Contextual Analysis of HIV in Sudan

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Appendices

Abbreviations

AAH – Action Against Hunger
ACORD – Agency for Co-operation and Research in Development
ADRA – Adventist Development and Relief Agency
AIC – Sudan – African Inland Church of Sudan
AIDS – Acquired Immuno Deficiency Syndrome
ANC – Ante Natal Clinic
ARC – American Refugee Committee
ART – Anti Retroviral Therapy
ARV – Anti Retroviral
BATC – Bishop Alison Theological College
BCC – Behaviour Change Communication
CCM – Comitato Collaborazione Medica
CDC – Centre for Disease Control
CMS – Church Missionary Society
CTG – Country Theme Group on HIV and AIDS
ECHO – European Commission for Humanitarian Aid
DMT – Tearfund's Disaster Management Team
FAR – Fellowship of Africa Relief
FHI – Family Health International
FOCUS – Fellowship of Christian Unions in Sudan
HARD – Hope Agency for Relief and Development
HIV – Human Immunodeficiency Virus
IDP – Internally Displaced People
IEC – Information, Education and Communication
IFES – International Fellowship of Evangelical Students
IMC – International Medical Corps
IRC – International Rescue Committee
INGO – International Non- Government Organisation
MOH – Ministry of Health
MSF – Medecins San Frontieres (F – France, H – Holland, CH – Suisse)
NSCC – New Sudan Council of Churches
NGO – Non-Government Organisation
OCHA – United Nations Office for the Coordination of Humanitarian Affairs
OV – Onchoceriasis
PEP – Post Exposure Prophylaxis
PHCC – Primary Health Care Clinic
PLHA – People living with HIV and AIDS
PLWA – People Living with AIDS
PMTCT – Prevention of Mother to Child Transmission of HIV
PSI – Population Services International
SCAN – Sudan Christian AIDS Network
SCF – Save the Children Fund (UK, US)
SEM – Sudan Evangelical Mission
SIM – Serving In Mission
SNAP – Sudan National AIDS Programme
SPLM/A – Sudan People's Liberation Movement/Army
STD – Sexually Transmitted Disease
STI – Sexually Transmitted Infections

SSAC – Southern Sudan AIDS Commission
SSOPO – Southern Sudan Older People's Organisation
TB – Tuberculosis
TOT – Training of Trainers
UN – United Nations
UNAIDS – The Joint United Nations Programme on HIV/AIDS
UNDP – United Nations Development Programme
UNFPA – United Nations Family Planning Association
UNICEF – United Nations Children's Fund
USAID – United States Agency for International Development
VCT – Voluntary Counselling and Testing
WFP – World Food Programme
WHO – World Health Organisation
ZOA – ZOA Refugee Care

Executive Summary

Background and Context

Sudan has been afflicted by war and drought for many years which has caused economic underdevelopment and poverty, political instability, population mobility, gender inequalities and unfavourable policies and legislation. Although HIV prevalence is low in Sudan, estimated to be 1.6%, these socio-cultural, political and economic factors can increase people's vulnerability towards the disease by limiting individual's options to reduce their risk. In January 2005 a cease fire began between the SPLM/A in the south and the northern Arab held government. An interim government began a six year term in the south which has meant the response to HIV and AIDS although originally led from the northern government currently translates into two AIDS commissions being formed. Both the north and south are beginning to respond to the epidemic but the post-conflict conditions, insecurity, poverty and socio-cultural factors have made the progress slow. Continued conflicts in Darfur and along the Chad borders in addition to insecurities in the south have made the response by NGOS and UN also very slow and uncoordinated.

There has been no national surveillance conducted to find out the HIV prevalence rates since peace was signed in 2005 and any estimates before then have been made during the war when movements were restricted.

Methodology

Techniques included a desk research, use of the web, interviews, field visits, and documentation reviews. A week visit was made to Juba in November where organisations working in southern Sudan were visited. Due to a problem with visas, a trip to Khartoum was cancelled and all other correspondence was done by e-mail and telephone. Tearfund partners were contacted by e-mail and telephone but not all responded.

Key Issues

HIV statistics have been difficult to compile in Sudan due to the 21 year civil war and continued insecurities in the country. Estimates suggest HIV is about 1.6% overall in the country with the south predicted to be slightly higher at 2.6%. Experts feel this could be a lot higher in pockets of the country where towns are close to borders and migration has caused a previously isolated country to open up to the impact of HIV. WHO stipulates that the prevalence rates across the country could range from less than 1% to 7%. In addition socio-economic factors, poor infrastructure, family and community structural breakdown, gender inequality, increase presence of military, NGOs and UN and detrimental traditional sexual union practices could all increase people's vulnerabilities to the disease.

Knowledge of the disease is limited. A survey in 2002 found only 20% recognised that AIDS was caused by HIV, and only 53% appeared aware of a sexual transmission risk. Over two-thirds of respondents had never heard of or seen a condom, and less than 10% mentioned its use as a means of prevention. More recently in Rumbek a survey conducted by WHO found that only 2% of those interviewed had used a condom the last time they had sexual intercourse.

Stigma is also an issue attributed by the lack of knowledge but also by the religious and cultural traditions of the Sudanese.

Gender based violence in Darfur, the general lack of decision making for women across Sudan and high illiteracy amongst women means they are more at risk of the

disease than men in Sudan. Children are also at risk with one in three rapes in the Darfur region being committed on children.
Currently there are very few NGOs implementing HIV activities across Sudan, with most just stipulating that they are doing some sort of HIV awareness. Much of the response has been in the Equatorian region and in some of the major towns such as Juba, Rumbek and Khartoum. There are very few VCT clinics in the south and only three towns have access to ARVs, in Juba, Malakal and Wau. Accessibility to VCT, PMTCT and ARVs in the north is much better although facilities are still centred around major towns and there is very little access in Darfur.
The response to HIV in Sudan so far has centred around prevention as prevalence is low, however scaling up of activities will be necessary to include treatment, home based care and the setting up of networks for people living with HIV once the impact is felt in Sudan. Currently there are many urgent issues affecting Sudan such as food insecurity, inadequate water and sanitation and poor access to health resources. HIV is therefore not often considered a high priority.

The National Response
In 1987 the National AIDS program was set up in Sudan, activities were sporadic and it wasn't until 2002 when a situation and response analysis was conducted by the government that a national HIV strategic plan for 2003-2007 was developed. The proposed targets for 2009 include covering four million VCT clients, treating 3, 000 mothers with PMTCT and targeting 40,000 with ART.
In June 2006 the National AIDS commission was established by the Interim government in the south replacing the original AIDS council formed after the war. This commission is made up of eight members whose mandate is to mobilise resources, coordinate activities and unify guidelines and protocols.

Tearfund's Response
There are very few Tearfund partners in Sudan and most of them do not have the capacity or mandate to do HIV activities. Across has the most experience and runs a VCT clinic as well as providing support for PLWA. Other partners are doing HIV awareness in their programmes targeting youth, church leaders and pastors. Tearfund DMT are mainstreaming HIV into their core relief projects, recognising the factors that fuel the epidemic such as gender inequality, and redesigning activities to reduce beneficiaries' vulnerability towards HIV. Tearfund DMT are also incorporating an HIV work place policy to help support those staff affected or infected by HIV.

Key Recommendations
1. Tearfund should continue to focus in Equatoria where prevalence is highest but partners should also consider expanding to areas where Tearfund DMT are, to assist with exit strategies. DMT and partners should consider working in Juba, Khartoum and Kassal where prevalence rates are high.
2. Partners need capacity building in project cycle management, including accessing funds and resource mobilisation, project proposal writing and monitoring and evaluating skills. Partners and DMT also need technical support into addressing HIV in Sudan in addition to assistance in communicating HIV and AIDS within a Christian (or Muslim) context.
3. Tearfund DMT need to share experience and resources on mainstreaming HIV in relief projects in Sudan and partners should consider how they can reshape their core activities to reduce people's vulnerability towards HIV.

4. All partners and DMT should consider conducting exposure visits of other Tearfund partners in Sudan, other organisations with expertise and experience of addressing HIV in Sudan and Tearfund other partners in bordering countries.
5. There needs to be more collaboration with partners, DMT and the church with the sharing of resources and expertise. SCAN should be reformed in southern Sudan to facilitate this collaboration. In addition an HIV and AIDS coordinator should be situated in Juba to assist DMT and partners in the south to implement HIV and AIDS specific and mainstreaming activities.
6. Tearfund should consider scaling up their approach to HIV in Sudan by capacity building current partners, encouraging more experienced partners to work alongside the church and other partners and by assessing and identifying potential organisations to be future Tearfund partners.

1. Background of the Study

1.1. Origin and Objectives of Study

This study was commissioned by Tearfund UK, East and Central Africa region, with the aim of providing information that will enable an appropriate response by Tearfund and its partners to the issue of HIV and AIDS in Sudan. Tearfund's new International Group Strategy requires every high intensity programme to consider the issue of HIV and AIDS as its key priority up to 2015. The Terms of Reference are given in Appendix 1.

1.2. Methodology

Due to the current situation in Sudan, the plan was to make two visits, one to the south and one to the north of Sudan. This is because currently southern Sudan is being managed by an interim government and so they have their own response and approach to HIV and AIDS that differs from the northern government. In addition many organisations have divided their operations and are based both in Juba and Khartoum. The report has been written to reflect this, with a section on southern Sudan and a section on northern Sudan.

The field visit to Juba in southern Sudan consisted of meetings with NGOs, UN agencies and the government ministries. Correspondence was also made by telephone and e-mail. Tearfund partners were all contacted by e-mail and telephone apart from Across.

Data and information was also collected from various websites.

1.3. Limitations of the Study

Unfortunately the planned trip to Khartoum was cancelled due to a visa problem. This limited the study considerable as the research for northern Sudan had to be done in Nairobi via the internet and using the telephone. This has meant there is more information about HIV and AIDS in southern Sudan than there is in northern Sudan.

Correspondence with partners was extremely difficult with organisations not responding to e-mails or phone calls. In some cases this has meant there is limited information about activities of some of the Tearfund partners. The Episcopal Church of Sudan did not respond so are not featured in this report.

2. HIV and AIDS in the Southern Sudan Context

2.1. General and Political Overview

Southern Sudan, has a population of about 9.6 million (2003 estimate Starbase[1]), and has historically been neglected in terms of development, which has been exacerbated by the sustained civil war. The 21-year civil war that restarted in 1983 between the SPLM/A and the Arab dominated Khartoum government displaced around four million people internally, while more than half a million fled across the border into Uganda, Ethiopia and Kenya. An estimated two million people have died during the conflict. Both sides in the conflict have been accused of widespread human rights abuses. In southern Sudan, the long-term effect of the war is the almost complete fragmentation of civil society. There are hardly any civil structures and 92% of the population live below the poverty line. Less than 25% have access to safe water. There are very few schools providing students with qualifications that would be externally recognised. Only one in three children attends school and the adult literacy rate is 15%. The health systems and health infrastructure have been decimated. Only 30-40% of people live within one day's walk of a health facility. The under five mortality rate is almost two in ten children and maternal mortality is around 865 per 100,000 live births. Sudan is projected to be the last country in the world to eradicate Polio, Sleeping Sickness and Guinea Worm[2]. Conflict has also increased people's vulnerability to famine, eroded their already fragile coping strategies and destroyed vital assets and livelihoods.

2.2. Social and Cultural Practices Relating to the Pandemic

2.2.1. Conflict and Impact of Migration

During the war there was reduced mobility and accessibility in and out of the country which may have prevented the HIV prevalence rates to increase[3]. However it is well documented that there are many factors that increase conflict-affected and forced migration population's vulnerability during the post conflict period[4]. In January 2005, peace was signed in southern Sudan and since that time thousands of refugees have returned[5]. It is feared that returnees from surrounding countries could bring the virus back with them and drive its spread. However some specialists dispute this and predict the higher levels of education and awareness of HIV could be a positive affect for the country. Peace has also meant that trade and employment opportunities have increased mobility within southern Sudan and into bordering countries. In addition post conflict has increased the presence of military, NGOs and UN from other countries which is likely to increase the sex trade.

The long civil war has left a very underdeveloped country with poor infrastructure, lack of income and basic needs and family and community structural breakdown all of which could increase the impact that HIV and AIDS has in southern Sudan. For

[1] http:www.unsudanig.org

[2] WHO 2001

[3] Centres for Disease Control and Prevention have shown lower than expected HIV prevalence rates in 2003 for southern Sudan, 2.3%, considering surrounding countries have high prevalence rates

[4] Spiegel, P. 'HIV/AIDS among conflict-affected and Displace populations', UNHCR, 2004

[5] IOM/ADRA of weekly Tracking and Monitoring from Kosti, Upper Nile, 2006 shows between 500-2000 refugees returning every week. UNOCHA report a total of 6,276 returnees to Aweil East between April and October 2005, of these 1,433 were to the Omdurman region.

example lack of education has resulted in poor knowledge of HIV with less than 10% of Sudanese youth knowing how to prevent HIV or understanding what a condom is[6].

2.2.2. Cultural and Traditional Practices

There are many traditions and practices within the southern Sudanese culture which have affected and will have the potential to impact the HIV epidemic. There are many tribes in Southern Sudan which differ in customs however there are some overall similarities that can be highlighted. Recent research by UNICEF has reported on family attitudes and sexual behaviour as it influences HIV and AIDS[7]. Some of these findings are summarised below.

Firstly traditional sexual practices are restricted by customary law. However as long as it does not lead to pregnancy or involves adulatory, sexual activities are not only accepted but even considered to be a vital part of human spirituality.
Polygamy for example is a widely accepted tradition. Change of sexual partners is frequent during adolescence, marriage and after death (when widowers are taken by other family members for example). The risk of transmitting diseases sexually therefore is great.
Even though customary law forbids it, adultery is common with arranged marriages of young girls, a lover's lack of bride-wealth and abstinence from sexual intercourse with a wife who is breast-feeding a child for example are common reasons for an offence which eventually leads to a heavy fine.
Rape has become more frequent than it used to be before the war. Changes in sexual conduct have occurred as social structure has broken down. For example soldiers or youth have become powerful not needing parents anymore and so forget about their moral values. In addition the basic instinct of survival in times of hardship particularly for women means having sex for food is common.

Sickness and disease are treated on a spiritual level by magic means in southern Sudan; even medicinal herbs are to expel a negative spiritual force out of the body rather than to attack the physical cause of the disease. There are some traditional practices such as tooth removal, tribal marking and cutting to 'release disease' that although not practiced as much anymore are still seen in the rural areas.

Condoms are still strongly linked to prostitution in many areas, people using them being accused of having a loose sexual conduct. It is common that both men and women find condoms very suspicious and think that only 'cursed' people would use them. In consequence, people asking for condoms may be socially stigmatised. In addition having large families is very important to most southern Sudanese, especially since the 21 year war killed many and people feel it their duty to procreate.

2.3. Magnitude of HIV and AIDS Pandemic

Currently there are no up to date statistical data for HIV and AIDS surveillance in southern Sudan. The SSAC are hoping to complete a nation wide surveillance of knowledge, attitude and practice as well as prevalence rates. However as Shelia Mangan, HIV and AIDS Programme Officer for UNICEF, highlights this type of survey is a huge undertaking when poor roads, remoteness of many areas, training

[6] Sudanese National AIDS control Programme survey, 2005
[7] Perner, C. '"But You know….Darkness is a big thing".., A background report on family attitudes and sexual behaviour in the south Sudan as a basis for HIV/AIDS awareness', UNICEF, 2001

reliable data collectors and preparing medical personnel for surveillance and blood testing are formidable obstacles to obtaining information.[8]
Recent statistics for southern Sudan estimate prevalence rates to be 2.3%[9]. WHO stipulates that the prevalence rates across the country could range from less than 1% to 7%[10]. There are many fears that these estimates are based on guesswork and the rates could be much higher.
The CDC has begun sentinel surveillance reporting based on a number of ANCs within hospitals and PHCCs across the country. Facilities participating in the study are INGOs and the MOH from nine areas. 1185 dried blood spot specimens from pregnant women have been submitted and tested for HIV at the CDC Nairobi laboratory between 2005 and July 2006. 774 qualified to be in the report. 27 of the 774 complete specimens (3.5%) are found to be positive. Table 1 shows the results by site.

Site	**HIV results**	
	No tested	Positive
Cuiebet – DEA (PHCC)	107	1 (0.9%)
Maridi – AAH (Hospital)	104	7 (6.7%
St Bakhita, Yei (Health Centre)	88	4 (4.5%)
Nimule – Merlin (Hospital)	171	3 (1.8%)
Boma – Merlin (Hospital)	138	10 (7.2%)
Pochalla (PHCC)	18	2 (11%)
Leer – MSF-H (Hospital)	138	0
Total	**774**	**27 (3.5%)**

Table One[11]

It is important to note that these results should not be interpreted as representing prevalence rates in pregnant women as a whole let alone population prevalence rates. The sample size was small and there is no guarantee the specimens represent all women attending ANCs in a given site or all the pregnant women in the community.

2.3.1. HIV Awareness

Levels of knowledge of HIV and AIDS amongst southern Sudanese are low. According to UNICEF on average in Sudan 58.9% of people know about HIV and AIDS, although this is based on a survey done in 1998[12]
In a recent study carried out by WHO, in the town of Rumbek fewer than four percent of adults could identify the two methods preventing HIV transmission and only 2% said they had used a condom the last time they had sexual intercourse[13].

According to a Tearfund DMT nutritional survey conducted in Wuror county (Central Upper Nile) of those 638 households surveyed, 6.6% knew what HIV and AIDS was and 4% knew how it was spread[14] At the beginning of two HIV and AIDS workshop's held in the Aweils in 2004, 70% of the participants asked in Malualkon

[8] PlusNews, 'Sudan: preventing HIV/AIDS in the south- a cash strapped mission', September 2006
[9] UN Population Fund, 2006
[10] IRIN News, 'Sudan: War-scarred south ill-equipped to deal with HIV/AIDS' April 2006
[11] Report prepared by Anthony Isavwa and Tom Boo, CDC, August 2006
[12] UNICEF, "Over view of Health situation in Southern Sudan 2002", 2002:42
[13] IRIN News, 'Sudan: War-scarred south ill-equipped to deal with HIV/AIDS' April 2006
[14] Nutritional Survey, Tearfund DMT, February 2004

(Bahr-El-Ghazal) could not give the correct definition of HIV and in Tierialet (Bahr-El-Ghazal) 20% could not give any ways it is transmitted. In Motot (Central Upper Nile) only 20% of participants asked knew two of the major ways HIV is spread and 20% did not know any ways it could be prevented. Overall the workshops showed that there was some knowledge mainly amongst the more educated groups but this was limited.

2.3.2. VCT

There are approximately ten areas that have VCT centres, these are as follows;
Juba, Rumbek, Yei, Maridi, Yambio, Kajokeji, Lui, Malakal, Wau and Tambura. Some of these VCT sites have reported data, but again these do not represent country wide prevalence rates as they are biased towards those attending the clinics for testing. Table two represents unofficial data from VCT clinics.

Site	HIV results	
	No tested	Positive
Juba – (WHO/MOH) 2004 – 2006	1000	216 (21.6%)
Maridi – (ZOA) 2004	400	16 (4%)
Yambio (ARC) 2004	700	119 (17%)
Rumbek (IRC) 2004		5%
Yei (ARC) 2004		7%

Table Two

2.3.3. Treatment – ARV

There are currently three main places in southern Sudan where ARVs are available; these are Wau, Juba and Malakal. There may be other NGOs and organisations who are providing or preparing to provide treatment but this has not been officially documented. PMTCT is also provided in these areas as well as in Nimule, Boma, Rumbek, Yei and Nyal

2.6. Key HIV and AIDS Issues in Southern Sudan

2.6.1. Stigma

Little is known how people would behave in case of a person infected by HIV and AIDS. Attitudes that lead to actions such as killing people who have the disease or keeping people isolated are thought to be common. Amongst the *Anyuak* tribe such a person would find it difficult to lead a normal life as nobody would dare to get in contact with them; people returning home from a place known to be a source of sexual diseases may be forced to decide to leave again, even if they are not carriers of any disease. Likewise *Dinka* and *Nuer* would stigmatise such a person and prevent them from leading a normal life. An unconfirmed report from the *Anyuak* stipulates that a court has held a person accused of having spread the disease guilty of murder[15]
A returning refugee who is living with HIV is excited about going home but afraid of revealing his HIV positive status to his family according to a recent article in IRINNews[16]. Although prevalence among the refugees is low in Kakuma camp in Kenya compared to the host community (Kakuma: 5% & Lodwar: 18% in 2002)[17] ,

[15] Perner, C. 'But you know…Darkness is a big thing' UNICEF, 2001
[16] PlusNews, 'Kenya-Sudan: HIV positive Sudanese refugees fear stigma in homeland', April 2006
[17] Spiegel, P. 'HIV/AIDS among Conflict-affected and Displaced Populations' UNHCR, 2004

the communities they are returning to are suspicious that returnees will trigger the spread of HIV in the region.
A recent Tearfund DMT staff survey conducted amongst both Kenyan and southern Sudanese showed there was a significant amount of negative attitudes amongst the staff towards those who may be HIV positive. For example 45% of participants said they would feel uncomfortable sharing food with a person living with HIV.[18]

2.6.2. Gender

Gender based violence is very common in southern Sudan. In addition many women, particularly young girls before or while married do not have any control or power within sexual relationships. Health campaigners contend that for these reasons women and girls are more prone to HIV than boys. Other decision making issues are very underrepresented by women in southern Sudan. Currently only 10% of the Southern Sudanese government is made up of women.[19] Lack of education is one of the underlying reasons for this lack of power and representative. The civil war has destroyed many schools, pushing up the illiteracy rate especially among women. If women are uneducated they are less likely to be equipped to make informed choices on health issues such as HIV and AIDS.
Another factor that causes women to be more vulnerable is how they cope with the affects of poverty and in times of hardship. Activities such as tea selling which is actually a cover for the sex trade is very attractive for women who need the income to support their family. Across the south, traders and truck drivers from Uganda are fuelling a lucrative sex trade. In Juba, 10 percent of tea sellers were found to be HIV infected.[20]

2.6.3. Children Orphaned by HIV and AIDS

There are many war orphans in southern Sudan however less is known about AIDS orphans. As the prevalence is low there are not as many orphans as there are in surrounding countries. However the low prevalence and reluctance to talk openly about the affects of the disease has meant that children who do have parents who have died of AIDS are often not told the truth. In a recent article in IRINNews[21] the story is told of Yomima one of 250 children known to be orphaned by HIV and AIDS in Juba. She does not know why her parents died as her grandmother is too afraid to tell her the truth. SSOPO supports 44 orphans and their caregivers in Juba.

[18] Perry, F. 'Baseline HIV and AIDS DMT staff survey summary', Tearfund, 2006
[19] Mulama, J. 'Sudan: Donors urged to tie Aid to Gender Equality', AEGiSnews, 2005
[20] PlusNews, 'Sudan-war-scarred south ill-equipped to deal with HIV/AIDS', April 2006
[21] PlusNews 'Sudan: Grannies step in to care for children orphaned by HIV and AIDS', April 2006

3. Responses to HIV and AIDS in Southern Sudan

3.1. Southern Sudan National Response to HIV and AIDS

Since peace has been signed in southern Sudan, the interim government has been busy setting up offices and establishing the supporting administration. Initially the National AIDS Council was formed with an HIV steering committee and working groups concerning behaviour & communication, prevention, monitoring & evaluation, care & treatment. In June 2006 the SSNAC was formed which replaced the council. This commission is made up of eight members whose mandate is to mobilise resources, coordinate activities and unify guidelines and protocols.

The SSNAC has begun a structure to decentralise the commission supported by UNDP. At each of the ten states there will be state councils and within each of the 48 counties there will be a director for the County and Payam level.

The SSAC has outlined the following three components as being important factors in the structure of the national AIDS response;

- One framework for HIV and AIDS response
- One coordination body
- One monitoring and evaluation system

3.1.1. Southern Sudan AIDS Commission Uniformed services

The SSAC has employed an officer seconded by UNDP to head up the AIDS programme for the uniformed services which includes the SPLA and police. There are currently three military hospitals in Juba, Wau and Malakal where the main army barracks are situated. Intra Health International is supporting the SPLA military secretariat to assist with construction of health buildings and equipment. They are also capacity building the military leaders and conducting assessments in Yei, Nimule, Juba and Kajokeji. PSI is also assisting by providing condoms and IEC materials.

3.2. UN response

3.2.1. UNDP

UNDP is currently supporting and funding the SSAC. UNDP are helping the commission by providing leadership training and advice on how to decentralise the AIDS commission to ensure there is representation and coordination at the grass roots level. UNDP has begun the process by conducting training for 25 change agents chosen by the community from Yei, Rumbek, Maluakon and Akobo. The training consisted of three sessions whereby two representatives from each location were chosen and will now head and set up the AIDS councils in each of these areas. UNDP will allocate funding (probably $70,000) for use to set up the administration and coordinate the HIV work in the county.

Via UNDP south Sudan will receive $8.8 million over a period of two years from the Global Fund for AIDS, Malaria and TB.

3.2.2. UNICEF

UNICEF work mainly through partners and concentrate their work in a number of different areas. They have a large youth programme concentrating on prevention and awareness with peer education as their main focus. They are looking into setting up STI treatment and VCT for youth providing youth friendly services.

The other area which is a main focus is PMTCT. In 2005 they had 18 pilot PMTCT projects which have finished and the data is currently awaiting analysis. Their aim

now is to have five main areas across southern Sudan that they will concentrate their work. These are;
Jonglei – Bor
Upper Nile – Malakal
Northern Bahr-El-Ghazal – Aweil
Western Equatoria – Yambio
Central Equatoria – Juba/Yei
They hope to work through partners to assist organisations to expand ANC services to provide a PMTCT plus package that concentrates on follow up care of those mothers who are HIV positive. This would include providing education on nutrition, hygiene as well as care of newborns who may potentially be HIV positive. This is all part of their safe motherhood programme which is in response to the high maternal and mortality rates in southern Sudan.
UNICEF also want to facilitate the setting up of 20 VCT centres around the country and are looking for partners to do this through.

3.2.3. UNAIDS

UNAIDS are currently conducting a mapping exercise for the whole of southern Sudan that will plot all the VCT and PMTCT sites and other such related activities as so far this has not been done. This should be ready at the end of 2006.

3.2.4. WHO

WHO has three ARV treatment sites in Juba, Wau and Malakal and hopes to establish up to eight by the end of the year. Their target is to have 200 patients receiving ARVs in Juba, Wau and Malakal by December 2006. From a field visit to the Juba HIV clinic there are currently 257 HIV positive clients accessing either ARVs or prophylaxis treatment. WHO is looking to scale up ARV treatment in areas with potentially high HIV prevalence rates. The initial focus would be in Yambio, Yei and Mundri all located close to the borders of DRC and Uganda. WHO is also encouraging organisations to set up VCT in others where there is no access to these facilities. WHO provide treatment guidelines for ARV and protocols for setting up VCT.

3.3. PLWA Networks

Currently there are about four or five associations for PLWA in southern Sudan. The main one is in Juba and there are other unofficial associations in Yei, Yambio, Maridi, Wau and possibly in Rumbek although that is unconfirmed. According to ACORD the Juba association would like to facilitate a network that will bring together all the associations for better coordination and advocacy for support and services for PLWA
UNDP has conducted a workshop in the middle of November for members of PLHA associations across south Sudan. The aim of the workshop is to agree to set up a national PLHA network for South Sudan.

3.4. NGO response

Main NGOs implementing/funding HIV and AIDS activities in southern Sudan

Organisation	Main activity	Area
ACORD	Home based care/orphans, PLWA networks	Juba
ADRA	Awareness, home based care	Nasir (Upper Nile)
ARC	VCT	Yei

Care International	Internal and external mainstreaming	Maridi, Panyagoor (Jonglei), Padak, Paluer
CCM	PMTCT	Adior, Bunagock (Lakes region)
FHI	Lead agency/partner for funding by USAID – collaboration with ARC, IRC	Equatoria mostly
IRC	VCT	Malaou (Lakes region), Rumbek
Goal	Awareness	Kurmuk (Southern Blue Nile)
HARD	Awareness	Wau
International HIV/AIDS Alliance	Funding, capacity building	Equatoria
IMC	VCT, ARV	Kajokeji (Eastern Equatoria)
Malteser	PMTCT	Rumbek, Yei
Medair	Awareness	Payuer (Upper Nile)
Merlin	VCT, PMTCT	Nimule , Boma (Jonglei)
Oxfam-GB	Awareness, mainstreaming	Upper Nile, Mundri, Bahr-El-Khazal
Samaritans Purse	VCT	Lui (Eastern Equatoria)
SCF-UK	Awareness, mainstreaming	Leer (Jonglei), Malualkon (Bahr-El-Khazal)
SCF-US	VCT, home based care	Maiwat (Upper Nile), Mvolo (Western Equatoria)
SIM	Collaboration partner with ADRA, Across	Rumbek - Adol
SSOPO	Home based care	Juba
Tearfund DMT	Awareness, internal and external mainstreaming	Malaulkon, Tierialet (Bahr-El-Khazal) Motot, Oriny (Upper Nile)
World Relief	Awareness	Pochalla (Jonglei)
World Vision	Awareness	Yambio, Tambura, Ezo (Western Equatoria) Tonj (Lakes region) Tonga (Upper Nile)
ZOA	VCT	Maridi

ACORD

ACORD work mainly in the Juba area. They began their HIV work in 1995 with HIV awareness. They helped set up VCT in Juba and also helped set up the current PLWA

Association that is in Juba. This network has currently 420 people registered. They have trained 48 counsellors from surrounding villages to follow up and support those PLWA. In addition these counsellors also conduct awareness to help reduce stigma. They also assist some orphans with school fees and provide some families with WFP food if needed.

Juba Hospital

Within Juba is an integrated clinic that administers treatment for TB, leprosy, OV and skin disease. Clients are referred to the clinic from the VCT centre in Juba. They get their CD4 count tested and are given either ARVs or prophylaxis as required. However the CD count equipment has been broken for the past 3 weeks. They also receive post counselling if necessary. The staff in the clinic consists of a Doctor and a Nurse.

3.5. Tearfund's Response

Tearfund DMT

Tearfund currently work in Aweil East and South in Bahr-El-Khazal and Wuror country and Shulluk Kingdom in Upper Nile. In all these programmes HIV awareness is being conducted amongst the beneficiaries through the health education programme. As well as the general population of the community, the health education programme targets, school children, teachers, youth and the army.

In addition to this is the Tearfund mainstreaming programme. Training has been conducted amongst the staff on the mainstreaming concepts to try and reduce beneficiaries' vulnerability towards HIV and help people better able to cope with AIDS by reshaping and redesigning core projects such as health, nutrition and food security. Tearfund is also implementing a work place policy to support staff and ensure they all have an adequate level of understanding of the basics of HIV and AIDS for their own protection

Tearfund are hoping to start some VCT centres and PMTCT in their health programmes subject to funding.

In 2004 and 2005 Tearfund facilitated a group of organisations and church leaders in southern Sudan to get together to share resources and information on HIV. The group was called SCAN. Some of Tearfund partners were involved including the Diocese of Mundri, SEM, Across and NSCC. The group met on a number of different occasions for workshops and designed a video for use in southern Sudan. This video was funded by Tearfund/ECHO and is available for use by all NGOs in southern Sudan.

Tearfund Partners

Organisation	Type of Activity	Area	Funding	Length of programme/funding
Across	HIV awareness, VCT, PLWA	Yambio, Nzara, Adol	CDC, UNICEF ($118,181) Hope to get MSF to fund as well after April 07	Adol: July 06 – April 07 (funds will last for 3 years but they need to renew/re-approve every year) Yambio: July 2003 – April 2007 (Looking to continue)

AIC – Sudan	HIV awareness	Nimule, Torit, Yei, Yambio, Adjumini refugee camp in Uganda	Norwegian Church Aid, British Embassy	1998 - ongoing
BATC	HIV awareness amongst Sudanese Bible students	Arua, Northern Uganda	Tearfund, Salisbury Diocese UK, CMS UK	1993 - ongoing
Diocese of Mundri	HIV awareness	Mundri and Lui	Tearfund Netherlands	On going
Diocese of Yei	HIV awareness	Yei, Morobo	Tearfund	On going
NSCC	Awareness – church leaders, TOT, Support for PLWA Resource for IEC	Juba, Kajokeji, Maridi, Nimule, Rumbek, Yambio, Yei	Norwegian Church Aid South Sudan Programme $8,000 Menonite Central Committee $3,000 UNDP South Sudan Program $22,000 UNAIDS country office $30,000	1999 - current
SEM	Behaviour change workshops for youth	Mundri and Lui	Tearfund UK (40,000)	2006 (although had previous programmes from 2003)

Across

Across and ZOA were previously working in partnership however now they have split their activities. ZOA has taken the food security programme along with the VCT centre in Maridi and Across has taken over the two VCT centres in Yambio and Nzara.

In addition to this Across started working in Adol as part of a consortium with SIM, ADRA and World relief. The activities they are doing are HIV awareness and home based care for PLWA.

In Yambio as well as the VCT they also have post test clubs, HIV training for church and community leaders, youth rallies/conferences and family life skills workshops.

Across plan to continue in Adol and will possibly expand to involve a mobile VCT in this area. In Yambio the plan is also to set up home base care for PLWA which they hope to implement in 2007.

In addition to these HIV and AIDS activities they also have a teacher training programme in Rumbek, Yei, Boma and a PHCC in Leer. Within all these programme sites they do HIV awareness.

AIC – Sudan
AIC supports and capacity builds church leaders mainly in Equatoria. Since 1998 they have been training church leaders, pastors, elders and community members on HIV awareness using TOT methods and facilitators from Uganda. The awareness messages concentrate on behaviour change and AIC also distributes IEC materials for use by those trained. Tearfund supports AIC in their community mobilisation work but not their HIV activities.

BATC
The college was originally situated in Yei but during the war got relocated to Arua in Northern Uganda. The college trains students on integral mission for a maximum of three years awarding certificates and diplomas. Since 1993 they have graduated eighty students. They have adapted the curriculum to include a core course on HIV and AIDS which has an exam at the end of it.

Diocese of Mundri
The Diocese of Mundri overseas seven archdeaconries and 34 parishes. The role of the diocese is to train church leaders, conduct pastoral work and evangelism. Within this work they include HIV awareness training based on Biblical principles on awareness and prevention. They particularly focus on abstinence, moral discipline and self control. They target church elders, leaders and youth.

Diocese of Yei
The Diocese of Yei overseas and manages a number of churches in its denomination in the area of Yei. They are including and plan to include in the future pastors and community leaders in HIV awareness trainings. They also plan to capacity build the management of the Diocese to implement HIV and AIDS activities over the next year. The awareness activities will include; seminars, presentations of films, dramas and developing HIV and AIDS materials. As well as pastors they also hope to target youth leaders and volunteers to disseminate messages in local schools.

NSCC
NSCC is an umbrella organisation comprising six churches namely: The Roman Catholic Church, Episcopal Church of Sudan, Presbyterian Church of Sudan, African Inland Church, Sudan Pentecostal Church and Sudan Inland Church.
NSCC launched its first HIV and AIDS awareness programme under its health desk in 1998. In 1999 they held five HIV and AIDS awareness workshops with church leaders, two in Nairobi and three in Southern Sudan. This was followed by the first TOT in Yambio County. Following response from these two initiatives, the NSCC Health Desk, decided to embark on TOT in AIDS awareness at ten project sites: six sites in Equatoria, two in Upper Nile and two in Bahr-El-Ghazal.
NSCC has its own HIV desk now which generates its own funding and has continued a number of HIV activities since 1999. These activities have included awareness with teachers, formation of county AIDS teams where materials have been translated and distributed, expanded TOT and a religious leaders advocacy training forum to assist churches with funding.

SEM
SEM has been working in HIV since 2003, although in 2006 they have specialised in behaviour change activities for youth. They target youth leaders in churches in

Mundri County, specifically Bahr-Olo archdeaconry from Mundri diocese and Byuagi archdeaconry from Lui Diocese. The aim of the programme is to monitor and support the role of the youth leader and to build their capacity to give factual and consistent messages on HIV and AIDS.

They hope to expand in the future to include behaviour formation programmes for children, life skills programmes, forming support action groups for youth and widening the youth programme to those who are in unstructured situations.

4. HIV and AIDS in the Northern Sudan Context

4.1. General and Political Overview

There are approximately 32.9 million people in the whole of Sudan (2002), with an annual growth rate of 2.5% (1975-2002), and a life expectancy at birth of 55.5 years, infant mortality rate at 64, and only 40.1% of people above 15 years being literate (2002). Although there is no single reliable estimate of poverty available, there is consensus among Sudanese analysts that its prevalence exceeds 50% in the north, with higher levels in Darfur and Kordofan, and Red Sea foothills.

In addition to the main conflict between the northern Arab led government and the non-Muslim, non-Arab southern Sudanese already mentioned, is a separate conflict that broke out in the western region of Darfur. In 2003 this conflict resulted in at least 200,000 deaths and nearly two million displaced; as of late 2005, peacekeeping troops are struggling to stabilize the situation.

In addition is an ongoing conflict between Chad and Sudan. Chadian rebels and Sudanese militia have attacked villages and towns along the border, stealing cattle, murdering citizens, and burning houses. Over 200,000 refugees from the Darfur region of northwestern Sudan currently claim asylum in eastern Chad.

Over the years, as the different wars have occurred refugees have been going backwards and forwards across the borders. Sudan has faced large refugee influxes from neighbouring countries, primarily Ethiopia and Chad, and armed conflict, poor transport infrastructure, and lack of government support have chronically obstructed the provision of humanitarian assistance to affected populations.

Khartoum compared to the rest of Sudan has better infrastructure and has a large oil refinery in the north which is funding a lot of the current development. The first oil pipeline between Khartoum and Port Sudan was completed in 1977. However throughout the 1970s and 1980s, Khartoum was the destination for hundreds of thousands of refugees fleeing conflicts in neighbouring nations such as Chad, Eritrea, Ethiopia and Uganda. The refugees settled in large slums at the outskirts of the city. From the mid-1980s onward, large numbers of internally displaced from the violence of the Sudanese Civil War and the recent Darfur conflict have settled around Khartoum.

4.2. Social and Cultural Practices Relating to the Pandemic

4.2.1. Conflict and Impact of Migration in Darfur

The persistent high levels of insecurity in 2006 have forced substantial numbers of innocent civilians to flee their villages and leave their cultivated farmlands, which are often deliberately destroyed. Thousands of newly displaced people continue to stream into IDP camps or are dispersed in the bush. Gereida in South Darfur now has the largest IDP concentration in the region, with approximately 128,000 internally displaced. The number of displaced in IDP settlements, at nearly two million, has reached its highest level ever since the conflict started in 2003. Another two million Darfurians are considered to be directly affected by the ongoing crisis and are in need of humanitarian aid, again the highest number ever since the beginning of the current crisis.

Only 51% of the recently surveyed households have cultivated land this year and this lack of cultivation in Darfur has meant that next year 70% of the conflict-affected

populations will be considered to be food insecure[22]. Currently about 25% of the conflict affected populations do not have access to safe water.

4.2.2. Cultural and Traditional Practices

In 1999, Sudan was one of the most ethnically and linguistically diverse countries in the world. It had nearly 600 ethnic groups speaking over 400 languages and dialects. Since that time migration has caused many linguistic groups to have been absorbed by other tribes and there are currently over 300 tribal groups.

Many of the traditions of Sudan will be the same between north and south; however religion plays an important part when considering HIV. The south is predominately Christian or animistic. However the majority of the north is Islamic. Many Islamic countries have been slow to respond to HIV due to the belief that practices that encourage the spread of the disease do not happen amongst Muslims. This has resulted in a blurring of faith and practice with communities denying what is happening in reality. Even though the prevalence is low in north Sudan this denial could increase the impact HIV will have in the future. The government has however begun to recognise the urgency of the situation and has set up a SNAP to address the issue. This still needs to filter down to the religious leaders and at the grassroots level where traditional practices are more engrained in the culture.

In addition Sudan has weak or absent democratic practices which can also fuel the epidemic. The rights of women are a major issue in regards to gender inequality and HIV, which is particularly a problem in the current Darfur crisis.

4.3. Magnitude of HIV and AIDS Pandemic

According to the recent UNAIDS global report 2006, the adult prevalence in Sudan as a whole is 1.6 percent, with an estimated 500,000 to 600,000 people living with HIV and AIDS. The actual registered number of both HIV and AIDS cases is 11,511 (September 2004). There are no estimates just for the north of Sudan unlike southern Sudan as was highlighted earlier. Prevalence rates in the north are thought to be the highest in Kassala, which is a town on the Eritrea border a country with high HIV prevalence rates, followed by Khartoum. However a recent report by UNAIDS has warned that infection rates may be on the rise in the Darfur region[23].

The most reliable available indication of the extent of the epidemic is the 2002 situation analysis study conducted in the north and the previously government controlled parts of the country (11 out of 16 states in the north and three in the south). The study yielded HIV prevalence rates ranging from 0.5% for soldiers, 1% for antenatal care attendees, truck drivers, and IDPs, 2.5% among female tea sellers, to 4.4 % among female sex workers. More recently, results of limited sentinel surveillance testing conducted during 2004 by SNAP yielded prevalence rates of 0.95% (18/1900) among pregnant women, 1.9% (9/465) among symptomatic STD patients, and 2.3% (33/1436) among TB patients.

The UN is planning a comprehensive survey in Sudan in 2007 to try and ascertain the nationwide infection rates.

4.3.1. HIV and AIDS Awareness

Awareness of HIV and AIDS is low as is the case in southern Sudan. Behavioural data is limited to the 2002 situation analysis study, which found that although 78% of

[22] 'Darfur Humanitarian profile No 25', UN Resident and Humanitarian Co-ordinator, October 2006
[23] IRINNews 'Sudan: Darfur at risk of mounting HIV/AIDS epidemic', December 2006

respondents had heard of AIDS, only 20% recognised that it was caused by HIV, and only 53% appeared aware of sexual transmission risk. Over two-thirds of respondents had never heard of or seen a condom, and less than 10% mentioned its use as a means of prevention. At the same time, wrong beliefs about the transmission of HIV were common, as were related indicators of stigma. About 28% and 24% believed that HIV could be transmitted by mosquitoes and sharing a meal, respectively, and about 44% would not share a meal with an infected individual, 31% would not nurse a patient, and 30% would not allow an infected child or teacher to attend school.

4.3.2. VCT

With the support of partners such as WHO and NGOs, SNAP is investing resources in the development of VCT services. It is official policy that VCT services are provided free of charge. In Khartoum state alone there are about 20 VCT centres providing VCT. With the support of the Global Fund, VCT services are being strengthened along with the treatment capacity in Kassala, Gedaref, Kadugli, Port Sudan, Medani, El Obeid, and Nyala. The training of counsellors is being upgraded to ensure a high quality of service in terms of information provided, confidentiality and referral for treatment. A few hospitals are already taking the step to provide VCT for those blood donors who wish to know their HIV status.

4.3.3. Treatment – ARVs

As of the end the end of March 2006, trained staff and ARVs were in place in eight locations in northern Sudan. These include Bashair and Omdurman teaching hospitals in Khartoum, as well as the teaching hospitals in Kassala, Gedaref, Kadugli, Portsudan, Medani, El Obeid and Nyala. At these locations ARVs are provided free of charge. These services have been made possible through the support of several partners including SNAP, WHO, the Global Fund and NGOs. WHO stated that during the following six months from March 2006, ART will also be made available in Blue Nile, White Nile, and North Darfur states, at locations yet to be determined.

4.3.4. PMTCT

Sudanese guidelines for PMTCT were formulated by SNAP and a pilot project for PMTCT was launched officially in March 2005. Under this project, trained staff and ARVs for PMTCT have been made available in five teaching hospitals located in Khartoum and Gedaref. In Gedaref state, the Sudan Family Planning Association branch by end of March 2005 had provided counselling and testing to 262 women, of whom 20 turned out positive.

4.3.5. Availability of PEP

National guidelines for PEP in Sudan exist. In addition counselling and testing facilities are available at the following teaching hospitals: Omdurman and Bahaer in Khartoum, Wad Medani, Kassala Gedaref, Port Sudan, Al Obeid and Nyala. Sites in all these hospitals already have ARVs necessary for PEP. The distribution of additional supplies for PEP to WHO sub offices in Nyala, El Fasher, Al Geneina is planned.

4.4. Key HIV and AIDS Issues in Nouthern Sudan

4.4.1. Stigma

Sigma is an issue in the north as it is in the south, however the conservative Muslim moral values means there may be even more prejudice. There are indications that

stigma against people infected with HIV may be stronger, and more closely linked to religious values in the North, than say, in Juba. For instance, PLWAs are more openly active within their home city in Juba in the south, than in the northern cities, where strong reactions from their families such as rejection after diagnosis still occur.
Consequences of sex outside marriage can be much more evident with the rules and regulations of customary and Islamic law. AIDS is often immediately associated with infidelity or adultery which brings with it dishonour to the family. Isolation is the immediate consequence as has been felt by many people in Khartoum. People still deny the existence of the disease in the north which has also increased the stigma and prejudice of those who have had the courage to talk about their status. A man of 28 admitted to being forced to lie about his status for fear of never being able to find work again. He contracted HIV in the Sudanese army. His 18 year old wife also is infected[24].

4.4.2. Gender

According to UNFPA approximately 80 percent of the encamped population in the western region of Darfur are women and children. Gender based violence is common in this type of environment. Rape has been used as a weapon of war and 25% of female IDPs are pregnant at any one time. Considering Sudan has one of the highest maternal mortality rates in the world, this is not a good statistic. Children are particularly affected with one in three rapes reported in the Darfur region being committed on a child[25]. Gender inequalities such as these could increase the impact of HIV. As is the case in southern Sudan lack of education is also a problem that could fuel the epidemic. A recent survey in Khartoum indicated that 61% of tea sellers could not read or write, with 32.5% having only received basic schooling and 11.8% having received intermediate or secondary education[26]. In addition up to 75% of women aged 15 to 49 were unaware that HIV could be transmitted from mother to child[27]. This isn't helped by the fact that Islam does require people to be modest and so it is not so much the discussion of sex and sexual matters that is an issue, but how this is done. For example, in sex or AIDS education, as far as possible, publications containing explicit graphic illustrations of the sexual organs should not be used.

[24] IRINNews, 'Sudan: Coping stigma in the conservative north', November 2006
[25] IRINNews, 'Sudan: Children bearing the brunt of Darfur conflict – UNICEF', December 2006
[26] IRINNews, 'Sudan: Women tea sellers struggle against the odds', October 2005
[27] IRINNews, 'Sudan: Children bearing the brunt of Darfur conflict – UNICEF', December 2006

5. Responses to HIV and AIDS in Northern Sudan

5.1. Northern Sudan National Response to HIV and AIDS

Even though the south has set up its own national AIDS response, the north does incorporate the south in all is statistics and information published.

Between 1987 when the national AIDS program was formed and 2002, efforts to combat the epidemic were sporadic, and included several short and long term plans which were not based on a clear analysis of the situation. This response continued until late 2002 when a situation and response analysis was undertaken by the government. The situation analysis included a study of HIV prevalence among sections of the population, and yielded findings that showed that Sudan had entered a generalised epidemic, with a rate of 1% among antenatal mothers. These findings may have spurred the response, resulting in the development of a broadly focused National Strategic Plan 2003-2007, with technical assistance from the UN and CTG. The plan includes activities for VCT, ART, along with PMTCT interventions. The proposed targets for 2009 are rather ambitious, and include providing four million clients with VCT services, treating 3,000 mothers with PMTCT interventions and targeting up to 40,000 with ART.

More recently during December 2004, the MOH led a delegation of National, UN, and Media personnel to Uganda, to learn about the successes there in combating HIV and AIDS, and how lessons could be applied to strengthen Sudan's response. Apart from the health sector, eight government ministries and one NGO Sudanese General Women's Union have identified HIV and AIDS activities to be implemented as part of the National Strategic Plan, with an updated time frame of 2004-2009.

SNAP is the technical department of the government responsible for HIV and AIDS national level policy, planning, and coordination. .

5.2. UN response

The CTG which is currently chaired by UNFPA includes other UN participants including WHO, UNDP, UNICEF, UNAIDS, WFP and OCHA. Technical Officers for these agencies also meet in a technical working group that is attended by SNAP and representatives from several international and national NGOs.

5.3. PLWA Networks

In 2000, the Sudanese People Living with HIV/AIDS Care Association was established by people living with HIV and AIDS in order to address the issues surrounding HIV. They do so primarily through awareness sessions, voluntary testing and home-based support. Today, this voluntary association has 14 branches and over 300 members. The Sudanese People Living with HIV/AIDS Care Association focuses on building community awareness and providing education in Sudanese churches and Mosques as well as in the universities, schools and clubs. The members of the association take part in the decision-making processes and in evaluating all of the results of their various programmes. Women living in marginalized areas are a particular target group that they focus on. This organisation has successfully changed the role of people living with HIV and AIDS from passive beneficiary to active partner.

5.4. NGO Response

A range of national and international NGOs are involved in HIV and AIDS work in Sudan. Most of these agencies' work has to do with awareness-raising, and six of them have been identified as sub recipients of global fund resources for activities targeting various vulnerable groups. The national NGOs coordinate their activities under an umbrella known as the Sudan AIDS Network (SAN). The active international NGOs are also mostly involved in awareness-raising for various target populations, although some are considering providing PEP in Darfur as part of gender based violence interventions.

Christian faith based organisations led by SCC are active both in awareness raising and PLWA support activities.

A curriculum for training Muslim leaders on HIV and AIDS advocacy and awareness raising was developed, prepared sermons distributed, and dialogue workshops conducted by SNAP in partnership with the Ministry of Guidance, during 2004.

5.5. Tearfund's Response

Tearfund DMT

Tearfund are currently working in El Geneina, Garsilla, Nyala, Ed Daein in Darfur and Renk in Upper Nile. Tearfund are doing relief and development activities that include; water and sanitation, health promotion, nutrition, food security and community development. Within this Tearfund has begun to mainstream HIV and AIDS by reshaping these core specialities to help reduce people's vulnerability towards HIV and AIDS. However Tearfund has found that there is very little awareness on HIV and AIDS in northern Sudan so are planning on concentrating on HIV awareness messages. This will be both amongst beneficiaries and amongst staff where a work place policy has been piloted.

Tearfund Partners

Organisation	Type of Activity	Area	Funding	Length of programme/funding
FAR	HIV awareness within gender training and church capacity building	Darfur Nuba Mountains Renk – Upper Nile, Kosti, Khartoum	Tearfund funds Partnership church programme	Ongoing
FOCUS	HIV awareness amongst university students	El Obeid, Juba, Khartoum, Malakal, Medmia, Port Sudan Wau	IFES, Tearfund	Ongoing

FAR

FAR is split into two programmes. The church partnership programme is a small component of FAR's work (5%). This programme's objective is to empower the local church. Currently 65 participants have graduated form the participatory evaluation

process. Although there are no HIV activities in this programme, the programme coordinator is keen to include some HIV awareness within the training. This programme is funded by Tearfund.

The second part of FAR is the development programme which is a very large component. FAR currently has livelihoods & household food security, water and sanitation, health and microfinance activities. They work in Darfur, Nuba Mountains, Renk, Kosti and Khartoum. Last year they ran a UN funded gender training and awareness programme in Nuba Mountains. This also included some public health education and micro credit.
They currently do not run any HIV activities within their development programme.

FOCUS
FOCUS is an organisation whose mandate is to encourage university students to be 'Godly Leaders'. They currently conduct trainings about three times a year. In addition each university has a fellowship group that meets once during the week. Sister Mary incorporates HIV awareness sessions during the conferences. FOCUS is based in Khartoum but works in both north and south Sudan university campuses in Khartoum, Wau, Malakal, Juba, Port Sudan, Medmia and El Obeid. They are funded by IFES, Tearfund and other donors at different occasions.

6. Suggested Approaches, Recommendations and Conclusion for Tearfund

6.1. Approaches

6.1.1. HIV Awareness

Currently both in north and south Sudan, HIV awareness is very low. Increasing understanding about HIV should be a high priority for all Tearfund partners and DMT. In order for any other HIV needs to be addressed in Sudan there must be better awareness. This is both for Tearfund partners and DMT staff as well as target beneficiaries. Poor understanding of HIV is not only dangerous in terms of increasing HIV prevalence due to risky behaviour but it also hampers any other HIV activities due to the stigma that it causes. In addition until people understand the danger of HIV and the potential impact it can have in Sudan, HIV activities will never be considered important.

6.1.2. Reduce Stigma

Stigma is a big problem in Sudan caused both by a lack of awareness but also due to religious and cultural traditions. As has been known in other countries, the attitude and beliefs of Christians and Muslims can facilitate stigma and discrimination if there is a lack of education and a sensitive approach. It is necessary therefore that Tearfund partners and DMT have a clear undertaking of how to train and teach about HIV using Biblical principles in a non judgemental approach. Partners and DMT in the north need to also consider Islamic teachings within their approach and have a clear understanding of where the similarities lie in the moral values in order to facilitate learning. This again needs to be done with extreme sensitivity to ensure that stigma is not increased.

Myths of how HIV is transmitted need to be ironed out both amongst staff and beneficiaries as these can facilitate stigma and discrimination.

6.1.3. Mainstreaming HIV and Gender

For DMT and partners implementing relief projects, mainstreaming is an extremely important approach to HIV and AIDS. Considering the socio-economic and cultural factors in Sudan that can fuel the epidemic, mainstreaming HIV is a good way to reduce people's vulnerability towards HIV by reshaping and redesigning core specialities. Currently DMT is beginning to do this but Tearfund partners such as FAR could also adopt this approach. Gender inequality issues are also a major factor that can increase the impact of HIV and these can be considered within mainstreaming concepts.

6.1.4. VCT and PMTCT

VCT has been known to help reduce stigma by the very fact that if there are more people who are known to have HIV then stigma should decrease as people become directly or indirectly affected by the disease. However Sudan is in the early stages of HIV awareness so starting VCT and other HIV activities will be very difficult as stigma will be very evident. This will especially be the case in areas such as Upper Nile and Bahr-El-Ghazal.

The government both in the north and south consider VCT and PMTCT as being very important in preventing HIV and AIDS in Sudan. Prevention is key for Sudan at the

moment as prevalence is low and it is important that Tearfund concentrate on all HIV activities that prevent the disease.
Currently some Tearfund partners are implementing these activities and DMT are considering introducing them in their programmes in 2006. This approach may not be appropriate for all partners, but as there is expertise already amongst some organisations it can certainly be considered as a way forward when capacity building in the future. In addition PMTCT is especially important in Tearfund's current strategy and fits well in the Sudanese context.

6.1.5. Home Based Care

Home based care is currently only applicable in some areas of Sudan where prevalence is at a higher level. However there are some partners who have already begun to consider this as they have seen the need in the community. As the disease progresses this approach will need to be considered by partners especially those based in Equatoria. For partners it will be a good opportunity to work closely with the church to ensure the church has the capacity to give pastoral care and meet the needs of those infected and affected by AIDS. In the north the prevalence is still at a very low level but in the future Christian partners can consider how they can demonstrate the love and compassion of Christ through home based care activities.

6.1.6. PLWA Networks

Some partners have already begun support groups for people living with HIV and AIDS. However this will become more important for all partners and DMT to implement as the disease becomes more prevalent. In addition psychosocial and spiritual support is a strength of the church and should be a priority. There needs to be careful capacity building and training of those running the groups to ensure there is no stigma or discrimination. In the future there is a great opportunity for a network to be established across the country of the groups affiliated with DMT and Tearfund partners.

6.1.7. Advocacy

Advocacy will be extremely important in Sudan as the needs are great and the capacity of the partners and DMT is limited. Assessments and a situation analysis will identify the gaps and Tearfund should lobby other organisations, UN and the government to ensure these are filled. Advocacy aimed at the government and other NGOs for those activities that are not Tearfund specialities such as ARVs will be essential. Advocacy for gender inequality, protection and the rights of those living with HIV and AIDS will also be important. Tearfund should consider government policies and legislation to ensure the rights of those infected and affected by HIV are highlighted.

6.2. Recommendations

6.2.1. Tearfund's Geographical Focus

Sudan is a vast country with limited development and infrastructure. In southern Sudan Tearfund's partners are mostly situated in the Equatoria region, however Tearfund DMT are situated in Bahr-El-Ghazal and Upper Nile where there are no partners. Although the prevalence is estimated to be lower in these areas, returnees coming from areas of higher prevalence will make it necessary to ensure there is good understanding and awareness.

In northern Sudan, there are only three partners, two of which specialise in church capacity building in a number of different towns rather than areas. FAR works in the same areas as DMT in northern Sudan in Darfur and Renk.
Tearfund need to consider which areas they want to work in and concentrate activities in these target areas. The following are some suggested recommendations;

- Partners in southern Sudan should consider expanding to areas where DMT are situated in order to address needs and assist with DMT exit strategies.
- Partners should continue to focus on Equatoria where HIV prevalence is estimated to be higher.
- DMT and partners should consider working more closely in Juba where HIV prevalence is estimated to be higher than in other parts of the country.
- FOCUS and the Episcopal Church should work more closely with DMT and FAR in Darfur and Renk to encourage greater capacity and concentration of resources.
- Partners and DMT should consider working in Khartoum and Kassal where prevalence is estimated to be higher.

6.2.2. Capacity Building

Currently Tearfund partners in Sudan have very limited capacity in regards to HIV. This is both due to the nature of the specialities of the partners and the limited knowledge, resources and skills of the partners. Tearfund need to spend a lot of time capacity building the partners and directly/indirectly the church in Sudan in the following ways;

- Accessing funds and resource mobilisation
- Project proposal writing
- Monitoring and evaluating skills
- Advocacy and lobbying skills
- Understanding Biblical principles to approaching HIV and AIDS
- Communicating HIV and AIDS within a Christian (or Muslim) context
- Mainstreaming HIV and AIDS and gender
- Introducing an HIV work place policy

6.2.3. Exposure Visits

One of the ways to capacity build partners and DMT is to encourage visits to other partners, organisations and DMT within Sudan and in other countries. HIV is a relatively young disease in Sudan compared to many bordering countries, so there are many opportunities for DMT and partners to gain experience from other Tearfund projects and programmes. The following are recommended;

- Encourage partners and DMT to attend professional training and attend workshops/conferences.
- Encourage DMT and partners to do exchange visits within Sudan and to begin communication via e-mail and meetings.
- Encourage partners to network and communicate with other partners from surrounding countries.
- Encourage partners and DMT to visit and communicate with other experienced organisations outside of Tearfund.

6.2.4. Collaboration Between DMT and Partners

Currently DMT and partners generally work separately. There needs to be more collaboration to ensure sharing of resources and knowledge to be better able to

address the HIV needs in Sudan. In addition there are many partners who have more experience than others in HIV as different parts of the country are more advanced than others. This collaboration needs to extend to the church wherever possible to ensure they benefit from Tearfund's skills and resources. The following is recommended;

- HIV and AIDS Coordinator situated in Juba to assist DMT and partners implement HIV and AIDS specific and mainstreaming activities.
- DMT, Across and FAR to share experience with partners on monitoring and evaluating programmes.
- DMT to share experience and resources on HIV mainstreaming programme.
- DMT to share experience and resources on their HIV work place policy.
- Across to share experience with other partners and DMT on implementing VCT in Sudan.
- Across to share experience in setting up PLWA groups/networks.
- Across to share experience in giving home based care to PLWA.
- Partners to share experience with DMT on incorporating HIV awareness sessions amongst youth, church leaders and pastors.

6.2.5. Re-establishment of SCAN

SCAN as highlighted earlier was a network of Christian organisations and the church in southern Sudan. It is recommended that this group is reformed to assist with sharing of resources and best practice regarding HIV and AIDS in Sudan.

6.2.6. Scaling Up and Incorporation of More Partners in Sudan

Currently many of the partners being supported in Sudan have limited capacity and are very specific in their line of work. This means that many of the needs highlighted in this document cannot be met by the partners or DMT currently. In addition the amount of partners supported compared to the size of the country means there are many gaps both in geographical areas and the HIV needs of the beneficiaries. There are a number of options that are recommended;

- Intensifying capacity building for current partners.
- Scaling up of HIV activities by partners and DMT.
- Facilitating more experienced and larger partners to work alongside smaller organisations and the church. For example, Across and FAR could help smaller partners in their areas of work.
- Tearfund need to assess and identify other potential organisations to support.

6.3. Conclusion

Sudan is in a unique position in regards to HIV and AIDS. Prevalence rates are relatively low so there is a window of opportunity as we learn from other countries and implement tried and tested activities to address the epidemic. However Sudan is also in a dangerous position as a country relatively protected during a 21 year civil war now opened up to outside influences and increased mobility. In addition many parts of the country are still experiencing political instability and insecurities. Development particularly in the south has therefore been non existent for the past decade meaning as HIV begins to take hold its impact could increase dramatically. Migration, poverty, poor infrastructure, illiteracy, gender inequality, detrimental cultural and traditional practices and political instability can all fuel the epidemic and increase the impact HIV has in Sudan over the next few years. The continued conflicts in Darfur and along the borders of Chad only add to the problems.

In Sudan HIV cannot be considered in isolation as it not only impacts the physical and mental health of individuals and communities but it also impacts on economies, education, food security and many other sectors. HIV and AIDS needs a muti-sectoral approach in Sudan as it is a cross cutting issue.

The Sudanese government in the north and the interim government in the south have identified HIV and AIDS as a major problem and have set up National AIDS Commissions to address the epidemic. The approach by both bodies is to monitor and coordinate activities. Funding is limited and they rely on organisations and the UN to implement activities. There are very few organisations currently implementing HIV and AIDS activities. Many organisations are doing HIV and AIDS awareness although how effective these are is not known. Some agencies have begun VCT and ARVs but considering the size of the country, this is a drop in the ocean.

Tearfund Partners and DMT need to concentrate on creating awareness as knowledge of HIV in Sudan is extremely low. Understanding the context and addressing those practices which can increase the spread of HIV is vital. By increasing awareness and a proper understanding of the disease, stigma and discrimination can be reduced. In addition to this those partners and DMT implementing relief projects can mainstream HIV by reshaping core activities such as water and sanitation to reduce beneficiaries' vulnerability towards HIV.

Currently Tearfund has very few partners in Sudan compared to the size and needs of the country. In addition many of the partners have limited technical capacities with weak management systems. Some partners are doing HIV and AIDS activities but are not directly supported for those activities by Tearfund. So Tearfund therefore has very few directly funded HIV related projects.
Tearfund DMT is planning to expand HIV activities in the south but is limited to DMT strategies and length and time of the operational funding period.
Scaling up of HIV and AIDS activities is crucial but will take a long time. Tearfund partners will need capacity building in all areas of project cycle management in addition to HIV and AIDS technical skills. Many of Tearfund partners and the church also need to be equipped to communicate HIV and AIDS within a Christian (or Muslim) context in a non judgemental way. The use of Biblical principles (wherever possible) needs to be incorporated into trainings with sensitivity to ensure stigma and discrimination does not occur within the church. In addition a harm reduction approach needs to be considered in areas where the cultural and traditional practices are putting people at risk and they need to know all the options of prevention including condoms. Local faith based organisations and the church do have the strength of being well accepted in communities and can excel at their strength of psychosocial and spiritual support.
There are partners that already have the capacity to scale up, such as FAR and Across, and Tearfund needs to work with them to increase funding and support and encourage them to help other partners and DMT. In addition to capacity building partners, Tearfund needs to consider funding additional partners as the needs in Sudan will continue to increase.

Appendix 1: Terms of Reference

Tearfund Terms of Reference

TITLE	Sudan Strategic Framework Development Process (HIV section)

Region: North and South Sudan
Category: HIV and AIDS
Type: Research
Beneficiaries: Tearfund UK, DMT, regional teams and partners
Activities: Research and analysis of HIV in Sudan

Consultants Name: Fiona Perry

Approved by:	Signatures	Approval Date
1. Fiona Perry, HIV/AIDS Coordinator	Fiona Perry	7th November 06
2. Morag Gillies, Assistant Head of Region 2	*M. Gillies*	*6th November 2006*

BACKGROUND
Tearfund is required to develop a strategic framework for each of its High Intensity Areas. Tearfund currently works in Sudan through the following three strategies; supporting partner organisations, advocacy and operational disaster response.
Tearfund International Strategy requires that the three areas of work be brought together under a common strategy.

MAIN PURPOSE OF THE CONSULTANCY
Contextual analysis of HIV in Sudan including;

- Situation analysis of HIV in Sudan including influences such as post conflict, gender inequality, poverty etc
- Current needs/priority issues
- MOH response (north and South)
- UN response
- Partner response
- DMT response
- Other key stakeholders

METHODOLOGY AND SCHEDULLING

- One week in Juba visiting key stakeholders such as MOH, UN and other NGOs
- 2 days in Khartoum visiting MOH, UN and key NGOs
- Correspondence by e-mail and/or via regional team with partners in north and South Sudan summarising response to HIV
- Desk study (2 days) on HIV in Sudan

EXPECTED RESULTS
The consultant will produce a written report of the findings of the research

TIMEFRAME AND BUDGET

Item	Cost	Timeframe
Return flight to Juba	£197.10	13th – 18th November
Return flight to Khartoum	No cost[28]	25th – 26th November
2 day desk study	No cost	4th – 5th December
Partner research/correspondence	No cost	6th – 8th December
Write up of research	No cost	11th – 13th December
Grand Total	**£197.10**	

Funding
Funding will be sourced from budget code: CA-00-IMP

[28] Visit coincides with other work for HIV mainstreaming programme

Appendix 2: Details of Organisations Interviewed

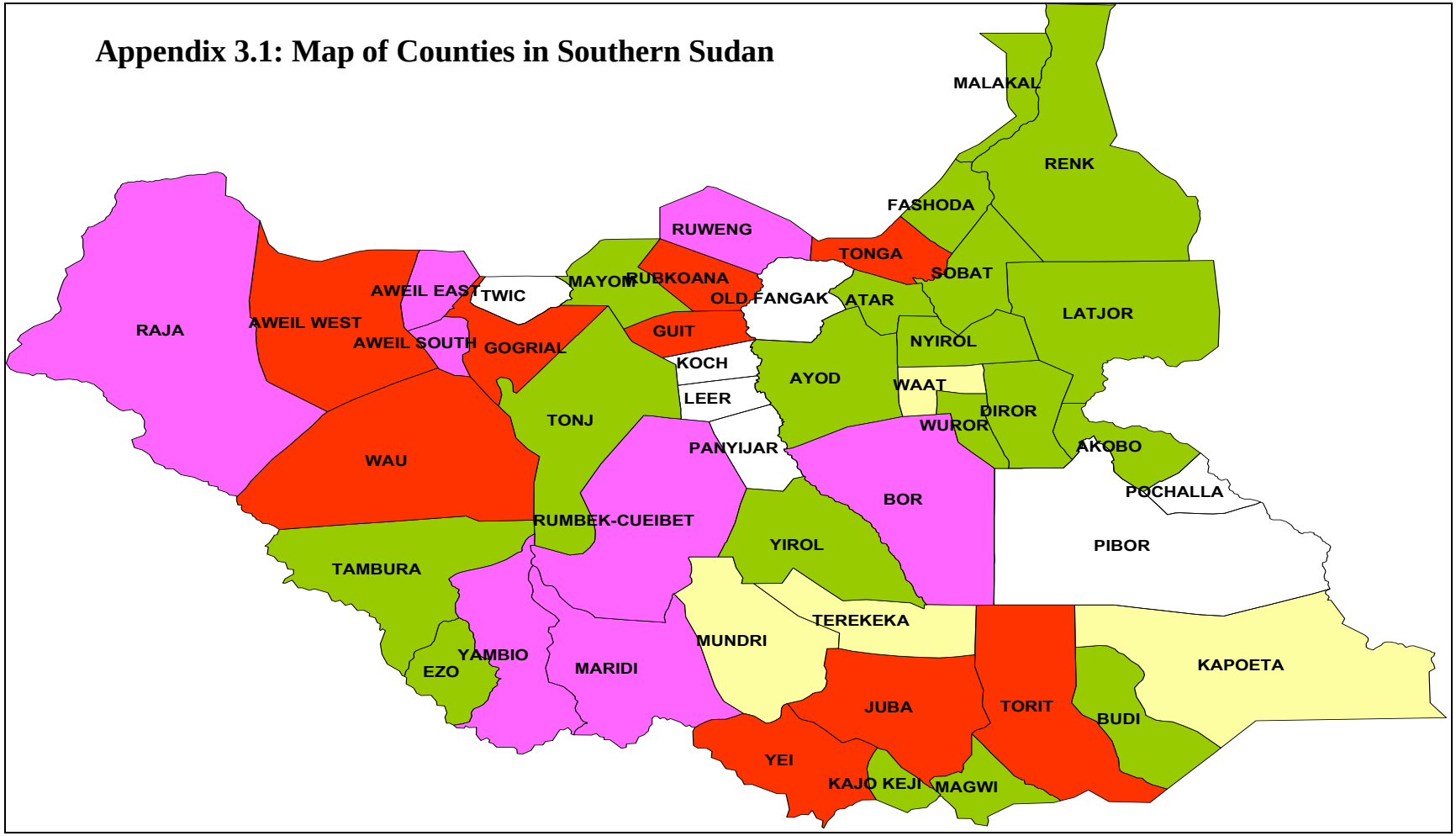
Organisation	Day of meeting	Meeting with	Contact person if different	Contact address/telephone	General work	HIV activities	Area of Work
MSF France	14.11.06	Morphelis Causing (Medical Coordinator)		Msff-juba@paris.msf.org	Health – PHCC & PHCU	Blood donor screening HIV awareness	Aquiem
SSAC	14.11.06	Dr Lul pout Riek Deputy (Executive Director)	Dr Bellario Ahoy (Chairperson) Dr Angok Kuol (Executive Director)	lulriek@yahoo.com	National coordination body for HIV and AIDS	Coordination National protocols Monitoring and Evaluation	All
HIV unit Juba Hospital	14.11.06	Dr Joseph & Nurse Lorna		Juba Hospital		Post counselling Providing clients with ARV and prophylaxis	Juba
UNDP	14.11.06	Amber Kimbro (HIV & AIDS Coordinator)		Amber.kimbro@undp.org	Development	Support of AIDS commission (training & funding)	All
ACORD	15.11.06	Savio Androga Joseph Longa		Joseph_longa@yahoo.com	Peace building Conflict	HIV awareness Support of	Juba

					resolution Food security Capacity building Gender mainstreaming	PLWA Association VCT Counsellors	
IRC	15.11.06	Lynnette Olembo (Programme Coordinator)	Rose Wahome	rosewahome@yahoo.com	Health – PHCC & PHCU	VCT Peer Educators	Aweil East Ganyliel Billing Rumbek
SCF– UK	16.11.06	HR manager	Sophia Ayoo (HIV Coordinator)		Education Food Security Water Protection	Mainstreaming HIV awareness	Upper Nile (Leer, Wat) Bahr-El-Khazal (Malualkon)
MSF- B	16.11.06	Esther Namuyo (Assistant Medical Coordinator)	Chris (Head of Mission)	Msfb-juba-sat@brussels.msf.org 00256477105566	Health – Hospital, PHCC & PHCU	Blood donor screening	Bor Pibor
MSF-CH	16.11.06	Jonathan Jennings Annamaria (Medical Coordinator)		Msfch-juba-medco@geneva.msf.org	Health – Hospital	Blood donor screening Focus Group Discussion	Marialol
Oxford – GB Northern Sudan office	16.11.06	Augustino Buya (Programme Coordinator North Sudan)		Khartoum office	Water Livelihoods Peace building	HIV awareness	Juba (closing)
Oxfam – GB	16.11.06	Augustino Buya	Gender		EP&R	Mainstreaming	Western

Southern Sudan office		(Programme Coordinator North Sudan)	Coordinator		Public Health Water Livelihoods Gender	HIV awareness	Equatoria - Mundri Lake state
Across	16.11.06	Rev. Thomas Kedini Legge (Field Director)	Hilda Timnerman (Manager)	Tkedini@across-sudan.org	Education Translation Teacher training Health – PHCC, PHCU Capacity building	VCT Support groups for PLWA HIV awareness	Yambio Nzara Rumbek Boma Leer
UNICEF	17.11.06	Shelia Mangan (HIV/AIDS Coordinator)		s.mangan@tearfund.org	All sectors	PMTCT VCT Peer Education Youth Mainstreaming	All
WHO	17.11.06	Patrick Abok (HIV focal point)			Health	VCT & Treatment protocols	All
SSAC	17.11.06	Edward Quirino (HIV/AIDS Uniformed Services Officer)		edward.quirino@undp.org	Support of uniformed services	Provision of IEC materials and condoms Capacity building (via PSI and Intra Health International)	Yei Nimule Juba Kajokeji

Medair	18.11.06	Caroline Boyd (Medical Coordinator)		medical-nairobi@medair.org	Health Water and sanitation Outbreaks	HIV awareness	Payuer (Upper Nile_ Outbreaks – all
FAR (telephone call)	4.12.06	Clive (Country Director)		Tel: 00249912163877	Livelihoods Household food security Watsan Health Microfinance	None	Darfur Nuba Mountains Renk Kosti Khartoum
FOCUS (telephone call)	5.12.06	Jeda (Director)		Tel: 002499122323191	Training university Students	HIV awareness	El Obeid, Juba, Khartoum, Malakal, Medmia, Port Sudan Wau
Diocese of Mundri	6.12.06	Canon Baringwa		Tel: 020 3873028	Capacity building church leaders	HIV awareness	Mundri, Lui
BATC	7.12.06	Rev, James Kenyi		Tel: 006772848390	Training Bible students	HIV awareness	Arua. Northern Uganda
AIC – Sudan	11.12.06	Rev. Peter Tibi		Tel: 0722740945	Capacity building AIC church members	HIV awareness	Adjumini camp,Uganda Nimule, Torit, Yei, Yambio

Appendix 3.1: Map of Counties in Southern Sudan



Appendix 3.2: Map of Sudan Showing Darfur Region