



Sudan National AIDS Control Programme

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Acronyms

ACORD	Agency for Co-operation and Research in Development
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
ART	Antiretroviral Therapy
BCC	Behaviour Change Communication
CCM	Country Coordination Mechanism
CDC	Centres for Disease Control and Prevention (United States)
CPA	Comprehensive Peace Agreement
FMoH	Federal Ministry of Health
FSM	Female Sex Worker
GDoP	General Directorate of Pharmacy
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GoNU	Government of National Unity
GoS	Government of Sudan
GoSS	Government of Southern Sudan
HAART	Highly Active Antiretroviral Therapy
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IMAI	Integrated Management of Adult Illness
M&E	Monitoring and Evaluation
MARPs	Most-at-risk Populations
MoH	Ministry of Health
MSM	Men who have sex with men
NAC	National AIDS Council
NCPI	National Composite Policy Index
NECHA	National Executive Council on HIV and AIDS
NGO	Non-Governmental Organisation
NSP	National Strategic Plan
OI	Opportunistic Infections
PEP	Post Exposure Prophylaxis
PLWH	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
PSM	Procurement and Supplies Management
SAN	Sudan AIDS Network
SHHS	Sudan Household Health Survey

SNAP	Sudan National AIDS Control Programme
SPLM/A	Sudanese People's Liberation Movement/Army
SSAC	Southern Sudan AIDS Commission
SSCCSE	Southern Sudan Commission for Census, Statistics and Evaluation
STI	Sexually Transmitted Infections
TB	Tuberculosis
UA	Universal Access (to prevention, treatment, care and support)
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
UNMIS	United Nations Mission in Sudan
VCCT	Voluntary Confidential Counselling and Testing (for HIV)
VCT	Voluntary Counselling and Testing (for HIV)
WHO	World Health Organisation

Foreword

The HIV epidemic in Sudan is already generalised across all population groups and regions. The low prevalence at 1.6% of the general population and 2.6% of the adult and productive population is not a stage to be complacent but an opportunity to curtail the pace and the associated devastating waves of consequences of the epidemic. Even at the low prevalence rate, Sudan as a country is already facing negative effects of the scourge in form of increasing numbers of orphans, person living with HIV that require more care services and support, increased strain on limited available resources for health and other social programmes.

It must be emphasised that building of an effective response to HIV and AIDS in the Northern Sudan requires, among other pillars, a functional in-country monitoring, evaluation and reporting system that can generate and avail strategic information. Informed response management at National / federal, state, locality and community levels is possible with a systematic use of information and coordinated efforts of the stakeholders. The commitment of the leadership of the Government of Northern Sudan to develop an UNGASS report every two years is vital for the guidance to the national response that is required of SNAP, sector ministries, state and locality authorities across all the 15 states of Northern Sudan.

Sudan is one of the fastest growing economies in Sub-Saharan Africa registering double digit annual growth rates. Most of Northern Sudan is in a peaceful post-conflict status and undergoing rapid economic rehabilitation and development as well as a lot of population mobility. The attendant programmes in the phase of rehabilitation and re-settlement also points to increasing diversity of the population and certainly the social behaviours that may increase or reduce the predisposing risks.

With the leadership of the Sudan Government of National Unity through SNAP and with support of partners who include the UN agencies, Multi-lateral, bilateral, international and national Non-governmental organisations the national response has registered a number of key achievements. These achievements include: the enhanced leadership commitment at National, State and Locality levels; enhanced decentralised coordination and management of HIV / AIDS programmes and projects with all 15 states with state SNAP coordinators; expanded prevention, care and support services in form of more HIV/AIDS awareness and Information, Education and Communication (IEC) programmes, more Behavioural Change Communication (BCC), sustained high level advocacy, more VCT centres, treatment of Opportunistic Infections (OI), ART programmes; enhancing human resource and service delivery and logistical capacity; more visibility, effective participation and support of PLHIV; record keeping, data collection at Service Delivery Points (SDP) and at management at facility and at locality, state and National programme levels.

The development of UNGASS report is just one major opportunity for assessing the national response. The stakeholders are however urged to ensure that they incorporate mechanisms for regular joint participatory assessments and planning of the various interventions they are implementing, coordinating or supporting so that we build an informed response.

All stakeholders thanked for all their efforts and contributions and are hereby urged to utilise the strategic information shared in this report so as to enhance institutional, community and individual personal level competencies required for the fight against the HIV and AIDS scourge in Northern Sudan.



Dr. Mohammed Ahmad Abdalhafiez
Manager, Sudan National AIDS Control Program

Acknowledgements

The production of the UNGASS report for Northern Sudan for the programme period 2006 – 2007 has been a very participatory process. The process has also been enriching to our strategies and approaches in the fight to empower our institutions and communities in the face of a raging epidemic.

As we produce this report, the Leadership of the National response in Northern Sudan wishes to extend thanks and appreciation to all partners and stakeholders for the individual and organisation resources, time, efforts, ingenuity and innovativeness and support invested into the HIV and AIDS programmes of the past two years at National, State, locality, workplace and community levels. SNAP wishes to particularly the Government of Sudan for it's leadership and support; the leadership and staff of all the UN agencies, the Global fund secretariat in Geneva and country office, the Bilateral agencies, the multi-lateral agencies, international and national or local NGOs and CSOs, the private organisations and individuals for the resources and technical as well as management support availed to the national response in the Sudan over the past two years. The stakeholders are also thanks for having opened up to self and external assessment required for the UNGASS reporting.

Special appreciation is hereby extended to the following persons whose sustained personal efforts over the report preparation that ensured the success of the process: the Hon. Minister of Health , Dr. Tabita Botros Shokai, Federal Ministry of Health; Dr. Mohamed Hussein Elduma and Dr. Osman Bilail of the M&E Unit and other staff at SNAP who mobilised the stakeholders; the two UNGASS Consultants in the names of Dr. Saul Onyango and Dr. Zainab Abdalaziz; the leadership and staff of the UNAIDS regional office in Cairo, the UNAIDS Country Coordinator Sudan, Mr. Musa Bungudu, the UNAIDS partnership officer, Mrs. Hind Hassan, and the Monitoring and Evaluation Officer, Mr. Bernad Mwijuka and other staff that helped to mobilise the resources and the consultants and supported the coordination of the process and; the leadership of WHO and HIV/AIDS unit staff- Dr. Rogers Busulwa, and Dr. Nuha Hamid and other staff who enriched the report with the care and support information gathered under the Health sector response report production. All other persons, not named here for lack of space or un-intended omission, who in different personal and official capacities facilitated the UNGASS reporting are acknowledged.

It is my sincere hope that this report will provide us with the level of analysis to boost our efforts in the National Response.

We shall continue to count on the continued involvement and support of all stakeholders in the next programme/ implementation period.



Dr. El Tayeb Mansour,
Deputy Manager, Sudan National AIDS Control Program,

Status at a Glance

The process for consultations and preparation for the country progress report on monitoring the follow up to the Declaration of Commitment on HIV and AIDS in North Sudan was highly participatory. With leadership from the Sudan National AIDS Control Program (SNAP) and technical support from the Joint United Nations Programme on HIV/AIDS (UNAIDS), stakeholders from government such as the Ministry of Health, Ministry of Defence, Ministry of Interior and Ministry of Higher Education; civil society organisations; the United Nations' Agencies were fully involved in the consultations. The draft report was discussed in a large forum comprising of the wide group of Development Partners and stakeholders as part of the consensus building exercise. The comments from the discussion meeting were used to make improvements and to prepare the final version of the report.

Sudan is in the early stages of a generalized HIV and AIDS epidemic which has an almost exclusively heterosexual transmission pattern but with indications of higher infection rates in the South than in the North. Years of civil war and limited epidemiological data make it difficult to generalize about the status of HIV/AIDS in Sudan. However, with an estimated prevalence of 1.6% among the adult population in North Sudan, by the end of 2006 approximately 350,000 people were living with HIV in this part of the country. The results of sentinel surveillance conducted on a limited scale in 2004 and 2005 by SNAP reported prevalence rates of 0.95% among pregnant women, 1.9% among symptomatic STD patients, and 2.3% among TB patients. Higher prevalence has been reported among the most-at-risk populations such as sex workers (4.4%) and men-who-have sex with men (9%); as well as among clients attending the voluntary counselling and testing services (5-15%).

The response to HIV and AIDS within North Sudan is multi-sectoral, coordinated by the Sudan National AIDS Control Programme that is located within the Federal Ministry of Health. First established in 1987, SNAP spearheaded the development of the current strategic plan for the period 2004 to 2009. This plan that aimed at maintaining the prevalence of HIV at less than 2% focused on establishing HIV and AIDS intervention in eight (8) line ministries. It is currently undergoing revision to reflect the changing realities of the epidemic, the new political context and with more focus on post conflict issues and vulnerable populations.

The priority programme interventions include advocacy and coordination; multi-sectorality and decentralisation of the response; information, education and communication (IEC) and behaviour change communication (BCC); voluntary confidential HIV counselling testing (VCCT); prevention of mother to child transmission of HIV (PMTCT); and antiretroviral treatment (ART). In addition, there are programmes that target some vulnerable and most-at-risk populations such as tea-sellers, prisoners, long-distance truck drivers, female sex workers, women and the uniformed forces; and focus to the people living with HIV (PLHIV). However, interventions for orphans and vulnerable children are not part of the current National Strategic Plan, which partly justifies the need for its revision.

The UNGASS Indicator Data Overview Table

National Indicators		
Indicator	status	Comments
National Indicators		
1. Domestic and international AIDS spending by categories and financing sources	√	The detailed component is attached
2. National Composite Policy Index (Areas covered:	√	The detailed component is

National Indicators

Indicator	status	Comments
gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation)		attached

National Commitment and Action

3. Percentage of donated blood units screened for HIV in a quality assured manner	100%	
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	1.5%	The number of identified PLHIV is still small
5. Percentage of HIV-positive pregnant women who received antiretroviral drugs to reduce risk of mother-to-child transmission	0.05%	Implementation started in August 2007
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	No Data	Reporting system for HIV/TB only recently updated to reflect this data at the national level.
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	No Data	No population based survey data is available
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results		Available data not fully consistent with indicator definition. Two studies in Khartoum released in 2007 captured those who had ever had an HIV test (not only in preceding 12 months) as follows MSM: 20%, Prisoners: 19.3%
9. Percentage of most-at-risk populations reached with HIV prevention programmes	No Data	Small scale interventions started for FSW, MSM, Tea sellers and Truck drivers
10. Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	No Data	No national estimates on OVCs, situation analysis is under process
11. Percentage of schools that provided life skills-based HIV education in the last academic year	1.36 %	224 schools out of 16,496 provided life skills-based HIV education

Knowledge and Behaviour

12. Current school attendance among orphans and among non-orphans aged 10-14	No Data	66.6% for orphans and 53.8% among non-orphans aged 10-14 years ¹ (SHHS)
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¹ Government of Sudan, April 2007. The Sudan Household Health Survey (*Draft*).

National Indicators

Indicator	status	Comments
13. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	No Data	The SHHS reported comprehensive knowledge among young people of 9.4% ¹
14. Percentage of most-at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	No Data	Most-at-risk population size is not known
15. Percentage of young women and men aged 15-24 who have had sexual intercourse before age of 15	No Data	Reported 12.4% married before 15 years; 36% married before 18 years of age ¹
16. Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	No Data	No population-based survey was conducted
17. Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of condom during their last sexual intercourse	No Data	No population-based survey was conducted
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	No Data	No special representative study was conducted
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No Data	No special representative study was conducted
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	Not Relevant	IDU is not recognized as a problem in Sudan.
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Not Relevant	IDU is not a relevant mode of transmission in Sudan

Impact

22. Percentage of young women and men aged 15-24 who are HIV infected	No Data	No sero-behavioural survey was conducted
23. Percentage of most-at-risk populations who are HIV infected	No Data	Most-at-risk population size is not known
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	52.4%	Data only from Khartoum State. Other states not yet ready. 14.6% of patients were dead, at end of first year.
25. Percentage of infants born to HIV-infected mothers who are infected	No Data	PMTCT program was launched in August 2007

Overview of the AIDS Epidemic

Introduction

The Republic of Sudan is the largest country in Africa, with an area of approximately 2.506 million square kilometres. It is 2,100 kilometres long and 1,600 kilometres wide at the extreme, with international boundaries traversing more than 7,000 kilometres circumscribing it from nine neighbouring countries five of which border Southern Sudan. The last national census was conducted in 1993 and the projected population in 2006 was about 40,169,996² people. The population distribution is mainly rural (70%), with remaining 25% in urban areas while 5% are nomadic. The life expectancy is estimated at 56 years for males and 60 years for females.

The country contains religious, ethnic and linguistic diversity with the majority of the population being Muslims. The rest include Christians, animists, and other minorities while up to 400 languages are spoken. Despite the diversity of the Sudanese people, environment and the

richness of resources such as oil, it remains one of the poorest countries in the world. Drought, famine, civil strife and war in the southern part of the country and Darfur, have caused large numbers of its population to be displaced over the common borders with its neighbours. The Comprehensive Peace Agreement (CPA) was signed to end war between Government of Sudan and the Sudan People's Liberation Movement in 2005; and peace negotiations are going on between the Unity Government and armed movements operating in the western part of the country. Administratively,



the country is divided into 25 states and corresponding local governance systems.

Under the CPA, a unity government under the presidency of the Government of National Unity (GoNU) was established in 2005 with more autonomy delegated to the Government of Southern Sudan (GoSS). The Northern Sudan covers a geographical area of about 1.45 million square kilometres, with a projected population in 2006 of about 32,669,996 people with an estimated 1,306,800 pregnancies per year. Administratively, the North Sudan comprises of the following 15 States: Khartoum, Northern, River Nile, Red Sea, North Darfur, West Darfur, South Darfur, North Kordofan, South Kordofan, White Nile, Blue Nile, Gezira, Sennar, Gedarif and Kassala.

Whereas the CPA has resulted in stability and security to the people, conflict and post-conflict within the context of HIV pose a major challenge that could undermine the development and reconstruction of the country. The war in Darfur has led to displacement of over 2 million people

² National Health Information Centre, Federal Ministry of Health. Annual Health Statistical Report 2006

out a population of about 6.7 million. The disruption of social structures, disintegration of family and household units as well as destruction of infrastructure that is associated with the war provides fertile ground for the spread of HIV. On the hand, the post-conflict environment that exists in Eastern Sudan and Kordofan also creates a conducive environment for spread of HIV as the displaced, poor population return to their homes and teams from outside the community join to support the re-construction process. The rest of the country that was not directly affected by war is not immune from the HIV epidemic. The economic growth of 11% that makes the Sudan third among African countries creates an environment where the rural population gets attracted to the urban centres in search of greener pasture. The result is a general increase in the mobility of population within and outside the country, which has implications for the prevention and control of HIV.

The HIV and AIDS Epidemic

The Human Immuno-deficiency Virus (HIV) has caused an epidemic that remains extremely dynamic, continues to grow and change in character as the virus exploits new opportunities for transmission. More than two decades since the first case was reported in 1981, globally about 33.2 million adults and children were reported to be living with HIV³. In the year 2007 alone, about 2.5 million people were infected while 2.1 million adults and children succumbed to AIDS. Within the Middle East and North Africa region, the reported numbers of HIV cases remain small with most infections occurring in men and in urban areas except for the Sudan where relatively higher prevalence is estimated. The country has the highest HIV prevalence in the region and unsafe heterosexual intercourse is reported as the most important risk factor for infection.

The first case of AIDS was reported in the Sudan in 1986, which was followed by two other cases in 1987. Since then the number of reported cases increased on an annual basis to a cumulative number of 10,959 by December 2003. The major mode of HIV transmission was heterosexual transmission, which accounts for about 97% of all reported AIDS cases. The adults of reproductive age (15-49 years) were most affected, accounting for about 90% of the reported AIDS cases. The national survey that was conducted in 2002 by SNAP⁴ with support from partners as part of the situation analysis reported that about 79% of the population had heard about HIV and AIDS. However, less than 25% knew the symptoms and only 17% could state the signs related to AIDS. More than two-thirds of the respondents had neither heard about, nor seen a condom while only about 4% had ever it. In addition, approximately 57% of all respondents reported that they would not buy food from an HIV infected seller.

The Sudan Household Health Survey (SHHS) was conducted in 2006 to provide estimates on a large number of indicators related to the situation of children and women at the national level and in all the 25 states of North and Southern Sudan. Whereas the diverse issues that influence maternal and child health were explored in the questionnaire, HIV was among them. The SHHS results indicate that the proportion of women aged 15-49 years from North Sudan who were married before age 15 ranged from 6.1% in River Nile State to 20.6% in Blue Nile State; while those who were married before age 18 ranged between 19.3% and 56.4% in the same states. The report revealed that while 70.4% of all the respondents in Sudan had heard about AIDS (with a range in North Sudan from 37.4% in West Darfur State to 94.3% in Khartoum State); 51% of respondents identified sexual intercourse as the main mode of transmission (with variation from 20.2% in West Darfur to 81.2% in Khartoum state), while 39.7% respondents identified blood transfusion as a mode of transmission (range from 12.7% in West Darfur to 73.9 in Khartoum state), 38.8% mentioned HIV transmission through injection by needles used by others (from 13.8% in West Darfur to 68.5% in Khartoum). Only 7.5% felt that HIV can be transmitted by not using condoms (variation from 0.4 in Sinnar state to 15.2 in Khartoum state). Only 4% in the country knew all the three ways to prevent HIV transmission (abstinence, faithfulness and condom use), with a in North Sudan from 0.1% in West Darfur, Gezira, Northern and River Nile States; to

³ UNAIDS AIDS Epidemic Update: December 2007

⁴ Federal Ministry of Health, Nov. 2002. Situation Analysis: Behavioural and Epidemiological Surveys and Response Analysis – HIV Strategic Planning Process.

6.8% in Khartoum State. Furthermore, while 54% of all the respondents knew that HIV could be transmitted from an infected mother to her baby, the range in North Sudan was from 21% in West Darfur State to 82.1% in Khartoum State. When asked about timing of transmission, only 26.4% knew all the three (pregnancy, delivery, breast milk); with a range North Sudan from 12.5% in West Darfur State to 40.8% in River Nile State.

The Sudan National AIDS control programme (SNAP) estimates that on basis of a total estimated population of 32,669,996 in North Sudan and prevalence among the general population of 1.6%, that the total number of people living with HIV in the country is about 522,720. The HIV prevalence among adults of reproductive age 15-49 years is about 2.6%. Approximately 52,272 (10%) of the people living with HIV are currently in need of antiretroviral treatment, out of whom about 1,759 from North Sudan were reported to be accessing treatment.

The magnitude of HIV and AIDS among the identified most-at-risk populations in the Northern Sudan has not been objectively reviewed since the national sero-behavioural survey that was conducted in 2002. The most-at-risk groups include prisoners, tea-sellers, long-distance truck drivers and female sex workers. A survey that was conducted among long distance truck drivers⁵ reported a lower HIV prevalence of only two HIV positive samples out of 374 that were tested (0.5%), compared to 1% among this sub-population from the national survey of 2002. Virtually all those who were interviewed had heard of HIV and AIDS but again the level of comprehensive knowledge was reported to be very low. Approximately 36% were of the view that mosquitoes can spread HIV and almost three-quarters would not buy food from a person known to be living with HIV. Furthermore, almost one-quarter of those interviewed had neither heard about, nor seen a condom while only 9% had used condoms.


A qualitative study that was conducted among the female sex workers from Khartoum State in 2006⁶ reported aimed at generating relevant information on their socio-cultural and economic conditions as well as their perceptions and understanding about HIV. The study recognized that while sex work is an old phenomenon in Sudan, it is also illegal and therefore, clandestine. This made it difficult to determine the true extent of the sex work industry, which is acknowledged to be substantial impact on the HIV prevalence in the country. The national survey of 2002 reported HIV prevalence among the sub-population of female sex workers to be highest at 4.4%. More than half of respondents in the study were less than 28 years and the majority reported joining sex work before 22 years of age. Awareness about the modes of HIV transmission was found to be very high but there was remarkable ignorance on strategies for prevention and misconceptions that could influence their capacity to protect themselves from infection. While the average number of clients received per day was reported as two, the proportion of female sex workers who reported condom use was very low. Very few respondents negotiated condom use with clients and the majority of these perceived condoms as contraceptives rather than tools for prevention of STI.

The national survey that was conducted in 2002 highlighted the tea-sellers as a most-at-risk sub-population, with an HIV prevalence of about 2.5%. A study conducted among this group from Khartoum State⁷ reported that while tea selling was considered a negative phenomenon by the authorities, the media and public at large, for most of the women interviewed it was their only source of family income. The majority of tea sellers had between 3 and 9 children and no source of income other than selling tea within the harsh antagonizing environment. There was no evidence that the tea sellers were involved in sexual activities with their customers but rather the highly competitive business environment made it inevitable for any woman tea-seller to take care of her appearance and to flatter her customers in order to keep them or to attract new ones.

⁵ Mohamed Salih Farah & Salah Hussein 2006. HIV Prevalence, Knowledge, Attitudes, Practices and Risk Factors among Truck Drivers in Khartoum State.

⁶ ACORD Nov. 2006. Qualitative Socio-Economic Research on Female Sex Workers and their Vulnerability to HIV/AIDS in Khartoum State.

⁷ Omayma S-A. Gutbi & Ahmed M. G. Eldin; Jan. 2006. Women Tea-Sellers in Khartoum and HIV/AIDS: Surviving Against the Odds.



While the level of awareness about HIV and AIDS was relatively high among the women tea sellers, this was nullified by misconceptions and stigma against those who are infected.

The factors driving HIV/AIDS epidemic in Sudan have been identified as war and the resulting population movements that include internally displaced persons, refugees, and military personnel; Sudan's long borders with nine African countries some of which have high HIV prevalence rates; the economic crisis in the country; and urbanization with remarkable rural-urban migration. All these conditions interact to provide an enabling environment for high risk sexual behaviours and rapid spread of HIV infection.

National Response to the AIDS Epidemic

Introduction

The Sudan National AIDS Control Programme (SNAP) was established in 1987 as part of the national response to HIV and AIDS. With support from the World Health Organisation, two short-term and two medium-term plans were developed between 1987 and 1998 to guide the country's response. It was not until 2001 that a Task Force was constituted to conduct a national epidemiological, behavioural and response analysis survey that would form the basis for the development of a comprehensive multi-sectoral strategic plan. An interim annual operational plan for the United Nations was developed in 2003 and thereafter a consultative process that involved key government sectors resulted in the current strategic plan⁸ that covers the period 2004 – 2009. The plan includes the HIV and AIDS response in eight line ministries namely: Health; Interior and Police Forces; Defence; General Education; Higher Education; Information and Communications; Youth and Sports; Guidance and Endowment; as well as the Sudanese Women General Union.

The historical declaration that was made by His Excellency the President, Omar Hassan El-Bashir in 2003 formed the fundamental turning point in the national response to HIV and AIDS in the Republic of Sudan. The First Lady has taken a lead in supporting the response at national and State levels, as well as in International and Regional African meetings.

Structure of the AIDS Response in Northern Sudan

The National AIDS Council was established in 2002 as the highest level policy and advisory body on all issues related to HIV and AIDS in Northern Sudan. Under the Chair of the Federal Minister of Health and with representation from all key sectors, it is the body that provides leadership and creates an enabling environment for the national response. The State AIDS Council headed by the *Wali* (Governor) was established in all fifteen northern states to provide the leadership at that level.

The National Executive Council on HIV/AIDS (NECHA) is chaired by the Undersecretary of the Federal Ministry of Health. The membership includes the United Nations Agencies, public and private sectors; national and international stakeholders and the terms of reference includes: execution and overall management of the national response; coordination between different partners and stakeholders from various sectors; review and endorsement of strategic plans and plans of action; raising of funds and mobilisation of other resources to meet the needs; monitoring and evaluation of the response by different stakeholders. Sub-committees were established within the NECHA to support interventions in specific areas.

The Sudan National AIDS Control Programme (SNAP) located with the Federal Ministry of Health, is the technical department with the responsibility for national level policy, planning and coordination. It liaises and works with the different sectors, including the Ministries of Defence, Interior, Education, Higher Education, Information and Communication, Youth and Sports; and Welfare and Planning. The Sudan AIDS Network is an umbrella forum for the non-governmental organisations (NGOs) working in the field of HIV and AIDS that promotes the role of civil society within the national response. In addition, there are other fora such as the Country Coordination Mechanism and different HIV/AIDS Technical Working Groups that were established to improve the public private partnership and engagement of the civil society. The United Nations Joint Team on AIDS serves to coordinate and facilitate the UN's technical support to the national response.

There are SNAP offices in each of the 15 States with the responsibility for the planning and implementation of HIV-related activities at that level. The State AIDS Taskforces were established

⁸ Sudan National AIDS Council 2004. Sudan National Strategic Plan and Sectoral Plans on HIV/AIDS 2004-2009.

to strengthen public-private partnership and coordination between the public sector and civil society. Furthermore, there has been effort to create a structure for fully fledged AIDS control Programmes in some States such as Khartoum, Northern, Gedarif and Kassala.

The Multi-sectoral Strategy

The government has embraced the multi-sectoral strategy for responding to the HIV and AIDS epidemic in North Sudan. The first Sudan National Strategic Plan for HIV/AIDS (2003-2007) was developed and launched by the President of Sudan in 2003. In order to strengthen the multi-sectoral dimension of the plan, it was revised in 2004 and the current plan covers the period 2004 – 2009. The first and second objectives of the Sudan HIV/AIDS national strategic plan are to maintain the level of HIV prevalence at less than 2% by 2009 and to reduce AIDS morbidity, mortality and improve the quality of life of people living with HIV/AIDS. The other objectives are related to building the capacity of different partners; mobilisation of political and community leaders; coordination of public sector, private sector and the effort from international partners. The current plan includes eight line ministries namely: Health, General Education; Higher Education; Defence; Interior; Guidance and Endowment; Youth and Culture; Women Union.

There was moderate involvement of the civil society organisations during the development of the current strategic plan. This was mainly attributed to the fact that few organisations were involved in HIV-related activities at the time as well as the limited capacity among the civil society organisations in general. The main civil society impetus into the strategic planning process was made through the Sudan AIDS Network, which is the umbrella for the network of about 30 organisations. The main programme interventions in the strategic plan include: advocacy and coordination; multi-sectorality and decentralisation of the response; behaviour change communication (BCC); Voluntary Confidential HIV Counselling and Testing (VCCT); Antiretroviral Therapy (ART); and prevention of mother to child transmission of HIV (PMTCT). The other prevention interventions include programmes for vulnerable and most-at-risk populations such as young people, women, tea-sellers, long-distance truck drivers, prisoners and the uniformed forces. However, the plan does not include any component on orphans and vulnerable children particularly within the context of HIV. This gap is one of the strong justifications behind the current attempt to review the strategic plan and develop a new one to cover the period 2008 – 2011. It will also enable the country to ensure that the plan and budget are aligned to the commitments towards universal access that was made during the High-Level AIDS Review of June 2006. The recent efforts to scale up HIV and AIDS interventions towards reaching Universal Access to prevention, care, treatment and support are also key behind the need to review the NSP to reflect the need to reach the re-defined milestones and targets.

North Sudan has made strides to integrate HIV and AIDS into the general development plans, particularly the National Development Plan and Common Country Assessment/ United Nations Development Assistance Framework (UNDAF). An effort is being exerted by UNAIDS and partners to ensure that HIV and AIDS is adequately reflected in the annual UN and the partners work plan in terms of programmatic coverage and funding. Some work still has to be done to complete integration in the Poverty Reduction Strategy Papers and the Sector Wide Approach. In addition, there will be need to evaluate the impact of HIV and AIDS on socio-economic development for purposes of effective planning. Overall, the strategy planning effort improved only slightly between 2005 and 2007, rated at 6 and 7 respectively. The main area of progress was attributed to a better understanding of the planning and coordination processes, which now utilise a bottom-up approach as opposed to the traditional top-down planning.

Political and Legal Framework

The country initiated the process of drafting the Act on HIV/AIDS prevention and protection of the rights of the infected persons in 2005. During the course of 2006 and 2007, the document was

taken through various stakeholders' discussions and consensus building workshops⁹. The document clearly spells out the principles and general provisions as applicable to HIV and AIDS in Sudan such as raising public awareness on transmission, consequences, prevention and control of HIV; prohibition of all kinds of discrimination against suspected cases of HIV infection; and prioritisation of major programmes for prevention and control of HIV within the National Development Plan. The laws also categorically prohibits publicity in the media and commercials that contradict the established scientific procedure; or don't conform to the medical principles and provides penalties that apply whenever is failure to comply with the different articles. The final draft is with the Ministry of Justice for discussions before submission to the cabinet and parliament for ratification.

The National Policy on HIV/AIDS¹⁰ was developed in 2004 on the basis of various international commitments of the government of Sudan. The overall goal of the policy is to provide a framework for leadership, coordination and implementation of a national multi-sectoral response to the HIV and AIDS epidemic, including guidance on appropriate interventions in prevention, treatment, care and support, for the general population as well as most-at-risk sub-populations. The policy upholds the rights of people living with HIV/AIDS to holistic care, access to counselling, condoms, and information to protect themselves and others from further HIV transmission. It also re-iterates the duty of health care providers to attend to people living with HIV without any discrimination on account of their HIV sero-status; and calls for the formulation of a national care and treatment plan, with due attention to strengthening health systems, as a prerequisite to improve the availability and accessibility to prevention, treatment, care and support services. The final draft version of the national Policy on HIV/AIDS is due for discussion at the cabinet level before final presentation to the National Assembly. In addition to the overall national HIV/AIDS policy, specific policy guidelines on antiretroviral therapy, Prevention of Mother to Child Transmission, Post Exposure prophylaxis; and Voluntary Counselling and Testing have been developed.

The rating of policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2005 was at 3; while 2007 was at 5. The progress was attributed to the fact that the law is in advanced stages of development and consensus building had been quite successful. The rating of efforts to enforce the existing policies, laws and regulations in relation to human rights and HIV and AIDS in North Sudan was at a level of 2 in 2005; and 4 in 2007. The progress was attributed better involvement of the youth and media in human rights issues; and mapping effort that was conducted for the most-at-risk populations.

There is strong political support for HIV and AIDS activities in North Sudan, with government and political leaders regularly speaking out about AIDS at important functions at national and State levels. The First Lady has specifically taken a lead and often participates in different fora within and outside the country. The National AIDS Council that was established in 2002 is the officially recognised AIDS management body in North Sudan. Chaired by the Federal Minister of Health, it has clear terms of reference; active government leadership and participation; as well as representation of the private sector, civil society and association of people living with HIV/AIDS. While not meeting every quarter of the year, the body is still able to review actions on policy decision and to actively promote the policy decisions. SNAP which acts as the Secretariat for the Council provides the mechanism for promotion of interaction between government, people living with HIV, civil society and the private sector for implementing HIV and AIDS programmes.

A seminar was organized in August 2006 for members of the Sudan National Assembly to sensitise them on issues related to HIV and AIDS with an aim of identifying the action and entry points that they could use to support the national response. The expected output included their having a better understanding, which would result in more effective participation in national government decisions concerning HIV and AIDS. A critically important outcome of the seminar was the

⁹ Government of Sudan, 2006. Draft Act on HIV/AIDS Prevention and Protection of the Rights of Infected Persons.

¹⁰ The Republic of Sudan, Office of the Minister of Health, 2004. National Policy on HIV/AIDS (Draft).

formation of the HIV/AIDS committee within the National Assembly with proposed key tasks to provide guidance and support to the State AIDS Councils; ratification of the draft law for protection of the rights of people living with HIV and AIDS; advocacy for mainstreaming HIV/AIDS in all relevant policies and programmes at the macro level such as the poverty reduction strategies; and supporting allocation of annual budgets for HIV/AIDS at national and State levels.

The overall rating of political support for the HIV and AIDS programmes in North Sudan reflected significant improvement from a value of 5 in the year 2005 to 7 in 2007. This was attributed to the overt demonstrations of openness about HIV and AIDS from the political leadership; the National Council was re-activated and re-structured by the Minister of Health; and the religious leaders were brought on board as members of the AIDS Consultative Council. The policy environment also improved with HIV Sectoral plans being reviewed or developed for line ministries such as Youth Culture and Sports; Higher Education; and General Education; while those for the Ministries of Social Welfare and Justice were initiated. Specific policy related activities included: adoption of the policy guidelines for PMTCT (including opt-out strategy) and development of the training module; drafting of the national paediatric treatment guidelines; finalisation of the HIV life-skills curricula for primary and secondary schools (2 teachers guides, 2 learners books and one parents guide); drafting of the module on HIV for lawyers; development of the standard package of BCC/IEC materials (more than 1,000,000 posters, fact sheets, TV and radio spots) on abstinence, faithfulness, condom use, PMTCT, promotion of VCCT, treatment, and fighting stigma and discrimination. In addition, the rapid assessment activity for establishing the baseline data on number of orphans and vulnerable children, including those affected by HIV was initiated.

There has been fairly good participation of the civil society in strengthening of political commitment of top leaders and in national policy formulation within North Sudan. The civil society representatives have been involved in the planning and budgeting process and there is reflection of civil society contribution in both the national strategic plan and national budget. However, variability in the capacity of indigenous civil society organisations limits the extent to which the diverse group gets representation in HIV-related efforts in North Sudan. The limited capacity was also responsible for a relatively lower access to adequate financial and technical support for implementation of their activities. Overall, the rating of efforts to increase civil society participation in 2005 was scored at 3 compared to 6 for 2007. The progress was mainly attributed to increase in the available resources that could be accessed by the civil society; and the deliberate effort to involve civil society as well as build their capacity to be able to effectively deliver.

HIV Prevention

During the initial stages of the HIV epidemic in North Sudan, most of the prevention interventions focused on raising awareness; supporting the communities to acquire updated and correct information on HIV; and to spread information and to reduce the risk of HIV transmission. The behaviour change communication component of the national HIV and AIDS response was introduced later in 2005, partly due to limited expertise in the area within the country. The Communication for Behaviour Impact (COMBI) strategy for example that was developed in 2005 was of limited scope, focused mainly on abstinence "Eiffa"; and was of short duration (one year) .

There is a Communication Strategy¹¹ that promotes information, education and communication on HIV to the general population in North Sudan. This document was developed with support from UNICEF in December 2006 and key messages explicitly promoted are based on the 'ABC' principles. There are deliberate activities that are designed to target mass media personnel as part of the strategy to promote accurate reporting on HIV by the media. For instance the media day was commemorated on 2nd December 2006, hosted by the Federal Minister of Information and communication, which drew full participation of the media personnel. The most-at-risk

¹¹ Sudan National AIDS Control Programme, December 2006. National Communication Strategy and Guidelines for Planning and Carrying out Effective Communication.

populations who are specifically targeted with information on risk reduction include the female sex workers and their clients; prison inmates; long-distance truck drivers and members of the uniformed forces and their families. HIV education has been in the school curricula but during the course of 2007, the content was reviewed and updated to improve on the quality and relevance to the national response.

The general understanding and acceptance of the concepts of behaviour change communication and interpersonal communication has improved with more partners getting involved especially from civil society and youth sector. There were specific interventions for out-of-school youth to be supported in to implement life-skills activities and to reach others through peer education and awareness-raising sessions. Initiated in 2007, the interventions are estimated to have benefited about 315,000 young people in the States of South Kordofan, North Kordofan, Kassala, Red Sea, Blue Nile, Gedarif, South Darfur, West Darfur, North Darfur, Khartoum and other Northern States. In addition, one youth friendly centre was identified for rehabilitation in South Kordofan, Kassala, South Darfur and North Darfur States as part of the strategy to ensure that more young people in the selected States have access to youth-friendly HIV and AIDS services through partnership with existing youth structures. However, only the one in Kassala became functional in November 2007 after the Management Team was recruited by the State Ministry of Youth, Culture and Sports.

Furthermore, mass media was used as a channel to reach young people in South Kordofan, North Kordofan, Kassala, Red Sea, Blue Nile, Gedarif, South Darfur, West Darfur, North Darfur, Khartoum and other Northern States. During the course of 2007, approximately 11.3 million young people from the above States were reached through state radio and community radios. This was complemented by the mass media campaigns, including radio and television spots and programmes that were broadcasted in form of drama series and songs in the local languages. A formal agreement was signed by Undersecretary Ministry of Health and the Minister of Communication, which entitled SNAP free airtime for 3 HIV/AIDS spots and granted the national Radio and Television the sole production rights.

An advocacy and consultation workshop was conducted in February 2006 that was attended by 98 representatives of private companies with potential to participate in the national HIV and AIDS response. The process was led by the Sudan National AIDS Control Program (SNAP), co-sponsored by Shell Company of the Sudan limited and ABB, with collaborative support from UNAIDS, Sudan AIDS Network (SAN) and the Sudanese People Living with HIV/AIDS Care Association. It was a unique workshop, the first of its kind in the country and was graced by the Federal Minister of Health. The key issues discussed included the concept of corporate social responsibility by urging private companies to be accountable in supporting and advancing social issues in the communities which they serve in; the need for national authorities to provide the private sector with a menu of priority partnership/support areas; stigma and discrimination against people living with HIV and the need to aggressively scale-up HIV related information dissemination with a comprehensive prevention package. Representatives of different companies pledged support in various ways including donation of \$50,000 worth of antiretroviral drugs for treatment.

There were specific interventions that aimed at reduction of stigma and discrimination while concurrently strengthening social support at community level. Community leaders were trained on fighting stigma and discrimination and selected families from the same communities provided with materials and psycho-social support as part of the strategy to increase the community capacity to support vulnerable children and families. During the course of 2007, about 1,070 community leaders were trained from Kassala, Red Sea, Gedarif, South Darfur and North Darfur States. During the same year, approximately 360 families and households from Kassala, Gedarif, South Darfur, North Darfur, Khartoum and the other Northern States benefited from material and psycho-social support.

The rating of policy efforts in support of HIV prevention reflected an improvement from a level of 5 in 2005 to a 7 in 2007. This was attributed to existence of a better focus and specific targeting of the most-at-risk populations as well as the national strategy on behaviour change communication that was endorsed during the period that were supported by UNICEF and UNAIDS.

In addition, strategic planning which is relevant to selected sectors has been initiated. The rating of efforts in the implementation of HIV prevention programmes also improved from a value of 5 in 2005 to 7 in the year 2007. The main progress recognised included the significant increase in geographical coverage of the HIV prevention programmes within all the States in North Sudan; and the increase in technical capacity for programme planning as well as implementation. There was also stronger participation of the community of people living with HIV and AIDS in implementation of prevention programmes.

Other important activities included the successful development of standard guidelines by the implementing partners for pre-testing IEC materials at national and State levels, which was coordinated by SNAP and UNICEF; the national IEC development workshop that brought artists from various backgrounds to produce various materials in different formats, from which 15 posters were selected for field testing in 9 locations representing Northern Sudan; and commemoration of the World AIDS Day. The production of IEC material increased substantially due to availability of resources from the GFATM in North Sudan; the set standards and guidelines as well as technical assistance from UNICEF and UNDP. The distribution system changed from the traditional quota and special events a more systematic one that put the needs and population size of the States into consideration thus ensuring optimum coverage. Furthermore, arrangements have been made with the National Telecommunication Corporation (NTC) to establish an information hotline for HIV and AIDS. The NTC has provided all the telecommunication equipment and technical assistance free of charge and its now under processing.

Treatment, Care and Support

The national policy on HIV and AIDS as well as the national strategic plan highlight treatment, care and support as priority interventions in the national response within North Sudan. The HIV and AIDS treatment care and support services have been introduced in all the 15 States of North Sudan and there is deliberate effort to scale up within the individual states. The country adopted a policy for provision of free HIV and AIDS related services, which has significantly alleviated the suffering of people living with HIV. However, some expenses that are encountered during the course of illness or hospitalization are not subsidized for instance cost of admission and other investigations that may not be specific to HIV. The bulk of ARVs and other HIV-related commodities are being accessed with resources from the GFATM and procured in accordance to the norms of paying the lowest possible prices for WHO pre-qualified drugs. Some of this procurement has been done through WHO, with a shift underway to transfer this role to UNDP (through IAPSO).

Quality assurance for treatment, care and support services was addressed through revision of the patient monitoring tools, which included updating the patient cards, registry books and VCT charts to facilitate follow up of patients; as well as preparing for a cohort analysis of the enrolled ones. There has also been deliberate effort to develop new policies and guidelines to standardise comprehensive care. For instance the Home Based Care guidelines were developed and are currently in use while enrolling patients into home based care programs. The paediatric HIV care policy is in the process of development and the first draft was shared in preparation for the consensus building workshop. The quality of testing services was addressed by ensuring the reliability of reagents and testing kits; procurement of ten (10) new CD4 machines; and training of laboratory technicians on testing and use of CD4 machines within the country (11 were trained in Khartoum State) and out of the country (4 received comprehensive training in Germany).

Consultation workshops were conducted during the course of 2006 to chart the road map to universal access to HIV prevention, treatment, care and support for all by the year 2010. Two-day State level workshops were convened for an average of 20 participants representing key player on the area of HIV/AIDS in 5 selected states; Blue Nile, North Darfur, Gadarif, Kassala and Gezira States. The consultations were based on the identified obstacles in order to agree on goals, targets and the indicators of success. The states consultations were followed by a national consensus workshop to finalize the North Sudan road map to the universal access of HIV services,

over 70 participants attended and represented stakeholder from states and federal levels. The road map developed at the workshop was used as a guiding document in the planning process of scaling up of the HIV services.

HIV counselling and testing services are provided through the established Voluntary Counselling and Testing (VCT) centres that are mainly attached to health care facilities though few stand-alone centres have been established elsewhere like at the universities and youth clubs. The testing is based on use of the rapid HIV test kits, with the goal of delivering results within 30 minutes to one hour. There are currently 56 VCT centres in North Sudan that by the end of December 2007 had provided HIV counselling and testing services to about 12,702 people. The majority of clients accessed the HIV counselling and testing services from public sector facilities but a small proportion accessed from non-governmental organisations such as the Sudan Council of Churches. There has been an increase in the demand for skilled counsellors in the North Sudan. The training of counsellors was conducted all through 2006 and 2007, both within the country and in the neighbouring countries to expose the participants to wider experience. The initial training that was conducted in Uganda and Kenya benefited 42 counsellors, while the in-country targeted 82 who received basic and refresher training in basic counselling skills; paediatric counselling; PMTCT counselling; and counselling in the context TB/HIV. The supervision of trained counsellors was relatively weak during the early phases but the system has been strengthened through training of supervisors who are expected to offer technical and moral support to their fellow counsellors. A gender-related assessment was conducted for the VCT services through a collaborative programme involving WHO and Ahfad University for Women. The results formed the basis for further adaptation of VCT guidelines and Standard Operating Procedures to greater gender-sensitivity. There has been a move to build the skills of service providers in the area of 'provider initiated testing and counselling and an initial group of 23 were trained in 2007 to provide services in the TB/HIV facilities.

The intervention for Prevention of Mother to Child Transmission of HIV (PMTCT) was started as a pilot programme in 2005 at 5 health facilities within in 3 states. The pilot phase stopped at the end of 2005 and during 2006 there were no PMTCT services in the country. However, some preparatory activities to re-introduce services were initiated and training efforts were undertaken. The PMTCT guidelines were developed and finalised with support from partners; and the policy endorsed in preparation for launching of the service, which was done in 2007. Training was conducted for health care providers in preparation to re-introduce the service at selected health facilities during the first half of 2007. The PMTCT services were started in August 2007 at 7 health facilities out of the 10 that had been set as the target for this year. The implementing health facilities are located in Khartoum, Kassala, Red Sea, South Darfur and North Kordofan States. Each state has one health facility that provides PMTCT services with the exception of Khartoum State where 3 sites are currently providing services. As of December 2007, it was reported that a total of about 2,590 women had benefited from PMTCT group and individual counselling services. Out of those who were counselled, 1,557 were tested for HIV and 8 (0.5%) were found to be positive. The approximately 40% opt out rate represented by these figures indicates the challenges that are likely to be related to stigma and assuring the quality of counselling services.

The services for antiretroviral treatment were first introduced in 2003 at 3 facilities in Khartoum State. The Integrated Management of Adult and Adolescence Illnesses modules were adapted in 2006 and formed the basis for all training that is conducted at national and State levels to prepare health care providers for HIV and AIDS treatment, care and support. The technical support from WHO and resources from GFATM resulted in the establishment of centres for provision of ART services in all other 14 states during the period between 2006 and 2007. The adoption of a policy for provision of free drugs that includes ARVs, drugs for management of opportunistic infections, STI and tuberculosis to all AIDS patients overcame the principal challenge that was posed by the cost sharing policy. The total number of people ever started ARV since January 2006 is 1,561, and currently 908 are under antiretroviral treatment which is still low when compared to the estimated number of people in need of treatment. A cohort analysis was conducted during 2007 for patients enrolled on ART in 4 centers in Khartoum state, a total of 377 patients were enrolled and only 179 of them are still on ART (47.5%). The management of opportunistic infections is

done all over the country through the centres that provide ART, as well as other health facilities such as TB centres. However, data on OI for PLWH is currently only received from the ART sites and as of September 2007, 1,973 clients were reported to have received Cotrimoxazole prophylaxis from 21 service delivery points.

Limited sentinel surveillance conducted in 2004 revealed HIV prevalence of 2.3% among patients with tuberculosis, which underscored the close relationship between TB and HIV. A further step in the management of OI was taken through establishment of TB/HIV service points in the States of Khartoum, Kassala, Gedarif, Red Sea, River Nile and South Darfur. The sites were selected on the basis of high numbers reported for TB cases and services were available from September 2007 at 5 sites. Overall as of December 2007, 184 TB clients had received HIV counselling services out of whom 183 were tested for HIV and 38 were found positive which accounts for 20.7%. The HIV positive TB patients were referred to ART centres. The guidelines for Post Exposure Prophylaxis (PEP) went through a series of discussions before being finalized and adopted. The services for post-exposure prophylaxis are now available for occupational and non-occupational exposures such as after incidents of sexual violence. Training modules were developed and used to conduct sensitization as well as training of officers at federal and State levels. The financial support from WHO was used to avail PEP kits to 21 sites all over the 15 States in North Sudan.

The management of sexually transmitted infections (STI) was integrated in the primary health care service delivery points in all the States to ensure wider coverage using the syndromic approach that was adopted by the country. The protocol was reviewed and updated, which was followed by development of a new training manual. During the course of the year, 180 health care providers were trained; and as of November 2007 approximately 14,920 clients were reported to have been treated for STI at 181 health facilities in the northern states. Condom distribution is primarily distributed within the context of preventing further spread of STI through the health facilities. The reports revealed that by November 2007 about 438,330 condoms had been distributed through the health facilities that provide STI services in North Sudan.

A Procurement and Supplies Management (PSM) unit at SNAP was established as a part of GFATM activities in round 3 and 5 grants for HIV/AIDS in Sudan to address the needs program supplies and commodities. In the Round 3 proposal, the PSM component was weak and the activities were limited to the procurement of ARVs, OIs, STI and laboratory supplies as well as the non-health items such as IT, electronics, furniture and condoms. The other important components storage and distribution were not included. Product selection was done through consultation with treatment experts and procurement of commodities was entrusted to WHO, while the Government of Sudan handled the component of storage and distribution. During the first year of Round 3 GFATM, WHO procured ARVs, drugs for OIs, STI drugs, equipment and supplies for CD4 tests; and laboratory consumables. SNAP conducted two rounds of distribution of ARVs and STI drugs to the sites as well as adoption and printing the monitoring tools (formats, reports).

A more comprehensive PSM component was proposed under the Round 5 proposal. Along with the start of implementation of this grant, the GFATM commodities unit was established in the General Directorate of Pharmacy (GDoP) with a medium term goal of supporting TB and Malaria PSM. The PSM activities have been scaled up to include conducting of an inventory on storage and distribution to the States and localities in addition to training, developing the reporting system and supervision. A PSM Coordinator was recruited in all the States; vehicles for distribution were procured; monitoring tools were developed, produced and distributed to all the States; and the storage facilities are to be upgraded in the States and at the ART sites. Central training was conducted for the PSM Coordinators from all the States to build their capacity to manage HIV programme supplies and commodities.

Furthermore, a Technical Committee was constituted with responsibility for scaling up the PSM activities, sharing plans and development of the modules to be used for forecasting. The Technical Committee was assigned the responsibility of commodity selection and specification for both health and non-health items after which the Principal Recipient (who is a member of the Committee), takes over the procurement, including selection of the supplier. The forecasting,

quantification and maintenance of the inventory is done by the new GFATM-PSM unit at the GDoP, in collaboration with the national AIDS control programme. Items procured include first and second line antiretroviral drugs for paediatrics; medical equipment, condoms and non-health items such as IT, furniture and vehicles.

The rating of general efforts in the implementation of HIV treatment, care and support services for North Sudan was significantly low at 2 in 2005 but felt to have increased to 6 in 2007. The progress was mainly attributed to an increase in the funding that came from GFATM that facilitated scale up of the services. The absence of a definite policy on orphans and other vulnerable children (OVC) has resulted in a non-conducive environment for implementation of services for OVC. The rating of efforts to meet the needs of orphans and other vulnerable children was constant at 2 for 2005 and 2007. The main progress was the preparatory activities that had been initiated to conduct a comprehensive situation analysis for OVC in the country.

Surveillance

Surveillance for HIV and AIDS was one of the functions routinely carried out by the national AIDS Control Programme right from its establishment. However, for various reasons the system collapsed and was only resumed in 2004 and 2005 to cover clients attending antenatal clinics; tuberculosis and STI patients. One of the biggest challenges faced by the Surveillance Unit was transportation and processing of blood samples in a very large country with hot climate and relatively weak infrastructure. In 2006, the situation was compounded by failure to receive the laboratory supplies in time and consequently HIV surveillance was not done for that year. A draft five-year HIV surveillance strategic plan has been produced and is under discussion, which will provide the framework for implementation of all activities in the country. In 2007 the country opted to change the HIV surveillance samples from fresh blood to dried blood spots, went through all the necessary ethical committee approvals and conducted training to orient the service providers. As of 31st December 2007, the required samples had been collected from 32 sites covering all the 15 Northern States in the country and transported to the national laboratory for testing. The quality control system was established through the Centres for Disease Control and Prevention (CDC) at their regional laboratories in Kenya and Uganda. While previous rounds included sentinel surveillance among STI patients, this was dropped from the 2007 round but will be resumed in the subsequent ones.

The AIDS case reporting in the country is still adjusting to changes in case definition from the traditional passive reporting based on clinical criteria to the one linked to monitoring patients for antiretroviral treatment. The Sudan National AIDS Control Programme in collaboration with Southern Sudan AIDS Commission developed a national protocol for conducting the AIDS Indicator Survey in 2008/09. The sample frame will be designed using data from the national population census that is scheduled for April 2008. During 2006, special studies were conducted / released among selected most-at-risk populations namely: long distance truck drivers and men who have sex with men in Khartoum State; and female sex workers in Gezira State. The studies provided behavioural data for these and other most-at-risk populations. The national capacity for both government and non-governmental organisations to use the Respondent Driven Survey (RDS) methodology was built during 2007, in preparation for conducting nationally representative studies among the most-at-risk populations in 2008 with a focus on youth, long-distance truck drivers, men who have sex with men; and female sex workers.

The Sudanese Association of People Living with HIV

The involvement of people living with HIV and AIDS is one of the key elements that determine success of the national response. The Sudanese Association of People Living with HIV was formed in 2004 and has achieved national and international recognition. Within the country it is represented in different platforms for instance, it's a member in the National AIDS Council which is the highest HIV/AIDS policy body in the country; the Association has representation in the Country Coordinating Mechanism (CCM), which is the steering committee for coordination of the Global


Fund to fight AIDS, Tuberculosis and Malaria; and the Association is represented on the executive board of the Sudanese AIDS Network (SAN), which is an umbrella organization for NGO working in the field of HIV and AIDS. At the international level, the Association effectively participated in the International AIDS Conference in Toronto, Canada and was presented with an award for excellence. The Association also participated in the New York AIDS Summit.

Greater involvement of PLWH is secured through acknowledging their role not only as beneficiaries of the services but also as partners. It is recognised that the PLWH can contribute to the response by improving the quality of their lives and the lives of others by reducing transmission of the infection. SNAP in collaboration with UNAIDS in the period between April and May 2006 conducted a mapping exercise to identify the support provided by stakeholders to PLWH; and to provide an overview of the situation of PLWH, partners supporting them; and gaps in capacity and skills within the Association. Key concerns raised by the PLWH included low socio-economic status; stigma, education, rights, medical care and psychological wellbeing. The suggestions for addressing the concerns included support for awareness and educational programmes; income generating activities; and enactment of laws and policies to support PLWH.

The Government has demonstrated strong commitment to support the rights of people living with HIV and to reduce stigma and discrimination. The Sudanese Association of people living with HIV provides the channel that government utilises to support the PLWH. The first lady H.E Mrs. Widad Babiker, chaired a high level advocacy meeting in December 2006 that was held in the National Assembly and attended by the Federal Minister of Media and Information among other high officials and with technical and financial support from UNAIDS. The key recommendations from the meeting included upholding the rights of people living with HIV and supporting them to lead a normal productive life. The meeting also underscored the need for government to adopt the Association's plans; the need for more advocacy and fixed media programs. The recommendations from the meeting formed the basis for a second advocacy media event to support the rights of people living with HIV that was conducted in April 2007 with support from UNDP. The Federal Minister of Health, the Minister of Media and Information, other government officials, media personnel, heads of UN agencies and civil society attended the meeting. Issues discussed included reduction of stigma and discrimination; role of the media; legal aspects of PLWH; and the link between HIV/AIDS and human rights.

People living with HIV have become more active in influencing policies and making decisions that affect their wellbeing. An assessment was conducted that revealed that there were no formal activities or plans for the provision of home based care to persons living with HIV. It was the efforts of PLWH through the Association resulted in development of the Home Based Care (HBC) strategy in 2007. The home based care activities are still fairly ad hoc, fragmented and centred mainly on provision of psychosocial support and very limited material support. The stakeholders had a 2-day meeting to discuss strategies for improvement and training was conducted to build and enhance the capacity of service providers, NGOs and PLWH. The training was attended by 14 organisations. There are few organizations that currently provide HBC services such as Together for Sudan; Sudan Council of Churches; and Sudan Red Crescent. There are few clients enrolled in the HBC programs possibly because the clients still prefer going to the hospital and so as to avoid disclosure of their HIV status.

There has been deliberate effort to build the capacity of Association and its members in the fields of leadership skills; organization, care and human rights. The Government of Sudan has put resources to construct offices for the Association at state level. A 4-days workshop in capacity building for PLWH was conducted in July 2007, where the first 2 days were spent to train on building technical skills; and the last 2 days covered the managerial skills. Thirty two participants from states and federal level participated. In addition, SNAP in collaboration with WHO conducted a workshop to train expert patients as part of the training team for the basic ART clinical course and basic ART aid course, which benefited 20 participants. Leadership modules were developed with Ahfad University for Women and UNFPA that formed the basis for training 32 participants using a highly participatory methodology. The participants identified their own gaps in leadership



skills, demonstrated strong commitment and provided valuable suggestions as well as recommendations that will be considered in future trainings.

Best Practices


The Sudanese Coalition on Women and AIDS

The issues of women vulnerabilities and proneness to risks related to HIV and AIDS have come under focus from the realisation that globally, the incidence of HIV among women is greater than men. One of the approaches adopted by UNAIDS was establishment of the Global Coalition on Women and AIDS in 2004. The Sudanese woman has participated in national, regional and international efforts that address the issues of women and AIDS. She is now represented in the parliament, national and academic institutions as well as civil society organizations including voluntary associations; women and labour alliances. The Ministry of Social Welfare and Woman and Child Affairs; the Sudan National AIDS Control Programme; voluntary associations and the academia, all aspired to establish a coalition in Sudan around issues of women and AIDS. This was partly due to the need to correspond to the international response; and to fulfil the objectives of the Organization of African First Ladies against AIDS to reduce the women vulnerabilities from AIDS and to engage women as active and effective partners in the national response.

The Attempt to establish the Sudanese Coalition on Women and AIDS started in 2005 after return of the Sudanese delegation from the Regional Meeting on "Women, Girls and HIV/AIDS in MENA", which was organized by the UNAIDS Regional Support Team for the Middle East and North Africa and held in Amman from 21st to 23rd February 2005. A national consultant was hired to assist in formulating the document of the coalition, working closely with SNAP, Ministry of Social Welfare; the national Population Council; and Ahfad University for Women. The procedures to draft a frame work for the coalition continued with exclusive meetings and discussions with stakeholders who showed interest in issues of women and AIDS. Meetings were conducted involving the concerned ministries and the governmental sector, especially the Ministry of Health – National AIDS Control Program; the Ministry of Social Welfare – Department of Woman and Family Affairs; the Ministry of Humanitarian Affairs; the National Population Council and the civil society sector including voluntary associations such as Sanad organization, Sudanese Women General Union, Sudan Workers Trade Unions General Federation, the academic sector, specifically Ahfad University for Women (AUW); and the UN organizations, notably the United Nations Population Fund (UNFPA). The political leadership was demonstrated through the commitment of the first lady, H.E Mrs. Widad Babikar, who personally took the lead on the Sudanese Coalition on Women and AIDS. The efforts were coordinated under the Presidency, which provided the logistic and financial support to launch the Women's Coalition against AIDS in Sudan. Promotional materials of the Coalition were printed and many sensitization as well as advocacy meetings were held in different geographical districts in North Sudan.

The efforts continued throughout 2006 and focussed to establish the Coalition at the province level through Sanad voluntary organization with technical and financial support from UNAIDS. While working in close collaboration with the State level coordinators of Sudan National AIDS Control Programme, Sanad provided training of trainers in a number of States about topics of women development including HIV prevention, care and support. The trainings were followed by setting up the Coalition committees at the State level in cooperation with Sanad organization and the office of Sudan First Lady. The Coalition is under patronage of the first lady at the federal level; and first ladies of the states at the States' level. It is proposed to be composed of two bodies: the general assembly and the planning and executive council at both the national and provincial levels. The responsibilities of member individuals as well as institutions were delineated. Currently, the Coalition has been established in 9 states: River Nile, Northern, Blue Nile, Red Sea, Gedarif, Kassala, Gezira, White Nile and North Kordofan. Establishment of the Coalition has been planned for the remaining States that include: Khartoum, Sennar, South Kordofan, North Kordofan, West Darfur and South Darfur.

A consultative workshop was held in May 2007 in Khartoum with the goal of activating the Sudanese Coalition on Women and AIDS within the country. It also aimed at developing the



Coalition action plan in collaboration with the stakeholders so as to effectively assume its objective role within the national HIV and AIDS response in Sudan. Utilising group discussions and plenary presentations, the consensus was reached on the name and definition for the Coalition; the objectives, guidelines and structure. The meeting also identified the priority activities of the action plan for the coalition in 2008-2009.

The Coalition has organized advocacy events such as the World AIDS Day (WAD) activities, which had a high level of participation. The River Nile, which is a lead State in Women Coalition, hosted the WAD commemoration in 2006, while Khartoum State hosted the function in 2007, with the first lady as the chief guest. The high level attendance included the UN Deputy Theme Group Chair, UNAIDS country coordinator and the SNAP Director among representatives from government sectors, UN agencies, civil society organizations and women union. Currently efforts are underway to build the institutional capacity of the Coalition at both the State and Federal levels to ensure that it may adequately contribute towards stepping up a more coordinated policy and action on issues of women and AIDS.

Major Challenges and Remedial Actions

Challenges for the Reporting Period and Progress on the Previous

The 2005 UNGASS country progress report from North Sudan highlighted several challenges that were identified as bottle-necks to the successful implementation of HIV and AIDS interventions. The table below presents a brief description of the progress that was made in addressing those challenges during the implementation period. In addition, a lot of progress was made in the national response to HIV and AIDS during the period between January 2006 and December 2007. Nevertheless, there were challenges faced that hindered the progress towards successful achievement of the set UNGASS targets. These are also summarised in the same table below.

Reported in 2005	Progress made by 2007	Challenges during the 2006 – 2007 period
<p>1. Inadequate coordination among the stakeholders in planning and implementing of the HIV/AIDS programmes</p>	<ul style="list-style-type: none"> ▪ There has been significant improvement in the coordination of HIV and AIDS programmes in the country. The mechanism was streamlined to facilitate joint planning that involves all stakeholders from the different sectors; and the link to the national AIDS Council was strengthened. The monitoring and evaluation framework was revised into a single one from the national to State levels, in line with the principle of “three-ones”. The coordination structures have also been decentralized and now include a mechanism for provision of technical support “The AIDS Task Forces ” that were established at State level. The advocacy-related challenges were streamlined as result of the improved coordination mechanism. 	<p>1. Low uptake of services</p> <ul style="list-style-type: none"> ▪ Government with support from the Development Partners established sites to provide integrated HIV and AIDS related services such as prevention of mother to child transmission of HIV (PMTCT); voluntary confidential HIV testing and counselling; management of opportunistic infections and antiretroviral treatment. However, uptake and utilization of the established services is still very low; this could be attributed to the fact that some of beneficiaries are not aware about the existence of these services and the deeply rooted stigma on HIV/AIDS. More efforts are underway to be done to address this challenge including BCC campaign , VCT promotion , out reach programs and advocacy efforts to tackle the stigma issue
<p>2. Inadequate capacity at different levels among different partners</p>	<ul style="list-style-type: none"> ▪ In general there has been deliberate effort to improve the financial, logistics and human resource capacity at all levels. This includes employment of new staff at national and State levels, including among the United Nations’ agencies; putting in 	<p>2. Limited integration of HIV/AIDS services into the existing PHC services</p> <ul style="list-style-type: none"> ▪ The initial prevention, care and treatment services were introduced using a vertical and parallel approach due to the

Reported in 2005	Progress made by 2007	Challenges during the 2006 – 2007 period
	<p>place an incentive and motivation policy/scheme; capacity building for the staff both within the country and at international locations; logistical support in form of office space, equipment and supplies; and building capacity within the civil society organizations. However, there is still significant room for improvement and a high staff turn-over continues to occur from the public to private sectors.</p>	<p>emergency aspect of the HIV and AIDS situation, which required an urgent response. The more recent interventions have tended to follow on the same approach since it appeared to provide quicker results. However, the HIV/AIDS services have ended up being external to the routine health care delivery activities and integration is necessary for sustainability and cost-effectiveness.</p>
<p>3. Existence of gap between Federal and State level</p>	<ul style="list-style-type: none"> ▪ There has been targeted capacity building and provision of technical assistance to strengthen the decentralization process. The position of Zonal AIDS Coordinators has been established as a further strategy for bridging the gap between the national and State levels. Clear reporting channels between states and the federal body are in place and more authority and delegation are transferred to states. Further efforts are done in some states where HIV control body are now function at locality level that represent the third level of governance in the Sudanese Federal System 	<p>3. Limited absorption capacity</p> <ul style="list-style-type: none"> ▪ The Government with support from Development Partners has been able to mobilise significant amounts of resources for the national HIV and AIDS response. The existing capacity to absorb and utilise the existing financial resources has been quite low, resulting in low coverage and accessibility of HIV-related services despite the availability of funds. The current Safe Guards policy that limits the extent to which government institutions can utilise the funds provided to the country by international donor agencies compounds the problem by creating more bureaucracy to overcome. Furthermore, the policy makes it even more difficult for civil society and other partners to qualify as sub-recipients, due to the stringent criteria applied. This further narrows options of deploying other non government absorptive capacity to execute GFATM activities. This results in longer periods being required to process funds, which in turn delays implementation of activities, accountability and reporting. It has also had a negative effect on the ownership of programmes and the leadership role that is traditionally played by government. The review of this policy could result in improved performance of HIV and AIDS programmes, including an improvement in the

Reported in 2005	Progress made by 2007	Challenges during the 2006 – 2007 period
		capacity to utilise the existing resources.
<p>4. Inadequate strategic information</p>	<ul style="list-style-type: none"> ▪ Attempts have been made to strengthen the whole area of strategic information. However, the documentation is still weak, the reporting quite irregular and the capacity for analysis and effective sharing of information remains limited. The preparatory phase for conducting specific targeted studies is complete and the results will improve on the existing data on HIV and the link to behaviour change process. An AIDS indicator survey has been planned for 2008 as a follow on to the national situation analysis that was conducted in 2002. 	<p>4. Weak decentralised structure</p> <ul style="list-style-type: none"> ▪ Decentralisation of HIV and AIDS related interventions has been recognised as a critical step that is required to scale-up and increase access to services. The existing structure at national and State levels is not robust enough to take on the required roles and responsibilities. It will be necessary to strengthen the structure and the decentralisation process as a whole.
<p>5. Gaps in collection, compiling and dissemination of HIV/AIDS programmatic and financial data</p>	<ul style="list-style-type: none"> ▪ The process for conducting research in the country has been standardized and should be in line with the guidelines produced by the Directorate of Research, Ministry of Health¹². All implementing partners are expected to report on the agreed HIV and AIDS indicators, within the single national monitoring and evaluation framework using the standardized tools. The capacity of the national Monitoring and Evaluation Unit has been strengthened; the national database HIV and AIDS database is undergoing a process of development. The national AIDS control programme continues to mobilize resources for further strengthening of the monitoring and evaluation component of the national HIV and AIDS response. Tracking of national resources for the HIV and AIDS response remains weak but the process has been initiated to establish the system 	<p>5. Limited allocation of funds by government</p> <ul style="list-style-type: none"> ▪ There is definite political commitment by government at national and state levels towards supporting the national HIV and AIDS response. However, the direct contribution of funds by the government to support HIV and AIDS activities at all levels has remained relatively small. The national response would be stronger if government made deliberate effort to increase financial support at national and State levels.

¹² Federal Ministry of Health, 2007. Guidelines for Ethical Conduct of Research Involving Human Subjects.

Reported in 2005	Progress made by 2007	Challenges during the 2006 – 2007 period
	<p>that will document resources to all sectors and programmes including the civil society organizations. An ongoing response analysis for CSOs will help this process and would contribute to better data generation by all partners</p>	
<p>6. Lack of prioritizing the HIV/AIDS service delivery areas</p>	<ul style="list-style-type: none"> ▪ This issue has been resolved and all planned activities including the last proposal that was submitted to the Global Fund, were based on the identified country's priorities. The HIV/AIDS strategic plan (2004-2009) has been the reference document for all interventions in the country. The ongoing process of the universal access and strategic planning will help better prioritization of the response considering the recent development. 	<p>6. Deficiency in strategic information and documentation</p> <ul style="list-style-type: none"> ▪ There is a consensus among the government and partners about the weakness in documentation and inadequacy of the strategic information to facilitate effective planning of HIV and AIDS programmes. However, despite the development of research protocols and guidelines as well as availability of funds, there were few studies conducted during the report period. In addition, the documentation system remains weak while the institutional memory is eroded as a consequence of poor documentation and high turn over of staff. There is need for further strengthening of the overall monitoring and evaluation system and to put in place a mechanism that will ensure effective use of the existing structures. Resource tracking is another area where information is either scattered or missing and there is an urgent need to develop a system to generate financial information for purposes of economic analysis and socio-economic impact assessments.
<p>7. No comprehensive strategy and package for the interventions with the most-at- risk populations</p>	<ul style="list-style-type: none"> ▪ There has been effort to conduct targeted studies among the identified most-at-risk populations, which include female sex workers, tea sellers, long distance truck drivers, prison inmates, refugees and street children. Specific modules and protocols have been developed to guide interventions among these sub-populations. 	<p>7. High turn-over of staff from the public to private sectors</p> <ul style="list-style-type: none"> ▪ Human resource development is an essential component of the national response to HIV and AIDS. Effort has been applied towards building the human resource capacity to effectively provide prevention, treatment, care and support interventions at national and State levels. The capacity of the public sector to retain the staff has been quite low and a

Reported in 2005	Progress made by 2007	Challenges during the 2006 – 2007 period
		<p>significant proportion of those who have been trained continuously move to the private and other sectors. It has been observed that human resource capacity of the donors and United Nations' agencies is being built at the expense of the public sector.</p>
<p>8. No comprehensive package for HIV/AIDS in emergency settings</p>	<ul style="list-style-type: none"> ▪ The process of defining the generic comprehensive package for emergency settings has been on-going at the international level. The country was able to adopt the IASC Guidelines for HIV/AIDS interventions in Emergency Settings and used it to conduct training of trainers for the selected targeted areas. Resource mobilization is being undertaken to facilitate implementation of the prioritized activities. 	<p>8. Limited promotion of condoms</p> <ul style="list-style-type: none"> ▪ Whereas significant gains have been made from advocacy on condoms, challenges remain. The current NSP (2004-2009) includes clear commitment to making condoms available for MARPs; and advocacy led government to accept inclusion of condom social marketing as a component of the GFATM Round 5 proposal. Nevertheless persistent criticism of condom distribution from the conservative groups resulted in difficulties to contract the identified private sector company to do condom social marketing, in part because of the Safe Guards policy of the GFATM.
<p>9. No standardized guidelines, protocols and policies for all the HIV/AIDS service delivery areas</p>	<ul style="list-style-type: none"> ▪ There has been deliberate effort to review, finalize and produce the draft guidelines, protocols and policies for most of the HIV and AIDS service delivery areas such as ART, IMAI, PMTCT, ANC surveillance etc. The ratification process for the workplace policy and law on HIV/AIDS is in the advanced stages. The next important phase is the one to ensure that all the guidelines, protocols and policies that have been developed are used to standardize the HIV and AIDS interventions. New polices and guidelines were developed in areas of surveillance, peer education , PMTCT , VCT and others , this has helped much the quality of the work implemented by all partners in the country. 	<p>9. Low community involvement of some most-at-risk populations</p> <ul style="list-style-type: none"> ▪ It would appear too ambitious at this point to expect full and open involvement of some most-at-risk groups in planning and formulation of HIV/AIDS activities and policies, as their behaviour remain illegal in the conservative cultural context. Nonetheless it is a notable opportunity that studies assessing HIV prevalence and risk behaviour in groups such as MSM and female sex workers are being conducted and interventions for them could be possible.

Proposed Remedial Actions

The following are the proposed remedial actions that will ensure that the national HIV and AIDS response remains on course towards achievement of the UNGASS targets.

1. Review of the national HIV/AIDS strategic plan

The current strategic plan was developed in 2004 and since then, there is a better understanding in the country about the HIV and AIDS epidemic as well as the multi-sectoral response. The country is experiencing a general increase in HIV-related funding and challenges in coping with conflict as well as post-conflict regions. Some key sectors have initiated the process of reviewing their components of the strategic plan to prioritise interventions and ensure their relevance. The national strategic plan will be reviewed to take into account the roadmap to universal access and align the overall HIV response to the context of Government's five-year plan.

2. Strengthen decentralisation

Significant strides have been made in the decentralisation of the national HIV and AIDS response to the State levels. There is need to consolidate this level of decentralisation but in addition, to introduce planning, implementation and monitoring of HIV/AIDS interventions at the Locality level, which is the functional unit of the State Local Governments. The Sudan National AIDS control Programme with support from UNAIDS is in the process of deploying Zonal Coordinators who will be expected to enhance the performance of the decentralisation system through provision of technical support to that level.

3. Widen multi-sectorality of the response

The current national strategic plan focussed on eight (8) line ministries that were considered the critical entry points to the national HIV and AIDS response. There will be need to broaden the response further through involvement of other new sectors while consolidating the interventions within the current implementing ones. This includes strengthening of partnerships and more meaningful involvement of the civil society organisations.

4. Scale up the HIV and AIDS services

HIV prevention, treatment, care and support services are available in all the States but access is still quite limited. There will be need to improve overall access to PMTCT and VCT as well as to strengthen the ART services at State level.

5. Strengthen monitoring and evaluation

Monitoring and evaluation is a key component of the national response to HIV and AIDS that provides the necessary input for continued improvement of services and programmes. There are significant gaps in strategic information, including the resources available at different levels for the national HIV and AIDS response. The monitoring and evaluation system will be improved with emphasis in the areas of quality and timeliness of the reports at all levels.

Support from the Country's Development Partners

Introduction

The support from Development Partners has been one of the critical strengths behind the national HIV and AIDS response in the Republic of Sudan. The major input was from the multilateral agencies such as the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM); the United Nations' Agencies comprising mainly of UNAIDS, WHO, UNICEF, UNFPA, WFP and UNMIS; as well as from the bilateral agencies, specifically the United Kingdom Department for International Development (DfID), the Swedish government, the Spanish government and government of the Netherlands. The support provided covered the following key areas:

- Procurement of equipment and logistics as a component of the operational support to programmes
- Building capacity of service providers through training in the different thematic areas
- Technical support in the form of consultants for different programme areas to work with national counterparts in order to strengthen capacity local capacity
- Direct financial support from the bilateral agencies for specific programme or thematic areas

Actions for the Development Partners

The recommended critical actions that need to be taken by the Development Partners in order to ensure that the country remains on course towards achievement of the UNGASS targets include the following:

1. Support the planning and implementation process of HIV and AIDS interventions. This includes the strengthening of partnerships between the public sector, private sector and civil society organisations, including the association of people living with HIV and AIDS. It will involve building the capacity of these partners at both the federal and state levels to plan, implement, monitor and evaluate HIV related programmes. In addition, there will be a component to engage the community and strengthen their active involvement in the national HIV and AIDS response.
2. Support further decentralisation of the HIV and AIDS response in the country. The planning and implementation of HIV and AIDS activities in the country has been shifted from the federal to the state levels, which has resulted in improved utilisation of the available resources. The decentralisation process should be strengthened and the response taken to lower levels within the States.
3. Support widening of the HIV and AIDS multi-sectoral response in the country. The active involvement of the other sectors is necessary in order to strengthen the national response. The support should be towards mainstreaming of HIV and AIDS within the sectors, including development of policy guidelines and strategic plans for implementation. Sectors should have focal persons with responsibility of leading the sector level HIV and AIDS response, in addition to being supported to mobilise resources for implementation of HIV and AIDS activities at the federal and state levels.
4. Strengthen the effective utilisation and accountability of HIV and AIDS resources. The Development Partners should be involved in the mobilisation of resources and promote transparency as well as accountability in the utilisation of all resources earmarked for the national HIV and AIDS response.

5. Strengthen the coordination structures at federal and state levels, in line with the principle of the "three-ones". The support should include the regular review of existing structures in order to ensure that they are functional and fulfil their mandate.
6. The Development Partners should support and strengthen the established monitoring and evaluation system in order to ensure that strategic information and programmatic data is available for overall management of the HIV and AIDS response in the country. This should include a mechanism for tracking all the resources including finance, which are invested in the national response by the different partners and stakeholders.

Monitoring and Evaluation Environment

Overview of the Monitoring and Evaluation System

It has increasingly become important for the programmes at State level as well as for SNAP to report accurately and on a timely basis using a standardized system to the national authorities and donors for purposes of monitoring and evaluation (M&E) of HIV/AIDS activities. This is part of the requirements for accountability and a necessary step in following up the progress of activities so as to identify the bottlenecks that need intervention in a timely manner. The development and finalization of the existing M&E tools and materials was through collaboration and partnership with multilateral agencies such as the United Nations (UNAIDS, WHO, UNICEF); the bilateral agencies and civil society organizations in the country in order to secure ownership and support, including continued funding for the scale up programmes and most importantly, utilization of the information for strengthening the programmes. Reporting of HIV and AIDS activities takes place at three main levels, as follows:

State level: This is the primary level for collection and consolidation of all reports for HIV-related activities. Each state has a program coordinator (State AIDS Coordinator) with the main responsibility of following up the implementation of the plans and to report back to the federal level. Activity reports are compiled at the service delivery points within the Locality level either at health facilities or from implementing partners who operate within the community. The reports are submitted to the State AIDS Coordinator on a regular basis who compiles quarterly reports of the State's activities and performance in relation to the set targets. The State AIDS Coordinator convenes meetings on a quarterly basis to discuss the reports with all the partners and stakeholders within State. In addition, there is a quarterly meeting for all the State AIDS Coordinators during which they discuss the implementation related challenges and strategies for improvement.

Zonal level: This level was introduced in order to strengthen the performance of the monitoring and evaluation system. The fifteen states have been grouped together on the basis of geographical location into five Zones namely: Eastern, Western, Central, Northern and Darfur. A Coordinator has been assigned from the Federal level to each zone who acts as the liaison between State and Federal programmes. The Zonal Coordinators spend up to 90% of their time within the States and are responsible for supporting the monitoring and evaluation activities within their 3 States, including compiling quarterly reports that cover the states in their zone. Unlike the State AIDS Coordinators whose responsibilities are confined to their states, the Zonal Coordinators constantly move between the States according to demand and have to be accessible and flexible to achieve good outputs.

Federal level: The national level M&E unit was established in the federal HIV/AIDS programme and has the responsibility of receiving and compiling reports from the States and the zonal levels as well as from the federal units and national level partners. The Unit supports and strengthens the sub-national M&E units within the states and organizes the quarterly meetings for State AIDS Coordinators as part of the capacity building process. The M&E Unit that is based in SNAP, has in collaboration with UNAIDS and other partners been responsible for the development of one agreed, functional HIV monitoring and evaluation framework. There is a national monitoring and evaluation Reference Group with specific terms of reference and membership that includes the UN agencies, civil society, government sectors, and research/academic institutions. Their primary task is to support programmatic issues related to monitoring and evaluation of the national HIV and AIDS response.

Achievements

The overall rating of the monitoring and evaluation efforts of the AIDS programme was 4 in 2005, which has increased to 6 in 2007. The main progress was attributed the strengthening of the Unit

at national, Zonal and State levels; the revision of the national monitoring and evaluation framework; and the development of the national monitoring and evaluation plan.

A handbook on HIV and AIDS core indicators was developed, discussed and adopted for national use by all the partners and stakeholders in the national HIV/AIDS response. The document is in line with the international definitions and agreed upon to be the standard for reporting at both State and Federal levels for Northern Sudan. During the course of 2006 the M&E framework was finalized and integrated with the handbook of core indicators through a consultative process that involved all the partners at national and sub-national levels. The national M&E framework is currently undergoing a process of revision and updating with from UNAIDS in order to integrate the GFATM and UNGASS indicators.

There has been significant effort to build the national capacity to perform monitoring and evaluation of the national response during the reporting period. Technical support for SNAP was secured from UNAIDS in the form of a full time international M&E consultant who was available throughout 2006. The M&E officers also benefited from long and short international courses as well as active participation at international conferences such as the International AIDS Conference in Toronto, Canada; and the regional ones. In addition, there were national and sub-national trainings that were conducted to strengthen the capacity of different cadres of service providers and representatives of the association of people living with HIV/AIDS in monitoring and evaluation of HIV/AIDS interventions. The courses were conducted in collaboration with UN agencies, the MEASURE project and CDC – Sudan. Other specific achievements included the development of the national database at the Federal level; development of the national M&E plan and the recruitment of staff at national and State levels. Furthermore, SNAP has produced and disseminated a quarterly HIV/AIDS newsletter to all UN agencies, civil society organisations and State level counterparts; as well as hosted in collaboration with UNFPA and UNAIDS, the quarterly State AIDS Coordinators' meetings.

Challenges

Despite the achievements that were made during the period of this report, significant challenges are still faced during the course of attempting to effectively implement a comprehensive monitoring and evaluation system:

1. The documentation of HIV and AIDS interventions at all levels still leaves a lot to be desired. There is a big gap the available important strategic information including sentinel sero-surveillance data; reports from national and local surveys; and financial performance of HIV/AIDS programmes.
2. Low output from the staff despite great efforts to build their capacity in management of the overall M&E system. This is compounded by high attrition of the trained staff at both Federal and State levels.
3. Inadequate resources are allocated to the monitoring and evaluation component of the programme, which limits the capacity to generate good quality information such as targeted evaluation studies and operations research.
4. Lack of infrastructure at state level to ensure effective utilization of the modern technologies (Fax, internet, conference call, data bases).
5. Limited dissemination of information and which extends to submission of reports that is often not timely.
6. Failure by some implementing partners to adhere to the agreed upon standards for reporting.

Remedial actions to overcome the challenges

The following are some of the proposed remedies to overcome the challenges that were faced in implementation of comprehensive M&E activities

1. Adopt the culture of routine documentation and introduce more effective ways of documenting events. The surveillance unit will be supported to produce timely and high quality data from surveys and surveillance (population base information). In addition, technical support will be secured to enhance the performance of the overall M&E system.
2. The capacity of staff will be built through regular training and mentoring. Innovative approaches will be utilised to provide incentives for designated staff to improve upon the retention. In addition, technical support supervision and data audits will be conducted to strengthen capacity and improve the quality of information at all levels.
3. Additional resources will be mobilised for support of M&E activities. Advocacy will be conducted among the implementing partners to encourage allocation of optimal resource to the M&E component of HIV/AIDS programmes. Coordination of activities will be promoted so as to ensure efficient and effective use of resources.
4. The M&E of the national HIV and AIDS response will be linked and integrated to the national health information system to ensure effective utilisation of resources. Advocacy will be conducted to create enabling environment that will enhance the use of modern technologies effective communication and timely transfer of progress, monthly and quarterly State reports.
5. The national and sub-national HIV databases will be developed and maintained to enable stakeholders access the relevant data for rational planning, programme management and improvement.
6. Specific needs for technical capacity building of the overall national monitoring and evaluation system includes the following:
 - Long term professional training (master or higher diploma) for M&E officers in state and federal level including civil society and people living with HIV/AIDS.
 - Short term courses that provide better background to achieve full scope of M&E activities e.g. National AIDS spending assessment course, CRIS
 - Study tours to other high performing countries with success stories so as to benefit from their experience.
 - Technical assistance in specific aspects of M&E such as evaluation
 - Technical assistance to develop a functional national data collection and analysis plan
 - Technical assistance to put in place a resource tracking system and build local capacity in this area



Annexes

1. National Composite Policy Index (NCPI) questionnaire
2. National AIDS Spending Matrix by Source.