HIV Legal Environment Assessment (LEA) Report

Sudan

15 December 2019

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Abbreviations

ANC: Antenatal Care

CCM: Country Coordinating Mechanism

CSOs: Civil Society Organizations

FMOH: Federal Ministry of Health

GFATM: Global Fund to fight AIDS, Tuberculosis and Malaria

IBBS: Integrated Bio Behavioral Survey

KPs: Key Populations

MARPs: Most At Risk Populations

MOI: Ministry of Interior

MOJ: Ministry of Justice

NGOs: Non-Governmental Organizations

PHC: Primary Health Care

PITC: Provider-Initiated HIV Testing and Counseling.

PLHIV: People Living with HIV

PMTCT: Prevention of Mother to Child Transmission

PSE: Populations Size Estimates

SPCA: Sudanese People Living with HIV Care Association

Executive Summary

People living with HIV or AIDS (PLHIV) and Key Populations (KP) in Sudan experience stigma, discrimination and limitations of their rights both in law and in practice. Through a series of interviews carried out to support this report, PLHIV, and KPs in Sudan provided strong evidence of the forms of stigma, discrimination and human rights abuses they experience on a daily basis.

It is widely accepted that a protective legal and regulatory framework can help reduce stigma and discrimination associated with HIV, to promote effective national responses to HIV and AIDS. Punitive laws and practices deter those most at risk of HIV from seeking essential HIV services they need. To support this, the Ministry of Justice in Sudan, together with UNDP, agreed to support this HIV Legal Environmental Assessment (LEA), to review current laws and assess the legal, regulatory and policy environment in relation to those susceptible to, living with and affected by HIV and AIDS in Sudan.

The Interim National Constitution of Sudan (2005), the supreme law of the land, is built upon human rights principles. The Constitution states that the 'State is committed to the respect and promotion of human dignity, and is founded on justice, equality and the advancement of human rights and fundamental freedoms'. The Constitution includes provisional articles that protect the dignity and rights of all Sudanese people and highlights that the state shall promote public health and guarantee equal access and free primary health care to all citizens (Article 19). The "Bill of Rights" is an integral part of the Constitution, which emphasizes the *right to life and human dignity, personal liberty and equality before the law.* Therefore, while the Bill of Rights does not explicitly mention HIV and AIDS, it notes that all Sudanese citizens should enjoy these rights. Sudan has also ratified various regional and international conventions, declarations, covenants and treaties designed to support the rights of PLHIV and KPs (e.g. UN Political Declaration on HIV and AIDS (2011)).

Applying broad laws and rights to HIV and AIDS is possible, but it is argued that this leaves gaps, challenges and uncertainties in the current legal and regulatory framework. As a result, some countries have enacted specific laws to address HIV and AIDS. In this context Sudan developed an HIV Law/Bill in 2007, but it has not yet been endorsed.

This HIV LEA identified several on-going challenges relating to HIV, the law and human rights in Sudan. Firstly, vulnerable and key populations in Sudan, including PLHIV, sex workers and Men who have sex with Men (MSM), are at higher risk of HIV exposure and /or of vulnerability to the impact of HIV and AIDS.

Secondly, although protective provisions in Sudanese law and policy were identified, the lack of laws which specifically deal with HIV and AIDS, or with the inequalities and human rights abuses experienced by PLHIV and KPs at higher risk of HIV exposure, remains concerning.

Thirdly, HIV-related stigma and discrimination exacerbates the negative impact of HIV. In addition, access to justice and law enforcement for human rights violations is limited. Populations are not fully aware of their rights, or of how to enforce these rights, with enforcement mechanisms generally unavailable.

Fourthly, there were a number of punitive or coercive provisions in law, many of which predate AIDS but which are now recognized as creating barriers to an effective HIV and AIDS response, e.g. the criminalization of sex work and homosexual acts. Punitive laws and such criminalization are now globally recognised as deterring those most at risk of HIV from seeking essential services. Such laws only serve to fuel stigma and discrimination towards key affected populations, including PLHIV.

Lastly, the HIV LEA found that while there are various health and other sectoral laws and policies which promote the health rights of all Sudanese citizens, including the National HIV and AIDS Policy (2004), resource and other constraints mean that these policies are often not implemented or supported.

Recommendations listed below will help strengthen the Legal Environment to support the rights of PLHIV and KPs in Sudan. It is hoped that they will be incorporated into Sudan's next HIV National Strategic Plan (2019-2024) and Sudan's next Concept Note/funding proposal to the Global Fund.

1. Ensure that all existing human rights commitments outlined in the Interim Constitution (2005) are guaranteed and enforced.
2. Ensure that Sudan does not enact any law that explicitly criminalizes HIV transmission, exposure or non-disclosure of HIV status, which are counter-productive.
3. Abolish all mandatory HIV-related testing

4. Review and repeal punitive laws in Sudan, to outlaw all forms of discrimination and violence directed against PLHIV and KPs most vulnerable to HIV. For more information, please refer to the recommendations section of this report.
5. Strengthen HIV-related legal services to facilitate access to justice/redress for PLHIV and KPs
6. Put in place Complaints Response Mechanisms (CRMs) to document and support the rights of PLHIV and KPs.
7. Enforce a legal framework that ensures social protection for all children living with and affected by HIV and AIDS.
8. Support HIV Stigma Reduction Programmes for the following key target groups:
    i. health care workers
    ii. lawmakers and law enforcement agents (Ministers of the Interior and Justice, the police, security personnel, prosecutors, judges, lawyers)
    iii. Support Community Stigma Reduction Programmes
    iv. Support 'Knowing Your Rights' training and awareness raising for KP and PLHIV
    v. Work with the guardians of customary and religious law to promote traditional and religious practices that promote the rights of PLHIV and KPs
9. Reduce harmful gender norms and gender-based violence and increase women and girls legal, social and economic empowerment.
10. In matters relating to HIV and the law, offer the same standard of protection to migrants, visitors and non-citizen residents as those extended to citizens.

Introduction

Background to the Legal Environment Assessment

Stigma and discrimination towards People living with HIV (PLHIV) and Key Populations (KPs) in Sudan remain an obstacle to an effective National HIV response. These groups face challenges from accessing, using and/or continuing their use of HIV- related health services due to stigma and discrimination widely experienced in healthcare and community settings. Stigma and discrimination serve to deny individual's access to basic health and legal services. They also fuel the spread of HIV, resulting in higher levels of new HIV infections.

In the framework of Global Commission on HIV and the Law's recommendations (2012), 192 countries committed to review their HIV/AIDS-related legislative framework, laws and policies, to examine their implications for respective national HIV responses, as part of wider efforts to create supportive legal environments towards ending the AIDS endemic by 2030. There is now a large body of international research and literature illustrating the negative consequences of punitive laws, coercive law enforcement practices and policies which jeopardize access to HIV prevention, treatment and support services.

In the above context, to strengthen the National HIV response in Sudan, the Ministry of Justice took the lead to develop this HIV Legal Environment Assessment (LEA) with technical support from UNDP. The HIV LEA offered an opportunity to identify and critically explore key laws, policies and regulations, to consider their impact on facilitating or undermining the access to HIV related services, by PLHIV and other Key Affected Populations (KAPs) in Sudan. The LEA is intended to inform efforts to address regulatory gaps, policies and practices that profoundly contribute to exclusion, stigma and discrimination against PLHIV and other key populations affected by the disease, access to justice and law enforcement in the context of HIV, and to develop key recommendations towards achieving a supportive enabling environment.

To develop this Sudan HIV Legal Environmental Assessment (LEA), the methodology adopted, included an extensive desk review of key documents, laws and policies, that was supported by Key Informant Interviews (KII) conducted with key HIV stakeholders in Sudan. This included interviews with representatives of People Living with HIV (PLHIV) as well as with Key Populations (KPs). A Draft HIV LEA report, outlining the findings and recommendations of the desk review and KII was subsequently presented and shared, at a National Dialogue meeting that took place in Khartoum from 21st and 22nd

August 2019. This provided an opportunity for participants to discuss and provide additional inputs to strengthen the report. Please find attached Annex 1 for Agenda of the National Dialogue, Annex 2 for National Dialogue Participants List, Annex 3 for National Dialogue Report and Annex 4 for Key Informant Interviews (KII) User Guide.

The expected outcome of the Sudan HIV LEA is to make recommendations to strengthen the enabling environment for an effective response to HIV in Sudan. More specifically, the outcome of the Sudan HIV LEA is to generate evidence and use it actively to strengthen the legal environment, (including through law review and reform), and to support programmes to increase awareness of rights and access to legal services. In this regard, it is intended that the findings from this assessment will be fed into the next HIV National Strategic Plan (2019-2024) being developed for Sudan, as well as Sudan's next Concept Note to the Global Fund.

Background to Sudan's Political Situation

Following months of public demonstrations and the overthrow of President Omar al Bashir in December 2018, Sudan's immediate and longer-term future remains uncertain. Nevertheless, Sudan remains a fragile developing country where approximately 50% of the population is living in poverty (2011)[1]. Many years of conflict and economic sanctions against President Omar al Bashir played a significant role in worsening the general social and economic situation in Sudan, leaving the majority of Sudanese to suffer and carry an enormous burden. Since the economic shock of South Sudan's secession (2011), Sudan has struggled to stabilize its economy and make up for the loss of foreign exchange earnings. The interruption of oil production in South Sudan in 2012 for over a year and the consequent loss of oil transit fees further exacerbated the fragile state of Sudan's economy. Consequently, in 2015 it was estimated that a third of Sudan's population was living in conflict-affected areas, with around 6.9 million in need of humanitarian assistance[2]. The estimated GDP per capita in 2015 was USD 4,300, with the key economic sectors contributing to GDP including Agriculture 28,9%, Industry 20.4% and Services 50.7%[3].

1 NSCE. Draft Report on Preliminary Findings for CPAP Outcome Indicators-Indicator Tracking 2009-2012 UNDP Sudan, 2011

2 Overview of HIV and AIDS in Darfur, Sudan. UNAIDS 2015

3 Socio-Economic Profiling of People Living with HIV and Mapping of Social Protection Systems in Sudan, UNDP 2016

Until the beginning of June 2019, negotiations between the Military Council and the Declaration of Freedom and Change Forces Alliance (representing the political parties that signed the Declaration of Freedom and Change and the Sudanese Professional Association) continued, with the aim to bring about a smooth transition to a civil state. These political changes remain ongoing and present an opportunity to push for greater rights for PLHIV and KPs in Sudan.

An overview of the HIV situation in Sudan

Sudan's first AIDS case was diagnosed in 1986 and the Sudan National AIDS Control Programme (SNAP) was established in 1987. The 1990s saw a lukewarm response to the HIV response, which continued until 2003, when Sudan developed the first National AIDS Policy and subsequently endorsed the first National AIDS Strategy 2004-2007. The first years of the HIV response in Sudan were characterized by untargeted, generalized messaging for the general population, with no specific attention to Most At Risk or Key Populations (KPs). This was despite evidence from a 2011 Integrated Bio-Behavioral Survey (IBBS) and 2010 Antenatal Care surveillance rounds and routine programmatic data from VCT and PMTCT sites, which suggested a concentrated HIV/STI epidemic among KPs in the country[4]. In 2016, HIV prevalence among women attending ANC clinics was 0.3%. From 2011 the epidemic was known to be concentrated among specific KPs namely Men having sex with Men (MSM) and Female Sex Workers (FSW), with great geographical variation; namely higher prevalence rates in Sudan's Eastern region. In 2011, HIV prevalence among MSM and FSWs was between 1 and 4.9%[5], while the latest IBBS in 2015 showed a decrease in the prevalence of HIV among FSWs and MSM; at 1.2% and 1.1% respectively. It is believed as illustrated by strategic information and available data on increased condom use and greater access to HIV testing among FSW and MSM in Sudan (IBBS 2015) that these two issues contributed to the decrease in HIV prevalence among these two groups. For example, results of the 2015 IBBS indicated that condom use among FSWs had improved from 16.2% in 2011 to 27.8% in 2015 (IBBS 2011 & 2015). In addition, access to HIV testing significantly increased from 10% (IBBS 2011) to 28.6% in 2015 (ibid). As for MSM, a comparison of 2015 and 2011 IBBS findings revealed an increase in the percentage of condom use in the last sexual relationships and an increase in HIV testing from 10.8% to 19.2% in 2011[6].

4 Global AIDS Response Progress Report, 2014
http://www.unaids.org/sites/default/files/country/documents//SDN_narrative_report_2014.pdf

5 UNAIDS MENA Regional AIDS Report, 2015

6 Sudan Funding request to the GFATM, 2017

In general, the country's HIV situation and dynamics cannot be detached from the wider picture in the MENA region. Similar to most countries in MENA, HIV prevalence in Sudan remains relatively low, with new HIV infections concentrated among key population groups. UNAIDS data therefore recommends the need to expand and improve HIV testing and access to treatment programmes in both the Islamic Republic of Iran and Sudan, which accounted for more than 60% of the region's deaths from AIDS-related illnesses in 2017[7].

Since 2017, the national HIV response in Sudan has been characterized by its multi-sectoral nature, where different government stakeholders including the Ministry of Health (MOH), Ministry of Justice (MOJ), Ministry of Interior (MOI) and other important federal and state actors, alongside CSOs and representatives of PLHIV, are actively engaged in the HIV response at country level.

Health expenditure from domestic resources remains significantly low and the Global Fund for HIV, TB and Malaria remains the main donor for the three diseases, including HIV, providing approximately 90% of finance to support the HIV response in Sudan[8].

Over the last nine years Sudan has witnessed substantial progress in the health outcomes and improved wellbeing of its population. Since 2010, Sudan has achieved remarkable progress in the decline of under-five mortality (68 per 1,000 live births in 2014, compared to 83 per 1,000 in 2010), but with severe geographical disparity and inequality between rural and urban areas. This variation is also evident in the HIV response, regarding access to services and health outcomes among PLHIV and key populations, as seen from key stakeholder interviews undertaken to support this assessment. Please see below for further details on this.

Sudan's National Strategic Plan for HIV (2017-2020) adopts and is aligned with the fast-tracked global targets (90-90-90), WHO's Test and Treat Policy to increase efficiency, coverage and strengthen people's

7 http://www.unaids.org/sites/default/files/media_asset/miles-to-go_middle-east-and-north-africa_en.pdf

8 Overview of HIV and AIDS in Darfur, Sudan. UNAIDS 2015

links to care and support, as well as support the reintegration of PMTCT into reproductive health services to expand women's access to essential HIV related services[9].

The National Health Sector Strategy Plan (2012-2016) and HIV disease-specific National Strategic Plan and related guidelines and policies are tailored towards creating resilient and sustainable healthcare systems focused on providing quality services in Primary Health Care centers. The strategic direction of the HIV response and the updated Strategic Plan (2017-2020) emphasize the importance of a multi-sectoral HIV response to expand prevention, care and treatment services for the most excluded and marginalized groups including *inter alia* FSWs, MSM, refugees and prisoners.

As detailed in Sudan's Funding Request to the GFATM (2017), the country is moving in a strategic direction in terms of integrating all health services in the Primary Health Care system including PMTCT, newborn, reproductive and adolescent health and taking measures to expand coverage and people's accessibility to PHC services.

However, the HIV response in Sudan is experiencing different challenges and constraints that impact adversely on HIV-related service coverage and efficiency, and raise serious questions about the quality of services available for key populations and PLHIV. In summary, these challenges (which emerged during key stakeholder interviews and meetings) include: high levels of stigma and discrimination in health care and community settings, low HIV testing among key populations, annual case detection below 3000 cases, low retention of HIV, stock outs of HIV testing kits and delays in introducing viral load testing.

People Living with HIV and AIDS:

By the end of 2017, Sudan had an estimated 51,000 people living with HIV, where the disparity of infection between men and women, indicated approximately 22,000 HIV positive cases among women above 15 years of age, and an estimated 25,000 of HIV positive cases among men above 15 years of age. The annual number of newly reported HIV cases has seen a steady rise from 4,400 in 2010 to 4,700 in 2017. Likewise, deaths from AIDS-related illnesses in Sudan significantly increased from 1,700 cases in 2010, to 2,600 in 2017.

9 Sudan Funding request to the GFATM, 2017

The Sudanese People Living with HIV/AIDS Care Association (SPCA) is the main legal body representing people living with HIV in the country. SPCA has over 5000 registered members across Sudan and the association is well positioned regarding governance of the AIDS response in the country. For example, it is a member of the Country Coordination Mechanism (CCM) which provides an oversight governance role for the implementation of GFATM grants. SPCA is also a key partner to all International Development partners working on HIV in Sudan. SPCA's internal structure and governance follows the administrative divisions of the country, with a Federal association and 18 branches to represent the 18 states of Sudan. The institutional capacity of these state associations varies significantly, based on their membership, history of establishment and the presence of development partners and government sponsors. This variation is significant in terms of service provision for SPCA members, as the leadership and motivation demonstrated by the association in some states has leveraged particular services and support for PLHIV[10].

Access (physical and social) and Availability of HIV Prevention and Treatment Services

Key Populations

In general, key populations in Sudan have profoundly constrained access to HIV prevention and testing services. This is partly explained by their legal status, which makes them hesitant to use HIV services. Between 2011 and 2017, outreach services for KPs were implemented through peer education and mobile VCT mechanisms. These approaches improved KP knowledge and access to voluntary HIV testing and counseling. However, to make these interventions more cost-effective, it was decided to change these interventions to Peer Driven Interventions (PDI), where by trained peers bring new MSM and FSWs to HIV testing and counseling centers and receive transportation costs as an incentive. These testing and counseling centers are either NGO or government-run facilities. In reality, KPs prefer to use NGO facilities which they have greater trust in, in terms of respecting their confidentiality and where they face less discrimination from service providers. Some KPs mentioned that the transportation incentive is not particularly attractive, when compared to the risks they face when revealing their identity and exposing themselves to service providers.

10 Socio-Economic Profiling of People Living with HIV and Mapping of Social Protection Systems in Sudan, UNDP 2016

"For key populations, general knowledge and risk perception are better than among the general population, but still low (less than 50%). There is no trust in the confidentiality available at public [government provided] health facilities. The accessibility of services remains challenging; even when PLHIV have appropriate knowledge, they often don't know where to be tested. Their preference is not to go to public health facilities, as if they are known as a key population they might be discriminated against by service providers. So they prefer to go to facilities managed by the NGOs. The Peer Driven Intervention (PDI) approach focuses on clients securing access through their peers. Widespread stigma and discrimination is worsening the situation" Key Informant Interview, 2019

"Many of them [MSM] don't even know about the existence of HIV services and the risks of stigmatizing behaviour of the service providers. Most of them [MSM] don't know that they won't be reported to the authorities if they use services, so they are afraid to seek these services. This also relates to the issue of using governmental PDI centres and their fears of being recognized and/ or reported. Many MSM don't feel safe and have stopped using the services. There are some incidents about sexual harassment and sexual exploitation by service providers, shared by female sex workers". KP Interview, 2019

Stigma and discrimination

Like elsewhere, stigma faced in healthcare settings in Sudan has emerged as a critical issue that constrains and drives KPs away from accessing HIV prevention, treatment and care services. Homosexuality and prostitution are not only criminalized in Sudan, but also highly stigmatized. There is much anecdotal evidence and research on stigma and discrimination faced by KPs which emphasizes that having stigma free HIV healthcare services and settings is *sine qua non* (an essential condition) to address this challenge.

In terms of availability, I know that there 39 PDI clinics in Khartoum and they are present in all states. However, these services reach a specific class so they rarely reach targeted people from

middle or upper classes, so there are issues in the accessibility of HIV information. I personally tried to go to Bashaier and dermatology centres – the experience wasn't nice at all. Because the service is free of charge, you need to go the accountant to get a paper before getting the service. They say that the clinic is separate [from other services] yet still to get the service you need to expose yourself to other offices with all the questioning and judgmental eyes there. So that was stigmatising. When I went to get the service, the counsellor quoted some religious "advice", like that HIV is punishment from God. I think the counsellors mix their professional advice and their personal religious beliefs. I don't know that it is related, but I know people who have stopped using the services because of the attitudes of the counsellor, because they think Am I going to be treated as sinner, a mental or a sick person?" Key Informant Interview, 2019

Incidents of stigma and discrimination in Sudanese healthcare settings are evident in UNDP's 2016 study, which reports that 11.5% of study participants were stigmatized by healthcare providers[11]. Many stories about stigma in healthcare settings were shared by the PLHIV, which they attributed to service providers lack of knowledge about HIV. PLHIV raised concerns that the stigma they face at health facilities might prevent people from disclosing their HIV status when accessing health services. Different informants indicated that this issue was still an issue after the introduction of Provider Initiated HIV Testing and Counseling (PITC). It is likely also linked to the strategic but potentially pre-mature move to integrate HIV services into wider healthcare services, without adequate prior preparation (especially service provider training on HIV related stigma and discrimination, confidentiality, ethics and rights and other related issues), as well as inadequate infrastructure.

"*The stigma in health care settings is very significant from the health worker cadres, especially at the beginning of disclosure. Many PLHIV who needed treatment were referred to Khartoum [several hours' bus ride away] and those who could not afford it simply died. We have raised many concerns about stigma and we have addressed this formally with the MOH with supporting documentation, but there has been no response"* Key *Informant* Interview*, 2019*

11 Socio-Economic Profiling of People Living with HIV and Mapping of Social Protection Systems in Sudan, UNDP 2016

"PLHIV suffer from the behaviour of health care providers, I know someone who had infected tonsils and she was supposed to get an operation for it. One of the essential tests for the operation was HIV testing, so she told the doctor that she has HIV. Consequently, she was taken off the list and the doctor refused to perform the operation. Following long negotiations between SNAP and the MOH, involving the doctor and the hospital, the doctor said that he didn't have the necessary equipment and that she had to bring in sterile bed sheets, and even sterilize the surgical instruments of the doctor. When the doctor refused her operation she had thought about suing the hospital, but she was afraid that this would take time and she was very sick." PLHIV Interview, 2019

"One of my friends used to be a sex worker in Sinnar State. She got very sick and when she went to the hospital they discovered that she had AIDS. The director of the hospital asked her to leave the hospital and threatened to call the police, so she died at home." KP Interview, 2019.

Self-stigma, also known as internal stigma dynamics, adds another layer of stigma experienced by PLHIV, particularly those who belong to key populations. Interview findings highlight that self-stigma is one factor that has an adverse impact on the enrollment in care. It often undermines the decision of PLHIV to seek voluntary testing, meaning that many don't enroll in treatment and care programmes.

"Self-stigma and other dimensions of discrimination all contribute to the enrollment in care. Late diagnosis, especially among the partners of PLHIV, leads to the late enrollment in care. The quality of preparation for ART initiation. The current retention in care is 60% in 2018" Key Informant Interview, 2019

Despite the work done to raise awareness among community members about HIV, high levels of stigma and discrimination towards PLHIV are still common in communities. There are reported cases of social isolation and expulsion from rented houses, when the owner found out about their tenant's HIV status

"One of my friends invited her neighbor's to her sons' circumcision but no single person came to that party because she is living with HIV and is an ex-sex worker". PLHIV Interview, 2019

Some informants mentioned cases of children being expelled from schools as a result of their HIV status: "*In West Darfur, last month alone saw 124 cases [of expulsions]*". This information resonates with the UNDP 2016 study on PLHIV socio-economic profiling, that indicated that 3.8% of participants had experienced their children being rejected from school in the last 12 months, because of their or their parents HIV status[12].

Availability and quality of health services, including counseling:

Different respondents and key informants commented on the issue of expired test kits and stock-out of kits at different VCT centers, as well as the absence of doctors and lab technicians who refuse to conduct HIV tests unless they receive incentives. All these constraints adversely affect the provision of quality services for people living with HIV in Sudan, including key populations. This issue should be further unpacked with different KPs and PLHIV, to measure its impact on healthcare service provision, quality and uptake.

"Somehow, treatment centres usually have the medicine for HIV, despite stock-outs that happen. Imagine if someone comes to the hospital and finds no treatment there because of stock-outs, he won't come again! Also the medicines and treatment of opportunistic infections is not available and people have to pay for them which is quite expensive!". PLHIV Interview, 2019

Different respondents also voiced concerns about the lack of accessible medical support and care for opportunistic diseases, which are the main causes of death among people living with HIV.

12 Socio-Economic Profiling of People Living with HIV and Mapping of Social Protection Systems in Sudan, UNDP 2016

"On ART compliance, adherence is more than 95%. But our real concerns are the opportunistic infections, which lead to the passing away [death] of considerable numbers of people. The ART centers don't provide any treatment for the opportunistic infections". Key Informant Interview, 2019

Voluntary HIV Counseling and Testing centers (VCT) are an effective entry point for linking persons/ populations in question with HIV care and treatment systems in any country. In Sudan, different respondents indicated that the key obstacle which hinders people, particularly key populations from accessing health services is the blatant stigma and discrimination perpetuated by service providers, including frontline workers like counselors. It was affirmed that this issue is also common in Khartoum state. Stigma is practiced by both trained and non-trained service providers. It is evident that poor quality counseling remains a key barrier to the expansion of HIV-related testing services, given the important role of counseling as a behavioral/cognitive intervention to encourage individuals to enroll in testing and other support services.

"When I was assisting someone living with HIV, one of the main challenges was counselling. Are counsellors trained to provide counselling for trauma, depression or suicidal cases? My idea is that counselling should be professional and separate from one's beliefs and culture, also it shouldn't be like religious counselling – I think they receive training on counselling skills, but from what I've seen in Bashaier Centre, it's not implemented at all." KP Interview, 2019

Integration of HIV related services in Primary Health Care (PHC):

Integrating different HIV services as part of wider health services illustrates an important and strategic move towards sustaining a long-term HIV response. Evidence from elsewhere highlights the benefits of utilizing existing services, in particular PHC services, to support a more effective national HIV response. This expands outreach activities and services to reach key populations and other vulnerable groups. Such an approach reduces prevention-related costs and more effectively links HIV care and support services. In the long term, the integration of HIV should help to naturalize and normalize the disease as a chronic illness and hence lessen the stigma associated with the virus. To achieve the potential positive benefits of

more integrated service provision, significant efforts to raise awareness and support for PLHIV among physicians and other health workers dealing with PLHIV is recommended. This is likely to reduce the vulnerability of PLHIV to stigma, and help ensure that they do not drop-out of treatment programmes.

> *"For the new midwives who were recruited as part of the [service] expansion, it is left to the States to recruit them and also provide the incentives if they can. A recent discussion is on how to ensure that the Medical Council follows up on their accountability [to service users]. The inclusion of HIV in the curriculum of midwives is based on infection control measures and PMTCT" Key Informant Interview, 2019*

Some informants indicated that the integration of service provision might result in mandatory measures, even without consent and counseling for HIV testing, which would go against the HIV Policy relevant guidelines on "no mandatory HIV testing". Some informants even argue that physicians' increased knowledge about HIV and HIV positive cases might result in denial of the provision of health services to key populations, especially in the absence of effective disciplinary measures at the health facility level.

Social Protection:

Evidence shows that supporting PLHIV and key populations affected by the virus to access different social protection schemes can play a significant role in helping to reduce their vulnerability and to manage the impact of HIV and AIDS on their lives. Sudan has classified Social Protection under Social Development and has included central government contributions to the Pension Fund and the Social Security Fund. These social subsidies that directly benefit the poor include electricity subsidies, free medication in emergency departments (only), free medicines for kidney dialysis and heart disease. A UNDP study on Socio-economic profiling of People living with HIV and mapping the Social Protection system in Sudan (October 2016), revealed that the Sudan's social support programme remains heavily over-burdened, with approximately 46.5% of the population living below the national poverty line.

Social Protection schemes (both structure and policies) in Sudan are governed by special laws. The social support system is managed by different Federal and State governmental authorities, where the overarching institution is the Federal Ministry of Welfare and Social Security (MoWSS). The MoWSS oversees social security funds including: The National Pension Fund (NPF), the National Social Insurance

Fund (NSIF), the National Health Insurance Fund (NHIF), the Zakat Chamber and the Savings and Social Development Bank (SSDB).

The 2016 study on Socio-economic profiling of People living with HIV and mapping Sudan's social protection system (October 2016), illustrated that most PLHIV in Sudan are among the most disadvantaged population groups and need to be covered by various social support programs. The study found, that about 68% of study participants and 74% of their spouses did not have paid jobs, while the majority of those with jobs were enrolled in causal labour (i.e. inconsistent, insecure and low paid). Forty-eight percent (48%) of participants and 52.2% of their spouses were daily wage workers (casual workers), while 20% of participants and 20.4% of their spouses were governmental employees. Approximately 13% of study participants and 4.8% of their spouses were self-employed. The study also found that the vast majority of PLHIV are living in poverty and that very few of them possess savings. The relationship between HIV, AIDS and socio-economic improvement is complex. On one hand, HIV and AIDS negatively affects economic growth. On the other hand, a vulnerable economic system makes it hard for nations, women and men to mount an effective, comprehensive and positive response to the epidemic. In addition, poverty is a well-known, widely recognised co-factor that increases vulnerability to and the spread of HIV and AIDS. In Sudan, deaths due to AIDS have shrunk the agricultural labour force, its productiveness and disposable incomes in many households in rural areas[13].

The same study indicated that only 28.3% of participants were covered with health insurance, i.e. 71.7% were not covered. Again, this significantly increases their vulnerability and exposes them to catastrophic expenses when they fall sick or need hospitalization. Ninety-one percent (91%) of those covered had public health insurance and 9% private health insurance. The value of their health insurance, even for those covered, remains questionable and not comprehensive (e.g. for oral health and hospitalization costs) Additionally, 53.6% of participants stated that they were unaware of a social protection program they might qualify for, while 31.2% had never thought of accessing a social protection program. Eighty-two percent (82.8%) of participants accessed the Zakat Chamber; the main social protection program, while 69.8% of participants received support as Zakat, while 19.8% of them received financial support[14].

13 Socio-Economic Profiling of People Living with HIV and Mapping of Social Protection Systems in Sudan, UNDP 2016

14 Ibid.

The profile of PLHIV that is described in the above study indicates the importance of working to develop HIV-sensitive social protection programs to address the economic determinants of the HIV/AIDS epidemic. It also highlights the need to address perceived and actual stigma and discrimination within the current social protection system, to expand and make it genuinely accessible (i.e. physically and socially) to PLHIV (particularly for the most vulnerable and needy individuals).

Overview of the relevant legal environment and laws in Sudan:

This section includes an overview of Sudanese laws, regulations and policies that protect and challenge the rights of People Living with HIV (PLHIV) and Key Populations, particularly sex workers and MSM. This includes looking at health laws as well as more general laws, for example, the Interim National Constitution of Sudan (2005), the National Public Health Act (2008), Draft Law on HIV/AIDS (2007), the Criminal Act (1991), and the Labour Act 1997.

The Interim National Constitution of the Republic of Sudan (2005) is the highest law of the land. It includes provisional articles that protect the dignity and rights of all Sudanese people and states that the state shall promote public health and guarantee equal access and free primary health care to all citizens (Article 19). The "Bill of Rights" is an integral part of the Constitution, which supports the rights of all Sudanese citizens. This therefore includes the rights of People Living with HIV and Key Populations. For example, Articles 27 to 48 of the Constitution emphasizes the *right to life and human dignity, personal liberty, sanctity from slavery and forced labour, equality before the law, the rights of women and children, sanctity from torture, the right to a fair trial, the right to litigation, and restrictions on use of the death penalty.* The Interim Constitution also includes *the right to privacy, freedom of religion and worship, freedom of expression and media, freedom of assembly and association, the right to vote, freedom of movement and residence and the right to own property*. Further, the Constitution *protects the right to education, the rights of persons with special needs and the elderly, access to public health care, ethnic and cultural communities, and the sanctity of rights and freedoms*[15]. It should however be noted, that in the current unfolding and unpredictable environment in Sudan, it remains to be seen, to what extent the above Constitutional rights will be respected by the state.

15 Redress and Faculty of Law-University of Khartoum, "*The Constitutional Protection of Human Rights in Sudan: Challenges and future perspective*", January 2014

In addition to the Interim Constitution (2005), a Draft law on HIV/AIDS was developed in Sudan in 2007, that includes a proposed Bill on the Rights of People living with HIV. However, this Law has not yet been endorsed. Therefore, the National Public Health Act (2008) is the main law that governs health policies and interventions for all diseases, including HIV and AIDS. In this regard, HIV is not included in the list of communicable diseases that is part of the National Public Health Act. However, HIV is often wrongly treated as a communicable disease by authorities, resulting in patients having to undergo mandatory HIV testing prior to surgical operations, to support medical fitness tests for certain jobs, and is cited as the reason for conducting HIV tests on immigrants from certain countries, before they are issued with a work permit.

Laws affecting Key Populations at risk of HIV

The Criminal Act of 1991, forbids and criminalizes any sexual acts and related activities (e.g. "seduction") outside wedlock. Article 146 of the Criminal Act of 1991 explains in detail what constitutes 'Zina' i.e. sexual intercourse outside wedlock. According to Article 146, punishment varies depending on the marital status of the person who has committed the crime. If an offender is married (Mohsan), it can mean capital punishment by stoning. If an offender was unmarried at the time of the crime, the punishment is flogging one hundred times[16].

In Sudan, prostitution (sex work) and men who have sex with men are two of Key Populations, most vulnerable to HIV infection. Both sex work (prostitution) and MSM are criminalized offences, according to the Criminal Act of 1991. For example, penalties for practicing prostitution are whipping, not exceeding 100 lashes, or imprisonment for a term not exceeding three years. Penalties for running a place of prostitution or renting premises or allowing the use of premises, knowing that it is to be used as a place of prostitution, are whipping, not exceeding 100 lashes, and imprisonment for a term not exceeding five years, and an order may be made for the closing or forfeiture of the premises (Article 154)

Penalties for seducing a person for prostitution are whipping, not exceeding 100 lashes, or imprisonment for a term not exceeding five years. If the victim is a minor or of unsound mind, or if prostitution is

intended to be committed outside Sudan, the offender shall be punished with whipping, not exceeding 100 lashes, and with imprisonment for a term not exceeding seven years (Article 155).

Article 148 of the Criminal Act also makes homosexuality illegal, with punishment applying to both men and women who engage in same-sex sexual activities. Punishments for sodomy range from lashing or imprisonment to the death penalty, if convicted of sodomy three times.

The criminalization of these behaviors' makes sex workers and men who have sex with men, particularly vulnerable to HIV. Criminalising sex work and men who have sex with men also presents challenges in terms of them accessing services, that include essential HIV health services.

The Criminal Act of 1991 also includes laws to address rape, but does not address domestic violence or marital rape. According to the original Criminal Act (1991) rape was defined as sexual intercourse, in terms of zina and adulterly. This made it very difficult for women to pursue cases of rape – sex that was not consensual – in court. To address this, in 2015, the Criminal Act was amended, and the amendment separated crimes of rape and adultery (Zina). The new definition of a rape offence in Article 149 of the Criminal Act states: *'There shall be deemed to commit the offence of rape, whoever makes sexual contact by way of penetrating a sexual organ or any object or part of the body into the victim's vagina or anus by way of using force, intimidation, or coercion by fear of the use of violence, detention, psychological persecution, temptation, or abuse of power against the person or another person, or when the crime is committed against a person incapable of expressing consent because of natural causes or luring-related or related to age'.*

Women's groups viewed the Criminal Act Amendment in 2015 as a considerable achievement. However, many women including sex workers who experience sexual violence and rape remain reluctant to initiate criminal cases, due to negative attitudes of the police, and as rape and sexual crimes remain closely associated with shame and disgrace.

In addition, a lack of clarity about the age at which a person can legally consent to sex without it being considered a crime of statutory rape under Article 149 remains unclear. This is because it is unclear whether the legal age of consent is determined by the Criminal Act of 1991 or the Child Act of 2010. The

definition of an adult under the Criminal Act of 1991 refers to puberty, while the Child Act of 2010 defines a child as any person under 18 years.

The Criminal Act of 1991 amended in 2015 also criminalized sexual harassment. Article 151 on Gross Indecency and Sexual Harassment states: *'There shall be deemed to commit the offence of sexual harassment whoever commits an act or speaks or behaves in a way that causes seduction or temptation for another person to engage in illegal sex, or to commit indecent or inappropriate behaviour of a sexual nature that psychologically harms the victim or makes the victim feel unsafe, shall be punished with imprisonment for a term not exceeding three years and whipping'*

Lastly, Article 152 of the Criminal Act of 1991 addresses 'Indecent and Immoral Acts'. The Article states: *'Anyone who commits, in a public place, an act, conducts an indecent manner, or a manner contrary to public morality, or wears indecent or immoral clothes, which cause annoyance to public feelings, shall be punished, with whipping, not exceeding forty lashes and/or fine. The act shall be deemed contrary to public morality, if it is so considered in the religion of the doer, or the customs of the country where the act occurs'.*

However, the vagueness of this offence, which is so broadly worded, continues to cause significant challenges for key populations and women. As a result, the Act is often misused and abused by the Police to intimidate women and Key Populations, who under this Act, can be detained or face charges of indecent dressing.

Knowledge of Key Populations and People Living with HIV about the legal system

Key informant and other interviews revealed that Key Populations (KPs) and PLHIV generally have minimal knowledge about human rights and protective laws. Some respondents were completely unaware of laws that could help protect them. Therefore, even where there are laws to protect the rights of Key Populations (KPs), such laws are rarely implemented by service providers.

The Sudanese People Living with HIV Care Association (SPCA) have conducted training on human rights for PLHIV to raise awareness about their rights. However, high levels of stigma, self-stigma and a lack of trust in the Sudanese legal system usually prevent PLHIV and KP from claiming their rights. The responses below from PLHIV and MSM highlight this.

"There are no protective laws and even if there are laws they are not implemented. The "regular" law would suffice if there was no discrimination. I know a woman living with HIV who was denied health care during birth, the doctor refused to assist her when she came to Khartoum to deliver her second baby. There are some documented discrimination cases but nothing happened, because laws are not implemented.

I also know someone [with HIV] who had a traffic accident and was detained but not allowed treatment, for unknown reasons. He could sue them, but nothing will happen. People are afraid to claim their rights because the stigma against them will increase" PLHIV Interview, 2019

Legal System Experiences of Key Populations and People Living with HIV

In Sudan, stigma towards sex workers and MSM is widespread among community members and law enforcers. Key populations report being discriminated against while in custody. For reasons shared above, such groups typically feel that they cannot report such incidents and that they are unlikely to be believed or taken seriously.

"We always face discrimination by the police and courts. When we try to report harassment by police officers, they do not listen and just say: 'Get out! You are no more than a prostitute'"
KP Interview, 2019

Key respondents also raised concerns about the Criminal Act (1991), highlighting that the text of the law is very vague. As a result, the interpretation of the Act is too dependent on the individual officer or judge concerned. In many instances, it appeared that the Act is used by police officers to harass KPs, with reports of sexual abuse at the hands of police officers.

When I was arrested by the Public Order Police, they threatened me either to have sex with them or go with them to the police station to open a case. There were four police officers and they had sex with me without condoms
KP Interview, 2019

“The police officers and arrested persons rape us, without condoms!”
KP Interview, 2019

"After we get released, they [Police Officers] take our phone numbers and call us asking for money or for sex, otherwise they will come and arrest us again” KP Interview, 2019

“Female sex workers and MSM are charged with feminine dressing, or improper dressing, or acts [of indecency] instead of adultery or sodomy per se, due to lack of evidence or due to the vagueness of the Public Order Act that is open to different interpretations by the police.” KP Interview, 2019

As outlined above, according to Article 148 of the Criminal Act (1991), evidence of adultery is the presence of four eye witnesses. In practice, however, if the police find a condom, or a man and woman going into a rented apartment, this can be considered evidence for “attempted adultery”. The same applies to sodomy, where the presence of four eye witness is considered “proof” of the act. However, often police officers verbally harass MSM by calling them gay just from their clothing. KPs are also often subjected to unauthorized phone searches and mandatory HIV tests, as outlined in testimonials below.

“If you are carrying a condom the police will start a criminal case against you, of attempted adultery.” KP Interview, 2019

“One day I was walking down Nile Street wearing a jacket and a white pair of shoes. The police officer arrested me for being gay. I asked how he could prove that I am gay and he replied ‘because you are wearing white shoes’. Usually when we get arrested by the police, they force us to do an HIV screening test" KP Interview, 2019

According to key informants, capital punishment for sodomy is (almost) unheard of due to the challenges of proving such incidents. Consequently, accusations and cases of sodomy very rarely reach the Courts and usually end up being resolved at police stations.

All of the above examples highlight the immense challenges faced when trying to estimate the scale and impact of HIV related stigma and discrimination in Sudan, i.e. the numbers involved and the different interpretations of relevant laws, at all levels. For these reasons, combined with the extreme sensitivity of the issues at stake, Key Populations and PLHIV face huge risks when trying to access HIV services. Due to the lack of a Complaints Response Mechanism (CRM) there is also no system in place to gather credible evidence or related statistics to help address this issue.

"Sodomy crime or the death sentence in Article 148 (Criminal Act 1991) has not yet been implemented in Sudan. However, it is used as a bullying or threatening mechanism. We conducted interviews with a Legal Aid agency, which mentioned that there were approximately 28 such cases countrywide each month. However, most of the cases are closed at Police Stations, because the conditions and evidence necessary to prove sodomy are very tough to satisfy, i.e. four eye- witnesses need to be present at the time of an incident. In recent years, only five cases have gone to court. Most MSM convicted receive lashes, are verbally or physically abused before a sodomy case is established and then it is defined as a Public Order crime" KP Interview, 2019

The problematic Application of Laws

Key informants indicated that the legislative framework in Sudan, ranging from the Interim Constitution (2005) to other laws, generally support the rights of people living with HIV. The challenge is how the law is interpreted and implemented on the ground that is problematic. This includes how abuses are documented and reported. Given that most PLHIV and KPs are among the most marginalized members of society, and heavily burdened by stigma, it is recommended that Sudan scale up programmes to support KP and PLHIV to 'Know their Rights' and put in place a Complaints Response Mechanisms (CRM) to document and support the rights of Key Populations in Sudan.

"Generally speaking there are no laws that discriminate against PLHIV per se. For example, if a PLHIV needs an emergency operation, there are no laws that prevent the PLHIV from getting health services. However, what we find is that the hospital

manipulates the situation and refuses to treat a PLHIV, or puts the PLHIV at the end of the list for services. Therefore, it is the application of the law that is problematic" Key Informant Interview, 2019

The Draft law on HIV/AIDS (2007) provides and mandates for the provision of legal protection for people living with HIV. Important as this is, some stakeholders are still hesitant about the importance of the law as outlined in responses below, raising questions about whether laws on their own can make a difference to the lives of PLHIV:

"It is important that Sudan ratify the Arab Convention, as it will provide a legal basis for the provision of services and to address stigma. There is a draft HIV Law (2007) that addresses the protection of PLHIV, however, further modifications of the law include criminalization of intentional HIV transmission".

Key Informant Interview, 2019

Discrimination against PLHIV in work environments, including getting fired from a job if it is discovered that an individual has HIV, is common, and relates closely to the vague description of "medical fitness" under the National Public Health Act (discussed above), and the Labour Act (1997). Article 22 of the Labour Act states that *'prior to employment, young persons shall undergo a full medical examination'* and that '*government hospital doctors shall perform the necessary examination and issue the necessary medical certificates'*. In this regard, key informants recommended that it would be helpful if the description of "medical fitness" in the law, was clarified.

Some laws affect PLHIV, such as when they state "medically fit" in public health law and work [employment] law. The interpretation of whether the PLHIV is medically fit or not is confusing. Does being HIV positive affect medical fitness? i.e. as there is no clear definition for being medically fit under the law. This fuels confusion in the law's application and fuels discrimination in some jobs" Key Informant Interview, 2019

Weak coordination and HIV awareness among Senior Leaders of the security forces and other law enforcement entities, was another critical issue raised during interviews, that needs to be addressed. For example, one key informant referred to the Ministry of Health efforts to sensitize security forces about HIV and related outreach activities, particularly at the beginning of projects. The challenge is when there are changes in police leadership, this often results in project teams - including services providers – being at risk of being harassed and detained. Interviewees shared examples of two States that have experienced related challenges: Kassala and Kordofan. Kordofan became significantly challenging and KPs experienced credible threats related to confidentiality when there were changes in police leadership. Consequently, KPs emphasized the importance of, and strongly recommended sustaining awareness-raising sessions with security forces and their leadership, to ensure legal protection for KP and different service providers on the ground.

Lack of a clear legal pathway for legal complaints and of mechanisms to resolve them

It is essential that effective, clear trajectories and pathways for reporting, documenting and solving complaints relating to the different violations experienced by PLHIV and key populations are established as soon as possible. Key Populations and PLHIV require professional support to help ensure the effective and quality implementation to report complaints, including in cases where key populations are denied health or other services they have the right to receive., due to illegal discrimination. Clear reporting and filing of complaints, through effective complaints mechanisms, that support the rights of PLHIV and KP, would also help increase the uptake of HIV services by KPs and PLHIV, and improve their adherence to treatment. This would indirectly benefit everyone in Sudan.

In Sudan, the Independent Commission on Human Rights is the main body responsible for receiving complaints relating to the violation of human rights, and for communicating and coordinating these complaints with the concerned Ministries. However, it is clear from the testimonies of participants interviewed for this study, that Complaints and Reporting Mechanisms (CRM) need to be strengthened and expanded, to ensure that effective support structures are in place to address the human rights abuses currently being experienced by Key Populations and PLHIV in healthcare and other settings e.g. in the security sector by police, courts and judges.

At health facility level there are also a lack of mechanisms to enforce relevant laws, including Medical Ethics Bylaws. For example, when the confidentiality of a particular patient is breached, there is no

complaints reporting mechanism in place to report this. This is an untenable situation, which will only deepen and exacerbate the vulnerability of key populations to HIV. At the Health Facility Level, a Complaints and Reporting Mechanism (CRM) is therefore recommended to be put in place by the MOH.

"It is also not clear which entity is responsible for complaints, when there is a denial of services. The denial of services is not honest, but usually the health care providers concerned try to make excuses. The high turnover among medical cadres and the continuous brain drain also weaken awareness raising efforts". Key Informant Interview, 2019

Some interviewees commented that as a result of not having an effective Complaints Response Mechanism (CRM), some individuals among key populations try to navigate the system and communicate informally with senior officials or law enforcement officers, for protection. Others said that the denial of different services is usually addressed or solved through "back-door" or "informal" mediations, but that there should be formal mechanisms, channels and policies in place, to use to address these challenges and abuses.

Conclusion

All the personal testimonies, challenges and experiences outlined above demonstrate that there remains a long way to go to help ensure that the safety, human rights and legal rights of key populations and PLHIV in Sudan are respected and honoured.

Concrete progress on related issues, including effective ways to tackle widespread stigma, discrimination and their implications, is urgently needed at all levels.

This is especially true of the interpretation and implementation of safeguards across different facilities (health, police/ safety, local administrations and the judiciary etc.) as well as at the community level. With effective oversight, such measures would significantly lessen the multiple vulnerabilities faced by key populations and PLHIV in Sudan, and give major cause for hope and optimism moving forward.

Recommendations

The recommendations listed below will help strengthen the Legal Environment to support the rights of PLHIV and KPs in Sudan. It is hoped that they will be incorporated into Sudan's next HIV National Strategic Plan (2019-2024) and Sudan's next Concept Note and funding proposal to the Global Fund.

1. Ensure that all existing human rights commitments outlined in the Interim Constitution (2005) are guaranteed and enforced.
2. Ensure that Sudan does not enact any law that explicitly criminalizes HIV transmission, exposure or non-disclosure of HIV status, which are counter-productive.
3. Abolish all mandatory HIV-related testing
4. Review and repeal all punitive laws in Sudan, to outlaw all forms of discrimination and violence directed against PLHIV and KPs most vulnerable to HIV, or perceived to be HIV-positive. In Sudan this would include reviewing the following laws:
    i. Revise the Criminal Act (1991) to decriminalize private and consensual adult sexual behaviours, including same-sex sexual acts and voluntary sex work.
    ii. Review the *Draft Special Law on HIV and AIDS (2007)* to make sure it does not criminalise the 'intentional' spread of HIV, which evidence from other countries demonstrates is likely to prevent many people from finding out their HIV status, and thus fuel the spread of HIV in Sudan.
    iii. Review the National *Public Health Act (2008)* to ensure and make clear that:
        a. HIV is not a communicable disease
        b. Review and revise the *Public Health Act* to ensure that PLHIV are not categorized as 'medically unfit' to work.
    iv. Review the Labour Act (1997) to ensure that mandatory HIV testing is not included in tests to issue medical certificates (Article 22).
    v. Sudan to ratify the *Arab Convention on the Prevention of HIV and AIDS and the Protection of rights of People Living with HIV* (2012), to help reduce stigma associated with the disease and support PLHIV to access health services.
5. Strengthen HIV-related legal services to facilitate access to justice and redress for PLHIV and AIDS and KPs, in cases of HIV-related discrimination or other legal matters. These services may include legal information and referrals; legal advice and representation; alternative/community forms of dispute resolution; and engaging religious or traditional legal leaders/systems with a view to resolving disputes or changing traditional norms/processes (i.e. village courts).

6. Put in place Complaints Response Mechanisms (CRMs) to document and support the rights of PLHIV and KPs. Complaints Response Mechanisms (CRMs) would help document cases and build a body of evidence, and should have a mechanism to support KPs in seeking redress to claim their rights. These programmes may form part of other HIV services (e.g. health care provision).
7. Enforce a legal framework that ensures social protection for all children living with and affected by HIV and AIDS. Laws must protect guardianship, property and inheritance rights, and access to age-appropriate, comprehensive sex education, health and reproductive care services.
8. Support HIV Stigma Reduction Programmes for the following key target groups:
    i. Support training for all health care workers/providers on human rights and medical ethics related to HIV, to reduce stigmatizing attitudes in health care settings and to provide health care providers with the skills and tools necessary to ensure patients' rights to informed consent, confidentiality, treatment and non-discrimination. This training should also ensure that health care providers know about their own human rights to health (HIV prevention and treatment, universal precautions) and to non- discrimination in the context of HIV.
    ii. Sensitize lawmakers and law enforcement agents about HIV, to help inform and sensitize those who make the laws (parliamentarians) and those who enforce them (Ministers of the Interior and Justice, the police (including their leadership), security personnel, prosecutors, judges, lawyers) about the important role of the law in the response to HIV. This should include highlighting human rights abuses affecting people living with HIV and KPs in Sudan, and the implications for the development, implementation and enforcement of national law by the police and the courts. This could also include developing a Guide for Legal Professionals on how best to deal with violations against PLHIV and Key Populations (KPs)
    iii. Support Community Stigma Reduction Programmes. This could include supporting community dialogues, community media and mass media awareness-raising campaigns (e.g. TV, radio, print, Internet), community mobilization and education initiatives.
    iv. Support 'Knowing Your Rights' training and awareness raising for KP and PLHIV, as this assessment found that KPs in Sudan have limited knowledge of their rights.
9. Work with the guardians of customary and religious law to promote traditional and religious practices that promote the rights of PLHIV and KPs, and respect/accept diversity and the protection of privacy.
10. Reduce harmful gender norms and gender-based violence and increase women and girls legal, social and economic empowerment. This may be done, for example, by supporting programmes to promote the rights of women and girls in the context of HIV e.g. Community Conversations. These programmes

should address the intersections between gender inequality, gender-based violence and vulnerability to HIV infection. Programmes should address women's and girls' inequality in sexuality and reproduction, access to health services, educational and economic opportunity, inheritance, property ownership, marriage, divorce and custody rights as well as addressing sexual and other violence. Supporting life skills programmes to reduce gender inequality and gender-based violence are also recommended. Lawmakers and law enforcers should also improve domestic violence laws and their implementation and enforcement.

11. In matters relating to HIV and the law, offer the same standard of protection to migrants, visitors and non-citizen residents as those extended to citizens. Restrictions that prohibit PLHIV from entering Sudan and/ or regulations that mandate HIV tests for foreigners in Sudan should be repealed.

Annexes

Annex 1: Agenda National Dialogue, 21st - 22nd August, Khartoum

Annex 2: National Dialogue Participants List

Annex 3: National Dialogue Report

Annex 4: Key Informant Interview (KII) User Guide

Annex 5: Interview Guide for People Living with HIV (PLHIV)

Annex 6: Interview Guide for Key Populations (KPs)

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