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HIV/AIDS In Sudan; The Forgotten Crises

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Introduction:

Sudan has the highest HIV/AIDS prevalence among countries in the Middle East ranging from 0.7 to 7.2%. Estimated people living with HIV are estimated to be 600,000 (this is data figure is from 2003). Sixteen out of every 1000 Sudanese people are now living with HIV/AIDS. The spread of the epidemic started in Sudan in the 1980s was first announced by the ministry of health .The first AIDS case was reported in 1986. HIV/AIDS prevalence was low in the 1980s but a rapid increase brought it to an estimated 2.6 percent among the adult Population in 2002 and an overall prevalence of 1.6 percent in the general population (SNAP 2005). Study among women for ANC in Juba have shown prevalence exceeding 3 percent in 1998 and another study in IDP Camps in Khartoum state estimated a prevalence of 5 percent , In addition high rates have been reported among vulnerable groups with high risk behavior, such as prostitutes (5%), ladies selling Tea Sellers (2.5%), Refugees (4%) and Street children (2.5%). Since no routine surveillance exists in rural areas, the trend of HIV/AIDS prevalence in these areas is difficult to estimate (WHO, 2004). There is not enough information so it is difficult to estimate prevalence of HIV/AIDS and the reasons behind that in different areas. In the south the difference exists because the civil war in the south has led to the collapse of the social, economic and health infrastructure leading to pockets of high prevalence in certain areas (SNAP 2005).

The aim of this paper is to provide information and give direction to policy makers regarding the relative importance of allocating more resources to prevention of HIV AIDS in Sudan in comparison to treatment. The paper also aims to formulate recommendations for policy makers regarding HIV/AIDS issues in Sudan.

The methodology applied to collate this paper is review of literature. Literature has been searched through documents on HIV/AIDS from different countries. Electronic and manual search has been done. Searched Pub Med, Google Scholar; systematic review of available literature; Experience from the field and observations have been used when necessary. Using the key words HIV, AIDS, HIV in combination with each of the terms: Prevention, HAART, Equity, cost effectiveness, politics and Sustainability, etc.

The prevention Strategies that I will talk about in this paper are: ABC, Voluntary counseling and testing, Prevention of mother –to-child transmission, STI mass treatment for general population, STI management for sex workers and blood screening, that is according the prevention methods adopted by Sudan National AIDS program (SNAP 2005).

HIV/AIDS Prevention verses Treatment:

HIV interventions (prevention and treatment) in Sudan should be given priority because Sudan is a signatory on many declarations globally and also within Africa. One of these is Declaration on Commitment to HIV/AIDS adopted by United Nations General Assembly Special Session in June 2001. This declaration commits Member States and the global unity to taking strong and immediate actions to address the HIV/AIDS crisis (SNAP 2005).

Sudan also participated in the Millennium summit in September 2000 became signatory on Millennium Development Goals which calls for combating and reversing the spread of HIV/AIDS by 2015(PANOS , 2003), (Hecht R 2006), In Abuja the African leaders including Sudan have committed to allocating at least 15% of their national budgets to the health sector to assist in the fight against HIV/AIDS (Piot P, 2001). The declarations have put general strategies and goals to be achieved however have left countries to choose and decide on the approach. Countries have to decide on prioritizing for either the preventive or treatment approach (SNAP 2005).

HIV/ AIDS program is difficult to continue without the political support, "Leadership by Governments in combating HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community and the private sector Leadership involves personal commitment and concrete actions", (UN 2001).

In terms of cost – effectiveness prevention is at least 28 times more cost effective than highly active antiretroviral therapy in other words the ratio between the cost effectiveness of HAART and of prevention is US$350:US$12.5 per DALY .this means that for every life year gained by treatment 28 life years could have been gained by prevention . (Marseille et al 2002).

In another different study it has been revealed that a case of HIV/AIDS can be prevented for $11 and it is also possible to gain DALY for $1; by insuring blood safety and also by targeted condom distribution. Using of the HAART as prevention method, mainly to reduce mother to child transmission, and the voluntary counseling and testing cost all together about $75 per DALY,(Creese et al 2002).

Other interventions considered more cost effective compared to treatment include Formula feeding for infants (Creese et al 2002). One study considers blood screening and STI control for sex workers as the most effective preventive intervention costing around $3.35 and $3.95 per LYS. The least cost effective program is the MTCT using the AZT, which costs $213.66 per LYS however it is still four times more cost effective compared to ARV treatment which costs 857.95 per LYS. If all the prevention strategies are implemented it would save roughly 45 times as many life years as ARV therapy with donated drugs (Maski et al 2003).

Prevention also benefits in acceptability and adaptability of the Equity prevention methods since these interventions are relatively easy to adapt to different cultures and religions. This is because the prevention methods are many types and we can easily choose the method that best suits certain group or religious groups (UNAIDS, 2005). For example if the condom use is a problem for certain communities we can promote for

abstinence or faithfulness to one partner. Also in conservative communities we can easily implement the intervention of certain sensitive methods (Condoms) to certain groups with high risk behavior IEC and education for HIV can be done through the use of local culture and the religious value in certain communities can be used to advocate for HIV (Ruxrungtham K 2004). If we compare this scenario to treatment then it is clear that treatment regiments cannot be made culturally appropriate or substituted by other alternatives.

Prevention interventions are less marked with problems related to equity (Farmer 2001), because of the mass approach and every body in the community is targeted however ARV is only directed to those who voluntarily attend or come for services and in male dominant societies like Sudan women are less likely to make decisions to seek voluntary testing, counseling and treatment(UNAIDS, 2005)

Preventive interventions produce impact on the longer run for the epidemic. The literature and documented experience of other countries shows that HIV prevention is better than spending money on HAART at an earlier stage when the epidemic is not severe and the prevalence low. Studies have also shown that the highest rate of transmission occurs during early-stage infection, a time when few people know their HIV status or receive ART. At that time they are more infectious and can transmit the disease rapidly because they look healthy and physical fit but the viral load is very high in the blood. So at that stage prevention might be more beneficial since people are not sick since their status is not known (Simon V, 2006)

Political Aspects of HIV Prevention verses Treatment shows preference of politicians for outcomes that produce quick measurable effects. The politicians are less supportive to the long term future outcome which is more representative of preventive interventions. In particular the HIV prevention programs will reveal effects and show tangible and measurable results after five to seven years from program implementation (El-Battahani).

Infra-structure in Sudan in Relation to HIV/AIDS Treatment and Prevention reveals many challenges. The lack of infrastructure for supply of the ARV drugs and management of drug prescription and provision besides the monitoring of regiments is contributing to the failure of HIV/AIDS treatment (Odi, 2006), Many areas in Sudan do not have laboratory services that will enable to monitor viral load during prescription of HAART or ARV (SNAP 2005).

HAART distribution is not that very simple and includes the need for a reliable distribution system, an inventory control, obtaining informed consent and also monitoring of the side-effects. In addition to the technical skills the managerial skills need to be polished as well to enable distribution of the drug at a large scale. (Marseille E, 2002) These conditions are all serious issues in Sudan and a massive budget will be needed to put all this in place in order to start providing treatment for HIV/AIDS.

Sustainability of HIV/AID interventions reveal that prevention programs are easily sustainable, because these supported by local funds since it is cost effective. To sustain supply of drugs and treatment Sudan will have to depend on external funds from the international community and external donors.

This kind of fund is not sustainable due to many factors. These include rapid change and turn over within international politics and change in the donor interests at the same time. Donor interest could easily change due to emergence of other epidemics. All these factors can hinder the funds and pipeline for treatment grants for HIV/AIDS.

In the case of Sudan there is political instability and also some international relations tension with some of the major donor countries. It is more advisable for Sudan to depend on preventive programs since it is more cost effective sustainability can be ensured from national funds for the program. This way the country will learn to manage the HIV/AIDS crisis on their own and produce interventions that will be long term.

Limitations of both HIV/AIDS prevention and treatment interventions highlighted many points. Some of these include the fact that although knowledge is increased; health seeking behavior is not improved due to lack of services and less motivation for the community to come for testing. This was clearly observed in Botswana. Awareness raising programs only are de-motivating for the health workers especially when they observe death of staff and colleagues. (UNAIDS, 2005).

The treatment programs have advantages in the high prevalence, because they have positive impact on prevention programs. This is seen when increased numbers of persons present themselves for voluntary testing. It is important to educate the people that there are ways to live life with good levels of quality even if someone is positive and that is possible through ARV treatment. It helps to reduce the morbidity and improve the quality of life for people who live with HIV/AIDS,(UNAIDS, 2005). It also reduces the mortality and therefore enables positive persons to be economically viable and still contribute and take care of their families. The treatment programs reduce the viral load for the infected individuals and that reduces the chances of transmitting the disease for other people (Simon V, 2006).

Conclusion:

HIV/AIDS control strategies must include both treatment and prevention. Neither should be seen in isolation. Synergy between the two should be recognized implemented accordingly. Prevention should remain the mainstay of expanded response to HIV/AIDS in Sudan because of the low prevalence rate at present. The epidemiological situation and financial and technical set up the Federal Ministry of Health at present will also be more capable of dealing with prevention programs at present. However if the sentinel surveillance to be done in August 2007 reveals pocket areas with high prevalence treatment programs should be combined with prevention interventions for population in those areas.

As mentioned above Sudan is signatory for many international agreements regarding HIV/AIDS. Because of all these declarations Sudan has regional and national commitment to confront and to fight HIV/AIDS. Therefore the Ministry of Health has to expand the HIV programs and provide supportive environment to preventing new infections and to care for those who are already affected. In addition the social and economic consequences of the epidemic have to be limited. The declarations left the choice for the country to design it is own programs, whether treatment or prevention programs.

When prevention of HIV/AIDS is considered from an ethical point of view it should be beyond all political justifications because

every country / state should take responsibility of the welfare of their nationals and provide all means to prevent their population from a crisis.

Yes, one of the motives that justify support to the prevention programs is the sustainability of the prevention programs because of the cost effectiveness explained earlier. A prevention program is relatively easy to deliver and gives bigger impact, and in most of the cases doesn't need high technical personnel. The community plays a big role in the prevention programs and sustainability is ensured through community empowerment. Some of the prevention activities can be delivered by teachers, religious leaders and volunteers in the villages.

HIV prevention and prevention in general is a public good with externalities so the public sector and the government are obliged to fund the interventions. And that has a big political impact on the future

Recommendation:

There are many traditional and local policies and some times misconceptions with regards to some of the religious beliefs that lead to the spread of HIV in Sudan. These include prohibition of condom distribution to the youth and un-married since it is said to lead to promiscuity. The reality is not faced that those youth and adolescence are going to practice sex in any case and thus are highly vulnerable to HIV infection. Therefore the Federal Ministry of Health in Sudan should formulate policy that involves all these groups. The Federal Ministry of Health needs to pressurize the National congress to allow the application of the preventive strategies for such groups actively.

The Federal Ministry of Health should also take the responsibility of establishing special programs for prostitutes and gay communities, including regular check ups for STIs and distribution of condoms as well as education programs directed at them. The medical check up for these high risk groups will not be possible unless the government ends the discrimination and conservative approach towards these groups. The discrimination and stigma against these groups will force them to hide their profession and continue practicing risky behavior and therefore the spread of the HIV infection will continue.

As observed the blood bank is available only within the district hospital where blood screening is performed. Most of the rural hospitals do not conduct blood screening however blood transfusions are performed during emergencies. It is a necessary universal precaution and most important that the Federal Ministry of Health makes blood screening available all the rural hospitals.

Most of the statistics and data are not updated and regular surveillance is not performed. There should be a national base line survey to include all parts of Sudan, including the conflict area and both internally displaced people and refugees.

We have to address the sexual issues openly keeping in consideration the culture sensitivity. Examples of these issues are use of condoms and model demonstration of condom application.

The Federal Ministry of Health should enable regular supply of gloves to the hospital in particular the maternity hospitals. Universal precautions should be picked up and seriously implemented by Federal Ministry of Health. In many of the maternity hospitals the midwives re-use the gloves after performing per-vaginal delivery. They wash the gloves with soap and water and hang to dry and then re-use..

After revising the National policy for HIV/AIDS in Sudan, I found that the

monitoring and evaluation system and surveillance system evolves around the hospitals only. The system should involve the clinics in the small districts as well since the majority of the population does not have access to hospitals.

In order to scale up and implement the treatment programs the human resource crisis in Sudan hs to be solved by training and producing more staff and health cadre.

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