The Republic of Sudan

Federal Ministry of Health

Sudan National HIV/AIDS Control Program (SNAP)

HIV/AIDS in Post-Conflict Sudan

Vision, Strategies, Challenges and Plan of Action

Draft Document

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Contents:

1. Introduction:

HIV/AIDS is a problem because it kills people. This problem is enhanced in conflict situations and emergency settings because there is an increased transmission of HIV, and the lack of food and the presence of other infectious agents, accelerate the progress to AIDS and finally death. A good response to HIV/AIDS ought to include the continuum of prevention, diagnosis, and care and impact mitigation.

The document provides links to different information which describe the magnitude of problems related to HIV/AIDS.

The document recognises the inadequacy of the national response and the challenges that emerged in the conflict period which need to be seriously considered during the post conflict period.

Before asking why we aren't handling this problem adequately, one should have a look at who all the stakeholders are, what their response is, and how they complement each other.

In Sudan international organisations provide food, shelter, protection, water, sanitation, and healthcare. Very few have projects specifically targeted at HIV/AIDS, or have incorporated HIV/AIDS into their existing programmes. The response in Sudan is mainly led by National AIDS program and some UN agencies, of which some have excellent programmes. Their scope of activities ranges from awareness raising to care and support for people *infected with* and *affected by* HIV/AIDS. The state AIDS control programme tries to co-ordinate and facilitate the response but has no resources to do so.

Many local associations have projects which are culturally sensitive, low cost, often to the point, and well accepted by the community. Numerous international NGOs and UN-agencies have formed 'partnerships' with local associations and NGOs. This is highly commended and should be encouraged, but often these 'partnerships' consist of ad-hoc support (some money for workshops or stationary), and we ought to be looking at ways to form a collaboration in which partners complement each other.

In Sudan National AIDS programme has been recently created a multi-sector response to HIV/AIDS. There is national strategic plan which was created as a joint effort with various stakeholders, and give a good reflection of what needs to be done to combat the HIV/AIDS epidemic in the country.

Reading the above, one should ask: "If the country has such good strategic plan, then why is the response still not adequate?"

First of all, these plans are new, and they have not yet received the funds on which they can build the plans. Secondly, many organisations were either not involved in these plans, or do not know how to translate the country-wide objectives into objectives that are manageable at project level.

Underlying factors to the 'inadequate' response are communication, co-ordination and planning.

With such a complex matter as HIV/AIDS, and with so many different actors, communication and co-ordination *within* organisations and *between* organisations is important.

It is already hard to find out "who does what", though what we ideally would like to know is "who does what best, and in the most efficient and cost-effective way". Only once we know this, we can look at ways to plan our actions while looking at the added value of each organisation, and distribute funds accordingly.

While prevention of HIV infection should be central to the response of the epidemic, it *must* also address the care and support for PLWHA for it to be effective. The full continuum of prevention, diagnosis, and care and impact mitigation is imperative for an adequate response.

In addition, needs assessments, vulnerability analyses, and behavioural studies are often done halfway through a project, without using the results to design comprehensive programmes or modify.

Mechanisms for Monitoring and Evaluation must be incorporated into the planning stage of a project and form a prerequisite for approval of a proposal. Indicators should be linked to the minimum or recommended standards of quality.

An effective response *must* involve high levels of participation by children, young people and PLWHA.

Implementing agencies are increasingly held accountable towards their donors, though no mechanism exist for accountability of either the donor or the implementing agency towards the populations they serve.

A genuine dialogue must be held with beneficiaries of humanitarian aid, so they are involved in the planning stages of projects and they receive reports which demonstrate the quality and impact of interventions.

Local community and all stakeholders should have improved access to information regarding who is responding to HIV/AIDS, the quality of response (guidelines and project reports), and the financing of the work (which donors fund what).

This document is seriously affected by the lack of information about the specific response and information at the field level. We have done our best to build on the existing information and the experience of other countries as well as the international guidelines in handling HIV in conflict and post-conflict situation.

This report emphasised the need of Information Centres or Field-Based Information Management System that should be established in the country. SNAP should shoulder the responsibility in addressing the gap in strategic information.

By developing such an Information Centre, organisations can access data on the scope of the problem, how others are responding, which interventions work best, and what response is most cost-effective. Donors can provide clarity as to who is funding which organisations, how much funds are available, what kinds of programmes they fund, and how and when funds can be accessed.

Federal Ministry of Health is trying to address the major issues and challenges linked to the expected overall response transformation that will be accompanying the promising peace. By doing so, we call for all actors to contribute effectively and efficiently in the National Response to HIV/AIDS in Sudan.

2. Country Overview:

 With 2.6 million km Sudan does occupy the largest area in Africa with a population estimated at 31 millions in 2002 and Annual Population Growth of 2.9%. Majority of the populations work in agriculture and 68% of the foreign earnings come from agriculture. Since 1998 a small quantity of oil is being produced but its effect is far from being felt, particularly at microeconomic level.

Sudan is unique in its long and complex emergency situation for war, recurrent draughts and famine that led to massive population movement estimated to be 4 millions internally displaced from the war areas.

Sudan suffers from many internal problems that perpetuate the vulnerability factors for the spread of the HIV epidemic. These include long standing civil strive that has affected one third of the country and contributed to the problem of internal displacement of civilians with continuous movement of the warring factions both internally and with neighbouring countries ranking Sudan as number one world-wide regarding the internally displaced people. Large-scale poverty that puts more than 85% of the population below the poverty line and the prevailing illiteracy rate is 34% among males and 51% among females, with lower rates in rural areas.

Health facilities infrastructure are inadequate both in quality and quantity, only 30% of the population have access to health facilities with government expenditure on health as a proportion of Gross Domestic Product has dropped from 0.5% in 1986/87 to 0.1% during 1993/94[14].

This means issues like infection control and blood screenings are frequently unobserved. Sexually Transmitted Diseases management is difficult to implement with low care seeking behaviour, low knowledge of preventive measures and inadequate budget. Blood transfusion is only available in 50 hospitals where more than 300 hospitals covering different parts of the country lack screening facilities. Furthermore awareness of methods against infection is very low (75%) of women do not know how to protect themselves against the infection.

These factors make Sudan a high risk country, yet current data reflect that it is relatively of low prevalence but it will not remain in this position for long before being one of the highly infected countries. Unfortunately the existing surveillance system is not well equipped to cope with this alarming epidemic.

In response to the first AIDS case discovered in the country, the government of Sudan has established an AIDS Control programme (SNAP) in1987 that falls under Ministry of health .SNAP is the national body responsible for planning, evaluation, monitoring and coordinating all the interventions related to HIV/AIDS control and prevention in Sudan. Its main mandates are related to policy development, national strategies and guidelines as well as fund raising. Most recently multi-sectoral National AIDS Council (NAC) was established and headed by H.E the Minster of Health and consists of the Ministries of Education, Health, Youth, Labour, Media, Finance, Guidance and Social Welfare as well as leading NGOs. Its main objective is to ensure multi-scrotal response to the epidemic. Both SNAP and the decentralized NAC have state counterparts that contribute towards the national strategy. Coordination between various stakeholders is achieved through the Country Coordinating Mechanism (CCM) headed by Undersecretary of Ministry of Health and the Country Theme Group (CTG) on HIV/AIDS

There are so many national and international NGOs, as well as UN-agencies working in the field of HIV/AIDS. Sudan AIDS Network (SAN) is the umbrella under which all NGOs work.

3. HIV/AIDS global and local situation:

World Health Organization has released, in collaboration with UNAIDS, the AIDS Epidemic Update up to December 2002 with estimates based on the most recent available data on the spread of HIV in countries around the world. There are 42 million people living with HIV/AIDS worldwide. 38.6 million Of these are adults, 19.2 million are women and 3.2 million are children under the age of 15. Five million new infections with HIV occurred in 2002 of which 4.2 million were adults and two million of them were women. A total of 3.1 million people died of HIV/AIDS related causes in 2002.

Sub-Saharan Africa has the highest number of HIV positive individuals (29.4 million people living with HIV/AIDS) followed by South and South-East Asia (6 million). In North America there are 980,000 people living with HIV/AIDS, 570,000 in Western Europe and 1.2 million in Eastern Europe and Central Asia. The number of HIV positive individuals in Australia and New Zealand has remained constant since 2001 (15,000 people). In Latin America and the Caribbean the figure is 1.2 million and 440,000 respectively. East Asia and the Pacific have 1.2 million people living with HIV/AIDS. North Africa and the Middle East have 550,000 people living with HIV/AIDS.

Being one of the least developing countries with open borders with nine countries, some of them among the highly HIV/AIDS affected countries in Africa and with deep socio-cultural links across the borders, Sudan faces real threat regarding the spread of the HIV. Cascades of vulnerability factors are influencing the country that necessitates an immediate effective and extensive response to the increasing epidemic burden to the country.

 By the end of October 2003 the total number of HIV/AIDS cases reported to the national program was 10000 with ….. AIDS cases while …….were asymptomatic HIV positive cases. The National AIDS Control Program estimated the prevalence nation-wide on December 2001 was around 1.6 %, approximately 500000 cases.

WHO/UNAIDS have recently estimated that the prevalence rate among adult population 15 to 49 years in Sudan is 2.8%. Around 97% of cases were as a result of sexual transmission, 1.2% was a result of infected blood while 1.2% was due to mother to child transmission The National AIDS Program has conducted and published in January 2003 a situation analysis report as part of the strategic plan process, involving 14 out of the 26 Sudanese states. The published data included prevalence rates in specific vulnerable groups and showed a prevalence of 4.4% among sex workers, one percent among truck drivers, 2.5% among tea sellers, two percent among prisoners, 1.1% among university students, 6.1% among *Tuberculosis* patients, 2.3 %among street children, 1.1% among internally displaced people and four percent among the refugees. Despite the fact that Military Personnel were included in this situational analysis, their data are not yet published but expected to be among the highest.

Considering the limitations of the surveillance system, the number of the reported cases is just the tip of the iceberg and the country is on the verge of a major HIV/AIDS epidemic and action must be taken now and with vigour to curb its spread, or the epidemic will take hold of the population in a way worst than any other epidemic due to enormous vulnerability in Sudan.

General denial and misconception have been engulfing HIV/AIDS in Sudan. Until recently the general attitude was, both public and official, that Sudan being a conservative country is naturally protected against the disease. However the increasing trends for the disease prevalence, which was shown later on, has proven this argument is far from correct. This denial has resulted in unreported cases and overall weak surveillance and baseline data systems. Weak awareness of the disease in the general population is another problem facing efforts to contain the spread of the disease. In some states only about 20% have ever heard of AIDS[4]. Thus the official agencies and the general public undermined the actual magnitude of the problem for a significant period of time.

4. HIV/AIDS and Conflict a double Emergency:

A growing body of evidence links wars and mass displacement to the spread of HIV/AIDS. In war and related emergencies, the epidemic is fuelled by sexual bartering – mainly rooted in poverty and powerlessness, sexual violence and exploitation, low awareness about HIV, and the breakdown of services in health and education services.

HIV spreads fastest in conditions of poverty, powerlessness and social instability - conditions that are often at their most extreme during emergencies.

Moreover, in situations of war and civil strife there is a strong likelihood that AIDS control activities, whether undertaken by national governments or NGOs, will have been severely disrupted or have broken down altogether. Thus people are left with very little scope for protecting themselves - no matter how well-informed or well-intentioned they are - at a time when they are especially vulnerable.

Conflicts create the conditions that make entire populations particularly vulnerable to HIV infection. Sexual and physical violence, forced displacement, the break down in the rule of law, and economic destitution leave entire populations at risk for HIV.

In her five year update report on children affected by armed conflict to, Graça Machel reports that 13 of the 17 countries with over 100,000 children orphaned by AIDS are either in conflict or on the brink of emergency. In the Democratic Republic of Congo, the country with biggest war in the world involving a number of African countries, 680,000 children have lost their mother or both parents due to HIV/AIDS at age 14 or younger since the beginning of the epidemic. In Ethiopia that, until December 2000, was long embroiled in a war with Eritrea an estimated 1.2 million children have been orphaned.

These are children who have lost their parents to a preventable disease whose transmission has been spurred by conflict itself. In Rwanda, for example, many women were raped during the 1994 genocide. In Burundi, where civilians were also heavily targeted by the violence, AIDS has become one of the leading causes of adult and infant mortality and the number of AIDS orphans is estimated at over 160,000. In Somalia, whereas blood bank data from major hospitals in Somaliland showed an HIV seroprevalence rate of 1 per cent, the Jijiga hospital based in neighbouring Ethiopia (an area of conflict) reported a rate of 17.8 per cent in 1995-1996.

In Sudan, data has shown that the most affected states are those were torn by the war. The southern states, which were directly affected by the conflict, have shown data as high as 3% in ANC, while Khartoum which is indirectly affected by the IDPs showed clearly high prevalence. Eastern states of Kassala and Gedarif showed prevalence of 4.4 among the refugees who are mainly Ethiopians and Eritrean. Even among the subpopulations included in the last situation analysis surveys, military and IDPs prevalence was among the highest. Data of orphans and deaths and orphans due to HIV/AIDS in Sudan are not available but both phenomena are clearly recognised.

With figures such as these, it is clear the correlations between conflict and HIV exist. What the pathways are, and the extent of causality still remains to be fully determined.

Today, ninety per cent of those killed because of armed conflict are civilians, compared to five per cent at the turn of last century. During the Sudan civil war, more than two million people were died as a result of conflict, and more than three times as

many were permanently disabled or seriously injured. Conflicts create the conditions that make entire populations particularly vulnerable to HIV infection. Sexual and physical violence, forced displacement, the break down in the rule of law, and economic destitution leave entire populations at risk for HIV.

5. The phases of conflict and displacement

This part describes the different phases of conflict and displacement, and the different ways that populations may respond to conflict.

1.1 People's reaction to conflict

People's reaction to armed conflict generally depends on the degree to which their physical and economic security and safety are adversely affected. Within a conflict situation, there are individuals, families and groups who:

- remain in their home areas ("stayees");
- are displaced from their homes but remain within the boundaries of their country of origin (internally displaced persons);
- Cross an international border to escape the conflict (refugees).

However, the artificial nature of these labels must be recognized: the labels often have more meaning for the organizations that are providing assistance than they do for the people themselves. Such labels may give a false impression of categories of people with common needs.

Internally displaced persons can be found in settings similar to refugee camps. They may also find themselves cut off from humanitarian assistance because of conflict or because of official denial of their existence or their needs.

1.2 The phases of conflict and displacement

From the point of view of giving assistance to the displaced, it is useful to think in terms of the four phases: pre-conflict, conflict, stabilization and post-conflict.

Phase 1—Pre-conflict

This stage occurs before the outbreak of full-scale conflict. It is generally characterized by deteriorating economic and social circumstances, civil disturbance and growing instability.

Phase 2—Conflict

Conflict can go through intermittent phases of relative stability and intense fighting.

Relative stability enables health care providers to offer a more comprehensive range of services.

Intense fighting will limit the range of HIV health services that can be offered.

Flight involves the mass migration of people who have fled from their homes in search of safety. During the journey people may suffer extreme hardship and may arrive at the place of sanctuary in very poor physical and emotional condition.

The Emergency phase involves the initiation of a humanitarian response to the needs of displaced and refugee populations. The purpose is to provide a secure environment to meet people's basic needs for shelter, food, water, sanitation and health care. The emergency phase is generally characterized as a period in which chaos is gradually replaced by structure and organization in order to meet people's basic needs.

Phase 3—Stabilization

Stabilization occurs when the initial emergency has passed, people have reorganized themselves into families and communities, and facilities to meet basic needs are well established. Life returns to some level of normality. Stabilization can also be defined as having occurred when the mortality rate has fallen to less than 1-2 per 10,000 per day.

Phase 4—Return and post-conflict

Return. This is when refugees or internally displaced persons may return to their country or area of origin, either spontaneously or as part of a planned resettlement.

Post-conflict. This is a period of reconstruction and of the reintegration of returnee and stayees communities.

Challenges of the Post-Conflict Period:

6. Armed forces:

UNAIDS conservatively estimates that militaries tend to have 2-5 percent higher HIV infection rates than their civilian counterparts. In Uganda, the country hailed as a success story of HIV prevention, studies of military personnel show a prevalence rate of 27 per cent between 1995 and 1997, when the nationwide adult prevalence was 9.5 per cent.[1] Statistics emerged in 2000 from the South African military with certain units claiming HIV prevalence rates between 60 per cent and 90 per cent.[2] But such high percentages are not a new phenomenon. Claire Bisseker reported far more inflammatory statistics in her 1998 article *Africa's Military Time Bomb*, with prevalence rates of "50 per cent in Congo and Angola, 66 per cent in Uganda, 75 per cent in Malawi and 80 per cent in Zimbabwe." Most data, however, remains piecemeal, uncollected, and unpublished, mainly due to militaries' fears that external information about their HIV prevalence rates will result in national security concerns.

Military Personnel have a high risk of exposure to sexually transmitted diseases including HIV. In peacetime, infection rates among armed forces are generally two to five times higher than in comparable civilian populations. The difference can be even greater in times of conflict. Studies in the United States, the United Kingdom, and France showed that soldiers from these countries have a much higher risk of HIV infection than equivalent age/sex groups in the civilian population. Recent figures from Zimbabwe and Cameroon show military HIV infection rates three to four times higher than in the civilian population.

There are a lot of factors in the military environment that raises the risk of HIV infection. These include:

1. Military and peacekeeping service often includes lengthy periods spent away from home, with the result that personnel are often looking for ways to relieve loneliness, stress and the building up of sexual tension.

2. The military's professional ethos tends to excuse or even encourage risk-taking.

3. Most of the personnel are in the age group at greatest risk for HIV infection (the sexually active 15–24-year age group).

4. Personnel sent on peacekeeping missions often have more money in their pockets than local people, giving them the financial means to purchase sex.

5. Military Personnel and camps, including the installations of peacekeeping forces, attract sex workers and those who deal in illicit drugs.

Probably the single most important factor leading to high rates of HIV in the military is the practice of posting personnel far from their accustomed communities and families for varying periods of time. As well as freeing them from traditional social controls, it removes them from contact with spouses or regular sexual partners and thereby encourages growth of sex industries in the areas where they are posted.[17]

HIV is a threat not only to Military Personnel but also to their families and community. Although Military Personnel are highly susceptible to STD and HIV infections as a group, military service is also a unique opportunity in which HIV/AIDS prevention and education can be provided to a large captive audience" in a disciplined, highly organized setting. Military HIV programs are most effective if there is close collaboration with civilian health authorities.

The story does not end with armed forces in action. In peace time and when conflicts end, some military personnel will be demobilized and sent home. Demobilization presents an excellent opportunity for educating men on responsible sexual behaviour and the need to prevent HIV infection. It also presents the possibility of using these men as HIV educators in their own communities. In Eritrea, 80 percent of demobilized troops received information about HIV.

Eritrea is, however, the exception. In neighbouring Ethiopia, the demobilization process happened very rapidly with direct negotiations between the World Bank and the Ethiopian government. Soldiers received two-hours of basic HIV awareness before being sent to their home communities. The government, having conducted a rapid study to investigate HIV prevalence rates in the military found that only 5.5 per cent of those tested were HIV positive. This being less than the national 10.6 per cent prevalence of Ethiopia, the military concluded that HIV infection rates were low in the military and therefore that it was no problem to send the troops home. The hidden factor though, is that most soldiers had been screened prior to entry into the army, and that those with HIV had been rejected. The length of stay in the military averaged at 10 months, meaning that these military conscripts had become infected very fast

Demobilisations is expected to occur in Sudan when there will be huge redistribution of armed forces as part of the peace agreement. This challenge should be seriously considered and dealt with as counselling and testing services should be available , linked to education activities in a from of awareness raising as well as leadership peer to peer educational programs.

In Sudan, Ministry of Defence and the National HIV/AIDS Control Program are implementing and coordinating joint prevention activities and the defence authorities showed commitment at a higher level to incorporate HIV/AIDS prevention in all its settings as well as having clear plan to tackle the post- conflict challenges.

7. Children and post-conflict:

In the decade ahead, HIV/AIDS is expected to kill ten times more people than conflict. Although the highest HIV rates are recorded in countries without conflicts, rates are suspected to be high, and growing, in Angola, Burundi, the Democratic Republic of Congo (DRC), Liberia, Sierra Leone, Sudan and other states where surveillance systems cannot function properly. In conflict situations, young people are most at risk.

HIV/AIDS and conflict are combining to threaten the lives of young people, especially girls. Many children have also lost their parents to warfare or to AIDS, and are living without protection and assistance. They are often denied their basic rights to food, shelter, education and healthcare. Children have a fundamental right to life, survival and development; in conflicts it is often denied. In war, HIV/AIDS spreads rapidly as a result of sexual bartering, sexual violence, low awareness about HIV, and the breakdown of vital services in health and education. Children and young people are being denied their rights under the UN Convention on the Rights of the Child. Children have the right to be protected from all forms of sexual exploitation and abuse. But many young women and girls in refugee and post-conflict settings are forced to use their bodies to get food and clothing for themselves and their families. Amid the violence of conflict situations, rape, domestic violence and sexual exploitation often go unchecked. Powerlessness and fear heighten the risk of HIV transmission. These practices are all the more dangerous because, in most conflict situations, there is an acute lack of knowledge about and denial of HIV/AIDS.

Children have a right to information and materials that will promote their well-being, reduce their vulnerability to HIV/AIDS and protect them from the stigma and discrimination associated with HIV/AIDS. Behind the widespread lack of awareness is an almost total absence of sexual and reproductive health services in most conflict situations and refugee camps. This seriously undermines prevention efforts, and HIV/AIDS care in conflict settings is almost non-existent. Children have the right to the highest attainable standard of health and to facilities that treat HIV/AIDS and rehabilitate their health. Responses to the HIV/AIDS epidemic in conflict countries have so far been inadequate to slow down the spread of HIV. Governments in most conflict affected countries are not responding adequately, due to a lack of resources, capacity and commitment.

States like Sierra Leone, Liberia, Burundi and Angola are falling behind their neighbours in meeting targets agreed at the 2001 UN General Assembly Special Session on HIV/AIDS. Where they lack resources to uphold the rights of children, they must seek international co-operation. Associated with this, the lack of focus on the rights of children and young people in conflict situations leads to an increased risk for them of exposure to HIV infection. A lack of international funding is the single largest obstacle to reducing the spread of HIV in conflict situations. Without a greatly enhanced response and funding, conflict-affected countries will not meet their UN commitments on HIV/AIDS to meet basic needs and provide prevention, care and support, to alleviate the impact and to assist children affected by AIDS. International financing remains grossly inadequate. Contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria by donor governments are severely lacking, and almost no payments have been made to states affected by conflicts. In the same countries, moreover, humanitarian programmes remain seriously under-funded. Humanitarian agencies operating in most conflict settings are also failing to respond

adequately to the threat of HIV/AIDS. Struggling to provide for basic needs, humanitarian agencies are neglecting their responsibility to provide refugees and displaced people with access to HIV prevention and treatment services. This is endangering the lives of young people, whose vulnerability to HIV is strongly determined by the policies and practices of those wielding power over their lives. Children's best interests must be considered by humanitarian agencies in their programmes, and young people should participate in their design and implementation.

Humanitarian efforts to tackle HIV/AIDS have concentrated on preparing guidelines that field staff has often lacked the capacity and confidence to implement. Early intervention in the initial stages of an emergency is critical to success. But even where HIV/AIDS programmes have been implemented, they have been inadequate in scale.

Co-ordination is lacking among humanitarian agencies, especially at field level. Integrated multi-agency initiatives are needed to address HIV at country level.

Young people are too often neglected in existing responses. Yet young people are so often the agents of change in difficult settings. Solutions must begin with strengthening their skills and defences, and supporting young parents and heads of households living without their parents. The government of Sudan is working to share its experience with donors and partners to build effective child rights-based responses to HIV/AIDS in post-conflict period. Government, donors and humanitarian agencies must take urgent action to protect the lives of the young people directly threatened by HIV/AIDS in Sudan. In failing to do so, governments and their international partners are reneging on their obligations under the UN Convention on the Rights of the Child and the UN Declaration of Commitment on HIV/AIDS.

Effective action relies on the world's wealthiest nations and private organisations making adequate contributions, through mechanisms such as the UN's Consolidated Humanitarian Appeals Process and the Global Fund to Fight AIDS, TB and Malaria.

8. Women and Gender issues:

Evidence from individual countries in Sub-Saharan Africa confirms the disproportionate infection rates between men and women. For example, Uganda's 2000 figures reveal a 55% prevalence rate for all women, a prevalence rate of 6.65 to 8.99 percent for women ages 15 to 24, and a range of 2.56 to 5.12 percent for men in the same age group. Zimbabwe's rates are 23.25 to 25.76 percent for women in ages 15 to 24, compared to a range of 9.77 to 12.85 percent for men in the same age group. For Senegal, the rates are 53% for women, 1.12 to 2.97 for women in ages 15 to 24, compared to a range of 0.39 to 1.02 percent for men in the same age group. And for Botswana, the rates are 54% for all women, 32.55 to 36.07 percent for women in ages 15 to 24, compared to a range of 13.68 to 18.00 percent for men in the same age group. Estimates by UNAIDS further highlight the evidence that average rates of infections among adolescent girls in many of the countries in the region is over five times higher than those among boys in the same age group. And among women in their early 20s, rates are three times higher for women than men. The disproportionate impact of the disease on women and girls has been found to be linked to their weak social and economic status. The impact on women and girls is compounded by culturally prescribed standards of behaviour for men and women. Additionally, the poor economic status of women and girls tends to force them to depend on forming sexual relationships with men, and sometimes engaging in prostitution in order to meet their survival needs. Women and girls further get exposed to HIV/AIDS through sexual violence crimes such as rape. The burden of caring for those affected by HIV/AIDS also falls disproportionately upon women, due to their role as caretakers in the family. On the other hand, men's vulnerability stems from their position of power and socially promoted image of masculinity. The extent to which the above factors influence the vulnerability and impact of the HIV/AIDS pandemic on women and men, however, has been found to be closely linked to various other social and economic related environmental factors that include poverty, unemployment, migration, and weak health infrastructures.

Countries that have been affected by war and conflict in Sub-Saharan Africa have a history of a high degree of sexual violence and prostitution activities that are associated with the presence of military troops, which consequently increased the exposure of women and girls to HIV. In Rwanda for example, research indicates that 24,000 incidences of rape occurred during conflict, and 24% of those cases happened to women living in refugee camps. Furthermore, the wars have destroyed social support systems, infrastructure, and have also left many individuals, families and communities destabilized. The extent to which these factors are influencing the ability of individuals and communities to reduce their vulnerability to HIV/AIDS is still yet to be fully comprehended in terms of designing effective intervention programs to control and mitigate the impact of the HIV/AIDS crises in these countries.

In post-conflict societies in Sub-Saharan Africa, the vulnerabilities and challenges to coping with HIV/AIDS crises are compounded by the wide range of institutional breakdowns and the disastrous consequences that follow wars and their aftermath. Wars throughout the region have set women apart as easy objects for sexual crimes, such as rape, sexual slavery, enforced prostitution and forced pregnancy, all of which increased their risk of contracting HIV/AIDS. In all the countries where there were peace keeping forces, numerous horrendous stories have been reported about women

suffering from sexual violence and humiliation from the hands of soldiers and members of the enemy groups

The mental and emotional trauma that followed the incidences of rapes and forced pregnancies has been accompanied by stigmatization of the women by their community members. First for having been raped or having an enemy's child, and secondly, for being a potential source of HIV infection. Hence many women who might have gotten infected chose to suffer in silence. The wars also escalated the economic challenges for women, who found themselves either widowed, separated from their spouses, or had become displaced from their homes and productive resources. In order to survive, they often have to fend for themselves and their children most of the times through forming various types of sexual relationships with men in exchange for economic and social protection, or join the ranks of prostitution. If they were lucky they found some low paying jobs in the formal sector, or alternatively joined the informal sector. In many cases their families from their extended family network (including their in-laws) could no longer absorb them. In spite of the emotional and economic challenges that the women faced, they still assumed the burden of ensuring the well-being of their families including taking care of the sick, and the orphaned.

The experiences of men and women in post-conflict societies should be viewed in a context where social transformations have occurred in family structures in both rural and urban households, due to wars that break up families, the rebuilding process, and the cumulative effects of urbanization. These changes have had greater implications in many of the societies that include the breakdown of gender stereotypes in many communities; a shift in gender relations, and increased variation in experiences of women, men and their families. The shifts have come about through massive household disintegration and large scale demographic shifts related to military conflicts and their aftermaths. These changes have forced women to join the labour force, including taking up jobs in domains that were previously reserved for man. New forms of households including various types of single headed households emerged in both urban and rural areas. The several of households in the region reflect different levels of poverty and security. This applies to households headed by women or by men. In some case, female headed households (particularly those of younger or more educated women), often ended up being more economically stable than male headed households, depending on the economic industriousness of the woman. Also in some cases women themselves have initiated forming their own household in pursuit of diminished social and sexual obligations to husbands, and to escape the patriarchal familial obligations to their in-laws. These changes in family dynamics are still continuing in the lifestyles of many people particularly the younger generations in contemporary Sub-Saharan Africa. However, very few studies have attempted to interpret the changes in terms of their implications for gender relations and actual behavioural practices of men and women within a given society. The changes in family structures entail variations among different groups of women, men and types of households in relation to social and economic security, rights, responsibilities, obligations, duties, access to resources and freedoms. These changes have also occurred in the midst of breakdowns in traditional institutions, values and customs, which used to guide and support the daily lives of people. Therefore vulnerability issues and coping strategies related to HIV/AIDS in post-conflict societies can no longer be generalized across all groups of men, women and adolescents within the same country.

The analysis of gender experiences related to HIV/AIDS in post-conflict societies therefore will attempt to address the variation in the experiences of all affected individuals, paying attention to their lives as they have been shaped by different historical events. Such an approach will also allow us to avoid the trap of basing our analysis on gender stereotypes which are also often perpetuated by both men and women for different reasons. It is important to note however, that knowledge on gender experiences of many social groups particularly in the area of coping strategies is still limited, because research programs in HIV/AIDS interventions have been focusing on prevention, other than care, support and mitigation. Furthermore, the focus of research has tended to concentrate more on women than men, including also paying little attention to class differences. Notable knowledge gaps therefore exist concerning the experiences of men, adolescents and certain social groups among women. The need for the research and studies on the effect of the conflict on the Sudanese women is crucial for better planning of our interventions and the inclusion of gender role in all policy and decision making process . We need to understand the diversity of women status that varies in different Sudanese societies and states. Interventions that address the vulnerability of women are highly recommended when talking of a comprehensive and strategic National Response.

9. Sudanese Refugees in Other Countries (returnee):

There are quite large numbers of Sudanese refugees in countries with high prevalence of HIV/AIDS. UNHCR estimates more than 500000 Refugees. Those are supposed to return back to Sudan following the resolution of the conflict. Prevention and mitigation of HIV/AIDS must be seen as an essential component of the overall response. It is important to combat the stereotypical perception that "refugees will bring AIDS with them to the local communities". It is this perception that leads to discriminatory practises by host populations. While data on HIV/AIDS prevalence is scarce, it is believed that Refugees and IDPs are at increased risk of contracting the virus during and after displacement due to poverty, disruption of family/social structures and health services and increased sexual violence and increased socioeconomic vulnerability particularly of women and youth. Objectives of the national response should ensure that returnees live in dignity, free from discrimination and their human rights are respected .Second to reduce HIV transmission and improve HIV/AIDS treatment and care by improving planning and implementation of HIV/AIDS programs and by reinforcing surveillance, monitoring and evaluation.

SNAP main strategies to achieve this is first to ensure effective implementation the national and international protection policy and standards at field level and second to attract donors and organisations commitments to combat HIV at Refugees and IDPs settings. Third is to reinforce access to qualified technical resources and building partnerships and lastly to maintain minimal package of services in returnee situations.

Care to HIV positive returnee in communities and training of volunteers to visit and provide care and support to homebound patients, including but not limited to, AIDS patients. Home-based care initiatives are encouraged in place for terminally ill patients, whether they are sick because of HIV or another disease. Community health workers follow HIV infected children and those who are very sick are admitted to health facilities available at the local communities.

Humanitarian operations such as World Food Programme will expected to play HIV programmes through its food distribution channels. Such interventions provide good examples of how HIV can be incorporated into routine responses to complex humanitarian emergencies. Some examples of their activities may include: HIV education, condom distribution and promotion at WFP food distribution sites; school feeding with take home rations for children in HIV affected families and orphan; and training on HIV prevention volunteers in cooperation with local partners who will provide voluntary testing and will supply condoms.

11. Role of Organisations in the Post-conflict Era:

In the Sudan there are very many different actors, including a huge variety of both local and international organisations, UN-agencies and government bodies. The overall response is scattered and below the expectations, when looking at various sectors that could provide the whole spectrum of HIV/AIDS prevention, diagnosis, care & support and impact mitigation. Coverage of programmes is patchy and coordination between the implementing agencies is not functioning well enough to provide a comprehensive response. In general large international organisations have engaged mostly in projects for HIV prevention, while care and support for those affected is provided by predominantly smaller, local supporting and faith based group.

This relatively poor response was related to the lack of political will in the country and until 2001, the GOS was so sceptical in allowing or encouraging HIV/AIDS interventions. This was also linked to lack of National Strategic Plan, Policy and guidelines. On the other hand there is little co-ordination among donors and NGOs: most are not aware of all other donors doing in the country, which leads to overlap and gaps. There is a tendency to fund many small projects, or parts of projects for short periods, which leads to scattered projects with many actors all doing little things without anyone being accountable. A few hundred dollars for a workshop here, for a training session there, some petrol now and then, some money to print a leaflet, etc, but no structured support with an annual plan.

SNAP, the national body which is supposed to tackle the issues of coordination was lacking capacity and mechanism to organise this. While the Sudan's AIDS Network failed to gain the commitment of its members to handle the issue of coordination of its members.

At state level while SNAP has its counterparts in almost all the states of Sudan, the picture doesn't differ so much from the overall national response. It is worth mentioning here some local initiative like equatorial zonal taskforce on HIV/AIDS proved some success in creating effective partnership and coordination.

A huge inputs and funds are expected to come following the peace agreement and more international actors will invest in HIV/AIDS field. This necessitates more consideration to issues of coordination and mapping of actors to play specific roles that contribute to an overall effective and efficient national response. Capacity building of SNAP, SAN as well as NGOs is crucial in the successfulness of the response.

12. Current HIV/AIDS Services:

The health system in Sudan is characterised by a weak infrastructure at the States in terms budget, logistics, human resource, health systems and health services coverage. Moreover there is uneven distribution of health cadres between and within States. The main challenge is the provision of well-trained human resource. The ratio of physician/population is 1: 5,870, nurse/population of 1:5,485, and hospital bed/population ratio of 1:1000[1]. These ratios hide inequalities between urban-rural and affluent versus less developed States.

The public sector infrastructure comprises 2,558 PHC units run by community health worker for a population of 1000 – 3000, 1236 dressing rooms manned by a trained nurse or uncertified dresser, 1475 dispensary – staffed by a medical assistant and supported by a nurse and village midwife, and 915 health centres staff two doctors and supported by paramedics. There are 309 hospitals for secondary care with a bed capacity of 50-100, and 46 tertiary care teaching hospitals with all specialities. The major expenditure on health is on staff salaries. The resources for non-salary budget are meagre, especially for pharmaceuticals.

The main focus of HIV/AIDS control program has been on screening of blood and blood products through blood banks and consultation services for STIs. The participating donors are providing some resources for advocacy and awareness raising, but far less the desired need. The program has just started an intervention for high-risk groups.

Despite the formulation of the national council on HIV/AIDS, its structures are not yet effectively in place. The AIDS control program services are restricted to few areas like partial screening of blood and blood products, consultation for treatment of STIs, awareness raising and advocacy through NGOs, support to orphans and PLWHA through NGO, condom promotion on a small scale, services to refugees, and capacity building of NGOs including training. The program is its infancy and there are major gaps, which are summarized below.

1. There is absence of focus for providing package of preventive services to high-risk and bridging population groups to protect their risky behaviour and modify the behaviours through behaviour change communication. The high-risk population groups, as identified through the current baseline survey, include female sex workers, tea sellers, long distance truck drivers, jail inmates, refugees and street children.

2. There is Lack of focus on youth. UNICEF has started making modest inputs in this area. There is an urgent need to revamp the existing curriculum on life skills, backed by teachers training and provision of supplementary reading material at secondary school level. Street children also need to be covered to protect them sexual abuse.

3. There is absence of services for PLWHA, both for opportunistic infections and ARV treatment.

4. The general adult population also needs to be catered through behavior change communication and provision of STIs treatment along with medicines at no charge basis.

5. There is only one VCT centre in the whole country, which has just been established. The VCT services need to be established in larger cities to provide walk-in and confidential voluntary counselling and free testing services, both for high-risk and general adult population including youth.

6. The system for monitoring epidemic trend does not exist. There is immediate need to establish Second Generation System for monitoring epidemic and to develop and modify interventions in line future costs.

7. More inputs are needed to ensure 100% screening of blood and blood products against STIs especially HIV, HBV and HCV.

Transmission through blood:

In Sudan Blood banks are centralised in the major hospitals in the capital and larger cities. Blood is collected from donors in, tested and stored in the blood bank, and distributed to wards. Blood is tested for HIV and Hepatitis. Some hospitals use ELISA, and some use rapid tests for HIV. A Western Blot is not done. In general, testing is done properly, but there are not enough testing centres. The public sector finances are sufficient to screen 80% of total blood transfused and that too against HIV and HBV. There are frequent dry periods when test kits are out of stock. There are approximately 55 blood banks in the teaching and other hospitals, and 45 blood transfusion centres (without a blood bank facility) in the general hospitals in the public sector. The blood refrigerators in the 55 blood banks are quite old, more than half 20 years old. The HIV screening is done through rapid testing kits and also using ELISA readers. According to the current monitoring system, 131,000 blood bags were transfused in 2002 in Sudan. The private is small and 70% of blood transfused in the private sector is screened by the public sector blood banks. Only 30% of blood bags transfused by the private sector are screened by the private sector hospitals themselves and how much is the volume is any body's guess, but is certainly a negligible proportion of blood of total blood and blood produced transfused.

Universal precautions are usually not well observed. In all health facilities visited, there were disposable needles and syringes but no incinerators. Sterilization was not well observed and the act of risky injection is recognised in some remote communities

3. Preventing transmission through traditional practices (scarring, acupuncture, circumcisions, etc.) is not much emphasized in IEC campaign. The traditional practitioners are not aware of the risk practises they are doing

4. Intravenous drug use has not been mentioned as an issue in Sudan.

Voluntary Counselling and Testing:

Places for Voluntary Counselling and Testing are very small in Sudan! The demand for testing in the general population is also increasing.

Sudan has only one functioning VCT centre attached to Khartoum teaching hospital throughout the country counselling service are provided in the capital with a net work of counsellors attached t some facilities in Khartoum , while some NGOs like Sudan Council for churches provide it to IDPs and in the south of Sudan. Testing and confirmation are the most challenging ad usually done centrally at the national health laboratory.

Most of counsellor in Sudan complained that they had nothing to offer when someone is tested positive. There are still not enough places for follow-up and support of

PLWHA outside the capital and there is a need for improved (Anonymous) registration of PLWHA which records socio-demographic data, and can serve as feed-back into prevention programmes

Mother-to-Child (Vertical) Transmission:

Programmes for Prevention of Mother to Child Transmission (PMTCT) are not established in Sudan.

Problems include: Many women do not deliver in hospital and are lost to follow-up and there is no system for antiretroviral treatment for the mother (or child) before and after delivery. This means that the mother is likely to die in a few years and the child will become an orphan. The husbands of the women or fathers of the children should be part of the system.

Care and Support:

Malaria is mentioned by everyone as the main problem for people with HIV/AIDS; PLWHA suffer many more bouts of malaria than sero-negative adults. Diarrhoea, neuropathies, and skin diseases are mentioned very often. People who care for PLWHA mention oral Candidiasis a lot, and especially the fact that many fungal infections do not respond to regular treatment. In Sudan no routine drugs are given to PLWHA It is difficult to get a clear picture of care and support services from the organisations as most do not have projects targeting PLWHA, but focus more on prevention. Many people mentioned that when people get ill, they can no longer work to obtain food, and deteriorate quickly. Most people cannot afford to go to hospital; thus, hospital beds occupied by PLWHA greatly underestimate the scope of the problem.

AIDS Orphans are mentioned by almost everyone as a serious problem which hardly anyone addresses. However, solid data on the numbers of orphans are not available and no specific projects are implemented by organisations to tackle the issue.

Information, Education and Communication (IEC):

The Sudan's population is faced with the following handicaps: increasing levels of poverty (above 60%) with low levels of literacy, especially in women; cross border mobility with huge refugee population; commercial sex is wide spread in all major cities and along the major truck routes; a large population of long distance truck drivers moving across the region; some of the neighbouring countries are in serve grip of HIV/AIDS epidemic; sexually transmitted infections are prevalent while people have limited access to quality STI care; use and reuse of syringes and routine medical equipment without sterilization is common; low use of condoms for disease prevention (3.6% of respondents ever used condom for disease prevention); and large proportion of population is composed of adolescent and young adults (about 30% of total population) with low levels of awareness about HIV and knowledge of protective measures. All these factors fuel HIV epidemic.

It is therefore vital that the citizens are provided with information, and appropriate skills and tools to protect themselves from HIV infection.

After years of denial, both publicly and officially, Sudan has stepped forward and after many successive campaigns has managed to break the silence around HIV/AIDS and now it is open to talk and advocate for HIV/AIDS prevention. Still remain the

issues of sensitivity when talking about condoms and sexuality. The most challenging is to create an effective mechanism of communication that considers the diversity of Sudan in terms of different cultures, religions and races. The program has recently recognised the need for the shift for the classical IEC to the inclusion of clear behavioural goals by using strategies such as behavioural change communication (BCC) and communication for behavioural impact (COMBI).

Surveillance:

Sudan is experiencing generalized epidemic. Some of its neighbouring counties have a very high prevalence of HIV among adult population in the age group of 15-49 years. The recent 2003 behaviour and biological surveillance in Sudan in a sample of 6,500 covering 10 groups gave prevalence of 1.6 percent in the general adult population, 4.4 percent in the female sex workers, 4.3 percent in refugees, 2.5 percent among tea sellers, 2.3 percent in street children, 2.0 percent in jail inmates, 1.0 percent in long distance truck drivers and 1.0 percent in ANC attendees. The condom use rate was found to be very low. Only 4.3 percent of FSWs used condom with last client. It is therefore high time to start monitoring the trends of epidemic by introducing Second Generation Surveillance System (SGS) on an ongoing basis, both behaviour and biological surveillance, in selected high-risk groups and in ANC attendees through sentinel sites.

The objective of the SGS is to monitor trends of HIV epidemic through annual sample surveys in the selected high-risk population groups by measuring behavioural and biological parameters and guide the program planner to realign the program interventions in line with the current and future epidemic trends. The main activities include: undertake behavioural surveillance to assess the pattern of risky behaviours and the level of protective measure adopted by the high-risk and bridging population; point prevalence of HIV infection in high-risk groups through serological testing; measure HIV infection in ANC attendees through sentinel sites; and integrate data from routine program monitoring sources with SGS data to timely forecast future epidemic trends and modify program interventions accordingly.

Sexually Transmitted Infections (STIs):

Very little information was available on STIs in Sudan. In national plans protocols for Syndromic treatment exist, though in rural health centres these are not implemented yet.

Fighting Stigma and Discrimination:

There is still a lot of denial of HIV/AIDS. "Nobody dies of AIDS in the Sudan; People die of malaria or war'".

To reduce stigma, people who are not yet sick should disclose their sero-status and play an important role in awareness raising. This is not easy as AIDS is still associated with feelings of 'guilt and sin' and 'fear and shame'

 HIV-positive people do not dare 'to come out'. It is said that only the poorest, who have already sold everything to buy medicines (or had nothing to start with), disclose their sero-status, hoping for charity. This in its turn can enhance the stigma, as HIV/AIDS becomes associated with dire poverty and being destitute.

Sudanese PLWA are suffering stigma in all levels, in work, family, health settings as well as in the community.

There are 200 people on ARV. All persons receiving ARVs is a member of a PLWHA association. The newly established PLWA association has done much to tackle issues of stigma and its few members are actively involved in the national response. However they are lacking the enough capacity to tackle the prevailing issues

13. An Overview of Response of the Health Sector in Post-conflict Period:

This document is highly linked to the overall health plan adopted by the federal ministry of health. A brief summary of the plan is provided in the following paragraphs.

13.1. *Guiding principles*

1.	Equity in terms of resources allocation and service provision geographically as well as amongst the health sector components;

2.	Ensure provision of health care at the expense of state/government till alternative mechanisms for sustainable health financing are worked out.

13.2.	*Strategies*

1.	Embark on a forward looking comprehensive plan developed diligently on a solid information base;

2.	Emphasise interventions aimed at saving lives and reducing sufferings of those most vulnerable, while following the primary health care strategy;

3.	Ensure adequate capacity building in terms of health planning and management and service delivery for achieving the above principles; and

4.	Engage proactively different stakeholders in the planning and management of health system's recovery plans.

5.	Encourage inter-ethnic and inter-religious relations for developing grass roots mechanisms to support the health and nutrition programme as a catalyst for sustaining peace and reconciliation.

13.3.	*Proposed plans*

The post-conflict recovery plan for health sector envisages concurrent introduction of interventions divided arbitrarily as preparatory, urgent/life saving, mid-term/rehabilitation and long-term/development, with gender equality, HIV/AIDS and capacity building as cross-cutting issues needing special attention. It may, however, be noted that although, a time schedule has been flagged to the different phases/project, many would be carried over in the next phase, and yet others may become a permanent feature of the Sudan health system. Further, it will be the pace of the peace process and consequent movement of displaced persons determining the schedule of the implementation phase and remembering that the cost tag applied to various projects may be an underestimate.

NB -1: Health programmes include those for: Malaria; HIV/AIDS; Tuberculosis; Diarrhoea; Respiratory Infections; Nutritional Disorders; Immunisable Diseases including Hepatitis; Life style related disease, e.g. Hypertension, Diabetes Mellitus, and Cardiovascular diseases; and Vector-born diseases (Leishmaniasis, Onchocerciasis and Bilharzias;), Reproductive health, nutrition etc.

NB – 2: Health facilities include all levels of health care, primary, secondary and tertiary.

14. Project profiles

14.2. *Preparatory phase (6 months)*

This phase, which has already begun in certain respects, is aimed at preparing grounds for effective and efficient implementation of interventions proposed for saving lives and alleviating the human sufferings. The following five projects will be undertaken in this phase. However, it may be noted that while some of these projects are specific to this phase, others will continue into the next phase.

14.2.1.   Sudan health system study

Weak information base coupled with limitations due to the continuing conflict has rendered the available data fragmented, and the multiplicity of partners has made its standardisation difficult. Further, weak capacity to analyse, interpret and consolidate information from a variety of sources has left even the available information unutilised. The project, which is already underway, by filling the above gaps, will contribute to evidence-based health planning and developing relevant interventions for the mid-term and long-term phase, and their subsequent management.

14.2.2.   Capacity building for ensuring implementation of recovery plan

Another impact of chronic conflict is the decreasing capacity on account of brain drain and lack of resources for the training and upgrading of the knowledge and skills of health staff. Given the challenges posed by peace and the likelihood of resource availability, capacity of staff to plan, manage and deliver service will play a vital role in successful implementation and monitoring of any post-conflict plan. In this background, the project envisages training of suitable individuals, selected from states, in health planning, management and service delivery.

14.2.3.   Capacity building for the organisation and management of post-conflict health system

The continuing conflict has shaped the organisation and management convenient to the war time necessities. Given the prospects of peace there will be a dire need to build systems for the post-conflict health system. That is, under the new conditions how different components of health services will be organised and managed. Seeking guidance from the health policy guidelines (see below), it is envisaged to establish different operational manuals laying down routines and procedures for different levels, i.e. federal, state, province, locality and facility/ programme including job descriptions for the individuals.

14.2.4.   Campaign for the repatriation of Sudanese living abroad

Many Sudanese professionals left country due to growing hostilities and security concerns. Since they know the system, they can contribute immensely in rebuilding the Sudan health system. Under the proposed project, a campaign will be launched appealing such Sudanese to repatriate, and providing them the incentives and essential support for their absorption into the health system.

14.2.5.   Mechanisms for coordination amongst players in the health arena

Already many NGOs and bilateral/ multilateral agencies operating in the health arena, coordination has been an issue which, with many more partners joining the post-conflict rebuilding, is likely to become grave. The intervention proposes establishing mechanisms for effective coordination in order to avoid duplication of effort, efficient utilisation of scarce resources and effective monitoring of interventions. In this

regard, it may be noted that UN operates CAP as a cross-sectoral coordination mechanism. However, what is being suggested here is a coordination mechanism specific for health, and WHO can facilitate the process.

14.2.6.   Mechanism for assuring gender equality in health organisation and service provision

While no consistent figures are available, the ongoing conflict in Sudan has left the women marginalised both in terms of access to health services and as a partner on the health system organisation and management or provider of healthcare. The proposed intervention visualises establishing mechanisms for gender equality in the identified areas of health system ensuring women participation in rebuilding and sustaining the health system.

14.2.7.   Formulation of policy for the unified (north/south) health system

Given that the two major factions had separate policies about health, peace offers a unique opportunity to negotiate a policy for a unified Sudan health system. This document would lay down direction for the rehabilitation and development of post-conflict health system. In this regard, it is essential that all stakeholders are represented.

14.2.8.   Formulation of post-conflict recovery plans

Different intervention envisaged for the preparatory and post-conflict phase need detailed planning. Clearly, guided by the unified health policy and addressing the needs as determined by the underway Sudan health system study, technical assistance will be required for preparing plans. Accordingly, appropriate agencies are being requested.

14.3.   *Post-conflict urgent intervention phase (6-24 months)*

Whereas peace will enhance access to the hitherto not reached, the movement of displaced persons will pose challenges for extending health services calling for urgent post-conflict interventions. These are important to save life and alleviate human sufferings. Seven such projects are introduced below, and while some of these will conclude, others will continue in the next phase:

14.3.1.   Establish health posts for the returning IDPs

14.3.2.   Nutritional supplements to the women and children

14.3.3.   Mental health/counselling

14.3.4.   Communicable Disease Control

Communicable diseases remain the main killers in Sudan, Malaria is the main cause of morbidity and mortality, and Sudan is highly vulnerable. In the post-conflict period, when the movement of population will be unimpeded, the challenge would be how to protect people. It is planned to implement the various strategies such as Roll Back Malaria, IMCI and STOP TB in the endemic areas including provision of essential drugs for prompt case management and mosquito nets impregnated with insecticide to those entering such areas.

HIV/AIDS: the virus will move with people on the move. Many Sudanese refugees are currently in countries with high rates of infection. Infected soldiers will carry the virus as they return home. Some parts of the south have higher rates of infection than parts of the north where IDPs are currently residing. The level of awareness amongst

IDPs based in the north (and amongst people living in south) is low. HIV/AIDS prevention will be a cross-cutting issue in all the health programmes. The national strategy for HIV/AIDS will be implemented targeting those most at risk, which will include the provision of material for safe blood transfusion, health and educational material for safe sex to all returnees and community awareness programmes.

14.3.5. Nutrition, sanitation/ hygiene education

14.3.6. Integrated management of childhood illnesses

14.3.7. Organisation of safe motherhood initiative

14.3.8. Extension of vaccination coverage

14.3.9. Provision of safe water and sanitary latrines

14.4. *Mid-term phase for health system rehabilitation (24-48 months)*

14.4.1. Rehabilitation of physical infrastructure of health facilities/programs

14.4.2. Replace/replenish equipment at health facilities/programmes

14.4.3. Staffing the health system

14.4.4. Supply of essential drugs and other consumables

14.4.5. Re-organisation of health management information system

14.4.6. Programme for the Physical Handicapped

14.5.*Long-term development of health system (beyond 48 months)*

14.5.1. Extension of health area initiative to all localities/counties

14.5.2. Strengthening of patient referral system

14.5.3. Institutionalising for the repair/ maintenance of buildings and equipment

14.5.4. Building local capacity for the production of ORS, essential drugs and Iodised salt

14.5.5. Institutionalising the continuing in-service training of health staff

14.5.6. Introduce reforms in the health sector

The post-conflict HIV/AIDS response will follow the four phases of the national health response that recognises AIDS as a crosscutting issue but the overall national HIV response will not be restricted to it as there will be so many non-health actors. SNAP and other bodies will be a major role in integrating all interventions to effectively contribute to the response in its various phases.

13. Approaches and guidelines for service provision:

This part outlines the guiding principles that should govern the provision of HIV services during all phases of post conflict and displacement. These guiding principles should be emphasized in the training of all workers, even when the bulk of operations are not related to health.

An integrated approach

HIV/AIDS cannot be looked at in isolation. It affects and is affected by all aspects of the lives and health of women, men and adolescents. It is related to all other aspects of primary health care, including mental health, nutrition, water and sanitation, and with environmental care, education, employment opportunities, culture, and social and economic status. These guidelines therefore emphasize an integrated approach. HIV/AIDS should be treated as an integral component of the health care system, and the solutions to needs are sought both in the health sector and elsewhere. This includes recognizing the empowerment and education of women and youth key determinants in improving their health. Among refugees and displaced persons, an integrated approach means including the interactions between host and displaced communities in programme planning. It also means that wherever possible vertical programmes, such as maternal and child health, family planning, and STI/HIV control and prevention, should be linked or integrated to ensure that reproductive health care needs are met by the provision of a holistic service.

Coordination of response

As part of an integrated approach, close collaboration is necessary between   partners providing services to those affected by conflict and displacement. This will save resources, improve logistics, avoid gaps in coverage and prevent duplication of effort. The tendency to vertical delivery services even in stable settings makes the need for close coordination doubly important to avoid wasting resources.

A gender approach

The word "gender" is used to describe those characteristics of men and women that are socially constructed, in contrast to those that are biologically determined. In applying a gender approach to health, we should think beyond describing women and women's health in isolation but brings into the analysis the differences between women and men. A gender approach examines how these differences determine differential exposure to risk, access to the benefits of technology and health care, rights and responsibilities, and control over one's life.

The importance of a gender approach in programme planning and development is increasingly being recognized. However, there is still a strong tendency to neglect gender roles and relationships in emergencies. This can lead to women, adolescents or marginalized groups becoming more vulnerable rather than less as a result of the humanitarian response. If the humanitarian response is truly to benefit all sections of a community, and if services are to successfully meet the needs of all, a gender approach is needed during each phase of post-conflict and displacement. This means not only paying attention to the needs of women, but also examining the relationships between women and men, the structure of society and the impact that conflict has on the roles of groups within that society.

It is vital to explore how gender relationships change as a result of conflict or displacement. This experience can have a marked impact on men's and women's attitudes to all aspects of reproductive health, such as family planning, motherhood, extramarital sex, sexual violence and so

on.

Quality of care

WHO has defined the core elements of quality of care as follows:

- promotion and protection of health through preventive services (including counselling and education);
- ensuring accessibility and availability of services;
- ensuring acceptability (including cultural acceptability) of services;
- ensuring standards of practice and technical competence of health care providers;
- ensuring the availability of essential supplies, equipment and medication;
- respectful, non-judgmental client-provider interactions, information and counselling for the client and referral when necessary;
- involvement of clients in decision-making;
- comprehensive holistic care integrated into health care services;
- continuous monitoring of services;
- Ensuring cost-effectiveness and the appropriate use of technology.

High quality of care in HIV services may seem unattainable in especially difficult circumstances, such as during armed conflict or emergencies. However, evidence from stable settings indicates that quality of care is critical to the more efficient and effective use of limited resources and to increasing access to and use of reproductive health services. Quality is therefore an issue that should be addressed in any setting where health care services are provided.

Adherence to the highest ethical standards

Adherence to the highest ethical standards is an essential component of the quality of care during and after conflict and displacement. Services should be provided in ways that ensure respect for privacy, confidentiality and freedom of choice, and that ensure equity of care to all groups. In any situation these are key issues and can be difficult to achieve.

Equity of care

Equity of care to all—irrespective of gender, ethnic group, religion or caste—means ensuring that services are available, accessible and acceptable to all marginalized and vulnerable groups, for example, people without immediate family or relatives, adolescents and other groups with special needs such as unaccompanied women, unaccompanied minors and disabled persons.

Protection of human right

Special emphasis should be put on protecting and the advocacy for the rights PLWA in the post – conflict period. The need to review the current legislation on public health laws and the occupational policy are crucial in maintaining human rights.

Staff support

Managers of organizations working with refugees and displaced persons have an obligation to prioritize support for their staff, particularly those working with victims of HIV, rape or other trauma. It is vital that carers are aware of their own experiences and feelings, and this should form

part of their training. Other strategies that help are:

- all carers should be trained, well briefed and debriefed;
- working in pairs when doing group counselling or visiting people in their homes;
- meeting with a support team or with a "buddy" for personal and professional support;
- Receiving supervision and support from a professional counsellor to improve their skills and discuss difficult situations.

A participatory approach

These guidelines emphasize that a participatory approach should be an integral part of all aspects of the response to needs. The community should be involved in the initial programme assessment, at the planning phase and in the implementation, monitoring and evaluation of HIV/AIDS programmes. This approach will ensure respect for the culture and traditions of the community.

Some groups within a community may oppose the provision of some aspects of services, such as condoms or services for unmarried adolescents. It is important to assess the nature and extent of such opposition before proceeding with contentious services, even if members of the community have expressed a need for such services. In some circumstances, it may be possible through dialogue and advocacy to move to a position where community leaders are facilitators of service provision rather than barriers to it.

Support for coping strategies

In all societies, individuals and communities have different strategies they adopt in order to survive in times of crisis. Most people affected by conflict, whether stayees or displaced, survive by their own efforts rather than as a result of outside interventions or aid. For example, it has been suggested that food aid meets only 10% of needs in emergency situations, with most food needs being met through local coping strategies.

Where outside assistance is available and can reach the affected population, it should be firmly based on supporting and strengthening people's coping strategies. This is because:

- this is likely to be the most efficient way of assisting individuals and communities;
- The knowledge, capacities and coping strategies of the people themselves are their chief means of survival and hope for the future.

To undermine these coping strategies is to undermine a community's long-term capacity for recovery, peace building and reconciliation. Ideally, humanitarian relief during conflict and displacement should be channelled through organizations that have a good knowledge of the affected community and its survival strategies, and that understand of the roots of conflict. These organizations may be government bodies, women's groups, United Nations organizations or international NGOs with experience of development work with the affected community before the conflict. It is imperative that relief organizations that are new to a particular country or community rely on organizations and groups with local experience in order to identify and support (rather than undermine) community coping strategies. Relief agencies should avoid imposing their own beliefs and ideology, but should accept the culture and religion of the people.

A development approach

A relief approach to humanitarian assistance, with an emphasis on rapid decision-making and response, is essential in the early days of a crisis. Too often, however, crisis management style continues to be used long after the time of crisis is passed.

These guidelines emphasize that programme planning and implementation should be based on a development approach to the greatest extent possible during all phases of conflict and displacement. In practice this means that the principles of community participation, a gender approach, consultative planning, empowerment of communities and attention to long-term sustainability must be supported at all levels of an organization, and should be actively promoted in the field. One important aspect of sustainability that is emphasized in the guidelines is the provision of a level of care that is appropriate to local standards and that is in line with local norms and practices.

A public health approach

Violence against women, children, adolescents and vulnerable groups is now being recognized and treated as a preventable public health problem. There is also a growing perception that political violence, including armed conflict, should be treated as a public health problem, and that health practitioners should treat war as a particular kind of "societal disease". This means that health practitioners should study the causes of war, document its impact on physical, social and mental health, investigate preventive measures, take whatever action is in their power (as individuals and through professional bodies) to prevent the "disease", and develop strategies to treat its effects.

15. MATRIX FOR PLANNING

15.1. Matrix of key actions for responding to HIV/AIDS in post-conflict Sudan

This matrix provides guidance on key actions for responding to HIV/AIDS in the post conflict era. The matrix is divided into three parts: Preparedness, urgent Response and rehabilitative Response. These are three phases of the

post-conflict health sector plan developed by the MOH .Each programmatic sector is provided with guidance on responding to HIV/AIDS appropriately. The country response and capacity assessment will help determine what should be the additional HIV/AIDS elements to the developmental response. Detailed action points for each of the points will be provided.

15.2. PRINCIPLES:

- HIV/AIDS activities should seek to build on and not duplicate or replace existing work.
- Responses to HIV/AIDS in post-conflict Sudan will call for multi-sectoral responses.
- Establish co-ordination and leadership mechanisms prior to action, and leverage organization's differential strengths, so that each can lead in its area of expertise.
- Local and national governments and institutions and target populations should be involved in planning and implementation and may be able to allocate human and financial resources
- Activities should be developed in the light of national policies and guidelines and the SPP.
- HIV/AIDS activities for displaced populations and special groups should also service host populations to the maximum extent possible.
- Special focus should be given to underdeveloped areas and war torn states.

15.3. MATRIX FOR PLANNING

	Sectoral Response	*Emergency Preparedness*	Urgent response	Rehabilitative response
1	Coordination	• Determine co-ordination structures • Identify and list partners • Establish network of resource persons • Raise funds • Prepare contingency plans • Include HIV/AIDS in humanitarian action plans	1.1 Establish/activate co-ordination mechanism (SAN,CTG,NAC and CCM) 1.2 Raise awareness of decision makers and programme managers in areas of high HIV/AIDS prevalence in challenges of the post –conflict period 1.3 Raise awareness/ train local institutions in affected HIV/AIDS areas 1.4 Facilitate access to humanitarian assistance	• Continue fundraising • Strengthen networks • Enhance information sharing • Build human capacity • Link emergency to development HIV action • Assist government and non-state entities to promote and protect human rights
2	Assessment and monitoring	• Conduct capacity and situation analysis • Develop indicators and tools • Involve local institutions and beneficiaries	2.1 Assess baseline data 2.2 Set up/improve shared database 2.3 Monitor activities	• Maintain database • Monitor and evaluate all programmes • Assess data on prevalence, knowledge attitudes and practice, and impact of HIV/AIDS • Draw lessons from evaluations
3	Protection	• Review existing protection laws and policies • Promote human rights and best	3.1 Prevent and respond to sexual violence and exploitation	• Involve authorities to reduce HIV-related discrimination • Expand prevention and response to sexual

				violence and exploitation
		practices	3.2 Protect orphans and separated children	• Strengthen community based protection for orphans and separated children and young people
		• Ensure that humanitarian activities minimize the risk of sexual violence and exploitation and HIV-related discrimination	3.3 Ensure access to condoms for risk groups	• Institutionalize training for uniformed forces on HIV/AIDS, sexual violence and exploitation, and non-discrimination
		• Train uniformed forces and humanitarians on HIV/AIDS		• Put in place HIV-related services for demobilized personnel
	Sectoral response	**Emergency preparedness**	**Urgent response**	**Rehabilitative response**
4	Food Security and Nutrition	• Contingency planning/preposition supplies	5.1 Target food assistance to affected households and communities	• Develop strategy to protect long-term food security of HIV affected people
		• Train staff on special needs of HIV/AIDS affected populations	5.2 Plan nutrition and food needs for population with high HIV prevalence	• Develop strategies and target vulnerable groups for agricultural extension programmes
		• Include information about nutritional care and support of PWLHA in community nutrition education programs	5.3 Promote appropriate care and feeding practices for PLWHA	• Collaborate with community and home based care programs in providing nutritional support
			5.4 Support and protect food security of HIV affected & at risk HH and communities	• Assist the government in fulfilling its obligation to respect the human right to food.
		• Support food security of HIV-affected	5.5 Distribute food aid to affected	

		households	households and communities	
5	Shelter and Site Planning for IDPs and Returnee	• Plan potential sites to be safe • Train staff on HIV/AIDS, gender and non-discrimination	6.1 Establish essential HIV/AIDS service at designed sites	• Scale up the services to the displaced
6	Services	• Map current services and practices • Plan and stock supplies • Adapt/develop protocols • Train health personnel • Plan quality assurance mechanisms	7.1 Ensure access to basic health care for most vulnerable 7.2 Safe blood 7.3 Condoms 7.4 Syndromic STI treatment 7.5 Safe deliveries	• Universal precautions • Safe blood transfusion services • Management of STIs, including condoms • Comprehensive sexual violence programmes • Prevention and care for injecting drug users • Voluntary counselling and testing • Reproductive health services for young people • Prevention of mother to child transmission Provide care for PLWHAs through : • Palliative care • Home based care • Treatment of opportunistic infections • Prevention of opportunistic infections • Anti-retrovirals

	Sectoral response	Emergency preparedness	Urgent response	Rehabilitative response
8	Education	• Determine emergency education options for boys and girls • Train teachers on HIV/AIDS and sexual violence and exploitation	8.1 Ensure children's access to reproductive education	• Educate girls and boys (formal and non-formal) • Provide life skills-based HIV/AIDS education • Monitor and respond to sexual violence and exploitation in educational settings
9	Behaviour Communication Change, Communication for behavioural impact and Information Education and Communication (IEC)	• Prepare culturally appropriate messages • Prepare a basic BCC/COMBI/IEC strategy • Involve key beneficiaries • Conduct awareness campaigns • Store key documents outside potential emergency areas	9.1 Provide information on HIV/AIDS prevention and care	• Scale up BCC/COMBI/IEC • Monitor and evaluate activities