about its origin. Views change from time to time, and at this writing, funding, new social media, and complacency appear to be driving the controversies. These shall have far-reaching consequences on how the pandemic is contained in Africa. Of the three controversial elements, funding appears to be the most critical, as it could have significant im-

pacts on how the new social media are used as well as the effects of the broader mass media.

#### Funding

In a sense, there is a feeling of euphoria about HIV/AIDS in many parts of Africa because of the increased availability of local and external funding. It is now possible to extend ARVs to many HIV/AIDS patients in need. The Global Fund to Fight AIDS, Tuberculosis, and Malaria and PEPFAR are two of the most popular current funding sources. These two alone have radically changed the public perception of HIV/AIDS from an irreversible death sentence to a life-long health condition. Both provide financial resources to support treatment and care for people living with HIV, tuberculosis, and malaria. PEPFAR, which was established in 2003, during the George W. Bush presidency in the U.S., is one of the best legacies of the Bush administration and has endeared the U.S. to the African focal countries that have benefitted from this unusual generosity. The Global Fund was established in 2002 and has provided a dramatic increase in resources for the fight against the three pandemics.

Both Global Fund and PEPFAR have been very successful. In 2012 alone, 11 million pregnant women received HIV/AIDS testing and counseling due to PEPFAR. As a result, 230,000 children were born HIV free. Worldwide, approximately 9.7 million people were receiving compassionate care by 2008 and almost 2 million Africans had access to ARVs (PEPFAR 2012).

These achievements have not prevented rampant criticism and incipient controversies to follow the funds through parts of Africa. Among other things, receiving outside money might establish a culture of begging and dependency. Unilateral conditions unfavorable to African groups might also lead aided countries down the slippery road of perpetual indebtedness, laziness, poverty, higher inflation, and continuing dependency.

Some aspects of foreign funding are said to be responsible for the significant improvements in keeping more HIV/AIDS patients alive and looking healthier than would have been the case. By giving them a life line, literally in some situations, a false impression is created in some quarters that HIV/AIDS is no longer a mortal danger. Some are led to be less risk averse and to engage in more dangerous sexual conduct. In Uganda, abstinence-only campaigns as a result of PEPFAR have been blamed for HIV/AIDS infections, which had been reduced from 15 percent down to 5 percent by 2001. They had inched up to 7.3 percent a little over a decade later (Uganda Ministry of Health and ICF International 2012).

Yet another controversy is based on the unpredictable nature of foreign aid, which often depends on the internal financial and economic

policies of donor countries. The outlook for increased foreign aid, including funding for global health programs, will be affected adversely by the challenges of balancing the U.S. federal budget. When the U.S. Congress enacted the Leadership Act (for PEPFAR) in 2003, the mood regarding foreign assistance was different from the national mood in 2013, when the emphasis appeared to be more on budget cuts, sequestration, and foreign debt reduction.

No doubt, some of these controversies are based on half-truths and incomplete information that need open, aggressive, and strategic communication to correct. Both Global Funds and PEPFAR are engaging in robust public enlightenment through the mass media to make their stakeholders more appreciative of their work. Both traditional and new media have critical roles to play in HIV/AIDS healthcare management in Africa. Interestingly, the new social media are becoming more commonplace throughout the continent and should contribute to the improved public enlightenment about HIV/AIDS. Unfortunately, some of the new social media have become controversial.

#### *Social Media*

Mass communication in Africa today is a far cry from William Hachten's (1971, p. xiii) characterization of it as diverse and astonishing. He saw it then as "... a Sudanese camel driver jogging along listening to Radio Cairo on a small transistor radio; a Ghanaian civil servant reading the *Daily Graphic* while drinking a shandy at Accra's Ambassador Hotel; a Wolof man sitting with a group of his fellow Senegalese watching an experimental television program in Dakar." Today, the Sudanese is more likely to be watching Aljazeera by satellite from Doha, Qatar. The Ghanaian may be reading *Newsweek* Magazine online at home, and the Senegalese may be listening to Radio France International on his mobile phone. Even in Africa, it is a brave new world of new media.

Such is the pervasiveness of the global media, that there is no true distinction between national (local) and international (foreign) communication. Similarly, the new social media can be both local and global at the same time. Whatever social media tools and methods are available today in Western industrialized countries are also available and useable in the industrializing countries of Africa. Blogs, Facebook, Pinterest, and YouTube, among the many social media options, are veritable tools for HIV/AIDS prevention. They are ideal for mobilizing, engaging with, educating, and empowering young people (Sidibe et al. 2012). As Cameron et al. (2013) found, social media can be effective tools for addressing a variety of public health related problems in which communication and awareness are crucial objectives. It is in this regard that a new Facebook application has been designed to help people in need of organ transplants to

raise awareness about their condition and to ask for possible donors (O'Reilly 2013).

Although the many benefits of using social media in strategic HIV/AIDS communication are undeniable (Moore 2012; UNAIDS 2011), controversies swirl around the practice. In some of Africa's big cities, adventurous men and women now use social media to arrange and engage in high risk sexual escapades that portend grave consequences for HIV/AIDS and other sexually transmitted infections. One such forum is "No Strings Attached.com" (NSA), which has operations in Kenya, South Africa, and Uganda, with plans for further expansion to other African countries. Its modus operandi is to use a social media outlet to facilitate engagement in casual sex among strangers, who make no commitment or intend to ever meet again. The new social media in Africa, on their face, may appear to be the same as what has happened with new media in other parts of the world. In reality, the media in Africa are part of the continent's social landscape, and thus are taking on uniquely African cultural colorations. Only time will tell whether the new wine of social media can keep well in the old wine skins of traditional African culture. For now, the controversies that accompany use of the new social media as tools for HIV/AIDS communication in Africa are persistent and enduring. By their innovative and flippant nature, the new media in Africa tend to create a lackadaisical mood. For right or wrong reasons, they are accused of contributing to the perception, which is gaining ground in many areas, that AIDS and the diseases associated with it are no longer so deadly.

#### *Complacency*

Part of the mystique surrounding HIV/AIDS in Africa is how easily seemingly good developments, such as a positive funding climate or the availability of new social media, can become negative forces or turn into controversies. Such is the case with the current situation of reduced death from HIV/AIDS due to the successes of ARV treatments and public health education campaigns. In many African countries, cardio-vascular disorders (CVDs) are on the rise and are seen to be more dangerous than HIV/AIDS. The perception of HIV/AIDS has changed from an "instant killer" disease to a manageable health condition.

Ironically, because of the efficacy of Highly Active Antiretroviral Therapy (HAART), HIV/AIDS complacency is on the rise (Mackellar et al. 2011). Complacency is not peculiar to Africa. A recent United Nations annual AIDS epidemic update has shown that the increase in new infections is expected to rise to 5.3 million worldwide (Moulson 2012).

Complacency is partly responsible for the variegated nature of new infections in Africa, where some countries are still in grave danger while others have stabilized. According to the Uganda Ministry of Health and ICF International (2012), new infection rates had risen in that country

from 124,000 in 2009 to 128,000 in 2010 and 145,000 in 2011. Rising infections despite ongoing prevention efforts demand the search for vigorous and dynamic prevention strategies that address complacency.

Treatment may be available, with a possibility to live longer, but people living with HIV/AIDS generally experience a low quality of life. HIV/AIDS causes significant life changes, many of which are not easy to adapt to. Among other effects are anemia, diarrhea, nausea and weight loss, resistance to medication despite good treatment options, and the risk of contracting different strains of the virus (AVERT 2013).

Information on HIV/AIDS is readily available, but much of it may not be wholesome. The Internet and the other new social media tools are good platforms for prevention messages, but as noted above, they can contribute to complacency especially where there are no authoritative gate-keeping checks and controls. The best medicine against complacency is persistent communication to reiterate and reinforce the message that the battle with HIV/AIDS is not over. It is only contained for now. The preceding sections have shown that the problems of HIV/AIDS in Africa are compounded by contradictions and controversies. Now we will show that all hope is not lost, as the situation increasingly reflects our ability to contain the syndrome of diseases.

#### HIV/AIDS IN AFRICA: CONTAINMENT

The enormous amount of resources expended on HIV/AIDS treatment and education in Africa has resulted in significant progress in the fight against the disease and has led to a state of containment of the pandemic. Talk of a cure for the HIV virus is premature and the hope for a vaccine has not materialized, yet the achievements in containment are undeniable. Referring to the progress made in the last decade worldwide, including in Africa, Simon Bland and Mphu Ramatlapeng (2013, p. 5), as board chair and board vice chair of the Global Fund, noted that "few would have imagined back in 2002 that we would have been able to successfully save millions of lives and prevent millions of infections and that we would bend the curve by halting and reversing the spread of each of these diseases" (i.e. AIDS, tuberculosis, and malaria).

The outlook for successful management of HIV/AIDS in Africa is better now than at any time in the history of the pandemic because of a combination of positive forces that include local and international results-based funding, effective partnerships among program planners and implementers, involvement of local constituents, constant learning, and local/national public leadership.

Caldwell and Caldwell (1994, p. 214) referred to the Sub-Saharan HIV/AIDS epidemic as "an extraordinary phenomenon" because, "apart from some continued infection through blood transfusions, the epidemic is

sustained almost wholly by heterosexual vaginal intercourse, . . . [and] an AIDS epidemic unsupported by intravenous drug injection or homosexual, bisexual, or heterosexual anal sex is itself unique." This unique blessing has contributed in no small measure to the prevailing state of containment. The known causes of HIV/AIDS in Africa make it easier for preventive actions and strategies to be promoted among the populations at greatest risk, thereby enhancing the opportunities for better containment. HIV/AIDS containment has also benefitted from the ongoing social changes in African societies. Africa is a continent on the move, and at the same time is experiencing rapid changes in obvious and indiscernible ways. The changes are in areas ranging from government and politics to the acceptance of new values and ideas. As Berman (2013, p. 9) noted in his book, *Success in Africa*, in spite of the news media's penchant for reporting about famines and hunger in Africa while the entertainment industry builds "a fortune depicting Africa as a place for happy animals and miserable people," there is a new Africa of positive social change.

#### CHANGING SOCIAL VALUES

African social values and belief systems are changing fast because of the historical and ongoing encounters with Western culture. As Caldwell, Orubuloye, and Caldwell (1994, p. 233) explained, "African society and its belief systems have probably been changing more rapidly than is the case for any other major society."

These changes do not mean wholesale jettisoning of African tradition and past. In many cases, the traditional is situated side by side the modern in a creatively integrative manner. In a large number of African communities today, many erstwhile dangerous and risky behaviors and practices are being modified; some of these have implications for HIV/AIDS management and containment. Among these are early marriages for girls, wife or widow inheritance, female circumcision, and the non-education of the girl child. Family sizes, child spacing, polygamous marriages, and gender relations are some of the areas where globalization and new ideas from international development agencies have made a significant impact on African traditional values and practices. Advances in these areas are leading to improved empowerment of women, human rights, and gender equity. Many of these changes are leveraged by international organizations through their universalistic development programs, such as variegated support for the Millennium Development Goals (MDGs).

The health and education MDGs are especially providing a new sense of urgency and greater impetus for development in health and education all across Africa, even if some of the goals may not be realized in many countries by the deadline of 2015. Across the continent, new values and



practices congruent with expectations for societal improvements and economic development are increasingly being adopted. Improvements have come in such areas as reduced infant and child mortality, declining family size aspirations, and renewed momentum towards better health practices. These improvements indicate a brighter future for healthcare management in Africa and are contributing in no small way to better health for all in general and better containment of HIV/AIDS in particular. These achievements notwithstanding, there are still serious challenges for healthcare in Africa.

### HEALTHCARE MANAGEMENT CHALLENGES

HIV/AIDS in Africa is necessarily part of the global public healthcare management challenges. The survival of human civilization is completely dependent on our ability to successfully manage conditions in the international community. Africa is an important part of that community on account of its size, population, and proclivity for health hazards. HIV/AIDS healthcare in Africa is a necessary part of global public health, which Stone (2012, p. xxi) has explained in terms of collaborative efforts of strategic analyses and responses or interventions that transcend boundaries and address "public health problems confronting all the people of the world." AIDS in Africa cannot be isolated from global public health.

In Africa, the pandemic presents unique challenges that are compounded by the peculiar nature of the disease, the difficulty in determining how extensive it is, and the probable socio-economic and political impact. Even with the combined funding support of local and international partners, it is impossible to determine what levels are adequate to meet the needs for prevention and successful treatment.

Much progress has been made in learning about HIV/AIDS in Africa. However, the true incidence and nature of the illness still elude researchers and healthcare managers because of how sexual matters and private healthcare issues are treated in many traditional communities. Thus, over thirty years after the first cases of HIV were reported in Africa as "Slim's Disease," we still face conspicuous ignorance, conflicting points of view, unresolved controversies, and exaggerated or underestimated prevalence rates.

Poverty and political leadership complicate AIDS healthcare management. Although Africa is experiencing rapid growth in many areas, poverty is still endemic. The continent has some of the poorest countries in the world and poor people are at greatest risk for HIV/AIDS. Poverty is worse because bureaucratic political leadership in Africa serves as a catalyst for corruption, civil strife, and other social crises.

Fortunately, there are evident signs of political, economic, and social development that provide rays of hope. Many African countries are be-

ginning to pay more attention to healthcare issues, realizing that, without good health, a society cannot develop. It is becoming clearer to many that the continent's future is inextricably linked to its healthcare management, especially containment of HIV/AIDS.

### CONCLUSION

News about the discovery of "cures" for AIDS have served as a beacon of hope for combating the deadly complex of diseases, that has taunted the science community for over three decades. In July of 2013, two male AIDS patients in the U.S. were reported to be HIV-free after receiving bone marrow transplants. The virus didn't return, even after they stopped receiving treatment for a few weeks (Herper 2013). Early in the same year, an American infant was reported to be functionally cured of HIV by immediate and intensive treatment after birth. The baby had stayed free of HIV ever since (Pollack and McNeil 2013). Based on a UNAIDS report (2012b), in 2011, more than half a million fewer people died of AIDS than in 2005. This is largely due to the more affordable ARV treatment for people living with HIV.

Anecdotes and preliminary reports like these can easily raise people's hope that this may be the end of the incurable-HIV era. Besides, the decreasing incidence of new infections worldwide and the rapid growth in ARV coverage strengthens expectations for an AIDS-free generation. However, some experts are quick to caution: Not so fast—AIDS is not over (Sidibe, Piot, and Dybul 2012, p. 2058).

Globally, HIV/AIDS is still a big health burden to many countries. An estimated 34 million adults and children worldwide were living with HIV in 2011. Worldwide, the death toll was 1.9 million in 2001 and 1.7 million in 2011 (WHO 2013a). Africa, especially Sub-Saharan Africa, is significantly affected (UNAIDS 2012a). In the past decade, HIV intervention programs have achieved notable improvement in reducing mortality and diminishing new infections, yet many countries still face severe threats. Without a cure or a vaccine, HIV/AIDS will continue to cause serious setbacks in global healthcare management.

The situation in Africa is not helped by contradictions and controversies about the pandemic. The final picture that emerges combines conflicting views with controversies, in the face of a healthy dose of containment. These challenges for healthcare management suggest that, in the next several decades, the path to successfully combating HIV/AIDS in Africa will remain convoluted, complex, tasking, and tortuous. Africa, which is home to about 1.03 billion people, will remain unique in the global battle against HIV/AIDS.

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