Global AIDS Response Progress Reporting 2012 – 2013

Sudan National AIDS and STI Control Program

Federal Ministry of Health – March 2014

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
ART	Antiretroviral Therapy
CBOs	Community-Based Organizations
BCC	Behavior Change Communication
CCM	Country Coordination Mechanism
CT	Counseling and Testing
CSOs	Civil Society Organizations
FSW	Female Sex Worker
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HTC	HIV Testing & Counseling
HTTR	HIV Test Treat Retain Cascade
IBBS	Integrated Biological and Behavioral Survey
IDP	Internally Displaced Persons
IEC	Information, Education and Communication
MDG	Millennium Development Goals
MARPs	Most-at-risk Populations
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MOHE	Ministry of Higher Education
MSM	Men who have sex with men
NAC	National AIDS Council
NASA	National AIDS Spending Assessment
NECHA	National Executive Council on HIV and AIDS
NGO	Non-Governmental Organization
NSP	National Strategic Plan
OAFLA	Organization for African First Ladies against AIDS
OVC	Orphans and other Vulnerable Children
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
SAN	Sudan AIDS Network
SHHS	Sudan Household Health Survey
SNAP	Sudan National AIDS and STI Control Program
STI	Sexually Transmitted Infection(s)
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNHCR	United Nation High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VCT	Voluntary counseling and Testing
WHO	World Health Organization

FOREWARD AND ACKNOWLEDGEMENTS

Sudan remains committed to contribute to the global vision of achieving the three zeros in new HIV infection, discrimination and AIS related death. Since 2011, Sudan has made marked strides in the AIDS response in HIV prevention and working with populations that drive the HIV epidemic.

Our achievements in the national response would not have been made possible without the contributions, partnerships and coordination from the different governmental ministries, development partners and civil society at all levels.

We are very pleased to share the 2012 – 2013 national progress report that builds on the previous report. This report comprises of seven sections starting with Status at a Glance followed by Epidemic Profile, The National Response to the Epidemic, Best Practices, Challenges with Remedial Actions, Support from Developmental Partners and finally the last section on Monitoring and Evaluation Environment.

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1 Status at a Glance

This is Sudan's fourth National report submitted to UNAIDS to facilitate the purpose of Global monitoring and to reflect upon the country's commitment made in the successive UN General Assemblies. The report covers the overall progress made during the reporting period 2012-13 using updated information on a number of indicators generated through the population-based Sudan Health and Household Survey, ANC sentinel sero-surveillance, and integrated bio behavioral surveys among key and at risk populations.

1.1 Stakeholder inclusiveness in the report writing process

Governmental line ministries and departments, such as the Ministry of Health, Ministry of Defense, and Ministry of labor, Civil Society organizations (national and international), PLHIV associations and networks and United Nations Agencies were all involved in report writing process. Initially, stakeholders were invited for an orientation session on the report writing process. A road map for the report writing, methodology and stakeholder roles in the process was discussed and agreed upon. The input of stakeholders in terms of achieved progress and encountered challenges and revision inputs were all incorporated within this report.

1.2 The status of the epidemic

The understanding of the epidemic context in Sudan has increased substantially. Evidence from the 2011 integrated bio-behavioral survey (IBBS) among key populations, 2010 ANC surveillance rounds and routine programmatic data from VCT and PMTCT sites shed more light on the type of HIV epidemic that exists in Sudan. The data suggests a concentrated HIV/STI epidemic among key populations in specific geographical foci in Sudan. Data[1] indicate a two to seven fold higher HIV prevalence among key populations notably in states in the eastern region e.g. Red Sea, Kassala, Blue Nile compared to the HIV prevalence among general population[2].

The status of the epidemic is not expected to remain static with the challenging socio-political and economic changes that occurred in the post secession era. In addition, the existent low HIV knowledge and behavioral practices among key and general population if not addressed could potentially increase population's HIV vulnerability and increase transmission.

1.3 The policy and programmatic response

During this reporting period, there was no change in any HIV related policies. The draft PLHIV protection law still remains to be endorsed to re-enforce the implementation of other policies such as the HIV work policies that were developed in the last reporting period. The current response to AIDS in Sudan is based on NSP II (2010-2014) that was developed with the new understanding of epidemic profile in Sudan. This strategy focuses on scaling up of HIV prevention among at-risk and

[1] 2010 -2011 Integrated Biobehavioral Survey Technical Report

[2] 2013 HIV estimates and projection of Sudan, SNAP and UNAIDS

vulnerable population, provision of anti-retroviral treatment for those in need and adoption of provider initiated approaches for the service. It also addresses cross cutting issues such as gender empowerment, human rights protection, addressing stigma and discrimination, poverty and involvement of PLHIV. It has an M&E framework that contains key national targets, core indicators as well as program monitoring indicators with a costed work plan. NSP II is currently undergoing revision for the period 2014 to 2016. The new strategy will remain focused in the areas of the previous strategy but includes targets that are expected to have a meaningful impact on the HIV epidemic.

The HIV response remains multi-sectoral but mostly though a health sector response regularly coordinated by The Sudan National AIDS and STI Control Program (SNAP) under the national Ministry of Health. Eleven line ministries (Ministry of Defense, Higher Education, Education, Labor, Social Affairs, Finance, Youth and Sports, Justice, Interior, and Guidance) have developed their own sectoral strategic plans but most do not have earmarked budgets to implement them. Developmental partners specifically UN agencies (UNAIDS, UNDP, UNICEF, WHO and UNFPA) continue to work in close partnership with SNAP. The main funding source for the HIV response continue to be contributed from the global fund, with some funding from developmental partners and governmental contribution mainly provided through its human and facility health resources (see details in AIDS National Spending Matrix). Two significant changes occurred within the health sector response in this reporting period; HIV program integration and increased involvement of civil society. The Federal Ministry of Health issued a directive for the integration of all the nine vertical programs with the aim to reduce the fragmentation of the health system and efficiently expand HIV interventions within existent pathways in a cost effective manner e.g. incorporating HIV supply chain within the existent central medical stores supply system. Unlike previous national strategies, the civil society has played a significant role working with key populations. Over 60 National NGOs were trained on MARPs interventions and program management.

The national response is monitored closely through regular meetings among all key-implementing partners who meet regularly to review progress and identify implementation bottlenecks. For instance, a nationwide rapid assessment findings of the HIV response were used to develop an accelerated response to scale up HIV testing and treatment by the end of 2013.

Several achievements were made in areas of program implementation that will be detailed in subsequent sections with examples of best practices. Similarly challenges faced with their remedial actions will also be addressed.

1.4 The Indicator Data Overview Table

Table 1: Core Indicators for 2012 Global AIDS response progress reporting

Indicators	Indicator value reported in (2012)	Indicator value (2013)	Comments
Target 1: Reduce sexual transmission of HIV by 50 per cent by 2012 [General Population related indicators]			
1.1 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*	6.7% 11.1 (Male) 5.3 (Female) N=9,027 [SHHS 2010]	6.7% 11.1 (Male) 5.3 (Female) N=9,027 [SHHS 2010]	No new data available.
1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age 15	3.2% N=2146 [SHHS 2010]	3.2% N=2146 [SHHS 2010]	No new data available.
1.3 Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	4.49% N=5,573 [SHHS 2010	4.49% N=5,573 [SHHS 2010]	No new data available.
1.4 Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*	5.2% N=250 [SHHS 2010]	5.2% N=250 [SHHS 2010]	No new data available.
1.5 Percentage of women and men aged 15-49 who received and HIV test in the past 12 months and know their results	1.0% N=22,747 [SHHS 2010]	1.0% N=22,747 [SHHS 2010]	No new data available
1.6 Percentage of young people aged 15-24 who are living with HIV*	0.31% N=3,524 [2007]	0.11% (15 - 24), 0.14% (15 - 19), 0.09% (20 - 24)*	*Source for (2013) is the 2010 HIV Sentinel sero-surveillance survey among pregnant women attending ANC facilities in Sudan
[Sex workers related indicators]			
1.7 Percentage of sex workers reached with HIV prevention programme	1.5% N=321	6.44% (all), 5.23% (<25 years), 7.46% (25+ years)**	** Unadjusted sample proportions values for female sex workers only from 14 RDS studies (2010/2011) with a total sample of 4,242 FSW
1.8 Percentage of sex workers reporting the use of a condom with their most recent client	4.7%-55.1% [IBBS*]	22.49% (all), 22.41% (< 25 years), 22.56 (25+ years)**	* Values from six independent study locations of IBBS. ** Unadjusted sample

Indicators	Indicator value reported in (2012)	Indicator value (2013)	Comments
			proportions values for female sex workers only from 14 RDS studies (2010/2011) with a total sample of 4,242 FSW
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	4.4%-23.9% [IBBS*]	8.98% (all), 7.85% (< 25 years), 9.95% (25+ years)**	* Values from six independent study locations of IBBS. ** Unadjusted sample proportions values for female sex workers only from 14 RDS studies (2010/2011) with a total sample of 4,242 FSW
1.10 Percentage of sex workers who are living with HIV	2.27% [Spectrum 2011]	1.63% (all), 0.92% (<25 years), 2.23% (25+ years)**	** Unadjusted sample proportions values for female sex workers only from 14 RDS studies (2010/2011) with a total sample of 4,242 FSW
[Men who have sex with Men related indicators]			
1.11 Percentage of men who have sex with men reached with HIV prevention programme	No data	61.11% (all), 60.43% (< 25), 63.73% (25+)**	*Values from five independent study locations of IBBS. **Unadjusted values from 12 RDS studies (2010/2011) with a total sample of 3,361 MSM
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	8%-25.8%*	19.90% (all), 19.78% (<25), 20.38% (25+)**	*Values from five independent study locations of IBBS. **Unadjusted values from 12 RDS studies (2010/2011) with a total sample of 3,361 MSM
1.13 Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results	3.3%-15.4%*	4.58% (all), 3.75% (<25), 7.80% (25+)**	**Unadjusted values from 12 RDS studies (2010/2011) with a total sample of 3,361 MSM
1.14 Percentage of men who have sex with men are living with HIV	3.57% [Spectrum 2011]	2.38% (all), 1.95% (<25), 4.05% (25+)**	**Unadjusted values from 12 RDS studies (2010/2011) with a total sample of 3,361 MSM
Target 2: Reduce transmission of HIV among IDU by 50% by 2015			
Injecting drug use is not a known behaviour in Sudan and not a prioritized risk group for intervention, no data is reported as such.			
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths			
3.1 Percentage of HIV+ pregnant women who received anti-	1.49%	2.3% [N=74/3,245] Spectrum 2014	

Indicators	Indicator value reported in (2012)	Indicator value (2013)	Comments
retrovirals to reduce the risk of mother-child transmission	2011 Estimates		
3.2 Percentage of infants born to HIV+ women receiving a virological test for HIV within 2 months of birth	No data	No data	No data due to unavailability of testing (PCR)
3.3 Estimated percentage of child HIV infections from HIV+ women delivering in the past 12 months	35.7%	34.2% [1,110/3,245] Spectrum 2014	
Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015			
4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy*	9.46%	4.9% [3,308/67,830] (All), 5%[3,058/61,410] (Adults), 3.9%[250/6,420] (children) Spectrum 2014	
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of anti-retrovirals	62.16%	69.10%*	*Data from 17 sites in 7 states
Target 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent			
5.1 Percentage of estimated HIV+ incident TB cases that received treatment for both TB and HIV	1.29%	2.95% [127/4,300] Spectrum 2014	Denominator is 2012 TB Estimates (http://www.who.int/tb/country/en)
Target 6:Reach a significant level of annual global expenditure (between $22-$24 billion) in low-and middle income countries			
6.1 Domestic and international AIDS spending by categories and financing sources	Reported	Reported	Attached
7.1 National commitment and policy instruments	Reported	Reported	Attached
7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	No data	No data	
7.3 Percentage of women and men aged 15–49 who report discriminatory attitudes towards people living with HIV		No data	
7.4 Travel restriction data is collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed			"There is a current regulation for mandatory HIV tests as a requirement for country residence permit" SNAP

Indicators	Indicator value reported in (2012)	Indicator value (2013)	Comments
			verbal communication.
7.5 Current school attendance among orphans and non-orphans (10-14 years old, primary school age, secondary school age)*	78.38% (part A) [Male 85%, Female 69.3%] 81.76% (part B) [Male 85%, Female 78.5%]	78.38% (part A) [Male 85%, Female 69.3%] 81.76% (part B) [Male 85%, Female 78.5%]	No new data available, Part A is orphan while Part B is non-orphans. Source is SHHS 2010.
7.6 Proportion of the poorest households who received external economic support in the last 3 months	No data	No data	No study available to reflect this indicator in Sudan.

2 Overview of the AIDS Epidemic

2.1 Country Context: Socio-demographic profile

Sudan in the post secession era since 2011 has faced several socio-political changes. This included administrative subdivisions from 15 to 18 states with its consecutive health system administrative changes. Huge population movements occurred within and outside Sudan; about two million South Sudan returnees transited through White Nile and South Kordofan states and about half a million people have been displaced or severely affected by conflicts in the three protocol areas[3]. An estimated 46.5 % of the population lives below the poverty line[4].

The projected total population of Sudan for 2013 is 34,109,472[5], of which 33.2% live in urban area, 57.9% living in rural areas and 8.9% nomads. There is an almost equal gender distribution and youths (10 – 35 years) comprise almost half of the population. The population in Sudan remains multi-ethnic-linguistic and mostly Islamic.

2.2 The AIDS Epidemic

The HIV epidemic in the general population is still low. All the rounds of ANC surveillance, population based surveys and HIV testing data indicate an HIV prevalence of less than 1%. In 2013[6], HIV prevalence among adult population (15 – 49) is estimated at 0.31% – 0.42% translating to 67,830 (59,731 – 80,698) people living with HIV. The annual estimations of new HIV infections and AIDS deaths are 7,032 (5,631 – 9922) and 4,797 (4,163 – 5,623) respectively. Those in need for ART ranged between 22,701 and 29,396 for adult population and between 3,976 and 5,443 for children. Finally, the number of mothers needing PMTCT is estimated at 3,245 (2,731 – 3,995).

Despite the low national HIV prevalence, epidemiological data suggest an HIV geographic aggregation pattern among selected populations such as MSM, FSW and TB patients in the Eastern Zone (Red Sea, Kassala, Gadarif) and Khartoum state[7]. In addition, HIV prevalence in FSW and MSM was significantly associated with syphilis prevalence[8]. No clear temporal trend has been observed in any population groups or geographical areas. Injecting drug use in general population and drug use among most at risk groups is perceived to be low, but will need further data to support this.

The current situation does not preclude the possibility of an HIV epidemic potential in Sudan. IBBS data of MSM and FSW found low HIV comprehensive knowledge (3 – 40%); low (11%) consistent condom while less than a quarter (4 – 24%) ever had an HIV test. It is also important to note that

[3] OCHA 2012

[4] Sudan National Budget Household Survey 2009

[5] 2008 Population Census

[6] 2014 Spectrum Estimation and Projections

[7] 2010-2011 IBBS among FSW and MSM, 2010 SHHS, ANC surveillance data and HIV testing data among pregnant, VCT clients, FSW and MSM – Epidemiology of HIV in Sudan, staging and analysis – Jan 2014

[8] Epidemiology of HIV in Sudan, staging and analysis – Jan 2014

comprehensive knowledge of the general population is much lower 6.7%[9] (men 11.1% and women 5.3%). This, together with associated syphilis prevalence, low coverage of prevention services (4% of MSM/FSW received HIV test while 30% received any prevention service package) and additional vulnerabilities driven through poverty and population movements may further drive the sexual transmission of HIV. On the flip side, the almost universal male circumcision rate and limited use of intravenous drugs may protect/reduce sexual and intravenous transmission rates respectively.

[9] 2010 Sudan Health and Household Survey (SHHS)

3 National Response to the AIDS Epidemic

3.1 Strategic Planning and Political Support/Leadership

The National HIV strategy is being updated to cover the period 2014 – 2016. It will remain with similar strategies and cross cutting principles as the outgoing strategy (2010 – 2014) but with scaled up operational interventions and targets that will have a meaningful control impact on HIV infection and death rates.

With regards to political leadership and support, the NCPI findings are similar to the last reported findings in 2012. High officials continue to demonstrate leadership, for instance the Federal minister of Health took an HIV test while an increasing number of Walis (state governors) and state ministers receive/discuss state HIV reports in their meetings. The political support still remains mostly verbal and not translated into tangible actions such as local financial resources to fund activities in the HIV response. There is still opposing religious views on HIV related interventions for example prevention programs that target key populations and condom programming.

The National AIDS Council (NAC) has remained inactive for the past five years. The Sudan National AIDS and STI Control Program has taken the lead in coordinating the HIV response. It liaises and works with nine line ministries, four UN developmental partners and more recently an increased number of civil society members (over 40). The private sector involvement is weak at the moment. The HIV National Strategy Development Working Groups, GFATM Country Coordinating Mechanism and quarterly stakeholders/partners meetings provide mechanisms that promote interaction between government, civil society organizations, and the private sector for developing and implementing HIV strategies/programs. Achievements, challenges/bottlenecks, prioritization of interventions are discussed and agreed upon. In addition, joint-monitoring missions, mostly by developmental agencies and government counterparts provided an additional interaction mechanism.

3.2 HIV Prevention

3.2.1 HIV Testing and Counseling (HTC)

HIV testing and counseling modalities are diverse in Sudan. It includes outreach mobile HIV testing in rural and urban areas for the general population, outreach mobile HIV testing in urban areas for MARPs populations, fixed voluntary counseling and testing centers (mostly governmental and very few NGOs), HIV testing in health facilities -provider initiated testing and counseling in Antenatal and Delivery Care, TB Management Units and Primary Health Care Centers (for STI cases mainly), VCT within ART centers which test family members of PLHIV and unregulated HIV testing in inpatient settings and private sector (an estimated 1,500 private laboratories perform this HIV test in Khartoum state alone). There is no data to capture the scale of HIV testing among inpatient settings and private sector laboratories.

By the end of 2013, the number who received HIV testing and counseling increased seven fold (from 32,329 to 233,617) since 2011. This result is attributed mostly from contributions from

VCT through outreach campaigns (52 - 55%) and PMTCT services (36 - 42%)[1011].

The 2013 HIV test treat and retain cascade analysis found that that 18% of PLHIV know their HIV status and were mostly in late stages of disease. For example 2012 data from Omdurman ART center in Khartoum state, the largest center in Sudan, shows that 81% of newly diagnosed PLHIV were stages 3 and 4. These findings in low and late HIV case detection rates prompted national recommendations on remedial actions to increase HIV testing among those most likely to be HIV infected e.g. MARPs and their clients, TB and STI cases, hospitalized population through expansion of services or improving testing efficiency within existent services. These actions were not achieved in the second half of 2013 because of several constraints. This included logistical constraints in HIV test kits availability, non clarity in terms of reference between TB and HIV programs, overall weaknesses in STI control program, existent non supporting environment to access MARPs easily and turn over of national program staff. However, the recommended interventions and their bottlenecks have been incorporated into 2014 – 2016 National HIV strategy.

Table 2: HIV Testing and Counseling services and total tested in Sudan from 2011 to 2013

Services	***2011 (Reference)***	***2012***	***2013***
#VCT centers (outreach/fixed)	143	143	143 (tested=129,093)
#PMTCT sites	71	110	227 (tested=84,916)
# TBMU sites	45	75	80
# PHC – STI/HIV sites	0	6 (pilot)	358
# Total Tested	32,329	87,625	233,617

Source: SNAP Database

3.2.2 Prevention services to Key Populations and Vulnerable Groups

The current strategy is to provide or link specifically tailored prevention services to key populations (MSM, FSW and their clients) and vulnerable groups (prisoners, refugees, internally displaced populations, cross-border populations, tea-sellers, raksha and truck drivers, university students, soldiers and policemen). The service package constitutes of peer education, condom distribution, information exchange communication, HIV counseling and testing, STI diagnosis and treatment, and reproductive health services.

The existent Sudanese national laws criminalize FSW and MSM practices and therefore interventions targeting these hidden populations require much advocacy and coordination between government officials and regulatory bodies like the police and building trust between the implementers mainly civil society (over 60) and key populations.

By end of 2013, 118,262 FSW and MSM out of 399, 583 i.e. 30% were reached with the prevention package, 1,046,261 condoms distributed and 17,443 (4%) received HIV testing and counseling. Coverage has increased rapidly from service initiation by end of 2012 at 10% prevention package reach and 1% received HIV test to 30% and 4% respectively by end of 2013. Several approaches have been used to access these populations as detailed in the best practices section. The next steps

[10] 2012 Sudan HIV Test Treat Retain Cascade Analysis Report

[11] SNAP 2012 and 2013 Database

are to scale up the prevention services that are currently limited to one major city in 15 states.

With regards to vulnerable populations; several activities were carried out in this reporting period. Notably, in 2012, through SNAP and IGAAD initiative collaboration a behavioral surveillance survey was carried out among cross border and mobile populations in the Eastern zone while a comprehensive HIV service delivery point with community component was established in Joda, borderline small town between White Nile and South Sudan.

3.2.3 Prevention of Mother to Child Transmission of HIV (PMTCT) services

The policy and political commitment environment remains supportive of PMTCT services. Since the last report in 2011, the total number of facilities providing PMTCT services has increased substantially by about three fold (see Table 2). This resulted in three and half fold increase (25, 538 - 84,916) in testing pregnant women, four fold increase (336 – 1,226) in partner testing but to date no testing is offered for early infant diagnosis (EID) by PCR. However, these numerical increments translate into weak coverage; 7% of total pregnant women or 16% of pregnant women who access health facilities while 0.1% of expected partner population or 1.4% of women accessed PMTCT services received an HIV test. Moreover, the numbers of detected HIV positive mothers since 2011 increased modestly (91 – 150), that is only 2% of women in need of PMTCT have been reached by 2013. There is no national collated data to indicate the outcomes of mother baby pairs. With this scale of coverage the expected impact of PMTCT services in prevention of new HIV infections is very limited. The new NSP addresses this gap and proposes interventions using eMTCT framework to produce projected increments in coverage to reach 30% of those in need of treatment by 2016.

Despite the existent verbal political commitment to eliminate mother to child transmission in Sudan, the health system preparedness and support has been limited. Challenges remain in integrating human resource and HIV supplies management between of all RH, HIV programs, curative and laboratory directorates at all levels to work in unison to increase the coverage and quality of services in PITC in RH health facility outlets and at community level and linked detected positive cases to HIV care.

3.2.4 STI Prevention and Control

The number of reported STI cases has been steadily decreasing since the last reporting period from 89,625 in 2011, to 60,400 in 2012 and 33, 000 in 2013 (three quarters). This has been attributed to reporting weaknesses and non-submission of reports by high burden states like Khartoum state in the past two years. Growing evidence from surveillance rounds and blood bank screen data suggest increasing numbers of STI such as syphilis, Hepatitis B and C among the general population. The new strategic plan has allocated interventions to strengthen STI case detection and linkage to treatment through routine screening in ANC and blood banks and strengthening syndromic STI care detection and treatment in in Primary Health Care.

3.2.5 Condom Programming

An enabling environment for condom use remains far from optimal. Even though no laws or regulations are in place to prohibit condom use, condoms remain a “taboo” issue among policy makers and decision makers probably because of influential Islamic leaders anti-condom position. For instance, a condom programming situational analysis was carried out to identify the bottlenecks to address them. This however, did not progress much, as parliamentarians raised the condom issue

negatively and the national AIDS program had to minimize any condom related activity so that its other work among key populations for instance is not compromised. Condoms remain free of charge distributed within VCT, PMTCT, ART, STIs, family planning and TB facilities and outreach interventions for MARPs. Condom programming continues to be limited to distribution and raising condom awareness among key populations and PLHIV with no additional interventions to strengthen demand creation. There were similar challenges in condom procurement as the last reporting period. Consistent condom use remains low (11%)[12] among FSW and MSM, 0.1%[13] condom use among women in reproductive age and 5.1% among men who practice higher-risk sex[14].

3.2.6 Blood Safety

Blood safety activities in Sudan are mostly governmentally funded (80%) and provided through either hospital-based or stand alone blood centers. Blood donors are either voluntary (45% of total donations) donors reached through outreach programs targeting youth in universities and donor societies and family directed donors at hospital level. A total of about 450,000 units of blood are collected annually and all screened for syphilis, HBV and HCV. A new initiative through collaboration between Blood Bank System and SNAP was developed during this reporting period. Khartoum central blood bank unit (major contributor in national blood donation load) was selected to explore if donors are interested to know their blood screen results and thereafter develop a mechanism for those interested to receive confirmatory results on HIV.

3.2.7 Universal Precautions/Infection Control in Health Care Settings

The target for the outgoing NSP (2010 -2014) was to provide PEP services and ensure use of protective equipment by health care providers in 100% of health facilities. The PEP policy and guidelines have been developed but were not printed for distributions. PEP related medications are available in all ART sites or based within health facilities upon request.

3.2.8 Knowledge and Behavior Change and Communication (BCC)

3.2.8.1 Knowledge and Behavior

Much effort has been put into advocacy among policy makers to increase knowledge and increase demand for HIV testing and counseling services this past two years. This has been demonstrated by increasing political involvement at all levels to motivate general population to seek HIV services. For instance the Federal Ministry of Health took an HIV test, while the Minister of Health and Youths called upon youths and communities to utilize the available counseling and testing services and The Wali (Governer) of Kassala state regularly discusses HIV/AIDS issues in his cabinet. Nevertheless, challenges remain, for instance the implementation of a bio-behavioral baseline survey among youths in universities has been delayed by Ministry of Higher Education not approving the content of standard indicators on sexual behavior/health and HIV which were perceived as sensitive, non

[12] 2010-2011 IBBS

[13] 2010 SHHS

[14] 2010 SHHS

existent practices and potentially politically sensitive.

In addition, some gaps remain at policy, strategy and action plans that specifically address the needs of orphans and vulnerable children. Moreover, current BCC interventions targeting these populations are ad hoc and will need to be strategic and streamlined with relevant ministries to have an impact on the baseline data[15] generated in the last reported period.
The BCC program continues to be implemented in collaboration with different line ministries targeting to improve awareness of HIV among general population including youth. Some of its elements will be revised to include PMTCT messaging to pregnant women and their partners. In addition, there are plans to integrate BCC program components within communication strategies of other programs like RH and TB. In 2013, SNAP in partnership with UNICEF and NGO, trained 80 youth, 23,735 youth were reached through youth peer educators and 14,275 IEC material were distributed to beneficiaries. In addition, two HIV media fora hosted well-known Sudanese figures. In addition, social mobilization activities carried out by health care providers working in PMTCT service targeted communities residing near these sites.

No new surveys/studies were carried out during this reporting period to compare any change or trends in knowledge and behavior for general population since the last 2010 Sudan Household With regards to vulnerable populations, there is a need to carry out additional bio-behavioral surveys or research for vulnerable populations to build on baselines that range from 2002 and 2008. Key populations have an established baseline data from the 2010-2011 IBBS survey that will be used as reference for future research/surveys. The findings indicate low HIV comprehensive knowledge (3 – 40%); low (11%) consistent condom while less than a quarter (4 – 24%) reported ever received an HIV test all of which are being addressed in current prevention package offered to them.

3.2.8.2 HIV Stigma reduction

HIV stigma reduction activities have been a cross cutting component in all HIV activities such as advocacy, HIV awareness/education sessions, and HIV related trainings targeting general population, key and vulnerable populations, religious leaders, PMTCT populations and health care providers conducted by SNAP, UN partners and NGOs in the past two years. There has been no additional data/surveys to the 2011 national PLHIV stigma index survey baseline. The new national HIV strategy will continue working with the same modality but with much focus on health care providers as a necessary step to scale up the implementation of provider initiated testing and counseling and improve the quality of HIV clinical care.

3.3 Treatment, Care and Support

HIV treatment, care and support remain priority interventions in the national AIDS response. The current emphasis is not to increase the number of HIV treatment outlets but to increase detection of HIV cases, improve the efficiency of linkage of HIV detected cases to care services and to address attrition factors and provide support to retain them within care.

[15] KABP study on street children, orphans and displaced children in Khartoum, Kassala, and South Darfur

3.3.1 Treatment and Care

The 2013 HTTR exercise indicated that only 9% of the number estimated in need of ART are in care. The numbers of HIV case detection and patients on ART has increased compared to 2011, however the retention in care performance is low with slight or no improvement (see Table 3). Researches on HIV care attrition found that HIV disease stage, disclosure status and residence within state with treatment services to be significant factors associated with pre-ART retention[16] while facilities were found to have weak systems to detect and trace defaulters.

Several remedial actions and interventions to scale up HIV detection through scaling up HIV testing services among those most likely to be infected e.g. TB, STI and Most at risk populations and improve retention (see 2013 HTTR Report) through improving quality of care and early detection of defaulters, linkages with PLHIV associations and treatment supporters etc. were proposed and incorporated into the new strategy 2014 – 2016.

Table 3: HIV treatment services and PLHIV enrolled into care in Sudan between 2011 and 2013

HIV Treatment Services	*2011 (Reference)*	*2012*	*2013*
Newly diagnosed HIV positive	2,077	2,500	3,157[17]
Current on ART (adults/children)	2,500	2,575	3,308 (3,058, 250)
Newly started on ART	931	780	1,121
Retention on treatment (12, 24 and 60 months)		64.2%, 57.8%, 39.2%	69.1%, 55.5%, 42.5%
Number of ART centers	31	34	34

3.3.2 Support to People Living with HIV

Continued efforts in the past period were carried out to ensure policy and legislative support to ensure quality of life for PLHIV and capacity building efforts to engage them effectively in the overall HIV response. The existing draft legislation for PLHIV protection is yet to be endorsed by the Cabinet while the current labor law is being reviewed to ensure full rights of PLHIV. PLHIV remain represented in all decision making for a at Federal and state level, coordinating bodies such as NAC, CCM, SAN, Key steering committee and technical working groups in planning and implementation.

Support to PLHIV continued from 2011 to strengthen the function/structure of their existent association through provision of office equipment and trainings, work skills, through income generating projects and receive nutritional support in terms of cash or in kind at times from private charitable organizations. Notable achievements in past two years compared to 2011 was the growing involvement of several sectors with UNFPA in building the capacity of PLHIV; financial sectors such as Social Savings and Development bank provided revolving loans for income generating projects for about 150 beneficiaries; The Ministry of General Education and the Ministry of higher education provided vocational trainings for PLHIV; The Ministry of Justice provided human rights trainings; and finally private academic institutions provided English courses for the PLHIV.

[16] Pre-Antiretroviral Therapy Attrition Prevalence and Associated Factors in Six Antiretroviral Therapy Centers in Sudan

[17] Data does not include HIV positive cases detected from testing MARPs

4 Best Practices

4.1 Approaches to Increase Access of MARPs to HIV/STI Prevention Services

National NGOs have taken the lead in implementing prevention service packages through an umbrella approach i.e. one lead NGO subcontracting others and so forth depending on their capacity and expertise. Since October 2012, three approaches have been used by NGOs to increase MARPs access to HIV/STI Prevention Services.

One approach included using peers who held closed peer led meetings to raise awareness and encourage HIV testing to fixed HIV testing/treatment and STI screening services. It was noted that VCT services within NGO was a preferred option because of existent rapport and trust between peers and NGO staff and the ability to have open working hours beyond the normal governmental ones. However, this approach alone will not be able to yield high results because very few NGOs have VCT services. In addition, passive referral success rates were not high because of existent double stigma (HIV and population profile) and related non-affordable transport costs to access governmental based services.

Another approach included bringing prevention services closer through outreach activities that raise awareness in areas where they live accompanied by mobile VCT services. This increased the numbers of MARPs tested but still had constraints such as non sustainability because of its related higher costs and the inability to differentiate in records general population and MARP beneficiaries. Because of the inability of non-disclosure of MARPs status and maintain confidentiality within community, this approach also does not provide specific prevention services tailored to MARPs needs.

Finally, the third approach used involved peer educators who took the lead in identify other peers and so on using a snowball effect/respondent driven sampling method to either accompany or refer their peers to seek services in prevention service center.

These combined approaches showed marked success by increasing coverage from 11% to 30% in just one year. Challenges faced in implementation included non enabling environments e.g. non approval by local governments in some states e.g. West Darfur and operational challenges in HIV test kit stock outs primarily attributed to delays in procurement and the resultant mismatch between NGO contract period in implementation resulting in limiting the effectiveness and duration of NGO interventions. Finally, the linkage of HIV positive FSW/MSM for treatment is passive and dependent on counselor who may be not trained risk reduction and work with MARPs.

4.2 Rapid Scale up of PMTCT services

Since the declaration of Sudan's commitment in elimination of mother to child transmission in 2011, PMTCT services expanded substantially from 71 in 2011 to 112 in 2012 and 257 in 2013. This was achieved through concerted training efforts from the Sudan National AIDS and STI Control Program the National Reproductive Health Program, development partners namely UNICEF and civil society such as Health Alliance International and Jasmar. It is anticipated that Early Infant Diagnosis will be implemented in large scale in all states by the end of 2014. To ensure quality of service provision, a core team of state facilitators was established to provide onsite training and mentoring. The expanded service coverage and community involvement resulted in an increase in HIV testing of pregnant women from 37,000 in 2012 to 84,916 in 2013. However, still the current scale up

coverage equates to 12% of existent ANC sites that cover 56% of pregnant women in Sudan. In addition, states coverage varied for instance Khartoum, North and East Darfur states had the fewest number of operational services. PMTCT service coverage also is either minimal or absent in maternity and postpartum care. Prong one remains to be the main focus in implementation compared two's coverage in 3/33 ART sites (9%) as an example. Partner testing is still a challenging area given their low attendance rate and weak implementation of couple counseling. Similarly linkages of HIV positive pregnant from testing sites to treatment and follow up of mother baby pairs needs to be strengthened through active referral that has shown positive results and strengthening of M&E systems.

4.3 Strengthening Linkages and Integration between Reproductive and HIV Program

Several efforts have been made to strengthen gaps identified by two situational analysis carried out in 2010 and 2011 to assess the existence, the level and effectiveness of linkages and integrated activities between RH and HIV programs in four states (Khartoum, Kassala, Blue Nile and South Darfur). The MoH (RH and HIV Programs), UN development partners (UNFPA, UNICEF) and civil society (SFPA, HAI, Jasmar) developed a working partnership that started with situational assessment and continued down to implementation. It is important to note that the integration initiatives by this group preceded the official ministerial directives and their experience was used as best practice to guide the integration process that is currently implemented at federal level.

The ministry of health issued directives to integrate HIV and other vertical programs in the overall health system. Structural changes were made so that HIV program is within the PHC general directorate where RH program is based. Both these programs developed an RH/HIV guideline however there is lack of clarity in the functional component such as terms of reference. The process of integration is still work in progress and will continue to be strengthened.

At facility level, through support from civil society an integrated SRH/HIV service package was developed and distributed in thirty health facilities based in eighteen localities in four states. This model will need to be expanded further by the MoH.

While at community level, NNGOs worked with beneficiaries and local government representatives/community leaders through a community mobilization project to educate women communities on PMTCT by the community members in six states. Thirty groups of community educators (five per state) were trained. This created a sense of ownership and strengthened the capacity of two existent community based organizations and increased community awareness of these integrated services.

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5 Major Challenges and Remedial Actions

5.1 Policy, Strategic Planning, Political Commitment and management issues

- A comprehensive programmatic gap analysis was carried out in 2013 of which several recommendations for remedial actions were proposed
- SNAP institutional capacity remains limited due to high turn over of leadership and technical staff
- Integration processes within the ministry still unclear and has caused confusion regarding tasks and responsibilities of current programs. The level and scale of of functional integration between HIV programs and others e.g. TB, RH within primary health care need to be defined. Integration between HIV, RH, TB Laboratory and Curative Directorates need to be strengthened
- Political verbal commitment is not translated to action or financial support.
- Civil society specifically NNGO, CBO and PLHIV associations technical capacity and recognition is still limited to provide meaningful input into strategic planning
- Enact legislations through medical boards on doctors for negligence /refusal of provision of care of PLHIV patients who should be legally literate

5.2 Prevention

- Prevention of HIV among key populations continues to be challenging with existent criminalizing laws and HIV stigma among decision makers
- Logistics challenges in stock outs of supplies such as HIV test kits and condoms still remain
- Coverage of prevention services is low to have a meaningful impact on HIV infection rates and need to be scaled up

5.3 Care, Treatment and Support

- Coverage of PLHIV in need of care and treatment is very low and need to scale up the detection of HIV cases through increasing HIV test rates, by increasing demand creation through a communication strategy, increase PITC among TB and STI populations and revision of prevention package to MARPs populations. Other entry points for HIV testing need to be piloted e.g. Inpatient populations
- There is high attrition rates in HIV care (pre-ART and ART) attributed to late HIV stage, proximity of HIV care services and HIV status disclosure and weak systems identifying and tracing defaulters. These all need to be addressed through improved pre-ART package of care, sensitive systems to identify defaulters involving PLHIV associations and encouraging HIV status disclosure. Ensure finalization, fast track endorsement and dissemination of all guidelines and SOPs to the facility level
- HIV stigma among health care providers need to be addressed
- Capacity of PLHIV association needs to continuously supported to promote leadership and active role to contribute in all aspects of HIV response from planning down to implementation

6 Support from the Country's Development Partners

6.1 Areas of support

External support from multilateral agencies such as the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) has been instrumental for the expanded and sustained HIV/AIDS response. United Nations-Agencies comprising mainly of UNAIDS, UNDP, WHO, UNICEF, UNFPA, WFP and UNHCR have provided some support through their core funding resources, technical and administrative human resources.

The support provided covered the following key areas:

- Procurement of equipment and logistics as a component of the operational support to programs
- Building capacity of service providers through training in the different thematic areas including capacity building of partners in MARP prevention, M&E, HIV treatment, HIV prevention among youth and general population, coordination and management, etc.
- Technical support in the areas of development of national protocol and guidelines, strategic framework, global fund proposal for round 10, etc.
- Because of the safe guard policy, manage GFATM monies through subcontracting and provide financial management of grants

6.2 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 2011 Political Declaration targets include the following:

- Provide support to finalize NSP III (2014 – 2016)
- Continue advocacy with high-level policy makers to prioritize HIV response.
- Advocate for mobilization of resources from both internal and external sources.
- Provide technical assistance and capacity building particularly in the area of system strengthening and program management
- Capacity development in the technical areas of estimation, projection, survey and surveillance and other areas of strategic information.

7 Monitoring and Evaluation Environment

7.1 Overview of the Monitoring and Evaluation System

The following are key features of M&E System in Sudan:

- The M&E system in Sudan is built on the twelve components of the organizational structure for HIV M&E systems. All data related to HIV (including routine program monitoring, surveillance and research) is submitted to the M&E unit at the Sudan National AIDS Program (SNAP). At state level, M&E focal persons at State AIDS and STI Control Programs (SAPs) compile routine program data including data of community related interventions by NGOs in monthly reports and submit to the M&E unit at the federal level.
- At the central level M&E activities are coordinated by M&E TWG, which is chaired by the M&E unit at SNAP and includes stakeholders from all key partners including government, NGOs, UN and PLHIV.
- The core national indicators of the current M&E plan include the global and universal access indicators as well as other additional national indicators. In addition, the HIV M&E plan is aligned with the M&E framework of the national health sector strategic plan.
- All program routine data and strategic information are stored in a database (excel sheet format) at the M&E unit of SNAP.
- The federal M&E unit carries out regular supervisory and data auditing visits to all states jointly with key members of the M&E TWG.
- The M&E unit carries out regular quarterly meetings for reviewing progress and sharing information with all stakeholders involved in the HIV response in the country.

7.2 Challenges/Gaps

- The M&E unit comprising of only limited number of staff. The situation is further complicated by the continued high turnover particularly among trained senior M&E officers.
- The existing capacity of M&E Unit is limited to generating regular reports. Its scope of work needs to include provision of technical leadership in the overall M&E areas particularly undertaking research and studies, documenting lesson learnt/experience, etc. Therefore, there is a need to invest in expanding the capacity of SNAP M&E staff in this area.
- The database is still based on manual entry into Excel spreadsheets. UNAIS and WHO sponsored the development of an electronic database and electronic patient monitoring system, respectively, yet these have not been implemented to date.
- Program data analysis is not done or routinely used for decision-making especially at state level. States compile data and carry out basic summation to generate reports submitted to Federal level.
- There has been no evaluation of non health sector HIV response
- The M&E TWG has not been active and annual HIV M&E Country Reports have recently not been published

7.3 Remedial Actions and M&E Technical Assistance Needed

- Basic and regular refresher training for the M&E officers at the federal and state level is needed

to build their capacities and to cater for the turnover among them. In addition, selective M&E officers from field and federal level need to be given advanced M&E training in areas such as research/evaluation, technical writing, etc.

- Implement and launch both electronic database and electronic patient monitoring system in order to improve the timeliness and quality of data.

- External technical assistance will be needed in areas of modeling and implementation of specialized researches such as drug resistance studies.

- Need to carry out evaluations of performance and impact on non-health sector HIV response

Annex

A. NCPI Questionnaire (Reported separately)

B. AIDS Spending Matrix (Reported separately)