Senegal's Continued Campaign Against AIDS

By Nicole Grieve

Introduction

Senegal has arguably the most thorough and successful AIDS prevention campaigns in sub-Saharan Africa. Despite this, recent evidence suggests that the benefits of this program are not being felt throughout all sectors of the population, as certain groups are still experiencing high infection rates. Furthermore, the development of more affordable antiretroviral drugs means that Senegal can start to address treatment as well as prevention. Thus it would appear that although the current program has been highly effective, there are still modifications that can be made to further reduce the spread of the HIV virus.

Senegal before AIDS

Like many other sub-Saharan countries, Senegal had been struggling economically for many years. In the 1980s the per capita income level was below $600US per year, and due to high illiteracy rates (57% of males and 77% of females) job prospects for most of the population were limited. Despite these setbacks, Senegal was able to maintain a relatively strong health care system. Although 40% of healthcare costs still came from family budgets, the government effectively promoted important issues such as prevention and child and reproductive health, spending roughly 1USD per capita. Other groups in society also successfully endorsed other health issues such as immunization and malaria prevention. However, in the 1980s an economic downturn and the devaluation of the Senegalese currency led to the collapse of much of the government-run infrastructure in health. In order to combat this problem NGOs became very active in rallying public support for various health campaigns (Pisani, 1999).

Another factor influencing health in Senegal is religion, which plays a very important role in society. Ninety-three percent of the population is Muslim and five percent Christian, the majority of them active participants in their respective religions. Religion contributes to health, and particularly sexual health, in a variety of ways. First, both Islam and Christianity promote family and sexual norms that reduce transmission, such as forbidding extra-marital sex. Second, circumcision is universal and studies have indicated that circumcised men appear less likely to contract or pass on STDs, including HIV. Third, alcohol consumption is uncommon, a factor that can effect safe-sex practices. Fourth, social activity is organized around religious associations, which are active in development in both health and education (Pisani, 1999).

Several other factors of Senegalese culture and society that were prevalent before the outbreak of HIV/AIDS are influential in transmission rates. First, polygamy is still common, with nearly half of all married women sharing their husbands with other wives. Second, in recent years instances of premarital sex have increased, albeit for men more than women. Last, since the legalization of prostitution in 1969 sex workers have been required to register themselves and get regular health checks, and are given treatment for curable STDs (Pisani, 1999).

Response to AIDS

After the first case was identified in 1986, the government quickly set up a program to combat HIV/AIDS. Since then it has invested close to 20 million USD in AIDS prevention programs. Political support has remained constant, and effects have even been increasing; in a 1996 parliamentary meeting on AIDS with NGOs, People Living with HIV/AIDS (PLWAH), religious leaders, and other experts (Pisani, 1999). Although this program has evolved over the years, it consists of three main branches: prevention, treatment, and research. In terms of research within only a few years Senegalese researchers were collaborating with partners from other countries in establishing research projects, the results of which were used to generate political support for prevention and treatment programs (Pisani, 1999). One major research breakthrough came in the mid 1990s when Dr. Souleymane Mboup discovered a strand of HIV present in Senegal that differed from ones in Europe, which helped to fuel early health campaigns (Tamba-Jean, 2004).

The least widespread, and most recent, of these campaigns is the treatment program. In 1998 the government introduced HAART (Highly Active AntiRetroviral Therapy), and became the first African government to sponsor a HAART program. At first the program was limited and served as a test to determine how effective a full-scale program would be. During the experiment, results show that patient adherence to the program was good and similar to adherence in western countries. Also, viral resistance rarely emerged in the study. However, despite initial good responses, the mortality rate was high (12%) in a follow-up visit (Laurent et. al, 2002). Overall, two independent groups have determined that the HAART program is feasible, yielded clinical and biological results, and can be successfully implemented in Africa (Laurent, et. al, 2002 and Desclaux et. al, 2003). As a consequence of the study's results a national treatment program was set up in 2006 to treat 7000 patients (Desclaux et. al, 2003).

Senegal's extensive prevention efforts, as carried out under the National AIDS Prevention Committee (NAPC) primarily include: screening blood for transfusion, increasing awareness through education, widespread screening and treatment for STDs, promotion of condom use and provision of cheap condoms, and special interventions for high risk groups such as sex workers (Meda et. al, 1999). One of the biggest strengths of the NAPC is that it utilizes all levels of society, including women's groups, faith-based groups, the government, the private sector, and the media. According to UNAIDS this immense initial effort is still paying off in reducing HIV infections today (Tamba-Jean, 2004).

Perhaps the most elaborate of these efforts is the NAPC's massive education program. From the start of the education campaign the government realized that one of the most effective ways to disseminate prevention information was through religious groups and leaders. In many countries, especially ones with such strong religious influence, religious groups often inhibit prevention activities by providing contradicting information. However, from early on in the campaign religious leaders wanted to be involved and played a key role in educating the population. In order to ensure that both Christian and Muslim leaders could properly contribute the government first conducted a survey to determine what they knew of HIV prevention. The results indicated that

religious leaders felt they were poorly informed and wanted more information in order to correctly guide their followers (Pisani, 1999).

As a result, educational materials were distributed to them. Apart from general guidelines on prevention, the literature contained information on the human face of the epidemic, a message that was hidden at the time because prevalence was low. Training sessions for Imams were arranged, and they were given brochures to help decimate information to their constituents; AIDS also became a regular topic in sermons. Religious support continued and in 1995 two hundred and sixty Islamic leaders gathered for a conference, which established their clear support for prevention efforts. Furthermore, they supported the rights of people living with AIDS, including the use of condoms in marriage (Pisani, 1999).

Unlike Muslim leaders, at first Christians and Catholics were very resistant about educating their followers about prevention. This was a significant problem because Christian groups were traditionally very important health care providers in Senegal. Eventually they became more open to the idea of prevention, and also began to provide counseling and psychosocial support. Similar to their Muslim counterparts, in 1996 bishops and other leaders held a conference which established their support of the government's education campaign (Pisani, 1999).

Other aspects of the NAPC's education program include targeting children and high-risk groups. In terms of children, the government is making an effort to introduce safe sex education in schools before sexual activity begins. Furthermore, a special effort is being made to educate children not in school, and to encourage parents to educate their children. The high-risk group the government has paid the most attention to are sex workers. Educational campaigns focus on promoting condom use and support groups were created that promote safe sex. In order to increase safe sex among strangers preventative efforts are starting to focus on other areas of casual sex, such as markets, that are outside the prostitution network (Pisani, 1999).

The Senegalese government has also been active in helping communities to deal with AIDS related issues, such as prevention and social support. Economically, for example, the government has also set up programs to help its citizens cover some of the costs of their treatments and help families support sick members. The government has done so by granting initial funding to communities to start up economic projects such as small-scale farming and arts and crafts to provide families with consistent income. Socially, the government has trained some community leaders in counseling and prevention strategies (Tamba-Jean, 2004). The CEDPA has launched a youth and HIV/AIDS component of the ENABLE project to increase the capacity of youth and youth-serving NGOs to respond to AIDS related issues in their local communities. Youth leaders were brought together for recommendations on the best practices and strategies to promote safe sex. The recommendations include integrating reproductive health into all youth programs, addressing stigmatization for PLWHA, and strengthening parent/child communication (CEDPA, 2003).

Results

While the fact that HIV/AIDS infection rates are in general lower in Senegal than other sub-Saharan countries, what is debated is how much of this difference can be

attributed to the quick response of the Senegalese government because it is unclear what would have happened without intervention. Other factors in Senegalese society, such as social and religious values and long and active community participation in health care also helped to keep HIV/AIDS infection rates low (Pisani, 1999). The question now being posed by several experts is how to determine exactly what the effect of the government's effects is and whether these low rates could have occurred without the government's intervention. Although it is unlikely that Senegal's fight against HIV/AIDS would have been as successful without such a strong governmental response, when analyzing the results it is important to remember that government programs were not the only thing helping to prevent the spread of HIV.

The statistics about infection rates clearly demonstrate the success Senegal is experiencing in its fight against HIV/AIDS. At the end of 2001 the infection rate was only 0.5% according to UNAIDS; the number of infected people was only 40,900, and of those only 2,900 cases were children under 15. This makes Senegal's infection rate the lowest in sub-Saharan Africa, compared to rates of 40% in countries such as Botswana and Swaziland. Furthermore, from 1990-2002 only one in a hundred pregnant women were infected in Senegal, compared to one in five in many other West African countries (Tamba-Jean, 2004). Although some people question the accuracy of these numbers because information from rural areas is difficult to obtain, it is obvious that Senegal has achieved something its neighbors have not. Only one other African country, Uganda, comes close to these numbers (Pisani, 1999).

In general the education campaigns have been very effective; the general level of knowledge of prevention among the population exceeded 90% in the early 1990s and recent questionnaires demonstrate that most people know how to prevent the spread of HIV (Meda et al, 1999). Furthermore, people also understand the importance of safe sex, for example 70% of sex workers know about asymptomatic infection (Pisani, 1999). A study in the rural community of Niakhal demonstrated that 75% of people know of HIV/AIDS (Wade, Enel, & Lagarde, 2006).

Education has also increased the implementation of preventative methods. Sexual activity is beginning later, and extra-marital and multiple partner sex rates are declining. Even among extra-marital sex, condom use has greatly increased. Although pre-marital sex is on the rise, it is happening at later ages, in part because the age of marriage is also increasing. As a result, fewer teenagers are sexually active in Senegal than elsewhere in Africa. One-night stands are also increasingly uncommon (Pisani, 1999).

Another area where education has improved safe sex is condom use. Before AIDS came to Senegal, less than 1% of people used condoms, but now this number is much higher in casual sex relationships and among sex workers (although it has remained low among married couples). In particular sales have risen from 800,000 in 1988 to 7 million in 1997. One reason for this is that the government has made it easier to obtain condoms, a fact backed up by the response of sex workers. The only country with such high condom use rates is Uganda, which also has an active prevention campaign. Drops in STD infection rates also show that safe sex practices are increasing (Pisani, 1999).

Concerns

Despite these good results there are still several problematic areas in Senegal's fight against AIDS and areas of the campaign that need to be improved. One such area is rural communities, especially those who have limited or no access to free screening clinics, education, or treatment centres. One example is the tourist area of Mbour, located roughly 150 kilometers from Dakar; nearly 1% of all Senegalese infected reside here, in part because it lacks testing and care centres, and the high level of poverty increases the spread of the disease (Tamba-James, 2004). As part of an effort to assess the situation in rural Senegal, a study was done in Niakhal, comparing attitudes in 1997 and 2003, which produced startling results. It found that the number of people who felt that their personal risk of HIV/AIDS was high decreased from 49.1% to 17.2%; the number of people who reported having changed their behaviour dropped from 56.3% to 24.9% (Wade, Enel, & Lagarde, 2006). These figures demonstrate that at least in Niakhal, preventative attitudes were not sustained, despite the fact that levels of infection in four urban regions remained stable from 1989 to 1999 (Meda, et al, 1999). The study also demonstrated a decrease in fidelity and smart partner selection.

Also, several studies have identified problems in the education segment of the prevention program. For one, despite the fact that most people are generally well informed about HIV/AIDS and its prevention, there is still a lot of misinformation. For example, in a study done between 1997 and 1998 it was demonstrated that 1/3rd of the population thought you could catch HIV from mosquitoes (Pisani, 1999). Furthermore, education programs seem to not be influencing sexual behaviour as much as previously thought. Many youths are still having unsafe sex, polygamous marriages are still common, and clandestine sex workers are still prevalent (Tamba-Jean, 2004).

High-risk groups also still need further attention. In particular, men who have sex with men (MSM) and female sex workers (FSW) are especially at risk. Both groups are still highly infected with HIV and other STDs in comparison to the general population. In terms of FSW even the relatively low prevalence of HIV/AIDS is five times higher than the general population (Laurent, 2003). According to one study intervention programs are needed amongst MSM especially given the high levels of bisexuality (NewsRx, 2002). The main concern for FSW is that many women remain outside of the system, especially women under the legal age. However, few women mentioned age as a reason for not registering; other reasons include lack of knowledge of the legal system or refusal. These women obviously need to become a priority for the NCAP. Some suggestions from this study include: better informing FSW on the law and the procedures provided, helping those seeking to register, abolishing or lowering the legal age, and still giving aid to women who refuse to register (Laurent, 2003).

Many other issues are also hindering the prevention program. First, religion is still an obstacle in some situations, for example, polygamous marriage (Spira, 2000). Second, local research is uncoordinated. Third, there is duplication in work done by NGOs. In response to these problems the government has started getting more involved in some areas; it has taken direct control of the National AIDS Council, which was previously run by local medical practitioners (Tamba-Jean, 2004).

Conclusion

Several studies have shown that the measures the Senegalese government has implemented have been effective in reducing HIV/AIDS levels. Although societal changes – such as later onset of sexual activity and a reduction in extramarital sex – have also helped combat the virus, it is hard to imagine that the success Senegal has experienced would have been possible without government intervention. In particular condom promotion and STD testing and treatment are two areas that show high results (Pisani, 1999). However, despite this success there are still several areas of concern. Infection rates among rural populations and people from high-risk groups, such as FSW and MSW demonstrate that there is still a lot of work that can still be done to make HIV infection rates even lower.

Much of this success is the result of careful government planning, but experts have identified a few specific aspects about Senegal that have helped to reduce infection levels. First, the political leadership created constructive dialogue between religious and community leaders. Second, there was a long and active community participation in health. Third, the government put its existing health structure to maximum use, and fourth, it followed a pragmatic approach by emphasizing protection (Pisani, 1999). Most importantly, the government has continued to re-assess its program to identify areas for improvement and come up with new ways to continually reduce infection. Although other African countries might not be able to replicate all of these aspects, implementing just one can still help make a difference.

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