HIV Infection Amongst Youth in Sudan: What needs to be done

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My opinion

As a country in Sub-Saharan Africa, Sudan contributes a large share to the global burden of HIV infection amongst youth. Several factors specific to the country may be responsible for this, and thus the need for appropriate interventions to reduce the HIV wave in the country cannot be overstated.

In general, there seems to be a low level of knowledge about family planning, reproductive health and STDs among Sudanese youth.[i] Special groups such as rickshaw drivers, who are mostly otherwise unemployed (and often illiterate) adolescents, are abundant in Sudan and have been found to have poor knowledge about HIV/AIDS.[ii] Refugees, who are present mostly in the eastern parts of the country and who have been displaced by conflict or famine, have also been found to be a group with reduced awareness about AIDS and condom use.[iii] These mobile populations seem to be very susceptible to STDs and HIV infection. Moreover, this mixing of populations seems to have created new HIV-1 subtypes previously detached in Africa, with possible implications on the response to treatment.[iv] Pregnant women, who in Sudan are commonly in the younger age groups, have also been found to be less knowledgeable about HIV than their older counterparts, and less willing to undergo voluntary testing.[v]

Females aged 15–24 years in Sudan have a considerably higher prevalence of HIV infection (1.3%) compared to males (0.5%).[vi] Knowledge of HIV has been found to be inadequate even amongst the most educated of the population, including in one study, dental students.[vii] Men who have sex with men, though a marginalized community within Sudan, are also at high risk – their consistent condom use rates are extremely low (3.3%) and more than half did not recognize an association between anal sex and HIV infection.[viii] Interestingly, most MSM in Sudan were found to be students (i.e. youth) at the university level. It seems that the main factors which make youth in Sudan vulnerable to HIV infection are the lack of knowledge and awareness on the matter. Also, HIV infection remains a social and religious stigma that hampers young people from seeking safe sex practices and from undergoing voluntary testing. This may force them to adopt high-risk behaviour that may be easily avoided if the matter of HIV infection were opened to a free and non-judgmental discussion with youth. Other stigmata including that associated with homosexuality also hampers the ability of MSM groups to seek safe sex or HIV services. Economic factors also play a role – these are closely linked to the level of education of Sudanese youth, which is only about 40% enrolled in secondary school.[ix]

On the positive side, male circumcision is widespread in Sudan – while data before the separation of Southern Sudan indicates a 60% percentage of men who are circumcised, it is an almost universal practice in Northern Sudan.[x]

The appropriate interventions for reducing HIV infection among youth in Sudan are:

1. Enhance young people’s communication skills on sex and prevention techniques. They must be empowered to make conscious, life-changing decisions to reduce their risk, or otherwise enhance their access to relevant medical care. This would help provide them with the comprehensive correct knowledge on HIV that is lacking in the country. This can be done by organising support groups for those at most risk, providing anonymous voluntary counselling services and educating the general public on HIV, in the hopes of gradually diminishing the stigma. School-based programmes may also be of benefit, but the low percentage of youth in secondary schools may limit its efficacy.

2. Access to condoms is especially limited in Sudan, despite a recent increase in availability – they are present in pharmacies only (and are imported and thus, unlikely to be affordable to those in most need). Encouraging the local production and cheap distribution of condoms may also be of benefit. The free distribution of condoms in centres, though it has been heard that certain organisations have been doing so, is not practically available in Sudan (perhaps linked to the social stigma mentioned).

3. Encouraging policy makers to make HIV prevention a priority, and to adequately provide the necessary services on a widespread scale. In a country as large and diverse as Sudan, this may prove a difficult issue, as coverage and access to such services is patchy at the moment. This availability of supply, combined with enhancing the demand for these services by the aforementioned interventions, is likely to improve
overall utilization of HIV services.

Conclusion

Overall, the situation of HIV in young people in Sudan may benefit from enhancing the knowledge of those at risk, and of the community as a whole. Discrimination will only hamper these efforts and thus, Sudan may have a longer way to go than most countries as people’s stigma on the issue must be dealt with.

References

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