GLOBAL AIDS RESPONSE PROGRESS REPORT

SOUTH SUDAN
March 2012

Reporting Period: 2010-2011

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
ARV	Anti-retrviral
BCC	Behaviour Change Communication
BTS	Blood Transfusion Services
CBOs	Community Based Organizations
CDC	Centers for Diseases Control and Prevention
CPA	Comprehensive Peace Agreement
CSO	Civil Society Organization
DFID	Department for International Development
EU	European Union
FBO	Faith Based Organization
FHI	Family Health International
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GOSS	Government of South Sudan
HIV	Human Immunodeficiency Virus
HCT	Counselling and Testing
IDPs	Internally Displaced Persons
IDUs	Injecting Drug Users
IEC	Information, Education and Communication
M&E	Monitoring and Evaluation
MDTF	Multi Donor Trust Fund
MOH	Ministry of Health
MSM	Men who Have sex with Men
NGO	Non-governmental Organization
NSF	National Strategic Plan
OVCs	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PHCC	Primary Health Care Center
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
SPLM/A	Sudan Peoples Liberation Movement/Army
SSHASF	South Sudan HIV/AIDS Strategic Framework
SSNeP+	South Sudan Network of People Living with HIV
STIs	Sexually Transmitted Infections(s)
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WAD	World AIDS Day
WHO	World Health Organization

1 STATUS AT A GLANCE

1.1 Introduction

South Sudan has only just become an independent country on July 9th, 2011 following a successful referendum to secede from the Republic of Sudan held on January 2011 and therefore was not one of the 189 countries that adopted the United Nations General Assembly Special Session on HIV and AIDS (UNGASS) Declaration of Commitment in 2001. The Declaration reflects global consensus on a comprehensive framework to achieve the Millennium Development target of halting and beginning to reverse the spread of the HIV and AIDS epidemic by 2015. Under the terms of the Declaration, success in national HIV and AIDS responses is measured by the achievement of concrete, time-bound targets that call for careful monitoring of progress in implementing commitments. In this respect, the United Nations (UN) Member countries who signed the Declaration committed themselves to regularly report in the progress made on their country's response to the AIDS epidemic. The Joint United Nations Programme on HIV and AIDS, here after referred to as the UNAIDS Secretariat, was assigned the responsibility of developing the reporting process, accepting reports from Member countries, and preparing a regular report for the General Assembly.

Against this background, countries are expected to submit UNGASS Country Progress Reports to the UNAIDS Secretariat every two years. The first UNGASS Country Progress report for Sudan that included a section covering Southern Sudan was submitted in 2010, covering the period 2008 to 2009. This 2012 Country Progress Report is the first after South Sudan became independent on July 9, 2011. In line with the new Global AIDS Reporting Guidelines for 2012 (UNAIDS, 2012), the report is designed to highlight progress made since the last UNGASS report (and thus focuses on the period between January 2010 and December 2011), identify challenges and constraints, and recommend actions to accelerate achievement of the targets

1.2 The 2012 GARP Report-Writing Process

To undertake the development of this report, a consultant was engaged by the UN Joint Programme on AIDS (UNAIDS) and given the following Terms of Reference:

- To review previous UNGASS reports
- To collect data for the National Composite Policy Index
- To analyse all collected data
- To produce a narrative report
- To facilitate a stakeholder data verification and consensus workshop

A Team made up of representatives from the South Sudan AIDs Commission, UNAIDS and Directorate of HIV/AIDS in the ministry of health was convened to guide the report-writing process, while the UNAIDS office for South Sudan coordinated the overall report- writing process.

The process began with a presentation of a work-plan/activity schedule by the consultant to the UNAIDS office and the Technical Support Facility (TSF) office for the East Africa region. The presentation mainly focused on the proposed approach to the process, particularly the methods of data collection (document and literature review; key informant interviews, and stakeholder group meetings), as well as on agreeing on the work-plan.

The document and literature review was done concurrently with the data collection over a period of three weeks. Thereafter the consultant synthesized the data and wrote the different sections of the report. A data verification workshop was organized/conducted on March 26 to validate the different types of data the consultant and the National Programme Officer at UNAIDs had collected. The workshop was attended by a wide range of representatives from the different partners in the national response (see list in Annex A)—enabled partners to review data from each section, and to provide feedback and any outstanding or additional information. After the workshop the consultant incorporated all comments and additional data into a final draft which was submitted to UNAIDS for approval.

1.3 **Status of the Epidemic**

The HIV and AIDS epidemic continues to be a major challange both to public health and socio-economic development in The Republic South Sudan and if left unmonitored, it will threaten, or even reverse, some of the gains to be made in the new born nation.South Sudan shares borders with countries reported to have high rates of HIV/AIDS:-Uganda, Kenya, Ethiopia, Democratic Republic of Congo, Central African Republic. Accordinging to the 2008 Sudan population census, the General Population is estimated to be 8. 26 Million (Census 2008) and expected to be more than 10 Million by 2011.

HIV prevalence is estimated to be 3.0% (ANC Report 2009, MoH) and 4.4% among the military according to another survey conducted on SPLA in 2010. There is no HIV prevalence nor prevalence data available on Most at risk groups e.g. CSW, prisons etc. Some assessments have been conducted and plans are underway to conduct a survey on MARPS. A Behavioural Surveillance Survey conducted in Juba in 2007 found that casual sex partners were most common among unmarried men (19%) and those under the age of 25 (16%), while few women reported a casual sex partner in the past year (2%), and only two women in the survey reported ever having exchanged sex for money.

South Sudan has a low generalized epidemic. The 2009 ANC surveillance report on pregnant women aged between 15 and 45 years attending their first antenatal clinic services in 24 sites found the HIV prevalence of 3.0 percent. This figure became the official Ministry of Health estimate. HIV prevalence varied among different age groups ranging from 2.3% among the 15 – 19 years, 3.34 in the 20 – 24 age group and 3.0% overall.

The UNAIDS EPP/Spectrum tool estimates the number of people 15 years and above in need of ART in South Sudan to be approximately 49,000 and the number of mothers needing ART estimated to be 8300 and children (0 – 14 year) needing ART were estimated to be 11,000 in 2011 with 95% confidence intervals of [34,000 – 70,000], [5600 – 70,000] and [7300 – 15,000]. A total of 171,391 adults received testing and counselling in 99 testing and counselling sites in the Republic of South Sudan in 2010, representing only 4.5% of the population. Also 31,000 pregnant women received HTC in a total of 55 sites in the same period and 3442 people were on ART in 19 ART sites and 13,471 people living with HIV were on care/prophylaxis in 2011.

A nationally representative population-based biomedical and behavioural survey was conducted by the MOH, the South Sudan AIDS Commission and the South Sudan Census Office (2010). The results from this survey have been finalized but not yet released for public use. Unfortunately, blood samples collected from respondents who consented were not analyzed for syphilis and HIV.

1.4 Policy and Programme Overview

South Sudan has embraced the "Three-Ones" principle: the South Sudan AIDS Commission (SSAC) - (*One national coordinating body)* was established in 2006; the South Sudan national monitoring and evaluation framework (*One agreed national monitoring and evaluation system)* was put in place in 2008; and the first National South Sudan HIV and AIDS Strategic Framework (SSHASF) *(One agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners)*, covered the period 2008-2012. Following an extensive review, a costed action plan was produced in 2009 covering the period 2010-2012.

This supportive policy and legislative environment reflects the consistent commitment of the political leadership on HIV and AIDS which has prevailed since the epidemic was declared a national emergency. The top political leadership, for example, has consistently spoken out and supported the national HIV and AIDS response at the highest level.

There has been significant progress in developing and launching several national prevention, treatment and support services. For example, the Prevention-of- Mother-to-Child Transmission of HIV (PMTCT) was rolled out in 2010; ART services were implemented and rolled-out in the same year; and HIV testing was further enhanced through an increase in voluntary counselling and testing centres throughout the country. In addition, Home-Based Care provide important care and support for those infected and affected by the epidemic.

1.5 Core Indicators for the Global AIDS Response Progress Reporting

In keeping with the mandates of the UNGASS Declaration of Commitment the UNAIDS Secretariat collaborated with other stakeholders in 2002 to develop a series of core indicators to measure progress in implementing the Declaration. These indicators are divided into seven targets:

Target 1: Halve sexual transmission of HIV by 2015

Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015

Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS maternal deaths

Target 4: Have 15 million people living with HIV on Antiretrovial treatment by 2015

Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015

Target 6: Reach a significant level annual global expenditure (between $22billion & $24 billion in low and middle income countries

Target 7: Critical enablers and synergies with development sectors

The indicators themselves are categorized into three distinct levels:

National commitment and action indicators: These focus on policy and the strategic and financial inputs for the national HIV and AIDS response. They also capture programme outputs, coverage and outcomes.
National knowledge and behaviour indicators: These cover a range of specific knowledge and behavioural outcomes; and
Impact indicators: These indicators focus on the extent to which national programme activities have succeeded in reducing HIV infection and its associated morbidity and mortality.

The indicator **Table 1** below shows, to the extent possible, a summary of South Sudan's levels in the various indicators since the 3rd UNGASS report in 2010. Further analysis of the levels and trends is provided later in Section 3 and, where deemed appropriate, in other parts of the report.

Table 1: Overview of Core Indicators for the Reporting Period 2012

Core GARP Indicators	Indicator value	Sourxe/Comments
Financial Inputs for the National Response		
1.Domestic and international spending by categories and financing sources (US$ Million)		*Comment:* Data for the reporting period 2010-2011 were not available
Policy Development and Implementation Status		
2. National composite Index	Not calculated	
National programmes		
3. % of donated blood units screened for HIV in a quality assured manner	100%	*Source*: MOH – HIV/AIDS Directorate
4. % of adults and children with advanced HIV infection receiving antiretroviral therapy	7%	*Source*: MOH - HIV/AIDS Directorate
5. % of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	88%	*Source: MOH – HIV/AIDS Directorate* *Comment*: Data include women attending ,ANC, maternity and post-natal
6. % of estimated HIV-positive incident TB cases that received treatment for TB and HIV	No data	*Comment*: Although the TB monitoring system is well developed, it still requires integration with the HIV monitoring system in order to accurately assess referrals for HIV treatment
7. % of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	41%	*Source*: MOH- HIV/AIDS Directorate
8. % of most-at-risk populations that have received an HIV test in the last 12 months and who know their results	No data	*Comment*. No data. A Mapping exercise is currently underway to define and estimate most-at-risk populations
9. % of most-at-risk populations reached with HIV prevention programmes (PMTCT, VCT/RHT, and IPT)	No data	See comment under Indicator 8 above
10. % of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	No data	*Comment* : No OVC data
11. % of schools that provided life skills-based HIV education in the last academic year	No data	Not all primary and secondary schools in the country have teachers that are trained in, teaching, life-skills-based education, which has HIV and AIDS as a major component
12. Current school attendance among orphans and among non- orphans aged 10-14	No data	See comments in 11
Knowledge and behaviour		
13. % of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention	11%	*Source: S*udan Household Health Survey 2010

14. % of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention	No data	See comment under Indicator 8 above
15. % of young women and men aged 15-24 who have had sexual intercourse before the age of 15	23.3% (women) 29% (men)	*Source:* Sudan Household Health Survey 2010
16. % of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	6.8% (women) & 27% (men)	*Source*: Sudan Household Health Survey 2010
17. % of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months reporting the use of a condom during last sexual intercourse	2.6% (women) & 7.4% (men)	*Source*: Sudan Household Health Survey 2010
18. % of female and male sex workers reporting the use of a condom with their most recent client	No data	See comment under Indicator 8 above
19. % of men reporting the use of a condom the last time they had anal sex with a male partner (MSM, aged 15 - 49 years)	No data	See comment under Indicator 8 above
20. % of injecting drug users reporting the use of a condom the last time they had sexual intercourse	No data	See comment under Indicator 8 above
21. % of injecting drug users reporting the use of sterile injecting equipment the last time they injected	No data	See comment under Indicator 8 above
Impact		
22. % of young women and men 15-24 years of age who are HIV infected	12.9%	*Source:* MOH – HIV/AIDS Directorate
23. % of most-at-risk populations who are HIV infected	No data	See comment under Indicator 8 above
24. % of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	65.6%	*Source*: WHO & MOH – HIV/AIDS Directorate
25. % of infants born to HIV infected mothers who are infected	30%	*Source:* 2010 UNGASS Report-

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2 OVERVIEW OF THE AIDS EPIDEMIC

2.1 Status of the AIDS Epidemic

In 2000, a survey of 500 adult samples in each of Tambura, Ezo and Yambio counties (all in Western Equatoria) found an HIV seroprevalence of 1.6% in Tambura, 2% in Ezo and 7.2% in Yambio (with a 3% prevalence in peri-urban areas and 8.7% in Yambio Town). Surveys in 2002 and 2003 in Yei (southern part of Central Equatoria) and Rumbek (Lakes) showed great differences in prevalence, with a prevalence of 2.7% in Yei County, 4.4% in Yei Town, but only 0.4% in Rumbek town As well, these surveys showed differences between villages close to the roads versus those further away from the roads with, as expected, higher prevalences in the villages closer to the roads

A 2007 analysis of HIV/AIDS in South Sudan undertaken by the U.S. Centres for Disease Control and Prevention (CDC) indicated that the epidemic is extremely heterogeneous – with high prevalence found in some areas and much lower prevalence likely in other areas (the report underscored the paucity of robust epidemiological and behavioural surveillance data). The report highlighted that the prevalence levels recently obtained in some areas from antenatal surveillance were "alarming," as they indicated that the epidemic was further advanced than previously thought. Although ANC data suggested the existence of a generalized epidemic in South Sudan, noting the many limitations of the unlinked anonymous ANC surveillance data collected since late 2005, the CDC utilized them to underscore wide variations among locales, with prevalence levels ranging from 1% in Leer (Northern Unity State) to 12% in Tambura (in the Southern state of Western Equatoria, along the Congolese border).

In 2008 UNAIDS estimated a national Sudan prevalence of 1.4% in the 15-49 age range, with 345,000 people living with HIV (320,000 adults and 25,000 children 15 years and less) However, no separate regional estimates were produced for urban/rural or northern/southern. Despite limited data, attempts have been made to estimate the HIV prevalence based on available ANC surveillance data in South Sudan.

Under the auspices of SSAC, the CDC carried out an ANC surveillance exercise in 2007, which estimated an overall adult prevalence of 3.7%. This was based on a sample of 4,710 women tested from ten different urban sites. As can be seen from **Table 2**, prevalence levels ranged from 0.8% to 11.5%, with no overlap in the confidence intervals between the lowest and the highest figures. So the aggregate 3.7% prevalence figure does not reflect the impression gained from the detailed data – that South Sudan has a heterogeneous epidemic.

Table 2: Prevalence of HIV among ANC respondent by site – 2007

Site Name	Number tested	Number HIV Positive (%)	95% Confidence Interval
Leer – MSF Holland	874	7 (0.8%)	0.3 – 1.6%
Cuiebet-DEA	107	1 (0.9%)	0.02 - 5.1%
Akobo PHCC	110	1 (0.9%	0.02 - 5.0%
Kajo Keji Hospital	1,045	17 (1.6%)	1.0 - 2.6%
Nimule Hospital-Merlin	492	11 (2.2%)	1.1 - 4.0%
St. Bakhita	792	21 (2.7%)	1.6 - 4.0%
Maridi-AAH	244	14 (5.7%)	3.2 - 9.4%
Boma Hospital-Merlin)	429	31 (7.2%)	5.0 - 10.1%
Pochalla PHCC	18	2 (11.1%)	*
Tambura Hospital/PHCC	599	69 (11.5%)	9.1 - 14.4%
Total	**4,710**	**174 (3.7%)**	**3.2-4.3%**

95% CI could not be calculated because the sample size was very small
Source: CDC ANC Surveillance Report (2007)

This analysis described South Sudan epidemic as heterogeneous – with focal areas of high prevalence in Western Equatoria, in border areas with countries with high prevalence and in areas of high concentration of military activities**.** However, it was also recognised that only five out of ten states of Southern Sudan were represented here. In addition, all these sites were located in towns, so rates in rural areas were not represented. As well, details of the individual populations surveyed are not available, and so it is difficult to come to conclusions to explain the differing prevalence levels seen at the different sites. It should also be evident that the numbers tested varied considerably between sites (with only 18 women being tested at Pochalla), making most of the confidence intervals wide and leaving room for varying interpretations of the data.

As well, it was noted that whereas the rates found in ANC and true prevalence rates in the community can vary substantially from place to place, these relationships have not been defined in South Sudan, so the true prevalence in the communities studied may be slightly higher or slightly lower than the levels found here. A number of factors that have been postulated for the differing prevalence rates include geography (closer to the Ugandan or Congolese borders), distance from the highways, urban versus rural, as well as proximity to zones of conflict.

The results of the second round of ANC surveillance carried out in 2009 have recently been released These were taken from a sample of 5,913 women from 24 sentinel sites in all ten states – 14 urban and 10 rural - and found an overall prevalence of 3.0%. However, as can be seen from **Table 3,** this 3% figure does not describe the wide variations in prevalence between sites.

Table 3: Prevalence of HIV among ANC respondent by site - 2009

Site Name (U- urban; R – rural)	Number tested	Number HIV Positive (%) 2009	95% Confidence Interval
Awiel Civic Hospital (U)	299	0 (0.0%)	---
Cuiebet PHCC (R)	300	1 (0.3%)	0 – 0.98%
Akobo PHCC (R)	169	1 (0.6%)	0 – 0.7%
Kuajok PHCC (U)	289	2 (0.7%)	0 – 1.6%
Renk Civic Hospital (R)	216	2 (0.9%)	0 – 2.2%
Torit Civic Hospital (U)	298	4 (1.3%)	.03 – 2.7%
Wau Teaching Hospital (U)	299	4 (1.3%)	.04 - 2.6%
Bentiu State Hospital (U)	296	4 (1.4%)	.04 - 2.7%
Rumbek PHCC (U)	300	5 (1.7%)	0.2 - 3.1%
Leer – PHCC (R)	135	3 (2.2%)	0 - 4.7%
Kajo Keji Civil Hospital (R)	264	6 (2.3%)	0.5 – 4.1%
Maridi PHCC (R)	250	6 (2.4%)	0.5 – 4.3%
Boma PHCC (R)	159	4 (2.5%)	.08 – 5.0%
Bor Civil Hospital (U)	300	8 (2.7%)	0.9 – 4.5%
Malakal Hospital(U)	265	8 (3.0%)	1.0 – 5.1%
St. Bakhitia PHCC (R)	255	8 (3.1%)	1.0 – 5.3%
Malakia PHCC (U)	140	5 (3.6%)	0.5 – 6.6%
Bam PHCC (U)	169	6 (3.6%)	0.8 – 6.3%
Nyakuron PHCC (U)	300	12 (4.0%)	1.8 – 6.2%
Nimule PHCC (R)	249	14 (5.6%)	2.8 – 8.5%
Rumbek State Hospital (U)	283	16 (5.7%)	1.0 – 8.3%
Juba Teaching Hospital (U)	299	18 (6.0%)	3.3 – 8.7%
Pochalla PHCC	---	----	
Tambura PHCC (R)	250	19 (7.6%)	4.3 – 10.9%

Yambio Hospital (U)	129	20 (15.5%)	9.3 – 21.8%
Total	**5,913**	**176 (3.0%)**	**2.6 – 3.4**

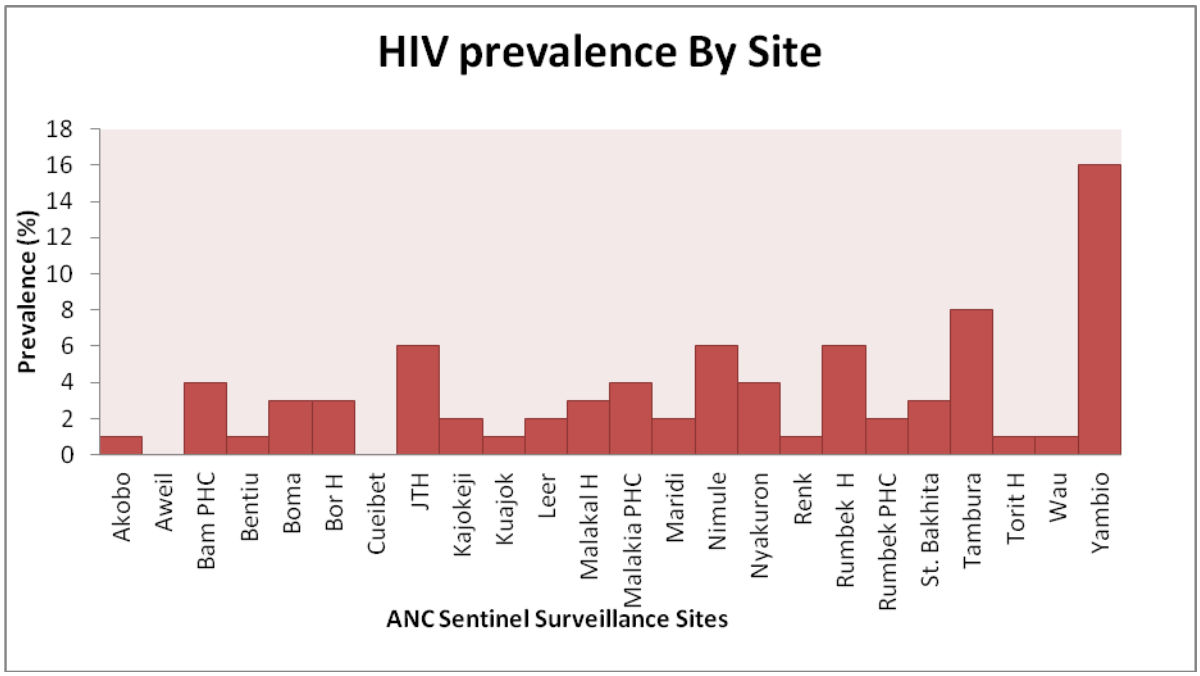
Source: Southern Sudan ANC Sentinel Surveillance Report, 2009

These results again show the marked heterogeneity of the epidemic, with significant differences between the sites of lowest and highest prevalence. The differences in prevalence between Rumbek PHCC (1.7%) and Rumbek State Hospital (5.7%) could perhaps be a sampling anomaly (the wide confidence intervals in both results do overlap), but the high prevalence levels in Juba (6%), Tambura (7.6%) and Yambio (15.5%) are of concern. .

2.2 Variations in HIV Prevalence

The 2009 ANC surveillance report revealed considerable variation in HIV prevalence across sites, States and population groups. The following subsections present some of these key variations in a descriptive format. That is, only the summary of the variations are presented; no attempt has been made to analyse the causality or behavioural modelling.

Figure 2.1: Prevalence of HIV among ANC respondents by site – 2009



Source: ANC Surverillance Report 2009

Table 4: HIV Prevalence by State South Sudan ANC Surveillance 2009

STATE (SITE)	Number of sites	Number tested	Number positive (%)	95% Confidence interval
Northern Bahr Ghazal (Aweil)	1	299	0 (0%)	---
Warrap (Kuajok)	1	289	2 (0.7%)	0 – 1.6
Western Bahr Ghazal (Wau**)**	1	299	4 (1.3%)	.04 – 2.6
Unity (Bentiu, Leer)	2	431	7 (1.6%)	0.4 – 2.8
Jonglei (Bor, Boma, Akobo)	3	628	13 (2.1%)	1.0 – 3.2
Lakes (Cuiebet, Rumbek x2)	3	883	22 (2.5%)	1.5 – 3.5
Upper Nile (Malakal, Bam, Malakia, Renk)	4	790	21 (2.7%)	1.5 – 3.8
East. Equatoria (Nimule, Torit)	2	547	18 (3.3%)	1.8 – 4.8
Central Equatoria (Juba, Nyakuron, St. Bakhita, Kajo Keji)	4	1118	44 (3.9%)	2.8 – 5.1
West. Equatoria (Yambio, Maridi, Tambura)	3	629	45 (7.2%)	5.1 – 9.2

Source: Southern Sudan ANC Sentinel Surveillance Report, 2009

These results demonstrate quite forcefully that in general the epidemic is worse in the southern part of the country and in Juba the capital city, with those states on the southern borders with Uganda and Democratic Republic of Congo having the highest HIV prevalence. In Eastern Equatoria, the prevalence in the border town of Nimule was 5.6% while in Torit further north it was only 1.3%. Yambio and Tambura in Western Equatoria had the highest prevalences in the country, and the prevalence in Western Equatoria (7.2%) would have been even higher had Maridi (2.5%) not been a part of survey. Conversely, the lowest prevalences are found in the more remote northwestern states – Northern and Western Bahr Ghazal and Warrap. Urban/rural differences seem to be of less importance than geographical location, for example, Nimule is a rural location with a high prevalence, but close to the Ugandan border, whereas Awiel and Kuajok are both urban, but located in a Northern low prevalence states, and Yambio (urban) and Tambura (rural) both are in Western Equatoria, where the prevalence is generally high.

An analysis of the trends between 2007 and 2009 is shown in **Table 5,** Again, there are striking differences between the sites, but one should be cautious drawing conclusions, given the range of confidence intervals and the underlying questions about sampling methodology.

Table 5: Change in antenatal prevalence between 2007 and 2009 by site

SITE	Prevalence 2007	Prevalence 2009	% change
Leer	0.8%	2.2%	+175%
Nimule	2.2%	5.6%	+154%
Tambura	7.6%	11.5%	+51%
Kajo Keiji	1.6%	2.3%	+44%
Bakhtia	2.7%	3.1%	+15%
Akobo	0.9%	0.6%	-33%
Cuiebet	0.9%	0.3%	-66%
Boma	7.2%	2.5%	-153%
Maridi	5.7%	2.4%	-173%

Variation by Age-groups

Table 6: the age specific HIV prevalence for the antenatal clinic clients in 2007, demonstrates that as would be expected, the highest prevalence levels were found in the 20-34 year population, although it is interesting that the highest levels are in the 20-24 year old group – in most countries with a generalised mature epidemic, the highest levels are found in the older women of reproductive age – the 30-35 year olds, which may imply a more recent arrival of HIV in the country. However, it can also be seen that the confidence intervals for the three groups 20-24, 25-29 and 30-34 largely overlap, so there may not be a significant difference in the prevalence levels between the different ages 20-34.

One factor that may explain this is the fact that more than 50% of South Sudanese women are sexually active by age 16. The 2010 Household survey found that a very low percentage of sexually active women use condoms or any other means of birth control, and that 90% of the women surveyed had given birth, implying that first pregnancies probably occur between the ages of 15 and 19, which is younger than in many other African countries.

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Table 6: Distribution of ANC Respondents By Age Group

Age Range	No. of Respondents	Percent	Cumulative Percent
15 – 19	1151	18.6	18.64
20 – 24	1905	30.9	49.49
25 – 29	1662	26.9	76.40
30 – 34	895	14.5	90.90
35 – 39	481	7.8	98.69
40 – 44	45	.7	99.42
45 – 49	34	.6	99.97
Missing System	2	.0	100.00
Total	**6175**	**100.0**	

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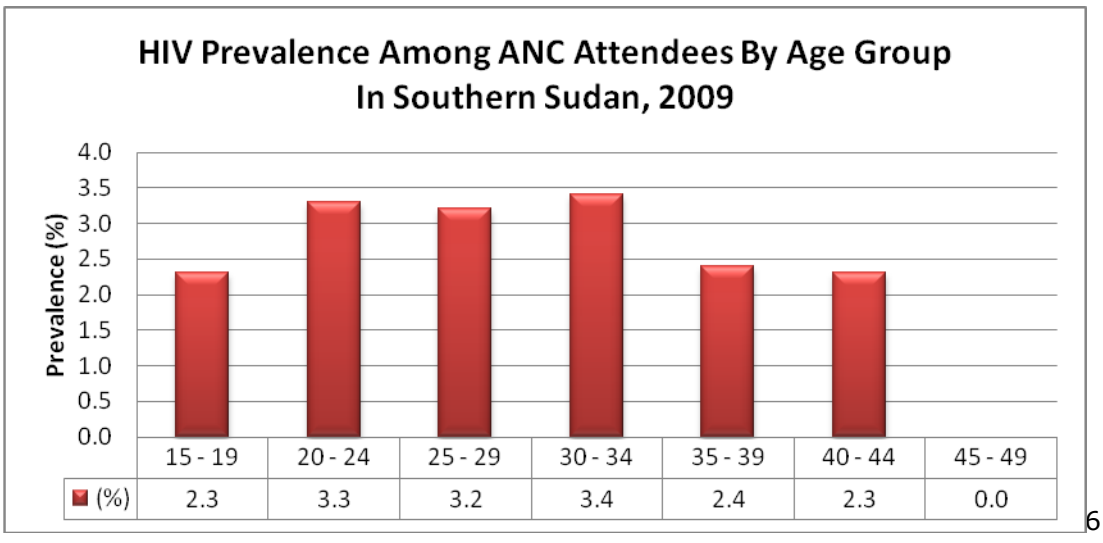
Figure **2.2** presents the age-specific prevalence for antenatal clinic clients in 2009. What is notable is that the prevalence in the 15-19 year olds has stabilized (changes not being significant), the higher levels seen in the 20-24 year group in 2007 are no longer seen, and the prevalence is essentially the same for all three age groups between 20 and 35 years, which would imply the continued maturation of the epidemic from the results seen in 2007 – with new incidence in the 15-19 group and a stable prevalence in the older groups (implying a continued incidence of new infections as well as mortality in those previously infected).

Figure 2.2: Age specific HIV prevalence for ANC respondents – 2009



Source: Southern Sudan ANC Sentinel Surveillance Report, 2009

Variation by Marital Status

Finally, **Table 7** shows the antenatal HIV prevalence by marital status. As can be seen, there is essentially no difference between the prevalence levels in women who are married, either in monogamous or polygamous marriages, and single women. One might be tempted to draw conclusions about the high prevalence (16.7%) in those who were widowed (husbands having died of HIV, or perhaps women turning to high-risk survival sex as a result of widowhood) but the small sample size does not give weight to these hypotheses.

Table 7: ANC HIV Prevalence by marital status - 2009

Marital Status	**Total tested**	**Number HIV positive (%)**	**95% Confidence Intervals**
Married monogamous	3580	107 (3.0%)	2.4 – 3.6
Married polygamous	2006	54 (2.7%)	2.0 – 3.4
Single	268	10 (3.7%)	1.5 – 6
Widowed	24	4 (16.7%)	1.8 – 3.2
Divorced/separated	29	1 (3.4%)	0 – 10
Missing	6	0	---
Total	**5913**	**176 (3.0%)**	**2.6 – 3.4**

Source: Southern Sudan ANC Sentinel Surveillance Report, 2009

There is anecdotal evidence suggesting that there could also be sub-epidemics among most-at-risk population groups in some of the major cities of Southern Sudan, particularly those bordering neighboring states, but no surveys are being undertaken at present to study these putative most-at-risk populations. The second Health Household Survey (SHHS II) to estimate HIV prevalence and other important behavioural indicators among the general population was carried out in 2010 (and some of its results are reported later in this report), but it did not examine any issues in most-at-risk populations.

2.3 HIV Incidence Estimates

The Sudan household survey conducted in 2010 for the first time included measurement of HIV prevalence as an objective for measuring the impact of HIV. HIV prevalence testing was, however not carried out on dried blood spot samples collected during the survey so it was not possible to systematically measure HIV prevalence in the general population in 2010. The EPP/Spectrum model estimates the number of new HIV infections in South Suda to be around 16,234 in 2011 and the incidence rate of 0.33.

2.4 Factors Influencing the Spread of HIV

The synthesis of the HIV situation in South Sudan has shown that a number of factors influence the patterns of HIV prevalence presented in the foregoing sections. These include, among others, engaging in multiple and concurrent sexual partnerships, adolescent and intergenerational sex, alcohol abuse, HIV and AIDS-related stigma and discrimination, as well as gender-based violence and sexual abuse

Multiple and Concurrent Sexual Partnerships coupled with low levels of condom use

Similar to the situation witnessed in most sub-Saharan African countries, Multiple and Concurrent Partnerships, (MCP), have been widely recognised as key drivers of HIV transmission in South Sudan. Concurrent partnerships are relationships whereby an individual has overlapping sexual relationships with more than one person. It can also be described as the overlap of one or more sexual partnerships for a period of one month or longer, in past three months, or in the past year or 12 months (Global Program on AIDS, 1996) . Multiple partnerships, on the other hand, are sequential or serial partnerships whereby an individual engages in a sexual relationship with only one partner, with no overlap in time with subsequent partners.

In the Household Health Survey 2010, 75% of the men who answered the question admitted to having two or more wives or other sexual partners, and 43.2% of the women said that their husbands had other wives. More than 27% of men had sex with more than one partner in the past 12 months, and of these, almost half had three or more partners. A report by UNICEF recorded on its fact sheet on HIV and AIDS in the Republic of South Sudan showed that casual sex partners were most common among unmarried men (19 percent) and those under the age of 25 (16 percent). Few women reported a casual sex in the past 12 months. Although the figures are low it is troubling, especially given the elevated risk that each of the members of any given group of sexual partners (sexual network) is exposed to over time. That is, as one person may have two to three sexual partners, so too could each of those partners have sexual relations with two or three additional people. Thus, a sex network process is created with single individual who may be linked to a large number of unknown sexual "partners", and as soon as one person in the network is infected, the risk to all others is increased.

Adolescent and Intergenerational Sex

Many studies conducted in some African countries tend to suggest that infections are much higher for girls than for boys in the 15–24 age-group and beyond. Early exposure to older men with a longer sexual history is considered to have accounted for the higher infections among adolescent girls, thereby bringing into play intergenerational sexual intercourse as a significant risk factor. Some of these studies also suggest that some of the major factors that appear to drive intergenerational sexual relationships are monetary gain and material support. Overall, the greater the economic asymmetries between partners, the greater the value of a gift, service, or money exchanged for sex, and the less likely the practice of safe sex.

Alcohol and High-Risk Sex

Several studies undertaken over the last few years have highlighted the importance of the strong linkage between alcohol consumption and elevated risk of HIV infection. Weiser et al (2006) reported a strong relationship between heavy drinking and multiple high risk sexual behaviours, including intergenerational sex, among both men and women in Botswana. Anecdotal findings tend to suggest that heavy alcohol consumption reinforce myths, misperceptions and fears about sexuality and condom use.

Stigma and Discrimination

HIV and AIDS-related stigma leads to discrimination, silence and shame, with the results that there are delays in diagnosis, and a limit to the delivery of behaviour change interventions to reduce HIV transmission, and access to appropriate treatment and care services to reduce morbidity, mortality and negative impact.

Gender Violence and Sexual Abuse

One explanation for the gender differential in HIV prevalence and incidence rates is that women are anatomically more vulnerable to HIV and other STIs than men (Temah, 2007). However, a growing strand of literature is showing that women's socioeconomic position, particularly economic dependency, is one of the most powerful drivers of HIV infection. It has been shown, for example, that women's comparatively limited access to, and control, of economic resources makes it more likely that they will exchange sex for money or favours, less likely that they will negotiate safe sexual practices, and less likely that they will leave a relationships that they perceive to be violent or risky –all of which are associated with risk to HIV infections.

Massive population movements (IDPs relocation, refugee influx, repatriation, ex-combatants transition to civilian life, and commercial transporters travel)

South Sudan is characterised by constant population mobility which makes the country to have one of the most mobile populations in the region. Traditionally South Sudanese have three abodes: the principal home in the village, the cattle camps for pastoral farming, and the arable lands for farming. With increasing urbanisation some people have a fourth home in an urban area. For several years people have shuttled between these domiciles in a complex pattern varying across seasons and stages of individuals' life cycles. An additional source of the high population mobility in the country is the repatriation of refugees/returnees from neighbouring countries and large groups of internally displaced populations. It is therefore not uncommon for married couples to live separately for long periods of time, and for young people to live away from their parental guidance. Being away from the security and stability of home and family increases the likelihood of engaging in high-risk sexual behaviours such as multiple and concurrent partnerships and intergenerational sex.

Extremely low knowledge about HIV/AIDS

The Sudan Household Survey conducted in 2010 found that only 11 percent of South Sudanese women aged 15-29 years are knowledgeable about three ways of preventing transmission of HIV/AIDS; only 53 percent of women aged 15-49 years have heard of HIV/AIDS; and 41.1 percent of women and 58.1 percent of men know that HIV infection can be avoided by using a condom correctly and consistently.

A high rate of sexually transmitted infections (STIs)

The Household Health Survey 2010 reports that upwards of 10% of the population have had symptoms of an STI, and antenatal surveillance and other reports show an extremely high rate of positive tests for syphilis in both males and females. As well, data also shows high rates of HSV-2 prevalence, but studies on prevalence of gonorrhoea and Chlamydia have not been done.

Most men in South Sudan who are not Muslim are not circumcised

A UNHCR survey in Juba in 2008 showed that among the non-Muslim men, 60% were not circumcised.

Early age of first sex and a low level use of condoms

In the Household Health Survey 2010 more than 50% of both young men and young women had initiated sexual activity by age 16, with a very low level of condom use at either first sex or thereafter.

Other factors

Other factors that fuel the spread of HIV/AIDS include:- poverty, desperately low school enrolment; and cultural norms such as tribal marking practices, polygamy and widow inheritance are also ingredients for rapid spread of HIV.

3 NATIONAL RESPONSE TO THE EPIDEMIC

3.1 Background to the National Response

South Sudan has experienced two phases of civic wars. The first one started in 1955 and ended in 1972 with the Addis Ababa Agreement and the second phase (1983 -2005) was the most severe and devastating with South Sudan experiencing the worst effects. There were about 2.5 million deaths, 4 million internally displaced people (IDPs), and over 1 million refugees due to the conflict. In 2005, a Comprehensive Peace Agreement (CPA) was signed between the government of Sudan and the Sudan Peoples' Liberation Movement (SPLM) thereby ending one of the longest running wars in Africa. This culminated in the establishment of government of National Unity in Khartoum (GoNU) and Government of Southern (GOSS) in Juba each exercising well defined authorities coordinated by the presidency composed of the Republic, the 1st vice president and president of Government of Southern Sudan and vice president. Since then, GOSS was working towards consolidation of peace and forging ahead with putting in place mechanisms for a country's development in all sectors. Establishment of ministries, Commissions, sector policies and strategies was part of the process of building a new government.

In the area of HIV & AIDS, the civil war is said to have contributed towards limited spread of HIV as the country was closed to extensive interactions with the outside world. The HIV situation in South Sudan can be described a generalized low HIV epidemic with prevalence estimated around 2.6 percent of the adult population. The peace process and subsequent opening of the South Sudan borders and interior, presents a challenge for the potential risk of increased HIV transmission. There is however limited statistical evidence and data to provide an accurate picture of the patterns and key drivers of the epidemic in the country. However, limited sporadic HIV studies point to generally accepted hypothesis that HIV rates vary widely within South Sudan, HIV prevalence rates may be higher in areas which have experienced greater population mobility and contact with other neighboring countries (said to have higher HIV prevalence rates: Uganda, Kenya, Democratic Republic of Congo, Central African Republic), HIV rates appear to be higher in urban than rural areas and rates in women are remarkably higher than in men. It is believed that the incidence and prevalence of HIV in South Sudan were lower than in the neighbouring countries. It is also assumed that South Sudan could be at higher risk of an increased incidence of HIV following the cessation of hostilities for several reasons, most notably that the four million displaced people who had survived the dislocations and refugee experience and had been living in zones of higher HIV prevalence, would be returning to South Sudan carrying HIV with them. As well, the high levels of poverty, low school enrolment, rudimentary health system, and low status of girls and women were also considered to be factors that could contribute to an accelerated HIV epidemic.

To this end, from 2005 onwards the Government of South Sudan (GoSS) began to create new administrative entities and government departments that would function in the post-conflict period. In the area of HIV/AIDS, the GoSS established the South Sudan AIDS Commission (SSAC) in 2006, with the mandate to provide leadership in coordination and management of the national multi-sectoral HIV/AIDS response through resource mobilization, advocacy, joint planning, monitoring and evaluation. In 2008, the Government set up the Directorate of HIV and AIDS in the Ministry of Health (MOH) to implement the HIV and AIDS programmes such as antiretroviral treatment, care and support, blood screening for HIV and sexually transmitted infections (STIs) and management and reporting of opportunistic infections. The Ministries of Health in the ten states of Southern Sudan also set up focal offices for HIV to coordinate the activities of the MOH, GoSS and monitor and report new cases of infections.

With leadership from SSAC and the MOH, the GoSS developed the Southern Sudan HIV/AIDS Strategic Framework (SSHASF 2008-2012) in 2007 and this was finalized in mid-2008. The SSHASF clearly articulates the need for targeting specific populations in a multi-sectoral response: women and girls, youth, sex workers, orphans and vulnerable children. Also outlined in the SSHASF was an HIV policy for other specific vulnerable population settings such as the workplace, schools and prisons. Through a broad consultative process involving a wide range of key stakeholders, South Sudan has developed key strategies which guide the implementation HIV work. The first SSHASF advanced six thematic goal areas and strategies:

3.2: Enabling Environment:

The goal for enabling environment is examines government commitment to HIV implementation in the specific areas of "A strong leadership and high political commitment among top leadership for HIV response at all levels. This thematic area has three outcomes focusing mainly on leadership commitment; resources for; HIV and strengthening policy, legal and institutional framework for coordination and management of the national response.

Prevention:

The goal for the prevention thematic area is "To reduce new HIV infections in South Sudan", Prevention has four outcomes in the areas of reduction of risky sexual behaviour, reduction in mother-to-child transmission of HIV; reduced unsafe blood contact strategies and creation of supportive socio-economic environment for HIV prevention. Key strategies include reduction in risky sexual behaviour include BCC promotion, counselling and testing of individuals, couples and families, promotion of care seeking habits and treatment of STIs, and social marketing of condoms.

Care, Treatment Support and Impact mitigation

The thematic area has two overall goals. The first goal focuses mainly on care, treatment and support and covers 2 outcomes in the area of service provision in care and treatment, strengthening of healthcare systems. The strategies include development of harmonized guidelines and training materials for care and treatment, enhancing capacity of service providers, strengthening referral systems and OI prevention as well as strengthening of care and treatment for PLHIV at community level. The second goal is reduction of socio-economic impact of the HIV epidemic among PLHIV and the affected.

Post Conflict:

This thematic area has one goal and one outcome "To mitigate exposure to and the impact of HIV and AIDS among emergency affected populations during the post conflict recovery and reconstruction phase"

Capacity Building

This area has only one goal and 3 outcomes. The overall goal is "A strengthened, decentralized and sustained human, institutional, technical and financial capacity for a multi sectoral HIV response"

Monitoring and Evaluation

The overall goal for Monitoring and Evaluation is "To strengthen evidence-based management of the national multi-sectoral HIV response at all levels". With 3 major outcomes: functional HIV/AIDS Monitoring and Evaluation system and research framework and development of structures for collection and analysis of HIV related data. The broad strategies address adoption of one M&E framework to guide all stakeholders and standardization of priority/core indicators to guide data

collection and reporting.

Road map to implement and tracking progress of the SSHASF

The SSHASF was designed to be implemented in two phases. Preparatory phase (2008-2009), and scale-up phase. Phase I covers gathering of baseline surveys, infrastructure and human capacity needs assessment, development of operational guidelines, setting up facilities and training of service providers. In the scale-up phase (phase II 2010-2012) will scale-up all interventions in the thematic areas.

3,3: National Spending/ Financial inputs for the National Response

INDICATOR 1: Domestic and international AIDS spending by categories and financing sources

Similar to the situation in many sub-Saharan African countries funding for HIV and AIDS prevention, treatment and care has depended largely on external sources the national HIV and AIDS response in South Sudan has been funded primarily by International donors. This situation is rapidly changing with the leadership providing increasing amounts of the required funds to combat the spread of HIV as exemplified by the recent announcement by the President of the country in releasing more than 34 million South Sudan Pounds (SSP), nearly 12.7 million US dollars. At the time of writing this report, there were no reliable data on the domestic and international AIDS spending by categories and financing sources. There is no most recent NASA report to guide a meaningful analysis of the resource gaps and so the National Spending Matrix template be populated.

3.4 Policy Development and Implementation Status

In addition to the SSHASF described earlier other national plans and policy guidelines and protocols have been developed and/or launched during the current reporting period to enhance the national response include:

- HIV/AIDS Behaviour Change and Communication (BCC) strategy (2008)
- HIV/AIDS Communication Strategy for South Sudan 2008-2012

The Communication Strategy is intended to serve as a plan to initiating, developing and delivering high and audience-appropriate communication interventions to:=

- Build supportive political, policy and service delivery environments and conditions for addressing the burden of HIV/AIDS at the GOSS, State and County levels;
- Enable community participation, dialogue and creation of effective partnerships that will contribute towards the creation of an environment that is supportive of changing risky behavior or maintaining safe behavior, and of seeking appropriate treatment or care and support at the community level,
- Generate awareness and knowledge (as an initial step to positively influence prevailing attitudes and perceptions) at the community, household and individual levels as a basis for promoting appropriate behavior, and to create demand for HIV/AIDS related services and commodities for HIV/AIDS-related services and commodities including HCT, PMTCT, ART, condoms and other preventive, care and treatment interventions.

A 2 year HIV/AIDS Action Plan for Implementation of SSHASF Jan 2011 – Dec 2012: The two year action plan 2011-2012 was launched by SSAC in 2011 The plan presents an aggressive Prevention, and implementation framework that will fill the gaps in current programming and intensify, unify and scale up the response. It also ensures that resources are allocated to interventions with the greatest potential impact for preventing new HIV infections. A long with this plan, the ministry of health and SSAC have develop a number of policy documents and guidelines. The list is by no means exhaustive.

- Southern Sudan HIV/AIDS Strategic Framework (SSHASF 2008-2012)
- HIV/AIDS Monitoring and Evaluation (M&E) framework (2008)
- Guidelines for ART use in adults and children (Revised 2010)
- Guidelines for syndromic management of STIs (plus training manuals)-2009.
- National blood safety strategy (2009)
- Guidelines for Voluntary Counselling and Testing (VCT) (2008)
- Guidelines for Prevention of Mother-to-Child-Transmission (PMTCT) 2010
- PMTCT training curriculum for trainers and trainees, Job aids and training slides (2010)
- National Condom Strategy
- Maternal, Neonatal and Reproductive Health (MNRH) Strategy
- 5 year Health Sector response work plan

3.5 National Composite Policy Index

Indicator 2: National Composite Policy Index (NCPI). Areas covered: Strategic Plan and Political Support; Human Rights; Civil Society Participation; Monitoring and Evaluation.

The National Composite Policy Index measures the extent to which countries have developed policies and strategies on HIV and AIDS in the broad areas of: strategic planning; political support; HIV prevention, treatment, care and support; human rights; civil society involvement; and monitoring and evaluation. A number of specific policy indicators are identified for each of these policy areas. The composite index is an average of rankings (on a scale 0 – 10) of the components. Detailed results of the NCPI for the current reporting period are shown in Annex C, and they can be succinctly summarised as follows:

- The political support that has been present in South Sudan since HIV was identified and declared an emergency is still continuing. This is evident in, among other things, senior government officials and the top political leadership consistently speaking publicly and favourably about efforts to halt the spread of the epidemic. In addition the South Sudan Legislative Assembly has been sensitized on the need to collectively work together to stop the spread of the HIV epidemic.

- The country has in place a national multisectoral strategic framework to respond to HIV and AIDS. The framework—developed through a consultative and inclusive process—covers prioritises areas of intervention to maximize impact of the national response to HIV and AIDS.

- Although South Sudan has non-discrimination laws and regulations which specify protection for most-at-risk populations there are, at the same time no laws, regulations and policies in the country that present obstacles to effective HIV prevention, and access to treatment, care and support for these populations.

- Civil society has, over the years, been a key player in the national HIV and AIDS response, actively participating in strategic fora and committees such as the National

Stakeholders' forum, the M&E Technical Working Group, and Country Coordinating Mechanism (CCM), and the National Technical Advisory Committee for HIV Prevention. However, civil society's effective participation continues to be hampered by high staff turnover and as well as financial resources.

- M&E efforts have not improved since the last UNGASS report in 2010. There still exist multiple reporting tools and channels; a challenge therefore still remains to harmonize reporting systems. M&E progress and challenges are discussed in more detail in Section 7 of this report.

3.6 National Programmes

Since the creation of SSAC and Directorate of HIV/AIDS at the ministry of health, South Sudan began a rigorous implementation of a number of HIV prevention efforts to reduce the spread of HIV. The first SSHASF placed prevention as the major priority of its response to HIV in the country. As a result, a number of prevention programmes were established during the period of the plan and were presented in previous 2008 and 2010 UNGASS reports. These include the Prevention of Mother-to-Child Transmission (PMTCT) programme, and Prevention with Positives. One notable change/achievement is putting into place a number of both local and international CSOs to receive sub-grants from the SSAC.

The World Bank-administered Multi-Donor trust Fund was launched in June 2010 with four major Lead Agencies receiving grants to do HIV/AIDS response in four clusters covering the entire country (10 States) to increase the coverage, efficiency, and sustainability of targeted and evidence-based HIV and AIDS interventions. Activities in this area included: (i) strengthening SSAC institutional management and coordination capacity; and (ii) financing strategic and innovative HIV and AIDS-related prevention and mitigation activities in the public and civil society organizations. This programme will end on June 2012. During this period, SSAC and the 4 lead agencies will dispense funds to implement all the components(SSAC's institutional strengthening; HIV prevention activities in six Ministries: (Health; Works and Transport; Labour; Education; Interior; and Youth, Sports and Culture; and gender) while some funds will be spent on HIV prevention activities of civil society organisations in the country

Blood safety

INDICATOR 3: Percentage of donated blood units screened for HIV with an external quality assured scheme [100%]

The National Blood Transfusion Service aims to ensure that all donated blood units in South Sudan are screened for transfusion- transmissible infections such as HIV, Hepatitis B, and others, so that only those units that are non-reactive are released for clinical use. As a result, universal (100 percent) screening of all donated blood is performed in selected health facilities in South Sudan. The Laboratories use standard operating procedures for the screening of blood units and for other laboratory tests. For the current reporting period (1st January 2010 and 31st December 2011), blood screening has seen a substantial growth. A total of 13,080 units of donated blood were screened in 2010 compared to only 647 blood donations in 2008 and 3,825 units in 2009. SSAC and USAID health systems 20/20 project, 2010. 100% of the donated blood units were screened.

Antiretroviral therapy

INDICATOR 4: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy [7%]

South Sudan provides antiretrovirals (ART) free of charge to its citizens. ART is now available in 22 health facilities countrywide. As of December 31st 2011. a total of 3442 adults and children on treatment as at end of 2011 was estimated to account for 7 percent of those with advanced HIV infection in need of ART according to the Estimation and Projection Package (EPP) and Spectrum mathematical models.

The distribution of ART clients in South Sudan tends to be highly skewed with the majority concentrated in major towns and less in the rural villages, thus reflecting the strategic location of ART sites as they were selected to serve places with the highest population densities.

Prevention of Mother to Children Transmission of HIV

INDICATOR 5: Percentage of HIV-positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmit

South Sudan has one of the worst statistics in the world for maternal mortality, with over 2000 maternal deaths per every 100,000 live births. The estimated prevalence of mother to child transmission of HIV stands at 30% in South Sudan, according to the EPP estimation model. The package of PMTCT services include, but not are limited to HIV education, pre-test counselling, HIV testing, post test counselling and referral. The main approach uses provider-initiated PMTC where mothers attending ANC for the first are identified and offered HTC services. There were an estimated 1037 HIV-positive pregnant women in 2011 and 88 percent of these women received antiretrovirals to reduce the risk of mother-to-child transmission.

The implementation of the PMTCT programme has seen some degree of scaling up during the reporting period. The number of service delivery points for the programme increased significantly from 35 in 2010 to about 60 in 2011. PMTCT guidelines have been widely disseminated and health workers are using them to enhance their performance. A total of 33,098 pregnant women in 2010 and 34,857 in 2011 were tested for HIV and received their results during pregnancy, labour and delivery, and during the post-partum period herein defined as within 72 hours.

Treatment of Tuberculosis

INDICATOR 6: Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV

South Sudan is not reporting on this indicator as no data is available

Generally, Tuberculosis (TB) is the single most common cause of death in HIV infected individuals. Thus, effective management of TB has a significant impact in reducing mortality. It is against this background that all health facilities offering TB treatment in South Sudan are required to report monthly to the National TB Programme of the Ministry of Health the number of newly registered HIV positive TB-patients who are enrolled on ART. Although the TB monitoring system in South Sudan has been developed , it still requires integration with the HIV monitoring system in order to accurately assess referrals for HIV treatment. In consequence, the country has not been able to report on this Indicator.

HIV testing

INDICATOR 7: Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results [41%]

Voluntary counselling and testing (VCT) for HIV is one strategy that has been shown to enhance safe sexual behaviour and hence lead to a lower risk of HIV infection. Counselling is particularly important because it may lead to behaviour change by helping people evaluate their current level of risk, providing them with the motivation and self- efficacy to curb primary and secondary infections, and allowing them the opportunity to engage in problem solving regarding challenging scenarios such as negotiating condom use.

In South Sudan VCT services are delivered mainly by public health facilities, CSO-run facilities, and faith based facilities. Routine HIV Testing (RHT)—the routine, but non-mandatory HIV testing has not yet been introduced in South Sudanese public health centres.

The total reported number of individuals testing to know their HIV status during 2010 and 2011 was reported to be approximately 66,301 and 105,647 respectively. This represents a sharp increase in HIV testing uptake from 27,076 in 2008.

INDICATOR 8: Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results

South Sudan is not reporting on this indicator as no data is available
There is currently no appropriate data to analyse the extent of condom use, and indeed, any sexual behaviour of most-at risk populations (MARPs) in South Sudan. This is largely because the lifestyles of these groups, for example, same-sex relationships and sex work are illegal in the country. As a result these groups of people are usually not easy to identify as they fear being arrested or stigmatized. To overcome the paucity of data relating to these populations, a MARPS rapid assessment and response evaluation study (RARE) was carried out in 2011. Findings from the RARE study are yet to be disseminated in order to inform future plans aimed at addressing MARPS interventions.

Reach of HIV prevention programmes

INDICATOR 9: Percentage of most-at-risk populations reached with HIV prevention programmes: South Sudan is not reporting on this indicator as no data is available

There is currently no appropriate data to adequately examine the sexual behavior of most-at-risk populations in South Sudan. Attempts have been made by civil society organisations, particularly the International HIV & AIDS Alliance to reach most-at-risk populations with HIV prevention programmes. For example in September of 2011, the USAID supported Global Health Technical Assistance programme conducted a rapid assessment, response and evaluation (RARE) study among sex workers, truck drivers and boda boda boys (a group of young people who earn their living by transporting clients/customers on motor cycles for a fee). The study was largely qualitative in nature and no concrete figures can be extracted from the findings.

Care for orphans and vulnerable children

INDICATOR 10: Percentage of orphaned and vulnerable children aged 0-17 years whose households received free basic external support in caring for the child [Not known]

HIV and AIDS has orphaned a large number of children in South Sudan. In response, the Government through SSAC and supported by UNICEF is mounting an intervention specifically addressing Orphan Care that will include providing food baskets, support with educational necessities, psychological counselling and to facilitate the waiving of school fees for orphans.

Using the EPP estimation model performed for the purposes of this report, the estimated number of AIDS orphans in South Sudan is 76021. The Ministry of Gender, Child and Social Welfare under whose mandate issues related to orphan and child protection, is in the initial stage of putting up structures to address the whole range of child related issues.

Life-skills-based education

INDICATOR 11: Percentage of schools that provided life skills based HIV Education in the last academic year [not known]

All primary and secondary schools in the country are expected to have teachers that are trained in, and are currently teaching, life- skills-based education, which has HIV and AIDS as a major component. This is not the case at the present.

3.7 Knowledge and Behaviour

Knowledge

INDICATOR 12: Current school attendance among orphans and non-orphans aged 10-15
South Sudan is not reporting on this indicator as no data is available

It is important to monitor the extent to which support programmes succeed in securing the educational opportunities of orphaned children. There is currently no data available to calculate this indicator in accordance with the GARP guidelines (UNAIDS, 2012).

The main objectives of any intervention designed to provide support to orphans is to ensure that orphans remain in school by waivering school fees and providing the children with educational necessities.

Emerging from many years of war with its current neighbour, the republic of Sudan, the country is struggling with myriad of recovery reconstruction and development issues, all of which require heavy investments. Against this background, South Sudan has still a long way to travel to achieve universal access to primary education.

INDICATOR 13: Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

The risk of acquiring HIV infection, especially for young people, has been known to be high and to be driven by, among other things, lack of functional knowledge about modes of HIV transmission. In recognition of this, the government of South Sudan, in collaboration with civil society organisations and development partners has for the last 6 years embarked on a number of

behaviour change communication and media campaigns to provide young people with appropriate information and skills to make informed, responsible choices about sex and relationships, and to prevent the spread of HIV. This is in addition to life-skills based education *provided* in schools as described above.

INDICATOR 14: Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
South Sudan is not reporting on this indicator as no data is available

See comment under Indicator 8

Sexual behaviour

INDICATOR 15: Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15 [23.3% women &29% men]

The positive impact of behaviour change communication and media campaigns is measured in a decreasing trend in the age at sexual debut. A study conducted by the International HIV/AIDS Alliance in 2008/9 estimated the percentage of young women and men aged 15 – 24 who had had sex before 15 years to be 30.5 in South Sudan.

INDICATOR 16: Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months [27% (6.8% (women)]

As mentioned earlier one of the drivers of HIV transmission in South Sudan, and elsewhere in sub-Saharan Africa is multiple concurrent sexual partnerships. This indicator is important for understanding the overall number of people with multiple partners, but it does not contain any information about how many of these partnerships are concurrent.

Condom use
INDICATOR 17: Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse (No Data}

No data were available at the time this report was being prepared.

INDICATOR 18: Percentage of sex workers reporting the use of a condom with their most recent client
South Sudan is not reporting o this indicator, as no data is available
See comment under Indicator 8

INDICATOR 19: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner
South Sudan is not reporting on this indicator as no data is available
See comment under Indicator 8

INDICATOR 20: Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse
South Sudan is not reporting on this indicator as no data is available

Use of sterile equipment

INDICATOR 21: Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected

South Sudan is not reporting on this indicator as no data is available

3.8 Impact: H*IV prevalence*

INDICATOR 22: Percentage of young people aged 15–24 who are HIV infected [2.89 percent]

The available data on HIV prevalence is limited to the population of women attending ANC services. It is therefore difficult to draw any conclusions regarding the HIV infection rates between women and men in same age groups. Data on HIV prevalence in the general population is currently not available. The data available for young women in ANC surveillance suggest that those in the age group 20 -24 (3.21) are more infected than those aged 15 – 19 (2.89). A study conducted among the military estimated the HIV prevalence at 4.4% (SPLA Survey 2010). No prevalence data available on Most at risk groups e.g. CSW, prisons etc.

INDICATOR 23: Percentage of most-at-risk populations who are HIV infected

South Sudan is not reporting on this indicator as no data is available

See comment under Indicator 8

Treatment

INDICATOR 24: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy [62.5.%]

The ART programme in South Sudan is new in terms of the number of years it has been implemented. Recent statistics from 22 ART sites suggest that 62.5 percent of adults and children with advanced HIV infection are known to be on treatment 12 months after initiation of antiretroviral therapy (582 of the 931 patients). This shows the level of success the ART programme in South Sudan.

INDICATOR 25: Percentage of infants born to HIV infected mothers who are infected [30%]

South Sudan's PMTCT programme provides HIV testing and ARV intervention to most pregnant women who attend ANC and deliver in the healthcare setting. For HIV positive pregnant mothers whose CD4 count is 250 or above and who present no clinical signs of AIDS, prophylaxis (Zidovudine) is administered from 28 weeks of pregnancy through to delivery, while those whose CD4 count is lower than 250, treatment (ART) is administered immediately. The latter group stays in ART even after delivery while the former stops Zidovudine treatment at delivery depending on the results of the tests carried out at that stage. Transmission rates have been reported as ranging between 14.1 and 30 percent.

4 BEST PRACTICES

4.1 Introduction

The *Guidelines on Construction of Core* Indicators for the 2012 GARP reporting instructed that, for the purpose of sharing lessons learned with other countries, this section "should cover detailed examples of what is considered a best practice in a country in one or more of the key areas, such as political leadership; a supportive policy environment; scale-up of effective prevention programmes; scale-up of care, treatment and/or support programmes; monitoring and evaluation; capacity building; and infrastructure development.

4.2 Best Practices

Establishment of the District Health Information Software (DHIS)

The Ministry of Health through a consultancy with an International firm - IMA World Health – has developed a powerful, yet user-friendly application to facilitate data collection, data entry, analysis and timely production of monthly reports for use at the data collection point and for upward reporting.

The software named DHIS – District Health Information Software - is a tool designed to facilitate easy and real-time transfer of information for evidence-based decisions about the operations of the health system at all levels, county, state and national. The system was developed in a number of phases.

Phase I consisted of identifying user-data requirements and specifications. This was followed by the development of the software. This phase has been successively achieved.

Phase two involved selection of pilot counties within selected states to test the system. Key team of people involved on data collection and data transfer from the pilot areas were trained on the use of the software, followed by provision of the software and computer equipment. This was also successively accomplished. Results from the pilot areas are now trickling in and monitoring of the performance of the system is being recorded.

Phase three is to roll out DHIS to all states ministries of health and the associated county health departments. The logistics of how this will happen are being developed/examined and soon the system is expected to be operational country wide.

Roll out of Standardized Data Collection & reporting Tools

Another notable lesson learned is the development of standardized data collection and reporting tools. The process started when the department of Planning, research, monitoring and evaluation at the Ministry of Health needed to pull together information from the actors in the health care delivery system and finding that analyzing data from multiple reporting formats was simply not feasible

A M&E Technical Working Group, consisting of members from key players was constituted in 2007 with clear terms of reference to review all available data collection and reporting tools from actors in the health system. This review led to the selection of useful set of tools.

Selected tools were then modified and new ones developed. The process was a very transparent, inclusive and consultative. Now, as we write this report, all recommended tools have been printed ad rolled out to all levels of the health delivery system and to all partners

5 MAJOR CHALLENGES AND REMEDIAL ACTIONS

5.1 Introduction

In the 2010 UNGASS Country Progress Report, a number of challenges faced by the public sector, civil society, and development partners in their efforts to achieve the UNGASS goals and targets were highlighted. This section presents the challenges as outlined in the 2010 report, and reports on the progress made regarding each identified challenge. Challenges experienced in the current reporting period, and proposed remedial actions to address the challenges are also discussed.

5.2 Challenges in 2010 and Progress Made

Challenges	Progress since 2012
Challenge 1: Lack of SSAC Board	No progress made as the national SSAC Board has not been formed. Once formed as recommended in 2010, the board was to be included in the SSAC action plan Together with key stakeholders, but this has not happened and so remains a challenge. SSAC should work out reasonable terms of reference for the board. These should include key principles of joint planning and review, mutual accountability for results.
Challenge 2: Absence of a functional HIV & AIDS oversight forum to oversee project implementation	TOR have not yet been developed for the secretariat at SSAC, therefore this challenge has not been removed..
Challenge 3: very low Implementation capacity at SSAC .	The suggested remedial action was to conduct a review of the organizational structure of each department based on expected outputs. In doing so the following were actions to be accomplished: Competitive recruitment of technical officers; Attractive remuneration package for professional and technical personnel; Need and performance based training; And review of the financial resource management capacities.
Challenge 4: The need to fully implement the M&E **framework**	The challenge was expected to be resolved by two separate actions: First, by placing a resident technical support at the level for establishment of the M&E system by UNAIDS and Second action: To revitalize the M&E Technical Working Group forum with clear terms of reference Some progress has been made with regard to the second action recommendation. The M&E TWG was restarted on 1 st March, 2012 and TORs have been developed and disseminated. However, the first action recommendation has not been implemented.

5.3: Challenges in the Current Reporting Period and Proposed Remedial Actions

Challenges	Remedial Actions
Challenge 1: Limited Human & Financial Resources	Conduct a training needs assessment to identify areas of staff weaknesses for which a training plan and curricula are required. Clearly define roles & responsibilities for each staff and design a good remuneration scheme to compensate high performers in the job. Design a system to pull together financial resources to a common source funding such as the Multi Donor Trust Fund, and sharing with other partners to ensure sustainability.
Challenge 2: Disharmony in Stakeholders/partners plans, priorities and coordination.	SSAC to encourage partners to prepare and submit their individual HIV/AIDS response plans and also to conduct HIV partner mapping exercise
Challenge 3: Poor coordination and harmonisation of the different stakeholders to ensure maximum impact of the multi-sectoral response	SSAC should commission an assessment of coordination, harmonisation and alignment within the HIV and AIDS national response in the country so that the results of the assessment will be used to improve programming, management and coordination functions as well as to foster increased levels of engagement, participation, harmonization, and alignment by all national and international partners in the national HIV and AIDS response.
Challenge 4: Poor policy implementation due to long consultative processes that often result in delays in policy implementation	SSAC together with key stakeholders should revise the national HIV and AIDS policy to include mainstreaming
Challenge 5: Mainstreaming—there has not been sufficient clarity on the concepts of mainstreaming HIV and AIDS to move the process forward. Additional challenges for mainstreaming include implementation capabilities as well as leadership for the process**.**	SSAC in conjunction with the partners should work to bring the mainstreaming agenda to the forefront of their act ivies, in particular, SSAC should: Collaborate with line ministries, & key partners including CSOs to review constraints to mainstreaming and make recommendations for effective mainstreaming to take place; Develop a concept paper for effective mainstreaming; and Undertake training of focal persons on mainstreaming and develop action plans to move the agenda forward.

6 SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

6.1 Introduction

Development partners are important players in the national HIV and AIDS response. Most of the development partners' funds are used for activities and programmes related to treatment, OVC support and HIV prevention.

6.2 Key Support Received Since Last UNGASS Progress Report

Since the last UNGASS report, two major programmes were launched by development partners to provide financial and technical support as well as capacity-building for the national HIV and AIDS response. For example; : the Multi Donor Trust Fund, mentioned earlier in the report providing much of the funding for engagement of civil society organizations through a sub-contracting mechanism to assist the Government of South Sudan as well as the public and civil society to increase coverage, efficiency, and sustainability of targeted and evidence-based HIV and AIDS interventions in the country.

The funds are pooled together as contributions from the major bilateral and multi laterals such as the European Union, the British government through the Department of Foreign and International Development (DFiD), and the United States Assistance for International Development (USAID). The funds disbursement is managed by the World Bank. PEPFAR has secured a 14 USD million USD funds to finance its HIV/AIDS response in South Sudan. The other major contributor to the response to the AIDS epidemic in South Sudan is the Global Fund to fight AIDS Tuberculosis and Malaria.

6.3 Challenges in 2010 and Progress Made

Several key areas of support needed by national partners from development partners where highlighted in the 2008 – 2012 SSHASF. These included improved harmonization and alignment of support with national policies and procedures; increased funding and capacity building; scaling up of support for prevention; increasing funding for health systems strengthening, and strengthening of civil society. The government of South Sudan, through the SSAC initiated a number of activities that are aimed at addressing these challenges, Key among these are:

The setting up of a forum to review and develop of the health sector strategy that included HIV/AIDS response effort/activities. This is a technical body of experts drawn from the government of South Sudan and its key development partners (the bilateral and multi lateral donors) to provide a platform for the development of appropriate health and HIV/AIDS strategies.

6.4 Current Challenges and Remedial Actions Needed

Despite the above remedial actions, development partners still faced some challenges during the current reporting period. These included financial challenges due to the failure in the country not receiving grants from the Global Fund for the last 3 successive rounds for HIV/AIDS portfolio. The global economic crisis has also affected development partners' support to government and civil society organisations, and high staff turnover in projects supported by development partners has slowed down achievements of targets. There is also weak coordination of and among partners which leads to duplication of efforts. Bureaucratic procedures of some key partners, for example the World Bank and Global Fund have tended to cause delays in the implementation of many civil society organizations that receive grants from these institutions.

Harmonization of development support efforts through pooling together of resources/funds, among other measures will overcome the financial challenges. Local staff training and mentoring by senior international staff will minimize the adverse effects of high staff turnover. Improving coordination

among national and international partners can facilitate sharing of information among partners. There need to be active participation of partners in government led fora at all levels, for example; participation in the GARP report writing,

7 MONITORING AND EVALUATION

7.1 Introduction

The Monitoring and Evaluation (M&E) system of the national HIV and AIDS response in South Sudan was established in 2008 as the third of the "Three- Ones" principle—One agreed national Monitoring and Evaluation system. The South Sudan HIV and AIDS Strategic Framework advice that "structures and systems of data collection, management and interpretation be put in place as a priority". The overarching goal of the M&E system for the national HIV response is to achieve evidence-based management of the multi sectoral ADS response at all levels and a set of four outcomes were identified:

- A functional National HIV and AIDS Monitoring and Evaluation system;
- Increased availability of and access to quality, and user-friendly information on HIV and AIDS epidemic and response at all levels;
- Increased use of the HIV and AIDS information at all levels by all stakeholders; and
- Establish a functional National Research Plan/Framework.

In order to deliver on the overall goal and to produce the desired outcomes, a national M&E technical working group was formed in 2007, provide technical guidance in the design and implementation of the M&E system, including the ffinalization of the National Core and Performance & data collection tools.

7.2 Major Achievements

Development of an M&E system with defined national indicators which are aligned with global ones to guide regular data collection and reporting. The system has also achieved some level of harmonization at the national levels. Along with this, data collection tools have been developed and harmonized and a system of data generation designed to yield requisite data at regular scheduled intervals. This includes quarterly programme performance reports and annual reports. A regular annual ANC surveillance system is in place to collect data for outcome and impact monitoring. A National population-based survey was conducted in 2010.

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Development of standardized data collection and reporting tools has been accomplished and tools have been rolled out to States and Counties all over the country;

The M&E unit at the SSAC has been adequately provided with modern equipment including computers, printers and internet services to enable effective functioning of the staff at the unit.

Deployment of State and County AIDS Commissions and staffing them with M&E Officers has improved M&E capacity at this critical level of the national response. However more needs to be done to complete the process of identifying and employing more states and county M&E Officers for the AIDS Commission at these levels.

Development of a National M&E Framework for HIV Prevention, care & treatment and support has been accomplished.

7.3 Challenges in t2010

Notwithstanding the achievements outlined above, M&E system has faced some challenges. For the current reporting period these included:

Inadequate human resources – despite efforts noted above to develop M&E in the country, significant gaps still exist in this area, especially at the programme level. Trained staff deviate from M&E functions as they progress professionally, which raises the need for replacement. In some cases, responsibility for M&E is not clearly defined, making it difficult for targeted training. .

Weak linkages & coordination between the M&E system and data generation points – data collection in the programme context is assigned to staff who have specialized core mandates, and therefore do data collection only when they have spare time from their core duties. This tends to compromise data completeness, quality, processing and reporting.

Disharmony within the M&E systems & partners-when it was established, the M&E system was believed to be a panacea for all HIV and AIDS information. As things appear now, this has turned out to be a challenge mainly due to lack of harmony between the various subsystems that feed into it. As a result there exists a real risk of duplication. Most importantly however, is the systems' shortfall in meeting some information needs for stakeholders. This challenge is exacerbated by evolving information needs resulting from changing programme focus as strategies are adjusted to tackle emerging challenges.

No plans for national evaluation research, including mid-term and end of project reviews – evaluation is a necessarily rigorous and thorough undertaking, requiring high level of technical expertise. It is also relatively expensive, especially in cases where complex designs are employed. To this end, inadequate human resources, particularly skilled and technical staff, makes the managing of evaluations to ensure delivery of expected output a major challenge.

Limited research and evaluation capacity in the national response . This remains a challenge across all the National AIDS Coordinating body and the line ministries.

7.4 M&E Challenges in the current reporting Period & Proposed Remedial Actions

The following remedial actions are recommended to address the challenges discussed above and in table

Challenges in current reporting period	Proposed Remedial Action
Inadequate human resources	Need to advocate for the development of a scheme of service for M&E Officers
Weak linkages & coordination between the M&E system and data generation points	Advocate for the integration of M&E into the day-to-day running of organizations that generate data.
Inadequate harmonization of M&E system	Revitalise the M&E Technical Working Group and adopt a unified data flow pathway
No plans for national evaluation research including mid term and end of project reviews	Resource mobilization Involve the M&E TWG
Limited capacity for research and evaluation in the national response	Identify local research institutions & Continue to build research and evaluation capacity

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25 Universal Access Report 2010**,** *Scaling Up HIV/AIDS Response,* Southern Sudan; SSAC

26 WHO Global Fund Annual Report – South Sudan**,** 2009

ANNEX A: List of Participants at the Data Verification Workshop, March 26, 2012

NAME	DESIGNATION	ORGANIZATION
Santino Tito Tito	CCM Member	Private Sector
Jino Gama	Coordinator – Line Ministries	South Sudan AIDS Commission
Alex Bolo	Strategic Information Advisor	CDC
Richard Aludra	M&E Officer	Family Health International 360
Dr. Acol Ayom Dor	Depoty Chairperson	South Sudan AIDS Commission
Medhin Tsehaiu	UNAIDS Country Coordinator	UNAIDS
Viola Aputu	M&E Officer	Ministry of Health
Ader Macar	ART Officer	Ministry of Health
Golda Ceasar	Surveillance Officer	Ministry of Health
James Ayieny	ART Officer	Ministry of Health
Eban T	M&E Officer SSAC	Center for Health & Population
Guillerme Luortinez	UNAIDS	UNAIDS
GERALD Kimondo	M&E Advisor	MOH/John Snow International
Joy Theophilus	NPO HIV/AIDS	UNFPA
Joseph Elisa Jibi	NPO HIV/AIDS	UNAIDS
Silvano Koribe	M&E Officer	South Sudan AIDS Commission
MamgbiArtaro	Senior Inspector	Ministry of Education
Taban Francis	Senior M&E Officer	South Sudan AIDS Commission
Lole Laila Lole	Chairperson	South Sudan Network of PLHIV
Moses Mutebi N	Medical Doctor	WHO
Asnakew Assefa	Senior Technical Officer – M&E	Family Health International360
Juma David Augustine	Deputy Team Leader	CHAS
Maring K. Muni	M&R Officer	IntraHealth

ANNEX B: National Composite Policy Index

COUNTRY: South Sudan

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:

Dr. Esterina Novello

Signed:_____

Postal Address: South Sudan AIDS Commission
P.O.Box 88
Juba,
South Sudan

TEL: +211
Email: lonyik@gmail.com

Date of submission: 31 March 2012

NCPI RESPONDENTS

NCPI - PART A [Administered to government officials]

Organization	Names/Positions	Respondents to Part A				
		AI	AII	AIII	A. IV	A.V
Ministry of Health	Dr. Ayat Jervese	√	√	√	√	√
JSI/Ministry of Health	Gerald Kimondo					√
S.Sudan AIDS Commission	Dr. Esterina Novello	√	√	√	√	√
S Sudan AIDS Commission	Gino Gama	√	√	√	√	√
S Sudan AIDS Commission	Silvano Koribe					√
Ministry of Gender	Ossa Lollu			√		
Ministry of Gender	Cecilia Peter			√		
Ministry of Education				√	√	√
Human Right Commission	D. Mathias			√	√	

NCPI - PART B [Administered to civil society organizations and development partners]

Organization	Names/Positions	Respondents to Part B [indicate which parts each respondent was queried on]			
		B.I	B.II	B.III	B.IV
Church Health Association of S Sudan	IDavid Augustine			√	√
Family Health International	Alege		√	√	√
USAID/PEPFAR	Dr, Denis Mali	√	√	√	√
	J. Ledikwe			√	

Part A [Administered to government officials]

I STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?

Yes	No	Not Applicable (N/A)

Period covered: 2008-2012 (first National Strategic Framework)

***IF YES*, complete questions 1.1 through 1.10.**

1.1 How long has the country had a multisectoral strategy?

Number of Years: **8 Years**

1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

Sectors	**Included in strategy**	**Earmarked budget**
Health	**Yes**	**Yes**
Education	**Yes**	**Yes**
Labour	**Yes**	**Yes**
Transportation	**Yes**	**Yes**
Military/Police	**Yes**	**Yes**
Women	**Yes**	**Yes**
Young people	**Yes**	**Yes**

Any of the following: Agriculture, Finance, Human Resources, Justice, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?

Through programmes supported by the Multi Donor Trust Fund and the Global Fund,

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* Sub-populations other than injecting drug users, men who have sex with men and sex workers, that have been locally identified as being at higher risk of HIV transmission (e.g., clients of sex workers, cross-border migrants, migrant workers, internally displaced people, refugees, prisoners).

Yes **No**

IF NO, explain how were target populations identified?

- Consultation and consensus
- Other research initiatives

1.5 What are the identified target populations for HIV programmes in the country?

- HIV positive populations
- Orphans and vulnerable children
- Sex workers
- HIV negative populations
- Pregnant women

1.6 Does the multisectoral strategy include an operational plan?

Yes	**No**

1.7 Does the multisectoral strategy or operational plan include:

a. Formal programme goals?	**Yes**	
b. Clear targets or milestones?	**Yes**	
c. Detailed costs for each programmatic area?		**No**
d. An indication of funding sources to support programme implementation?		**No**
e. A monitoring and evaluation framework?		**No**

1.8 Has the country ensured "full involvement and participation" of civil society* in the development of the multisectoral strategy?

Active involvement	Moderate involvement	No Involvement

F active involvement, briefly explain how this was organised:

- As part of the technical working groups
- As part of reference groups (steering committees)
- As part of those being consulted
- As part of appraisal processes

1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes	No

1.9 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners	Yes, some partners	No

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment /UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

Yes	No	N/A

2.1 ***IF YES***, in which specific development plan(s) is support for HIV integrated?

a. National Development Plan	**Yes**		
b. Common Country Assessment / UN Development Assistance Framework	**Yes**		
c. Poverty Reduction Strategy		**No**	
d. Sector-wide approach			**N/A**
e. Other:			

* Civil society includes among others: networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; community-based organizations; organizations of key affected groups (including men who have sex with men, sex workers, injecting drug users, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For

the purpose of the NCPI, the private sector is considered separately.

2.2 ***IF YES***, which specific HIV-related areas are included in one or more of the development plans?

HIV-related area included in development plan(s)		
HIV prevention	**Yes**	
Treatment for opportunistic infections	**Yes**	
Antiretroviral treatment	**Yes**	
Care and support (including social security or other schemes)	**Yes**	
HIV impact alleviation	**Yes**	
Reduction of *gender* inequalities as they relate to HIV prevention/treatment, care and/or support	**Yes**	
Reduction of *income* inequalities as they relate to HIV prevention/treatment, care and /or support	**Yes**	
Reduction of stigma and discrimination	**Yes**	
Women's economic empowerment (e.g. access to credit, access to land,	**Yes**	

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

Yes	**No**	**N/A**

3.1 ***IF YES***, to what extent has it informed resource allocation decisions? **5**

Low					High
0	1	2	3	4	**5**

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

Yes	**No**

4.1 ***IF YES***, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?

Behavioural change communication	**Yes**	
Condom provision	**Yes**	
HIV testing and counselling	**Yes**	
Sexually transmitted infection services	**Yes**	
Antiretroviral treatment	**Yes**	
Care and support	**Yes**	

If HIV testing and counselling *is provided* to uniformed services, briefly the approach taken to HIV testing and counselling (e.g. indicate if HIV testing is voluntary or mandatory etc):

Voluntary testing and counselling using public facilities as well as their dedicated facilities.

6. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

Yes	**No**

7. **Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?**

Yes	**No**

7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

Yes	**No**

7.1 Have the national strategy and national HIV budget been revised accordingly?

Yes	**No**

7.2 Have the estimates of the size of the main target populations been updated?

Yes	**No**

7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of current and future needs	Estimates of current needs only	No

7.4 Is HIV programme coverage being monitored?

Yes	**No**

(a) ***IF YES***, is coverage monitored by sex (male, female)?

Yes	**No**

(b) ***IF YES***, is coverage monitored by population groups?

Yes	**No**

(c) Is coverage monitored by geographical area?

Yes	**No**

IF YES, at which geographical levels (provincial, district, other)?
National State and Countyt

Briefly explain how this information s used:
For programme and policy formation, implementation, monitoring and evaluation.

?

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes	**No**

Overall, how would you rate *strategy planning efforts* in the HIV programmes in											
2011	Very poor										Excellent
	0	1	2	3	4	5	6	7	**8**	9	10

Since 2010, what have been key achievements in this area:

What are remaining challenges in this area:
Limited resources and limited implementation capacity.

II POLITICAL SUPPORT

Strong political support includes: government and political leaders who speak out often about AIDS and regularly chair important AIDS meetings; allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

1. Do high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

President/Head of government	**Yes**
Other high officials	**Yes**
Other officials in regions and/or districts	**Yes**

2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?

Yes	**No**

2.1 ***IF YES***, when was it ceated?

Year: **2008**

2.2 ***IF YES***, who is the Chair?

Name: Dr, Esterina Novello Position/Title: **Chairperson**

2.3 ***IF YES***, does the national multisectoral AIDS coordination body:

Have terms of reference?	**Yes**
Have active government leadership and participation?	**Yes**
Have a defined membership? ***IF YES***, how many members? 40 Include civil society representatives? ***IF YES***, how many? 10 Include people living with HIV? ***IF YES***, how	**Yes** **Yes** **Yes**
Have an action plan?	**Yes**
Have a functional Secretariat?	**Yes**
Meet at least quarterly? Review actions on policy decisions regularly? Actively promote policy decisions? Provide opportunity for civil society to influence decision-making? Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	**Yes** **Yes** **Yes** **Yes** **Yes** **Yes**

4. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

Yes	**No**	**N/A**

IF YES, briefly describe the main achievements:

Information sharing through regular stakeholders meetings abd M&E rechnical working groups

Briefly describe the main challenges:

No meaningful partnerships among the different players

Meaningful partnership where there is less reliance on Government

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?

Percentage: **10-15 %**

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Information on priority needs	**Yes**	

Technical guidance	**Yes**	
Procurement and distribution of drugs or other supplies		**No**
Coordination with other implementing partners	**Yes**	
Capacity-building	**Yes**	
Other: **Operational costs including wages and salaries.**	**Yes**	

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?

Yes	**No**

6.1 ***IF YES***, were policies and laws amended to be consistent with the National AIDS Control policies?

Yes	**No**

Overall, how would you rate the *political support* for the HIV programme in 2009?											
2010	Very poor										Excellent
	0	1	2	3	4	5	6	7	**8**	9	10
Since 2010, what have been key achievements in this area: ☐ Strengthened political support ☐ Resource mobilization and allocation *What are remaining challenges in this area:*											

III PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the *general population*?

Yes	No	N/A

1.1 ***IF YES***, what key messages are explicitly promoted?
√ Check for key message explicitly promoted

a) Be sexually abstinent	**YES**
b) Delay sexual debut	**YES**
c) Be faithful	**YES**
d) Reduce the number of sexual partners	**YES**
e) Use condoms consistently	**YES**
f) Engage in safe(r) sex	**YES**
g) Avoid commercial sex	**YES**
h) Abstain from injecting drugs	N/A
i) Use clean needles and syringes	**YES**
j) Fight against violence against women	**YES**
k) Greater acceptance and involvement of people living with HIV	**YES**
l) Greater involvement of men in reproductive health programmes	**YES**
m) Males to get circumcised under medical supervision	**YES**
n) Know your HIV status	**YES**
o) Prevent mother-to-child transmission of HIV	**YES**

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes	No

2. Does the country have a policy or strategy promoting HIV related reproductive and sexual health education for young people?

Yes	No	N/A

2.1 Is HIV education part of the curriculum in:

Primary schools?	**Yes**	
Secondary schools?	**Yes**	
Teacher training?	**Yes**	

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes	No

2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes	No

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions *for most-at-risk or other vulnerable sub-populations?*

Yes	**No**

IF NO, briefly explain:

The Research Triangle Institute recently started some work on Most At Risk Populations (MARPS). RTI and Ministry of Health are in the process of developing a strategy for MARPS

IF YES, how were these specific needs determined?

They were determined using data from programme monitoring.

4.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access		
Blood safety		**Disagree**	
Universal precautions in health care settings	Agree		
Prevention of mother-to-child transmission of HIV		**Disagree**	
IEC* on risk reduction		**Disagree**	
IEC* on stigma and discrimination		**Disagree**	
Condom promotion		**Disagree**	
HIV testing and counselling		**Disagree**	
Harm reduction for injecting drug users			**N/A**
Risk reduction for men who have sex with			**N/A**
Risk reduction for sex workers			**N/A**
Reproductive health services including sexually transmitted infections	**Agree**		
School-based HIV education for young	**Agree**		
HIV prevention for out-of-school young		**Disagree**	
HIV prevention in the workplace		**Disagree**	

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2010?

2012 Very poor Excellent

0 1 2 3 4 5 6 7 **8** 9 10

Since 2010, what have been key achievements in this area:

What are remaining challenges in this area:
Behavioural change

* IEC = information, education, communication

Overall, how would you rate *policy* efforts in support of HIV prevention in 2011?											
2009	Very poor										Excellent
	0	1	2	3	4	5	6	7	8	9	10
Since 2007, what have been key achievements in this area: What are remaining challenges in this area:											

5. Has the country identified specific needs for HIV prevention programmes?

Yes	**No**

IF YES, how were these specific needs determined?

☐ They were determined as specific needs of districts and communities as defined in the sentinel surveillance and BAIS I & II surveys

IV TREATMENT, CARE AND SUPPORT

1. **Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).**

Yes	**No**

1.1 ***IF YES***, does it address barriers for women?

Yes	**No**

1.2 ***IF YES***, does it address barriers for most-at-risk populations?

Yes	**No**

2. **Has the country identified the specific needs for HIV treatment, care and support services?**

Yes	**No**

IF YES, how were these determined?
Statistics from Routine Programme Monitoring and Evaluation data.

2.1 To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have		
Antiretroviral therapy	**Disagree**		
Nutritional care	**Disagree**		
Paediatric AIDS treatment	**Agree**		
Sexually transmitted infection management	**Agree**		
Psychosocial support for people living with HIV and their families	**Disagree**		
Home-based care	**Disagree**		
Palliative care and treatment of common HIV-related infections	**Disagree**		
HIV testing and counselling for TB patients	**Agree**		
TB screening for HIV-infected people	**Agree**		
TB preventive therapy for HIV-infected people	**Agree**		
TB infection control in HIV treatment and care facilities	**Agree**		
Cotrimoxazole prophylaxis in HIV-infected people	**Agree**		
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	**Disagree**		
HIV treatment services in the workplace or treatment referral systems through the	**Disagree**		
HIV care and support in the workplace (including alternative working arrangements)	**Disagree**		
Other: *[write in]*			

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

No

4. Does the country have access to *regional* procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?

No

IF YES, for which commodities?:

Overall, how would you rate the efforts in the *implementation* of HIV treatment, care and support programmes in 2011											
2011											
	0	1	2	3	4	5	6	7	8	**9**	10

Since 2009 what have been key achievements in this area:

Scales up ARV therapy in now 22 sites up from 19
More health workers trained in laboratory skills

What are remaining challenges in this area:

Inadequate and inexperienced human resources
Difficulties in ensuring treatment & medication adherence

5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

No

5.1 ***IF YES***, is there an operational definition for orphans and vulnerable children in the country?

No

5.2 ***IF YES***, does the country have a national action plan specifically for orphans and vulnerable children?

No

5.3 ***IF YES***, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

No

IF YES, what percentage of orphans and vulnerable children is being reached?

undetermined.

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?											
2011 Very poor											Excellent
	0	1	2	***3***	4	5	6	7	**8**	9	10

Since 2009, what have been key achievements in this area:

What are remaining challenges in this area:

I MONITORING AND EVALUATION

1. Does the country have *one* national Monitoring and Evaluation (M&E) plan?

Yes		**No**

1.1 ***IF YES***, years covered: 2008-2012

1.2 ***IF YES***, was the M&E plan endorsed by key partners in M&E

Yes	**No**

IF YES, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes	**No**

1.4 ***IF YES***, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners	**Yes, most partners**	Yes, but only some partners	**No**

IF YES, but only some partners or IF NO, briefly describe what the issues are:

porting lines have clearly been outlined, however there still remains a challenge to harmonize reporting with partners, leading to some programmes having to report the same information twice.

2. Does the national Monitoring and Evaluation plan include?

a data collection strategy	**Yes**	
IF YES, does it address:		
routine programme	**Yes**	
monitoring behavioural	**Yes**	
surveys	**Yes**	
HIV surveillance	**Yes**	
a well-defined standardised set of indicators	**Yes**	
guidelines on tools for data collection	**Yes**	
a strategy for assessing data quality (i.e., validity,		**No**
a data analysis strategy	**Yes**	No
a data dissemination and use strategy		**No**

3. Is there a budget for implementation of the M&E plan? YES

Yes	In progress	No

3.1 ***IF YES***, what percentage of the total HIV programme funding is budgeted for M&E

activities? approx <1% in the 2011 budget

3.2 ***IF YES,*** has *full* funding been secured?

	No

4. Are M&E priorities determined through a national M&E system assessment?

	No

IF NO, briefly describe how priorities for M&E are determined: Through the M&E Technical Working Group

5. Is there a functional national M&E Unit?

Yes	**In progress**	**No**

5.1 ***IF YES***, is the national M&E Unit based

in the National AIDS Commission (or	**Yes**	
in the Ministry of Health?	Yes	
Elsewhere?		**No**

5.2 ***IF YES***, how many and what type of professional staff are working in the national
M&E Unit?

Number of permanent staff:		
Position:	Full time / Part time?	Since when?:
M&E Director	Full time	2010
Senior M&E Officer	Full time	2009
M&E Officer	Full time	2010

5.3 ***IF YES***, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes	**No**

IF YES, briefly describe the data-sharing mechanisms: Data from facilities is compiled by M&E officers and programme officers at State level and sent to the Ministry of Health Head Quarters for aggregation into a national report, which is then forwarded to SSAC.
What are the major challenges? Data quality and completeness of data reported and timeliness issues

6. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No regularly	**Yes, but meets irregularly**	**Yes, meets**

6.1 Does it include representation from civil society? **YES**

Yes	**No**

IF YES, briefly describe who the representatives from civil society are and what their role is: CSOs, MOH, FBOs, UN Agencies & Development partners

7. Is there a central national database with HIV- related data? YES

Yes	**No**

7.1 ***IF YES***, briefly describe the national database and who manages it

The Ministry of Health is in the process of developing a database that will serve as re a central repository of National data managed by the Research, Planning & Monitoring and Evaluation at NACA

7.2 ***IF YES***, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

a. **Yes**, **all of the above**
b. Yes, but only some of the above:
c. No, none of the above

7.3 Is there a functional* Health Information System?

At national level	Yes	**No**
At sub-national level ***IF YES***, at what level(s)? ***Data is entered into e***-BHRIMS (cris) at district level*[write in]*	**Yes**	No

*(*regularly reporting data from health facilities which are aggregated at State and sent to national level;and data are analysed and used at different levels)*

8. Does the country publish at least once a year an M&E report on HIV and on, including HIV surveillance data?

	No

9. To what extent are M&E data used

9.1 in developing / revising the national AIDS strategy?:

Low High

0 1 2 **3** 4 5

Provide a specific example:
Development of the SSHASF

What are the main challenges, if any?
Training of staff, timeliness of reporting, quality assurance & data audits

9.2 for resource allocation?:

Low High

0 1 2 **3** 4 5

Provide a specific example:
Resource allocation in the National AIDS Spending Assessment

What are the main challenges, if any?
Competing priorities such treatment versus prevention

9.3 for programme improvement?:

Low High

0 1 2 **3** 4 5

Provide a specific example:
National AIDS Response Strategy Development

What are the main challenges, if any?
Data use at the facility level and service delivery level is low

10. Is there a plan for increasing human capacity in M&E at national, sub-national and service-delivery levels?:

a. **Yes**, at all levels

b. Yes, but only addressing some levels:

c. No

10.1 In the last year, was training in M&E conducted

At national level?	**Yes**	No
IF YES, Number trained: 1the head of the M&E unit		
At sub-national level?	**Yes**	No
IF YES, Number trained: more than 10 M&E staff		
At service delivery level including civil society?	**Yes**	No
IF YES, Number trained:		

10.2 Were other M&E capacity-building activities conducted other than training?

Yes	**No**

IF YES, describe what types of activities:

Overall, how would you rate the *M&E efforts* of the HIV programme in 2011?											
2009	Very poor										Excellent
	0	1	2	3	4	5	6	**7**	8	9	10

Since 2011 what have been key achievements in this area:

- Successfully conducted the 2008 BAIS
- Development and implementation of an M&E training curriculum
- Development of a national Evaluation Agenda

What are remaining challenges in this area:

- Inadequate Human Resources
- Weak linkages between the M&E system and data generation points
- Limited integration of M&E into planning
- Capacity challenges and resource challenges
- Slow implementation of the national evaluation agenda

Part B

[Administered to representatives from civil society organizations and development partners]

I HUMAN RIGHTS

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)

Yes	No

2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?

Yes	No

2.1 ***IF YES***, for which populations?

a. Women	**Yes**	
b. Young people	**Yes**	
c. Injecting drug users	**Not applicable**	
d. Men who have sex with men	**Not applicable**	
e. Sex Workers	**Not applicable**	
f. Prison inmates		**No**
g. Migrants/mobile populations		**No**

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented: Use of the court system by aggrieved persons law enforcement agencies.

Briefly describe the content of these laws:

- Article in the interim constitution regulates any form of domestic violence in relationships in families; among people living together; relatives living with couples/ families, etc.
- Children's Act looks at children's right in relation to the UN Convention on the Rights of the Child

Briefly comment on the degree to which they are currently implemented:

.

Children's Act was passed in 2010

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?

	No

3.1 ***IF YES***, for which subpopulations?

a. Women		No
b. Young people		No

No

c. Injecting drug users		No
d. Men who have sex with men		No
e. Sex Workers		No
f. Prison inmates		No
g. Migrants/mobile populations		No

If YES, briefly describe the content of these laws, regulation or policies:

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes	**No**

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

There is mention of respect of human rights in the South Sudan Legislative Assembly and even in the SSHASF.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulations?

IF YES, briefly describe this mechanism:

6. Has the Government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?

Yes	

IF YES, describe some examples:

There is the network of people living with HIV being supported by the SSAC

7. Does the country have a policy of free services for the following:

a. HIV prevention services	**Yes**	
b. Antiretroviral treatment	**Yes**	
c. HIV-related care and support interventions	**Yes**	

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

Government, with the assistance of multi laterals and bilateral, is scaling up provision of ART services to those who need them. In this regards, Government and its development partners have submitted an application for the Global Fund grants for round 11 to finance some of the scale up plans.

8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes

8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

Yes

9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?

	No

9.1 ***IF YES***, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?

	No

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

No

11. Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

	No

11.1 ***IF YES***, does the ethical review committee include representatives of civil society including people living with HIV?

Yes	**No**

12. Does the country have the following human rights monitoring and enforcement mechanisms?

– Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombud- s persons which consider HIV-related issues within their

work

	No

– Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

	No

– Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

s	**No**

13. In the last 2 years, have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?

	No

14. Are the following legal support services available in the country

– Legal aid systems for HIV casework

	No

– Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

	No

– Programmes to educate, raise awareness among people living with HIV concerning their rights

Yes	

15. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes	

IF YES, what types of programmes?

Media	**Yes**	
School education	**Yes**	
Personalities regularly speaking out	**Yes**	

Overall, how would you rate the *policies, laws and regulations* in place to promote and protect human rights in relation to HIV in 2011										
2011 Very poor										Excellent
0	1	2	3	4	5	6	7	8	9	10
Since 2010, what have been key achievements in this area: *What are remaining challenges in this area:*										

Overall, how would you rate the *effort to enforce* the existing policies, laws and regulations in 2009?										
2009 Very poor										Excellent
0	1	2	**3**	4	5	6	7	8	9	10
Since 2007, what have been key achievements in this area: People employed in the Public Sector will not be discriminated against in general. *What are remaining challenges in this area:* The same as in 2007.										

II CIVIL SOCIETY* PARTICIPATION

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

Low				High	
0	1	2	3	**4**	5

Comments and examples:
The prevention, Treatment and Advocacy interventions , which is aligned to the goal of reduction of new infections has enlisted the support and participation of members of the Parliament at its formative stages.

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?

Low				High	
0	1	2	3	**4**	5

Comments and examples:
Civil Society participation in the technical review processes of the National Strategic Plan. They also participate in the M&E Technical Working Group and Stakeholders' fora.

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included in

a. the national AIDS strategy?

Low				High	
0	1	2	3	**4**	**4**

b. the national AIDS budget?

Low				High	
0	1	**2**	3	4	**3**

c. national AIDS reports?

Low				High	
0	1	2	**3**	4	**4**

* Civil society includes among others: networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; community-based organizations; organizations of key affected groups (including men who have sex with men, injecting drug users, sex workers, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

4. To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. developing the national M&E plan?

Low High **5**

0 1 2 3 **4** **5**

b. participating in the national M&E committee / working group responsible for coordination of M&E activities?

Low High **5**

0 1 2 3 **4** 5

c. M&E efforts at local level?

Low High **2**

0 1 **2** 3 4 5

Comments and examples:
M&E is still largely undeveloped at community level with little or no systems.

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?

Low High **4**

1 2 **3** 4 5

Comments and examples:
Networks of people living with HIV are included together with faith based communities.No sex workers are included.

6. To what extent is civil society able to access:

a. adequate financial support to implement its HIV activities?

Low High

5 **1** 2 3 4

b. adequate technical support to implement its HIV activities?

Low High

0 1 **2** 3 4 **5**

1

Comments and examples:
The Civil Society is highly constrained both technically and financially to be able to implement its programmes effectively.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for youth	**<25%**	**25-50%**	51–75%	>75%
Prevention for most-at-risk-populations				
- Injecting drug users	**<25%**	25-50%	51-75%	>75%
- Men who have sex with men	**<25%**	25-50%	51-75%	>75%
- Sex workers	**<25%**	25-50%	51-75%	>75%
Testing and Counselling	<25%	25-50%	**51–75%**	>75%
Reduction of Stigma and Discrimination	<25%	**25-50%**	51–75%	>75%
Clinical services (ART/OI)*	**<25%**	25-50%	51–75%	>75%
Home-based care	<25%	25-50%	**51–75%**	>75%
Programmes for OVC**	<25%	25-50%	**51–75%**	>75%

**ART = Antiretroviral Therapy; OI = Opportunistic infections*

***OVC = Orphans and other vulnerable children*

Overall, how would you rate the efforts to increase *civil society participation* in 2009?										
2009 Very poor Excellent										
0	1	2	3	4	**5**	6	7	8	9	10

Since 2010, what have been key achievements in this area:

Participation in strategic development and M&E Technical Working Group and Stakeholders' fora and CCM meetings

What are remaining challenges in this area:

Government and SSAC need to provide meaningful and deliberate support to ensure that Civil Society programmes are actually initiated and implemented.

III PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

Yes	No

IF YES, how were these specific needs determined?

Areas such as, PMTCT, Prevention with Positives (PLHIV)

1.1: To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access		
Blood safety	**Agree**		
Universal precautions in health care settings	**Agree**		
Prevention of mother-to-child transmission of HIV	**Agree**		
IEC* on risk reduction		**Don't Agree**	
IEC* on stigma and discrimination		**Don't Agree**	
Condom promotion		**Don't Agree**	
HIV testing and counselling		**Don't Agree**	
Harm reduction for injecting drug users			**N/A**
Risk reduction for men who have sex with			**N/A**
Risk reduction for sex workers		**Don't Agree**	
Reproductive health services including sexually transmitted infections prevention and treatment		**Don't Agree**	
School-based HIV education for young	**Agree**		
HIV Prevention for out-of-school young		**Don't Agree**	

* IEC = information, education, communication

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2011											
2009	Very poor										Excellent
	0	1	2	3	4	***5***	6	7	8	9	10
Since 2007, what have been key achievements in this area: What are remaining challenges in this area:											

IV TREATMENT, CARE AND SUPPORT

1. Has the country identified the specific needs for HIV treatment, care and support services?

Yes	

IF YES, how were these specific needs determined?

Home based care and the policy decisions to scale up the roll out of the ART programme was as a result of consultations with multi sectoral partners and the determined leadership at the national level.

1.1 To what extent have HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access		
Antiretroviral therapy		**Don't Agree**	
Nutritional care		**Don't Agree**	
Paediatric AIDS treatment	**Agree**		
Sexually transmitted infection		**Don't Agree**	
Psychosocial support for people living with HIVand their families		**Don't Agree**	
Home-based care		**Don't Agree**	
Palliative care and treatment of common HIV-related infections		**Don't Agree**	
HIV testing and counselling for TB		**Don't Agree**	
TB screening for HIV-infected people		**Don't Agree**	
TB preventive therapy for HIV-infected		**Don't Agree**	
TB infection control in HIV treatment and care facilities	**Agree**		
Cotrimoxazole prophylaxis in HIV-infected people	**Agree**		
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	**Agree**		
HIV treatment services in the workplace or treatment referral systems through the		**Don't Agree**	
HIV care and support in the workplace (including alternative working		**Don't Agree**	
Other programmes: - Peer counselling and peer education in the workplace	**Agree**	**Don't Agree**	

Overall, how would you rate the efforts in the *implementation* of HIV treatment, care and support programmes in 2011?											
2011	Very poor										Excellent
	0	1	2	3	4	***5***	6	7	**8**	9	10
Since 2010, what have been key achievements in this area: ☐ Provision of ART to increased numbers of PLHIV *What are remaining challenges in this area:* Constant stock outs in most ART sites leading to frustration among PLHIV Lack of CD4 Count machines in most of the ART sites											

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes

2.1 ***IF YES***, is there an operational definition for orphans and vulnerable children in the country?

Yes

2.2 ***IF YES***, does the country have a national action plan specifically for orphans and vulnerable children?

	No

2.3 ***IF YES***, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

	No

IF YES, what percentage of orphans and vulnerable children is being reached? %

Overall, how would you rate the efforts to *meet the HIV-related needs* of orphans and other vulnerable children in 2009?											
2010	Very poor										Excellent
	0	1	2	***3***	4	5	6	7	8	**9**	10
Since 2011, what have been key achievements in this area: *What are remaining challenges in this area:* No access to the food basket and school needs for the majority of orphans											